Ghosts That We Knew:

Spiritual Care for Clinicians With Moral Injury

Kathleen Turner

University of California San Francisco Medical Center

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Abstract

For when a diseased condition is stubborn and the evil grows, in the perplexity of the moment most things go wrong. (Hippocrates, "Precepts", trans. 1868, p. 238)

In the course of routine practice, clinicians may harm those in their care or witness a trusted colleague cross a line. Others meet violence from patients, visitors, and co-workers or are depersonalized by the healthcare system. Personal and relational integrity are fundamentally compromised. This is moral injury, familiar from soldiers' narratives but largely unrecognized in healthcare. Clinicians vow to end suffering, refrain from harm, and hold all in equal regard; the Buddhist chaplain has made similar commitments. By recognizing and responding to moral injury, the chaplain embodies her vow and helps clinicians to live out theirs.

This paper proposes a collaborative spiritual care model for working with moral injury. The chaplain meets her clinician peers sometimes as tenzo, sometimes as server, and always with humility. Assessment, support, counselling, education, and ritual resources for meeting moral injury follow. "The ghosts that we knew will flicker from view, and we'll live a long life" (Mumford & Sons, 2012). These ghosts of harmed patients and wounded colleagues are invited in and given refuge. The chaplain views moral injury through a systems lens of dependent co-arising. Adapting a physical illness prevention model, she responds to discrete events, contributing processes, and underlying mindsets. Future work should validate assessment measures for clinician moral injury so that its contours may mapped and effective approaches confirmed.

Introduction

"I can't tell you the nights of sleep I've lost over things I've done ... "

"I guess I should feel lucky to have gotten this far in my training without something like this happening. Do you think I killed that man?"

"The collective guilt of the unit ... months and months with no way out, for anybody. I want to hurt that surgeon."

"She was screaming 'Stop' and I didn't. How did I become the kind of person who does that?"

These are real burdens of real people, my fellow clinicians, offered up for your consideration. Litz and colleagues (2009) asked: "What happens to service members who are unable to contextualize or justify their actions or the actions of others and are unable to successfully accommodate various morally challenging experiences into their knowledge about themselves and the world?" (p. 696). I ask the same thing regarding my colleagues—human beings whom you, the reader, entrust with your life.

Several years ago, while preparing a talk on the grief experienced by clinicians and families, I tapped into a lode of work on adverse psychological and behavioral health outcomes in critical care. It seemed that my patients, their families, and my co-workers fared little better than troops returning from active duty. I first heard the Mumford & Sons song "Ghosts That We Knew" (see Appendix A) around that time. It recollected the way we clinicians are often haunted by our patients and by our actions towards them. "The ghosts that we knew leave us black and all blue, but we'll live a long life" (Mumford & Sons, 2012). Who are "the ghosts" and who are "we"? The scalpel cuts both ways. Our wounds of the spirit—moral injuries—may benefit from the Buddhist chaplain's care. Let's find out.

This paper contains examples of morally problematic events. Where I have drawn them from published literature, I have credited the sources. Where there is no source listed, the incidents and statements were shared with me by colleagues or are drawn from my own practice. In order to protect the identities of the clinicians and patients, I do not name those sources. I have also changed details about the patients and often about the clinicians, including their discipline. Quotes and descriptions of thoughts and feelings, such as the set that began this introduction, are paraphrased in order to further anonymize the speakers. I invite the reader to be mindful that the people involved are fellow human beings, to look on their tales with compassion, and to check in periodically with yourself to notice what sensation, thoughts, and feelings are arising.

Background

Captain Tyler Boudreau offered this description of moral injury: "Moral injury is about the damage done to our moral fiber when transgressions occur by our hands, through our orders, or with our connivance" (as cited in Dombo, Gray & Early, 2013, p. 198). There is an event or series of events in which one is an actor, witness, or recipient; the act itself may be one of commission or omission. There may be acknowledged harmful intent or not. While accessible signs of injury are psychological and behavioral—depression, suicide, addiction, burnout—the wound itself is spiritual. The clinician lives her core values through vows and codes of ethics. Fidelity to that life is part of the alchemical transformation of suffering. Aspiration, practice, realization, and nirvana may go by different names in the clinical world, but the Way is the Way. The Buddhist chaplain heeds the call. "We must turn toward those who serve ... make ourselves

available to their fear, exhaustion, grief, and moral anguish, and accompany them on their terms" (Moon, 2019, p. 94).

Epidemic of Harm: The First Arrow

Harm events produce a pain, "just as if they were to shoot a man with an arrow" ("Sallatha Sutta: The Arrow," trans. 1997). Such situations are common in healthcare. Every year, adverse events will contribute to the deaths of nearly a quarter-million people (James, 2013, p. 125). Preventable serious-but-not-lethal incidents harm 2-4 million patients annually. Each of these situations impacts many clinicians, whether as involved parties, witnesses, or members of a system—what Captain Boudreau described as connivers.

While adverse events may be inevitable in clinical practice, individual clinicians feel personal responsibility for their occurrence and experience them as harming the patients for whom they have a duty of care. In a longitudinal study conducted at Mayo Clinic, 34% of medical residents self-reported making a serious error (West et al., 2006). Making an error tripled a resident's likelihood of depression and was associated with increased burnout across all three domains (emotional exhaustion, depersonalization, lost sense of personal achievement). Decreased empathy and perceived quality of life followed mistakes. Residents screening positive for these sequelae were more likely to make subsequent major errors. The link between errors and physician distress extends beyond training. Ten percent of physicians surveyed through the American Medical Association reported making a major error in the past three months (Tawfik et al., 2018, pp. 1573-1574). Burnout, depression, and suicidal ideation were more prevalent among these physicians than among their colleagues.

Potentially morally injurious events include the errors in judgment, equipment failures, and slips of the scalpel captured in traditional formulations of adversity. Moral injury also arises when clinicians act in ways they know are wrong. "Physician assisted birth-giving to premature twins who should have been dead but were not. I had to put a towel over them until they stopped floundering" (Larrson et al., 2018, p. 181). Chronic sources of moral adversity are often system-based. Thirty-day postoperative mortality is a key quality indicator, incentivizing surgeons and hospitals to continue aggressive care even when they believe it is not in an individual patient's best interest. Not only does the surgeon who makes this choice carry the burden of causing physical harm with little or no expected benefit, she also transgresses the value of truthfulness and leads others on the team into doing so. Talbot and Dean (2018) described a related form of systemic moral injury:

> Continually being caught between the Hippocratic oath, a decade of training, and the realities of making a profit from people at their sickest and most vulnerable is an untenable and unreasonable demand. Routinely experiencing the suffering, anguish, and loss of being unable to deliver the care that patients need is deeply painful. These routine, incessant betrayals of patient care and trust are examples of “death by a thousand cuts.” Any one of them, delivered alone, might heal. But repeated on a daily basis, they coalesce into the moral injury of health care. (para. 10).

Exposure to workplace violence is another source of chronic moral injury in healthcare. May and Grubbs (2002) found that 74% of nurses had been physically assaulted by a patient or visitor in the preceding year, 70% had witnessed verbal or physical assault on another nurse,

90% felt unsafe at work, and 61.9% believed their employer failed to protect them from violence.

Models of Individual Moral Injury: Second Arrow, Second Victim

Clinicians may view their action or inaction as diagnostic evidence that something is wrong with them as human beings, becoming overwhelmed with guilt and shame. Reflecting on what it is like to have a patient develop a surgical site infection, orthopedic surgeons described it as "a bit soul-destroying;" "horrible because you've harmed someone;" "you remember them by name, x-ray appearance, and quite often organism as well ... it's devastating" (Mallon, Gooberman-Hill, Blom, Whitehouse, & Moore, 2018, p. 5). These feelings condition future interactions with patients, colleagues, and perhaps clinicians' own families. Moral injury has followed adversity. The clinician "feels the pain of two arrows ... grieves, laments ... becomes distraught" ("Sallatha Sutta: The Arrow," trans. 1997). Speaking of the first and second arrows, Buddha described the relationship between circumstances and the suffering caused by one's reactivity to them. A doctor or nurse might understand sepsis as an analogous model. The infection is the first arrow, unpleasant but with limited ability to do serious damage. It is the sufferer's physiologic response to the infection that begins shutting down vital organs. The second arrow is shot by the self.

"Moral injury ... violates assumptions and beliefs about right and wrong and personal goodness"(Litz et al., 2009, p. 698). A nurse is verbally abused by his patient and he hits her across the face. Another patient is having a urinary catheter placed and has her legs held open by multiple staff members; she screams "Stop! Stop!" and the group proceeds while other staff chat out in the hallway. For these clinicians—perpetrators, witnesses, and connivers alike—a

chasm has opened between the virtuous people they believe themselves to be in their street clothes and what they see themselves capable of in scrubs. Shame and guilt arise. The individual consciously or unconsciously attempts to mitigate this distress through avoidance. As one surgeon put it, there is a temptation to "bury your head in the sand because you don't want to accept that there's a problem with something you've done" (Mallon et al., 2018, p. 7). By not engaging with the incident, sensemaking and reconciliation cannot occur.

A resident working overnight is left to manage three crashing patients, admit five others, and perform numerous procedures in addition to her routine work. She receives no assistance from her seniors and is shamed during rounds for the poor outcome of one of the patients. Almost every day she feels set up to harm and fail. Her moral injury arises from leadership malpractice, "a betrayal of what's right by someone who holds legitimate authority in a high-stakes situation" (Shay, 2014, p. 183; see also Gibbons, Shafer, Hickling, & Ramsey, 2013). Duties of care and loyalty obligate authority figures on the clinical team to give weight to the interests of others. The more powerful individual should "subordinate their own interests to those of the person or persons in their care should they conflict" (Shay, 2014, p. 186). Clinicians routinely subordinate even their own needs for food and rest to patient care. That level of sacrifice is only maintained by a strong social contract within the team.

Moral injury can arise with or without the agent's conscious intent to cause harm. The staff placing the urinary catheter in the patient who believed she was being assaulted felt guilt and shame for her trauma. Their colleagues outside in the hall felt ashamed for their bystander behavior. No one talked about it. The individual does not knowingly select a harmful action but the result for the patient is the same as if they did. The outcome obscures the intention. The

clinician experiences "subjective guilt that doesn't accurately track culpability, and the crippling shame that guilt often covers up" (Sherman, 2014, p. 217). An honest mistake may provoke strong guilt. A resident checks a box above the one he meant to check and in doing so massively overdoses a patient. There was an error, but no intentionality. A nurse administers a previously tolerated dose of pain medication, but this time the patient stops breathing. Her intention and its expression were beneficent, but the outcome of that action was potentially fatal.

Guilt and shame differ in ways of particular relevance to the Buddhist chaplain. If the clinician believes that only her behavior was bad, guilt arises and from it comes a prosocial drive toward reparation (Litz et al., 2009; Dombo et al., 2013). If the clinician instead assigns wrongness to himself, shame prompts isolation, loss of empathy, and a belief that remedy is impossible. This type of isolating, destructive shame contrasts with what Pema Chödrön (2003) described as *positive shame*, characterized by: "recognizing when we've harmed ... regret[ting] causing harm ... acknowledging what we did cleanly and compassionately" (p. 120). Positive shame contains repentance.

Second victim is a term used in the literature and by some healthcare organizations to describe providers involved in adverse events (Wu et al., 2017). The patient and family are held to be the first victims. Second victim is intended to highlight the emotional consequences to the provider. The term is controversial with both clinicians and patients, as it connotes blamelessness and helplessness. "We ... create hierarchies of virtuous suffering. Suffering chosen to redeem others who are more vulnerable than ourselves is usually ranked highest, and the suffering of an oppressor ranks lowest" (Graham, 2017, p. 23).

The Karpman Drama Triangle describes Victim, Rescuer, and Persecutor roles toward which individuals gravitate, particularly when under stress (Choy, 1990, see Figure 1). Healthcare providers choose the highly valued form of Rescuer suffering, sacrificing physical and emotional well-being and family life in their training and often throughout their career. The clinician who has harmed a patient is abruptly cast into the Persecutor role, in their own eyes and those of their organization.

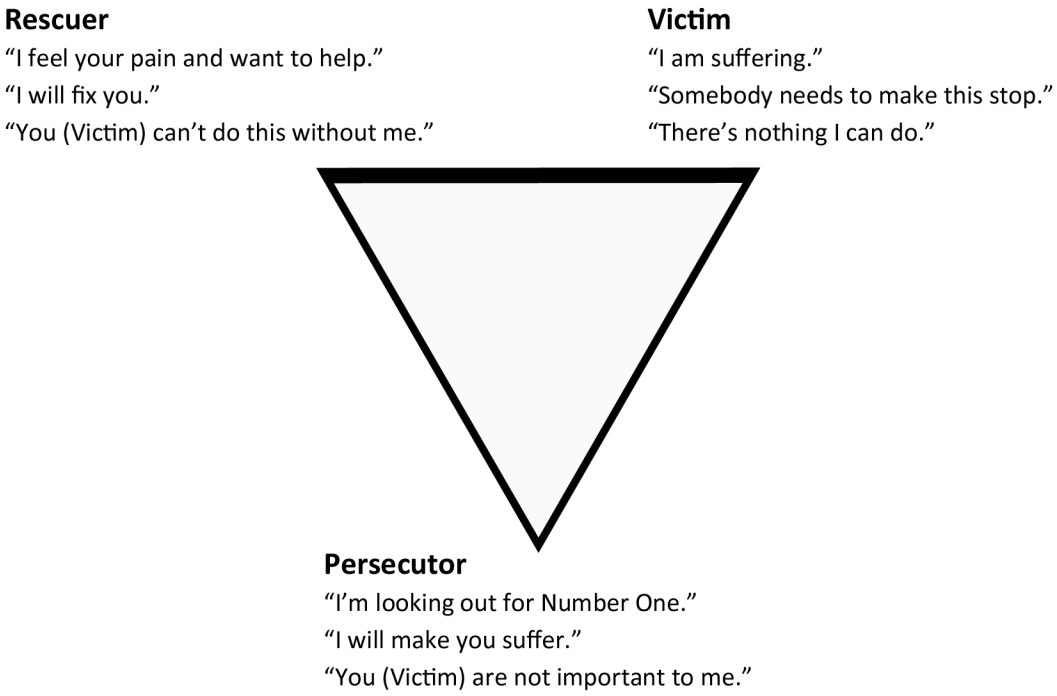

Figure 1: Karpman Drama Triangle describing mindsets of individuals in conflict. Adapted from "The Winner's Triangle" by A. Choy, 1990, *Transactional Analysis Journal, 20*(1), p. 41. Copyright 1990 by the International Transactional Analysis Association.

Second victimhood offers a way out of the Persecutor position and into the better-regarded Victim role. If the clinician subscribes to the implied lack of agency, moral apathy or decline may be an end-effect. Physician-anthropologist Arthur Kleinman noted "I

hadn't reckoned with people's capacity to routinize and objectify others' suffering and fears in the quest to render their tasks manageable" (2013, p. 1376).

The Buddhist chaplain finds an alternative to the second victim model in *The Way of the Bodhisattva*: "Do not be downcast but marshal all your strength; / Take heart and be the master of yourself!" (Shantideva, verse 7.16, p. 84). The clinician is responsible for her own feelings and is empowered to transform them. She is not a victim. Shantideva did not promise that this approach would make things go smoothly or that relationships harmed would be repaired. Even so, one is to proceed with all one's strength, even if that amount is smaller than one would like.

Systemic Moral Injury: A Third Arrow

Graham (2017) described a systemic type of moral injury: "the burden of harm and the diminishment of vitality that arises in individuals and communities when we (or others) violate our moral compasses" (p. 13). Harm and diminishment are occurring in healthcare organizations. Institutional culture and processes may offer retribution, shunning, or shaming rather than providing consequences that result in reparation. A physician describes her actions in a morbidity and mortality conference. A nurse writes himself up in an incident report read by his manager. Beliefs about wrongness are affirmed; clinicians leave their organization or their profession. A third arrow arcs, driving home the first two and deepening the wound of moral injury.

Leadership malpractice begets community moral injury through fragmenting trust and belonging. A surgeon commits the nursing staff to a year of caring for a patient whose body is coming apart. Her personal moral code forbids discontinuing life-sustaining interventions. Nurses come to see themselves as complicit in what they describe as "an atrocity." They

describe feeling used to meet the surgeon's need to preserve her own integrity. They feel betrayed by hospital leadership who see but do not intervene. Described in a military context:

> If I begin to feel dissonance about the war in general, and then dissonance with specific leaders who waged that war, at which point in the chain of command does this dissonance separate me from those human beings whom I love and respect? (Yandell, 2019, p. 12)

Related Phenomena: Moral Distress, Post-Traumatic Stress

Moral injury stems from past wrongs. The powerlessness, frustration, and anger of moral distress arise from a present-moment threat to integrity (Epstein & Hamric, 2009; Rushton, 2018). "We went into nursing because we want to make things better and here we are causing people pain and distress ... it's such a torturous experience and I'm like, that's me ... I'm the torturer" (Forozeiya et al., 2019, p. 26). Moral distress may be viewed by clinicians as a necessary aspect of caring for high-acuity patients under conditions of medical uncertainty and diverse value systems. A neonatal ICU physician wrote, "I think if one does not experience moral distress occasionally in our environment they should not be working with our patients" (Prentice, Gillam, Davis, & Janvier, 2018a, p. F443). The physician implies that such a colleague would lack moral sensitivity, a prerequisite for ethical care.

Situations involving profound threat to self can produce post-traumatic stress disorder (PTSD) in addition to placing clinicians at risk for moral injury. A study examining psychological symptoms of nurses across the care continuum found 18% of nurses met diagnostic criteria for PTSD (Mealer, Burnham, Goode, Rothbaum, & Moss, 2009, p.1121). Prevalence ranged from 5% in the outpatient setting to 23% in the intensive care unit. Delivering futile care was a primary

risk factor. While moral injury and PTSD share many characteristics (see Table 1), key differences impact types of spiritual care interventions which may be required.

Table 1

Defining features of Moral Injury versus Post-Traumatic Stress Disorder

Feature	Moral Injury	PTSD
Triggering event	Acts that violate deeply held moral values	Actual or threatened death or serious injury
Individual's role	Perpetrator, victim, or witness	Victim or witness
Predominant painful emotion	Guilt, shame, anger	Fear, horror, helplessness
Reexperiencing?	Yes	Yes
Avoidance or numbing?	Yes	Yes
Heightened SNS arousal?	Depends on role	Yes
What necessity is lost?	Trust	Safety

Note: PTSD = post-traumatic stress disorder; SNS = sympathetic nervous system.

Recovery from PTSD requires extinguishing fear responses to past incidents involving actual or perceived life-threat. Healing from moral injury in which one was a perpetrator or witness entails reclaiming agency from guilt or shame. Moral violation resulting from leadership betrayal generates a sympathetic nervous system arousal and perceived threat to personal safety similar to that seen in PTSD (Shay, 2014). The chaplain working with such a clinician will be addressing upregulating emotions of fear and anger alongside avoidance or shutdown precipitated by shame. Re-experiencing is a shared characteristic and is directly addressed by adaptive disclosure interventions discussed elsewhere in this paper.

Sequelae: Horizontal and Vertical Violence, Depression and Suicidality, Burnout, Addiction

While it is beyond the scope of this paper to present a comprehensive review of the literature in these areas, examples suggesting their scope and connection to moral injury follow.

A recent systematic review by Williamson, Stevelink and Greenberg (2018) explored links between occupational exposure to potentially morally injurious experiences (PMIEs) and psychological morbidity. PMIEs were associated with PTSD in military and nonmilitary settings. Anxiety, depression, suicidality, and hostility increased with exposure; resilience and perceived social support decreased.

Hostility precipitated by moral injury may find its outlet in horizontal and vertical violence. Chronic or systemic sources of moral stress prompted reactions such as complaining, irritability, impatience, and speaking harshly of others (Larsson et al., 2018, p. 180). Conflict prevalence offers a lens through which to look for these behaviors in clinical practice. The Conflicus study (Azoulay et al., 2009) asked interdisciplinary team members from 323 intensive care units in 24 different countries about conflicts which may have occurred in the past week. Seventy-two percent of respondents had been involved in a conflict with a colleague, patient, or family member. Personal animosity was the prevailing source of conflict, experienced by half of respondents in the preceding week. Clinicians believed these preventable conflicts adversely impacted patient care. Hostility begets adversarial relationships which in turn predispose future PMIEs in a recursive cycle.

"The moral-emotional core of [injurious] experiences deserves greater primacy—as does the social suffering that affects everyone, but especially marginalized people already injured by

poverty, isolation, and other forms of structural violence" (Kleinman, 2013, p. 1377). Many care team members occupy positions which make them invisible, a type of structural violence.

> *A patient wrestles with unseen attackers. Her agitation prompts the use of a sitter, an aide whose task is literally to sit and watch. His clinical purpose is prompt notification of nursing staff should the woman deliberately or accidentally harm herself. She looks directly at this man staring at her and screams. His job, one of the lowest-paid and least-respected in the hospital, requires him to remain at her bedside. What is he to make of believing hour after hour that his very presence is toxic? Family members at home and abroad depend on his paycheck, but taking money for this night's work feels dirty.*

An aide is cornered and groped in the supply room by a co-worker. A pair of nurses badmouth a new resident sitting nearby. Within-rank violence causes moral injury in the recipient as a breach of trust, and in the perpetrator if she recognizes the wrong.

Three-quarters of physicians, surgeons, and nurses have provided futile or potentially inappropriate care in the past 6 months, most often at the insistence of their patient's family (Chamberlin et al., 2019). These clinicians acknowledged responding with compensatory behaviors toward the patient, such as obtaining extra pain medicine or a nicer room. More frequently, they avoided that patient, their family, and other colleagues on that patient's care team. Avoidance escalated in a dose-dependent fashion with the amount of futile or potentially inappropriate care witnessed or provided.

Clinicians have greater prevalence of suicidal ideation than the general population (Kuhn & Flanagan, 2017; Shanafelt et al., 2011). This begins during medical school and increases

through residency. The highest rate of completed suicide for both medical doctors and surgeons is during middle age. Believing oneself to have recently made a major error tripled the prevalence of suicidal ideation among surgeons (Shanafelt et al., 2011, p. 57). In the same study, prevalence of suicidal thoughts strongly correlated with burnout severity.

Burnout syndrome is characterized by vital exhaustion, depersonalization of others, and a decreased sense of personal accomplishment. In nurses, increased burnout severity was noted in the dissonance between greater self-reported predisposition for empathy and decreased activation of empathy neural pathways. Burnout was also linked with alexithymia (Tei et al., 2014). Mealer and colleagues' (2009) study of psychological morbidity among nurses found 86% of respondents were experiencing moderate burnout. Nurses detached in order to continue on, as did soldiers with moral injury: "If I didn't have that numb feeling and I had full emotions, then I wouldn't have been able to do ... some of the things that I've done" (Currier, McCormick, & Drescher, 2015, p. 113). Medication errors are more likely when burnout is present (Kuhn & Flanagan, 2017, p. 159), placing the clinician at risk for additional moral injury. Avoiding patients and peers involved in futile or potentially inappropriate care was associated with burnout, present in 43% of respondents in the study by Chamberlin et al. (2019).

Provider substance abuse is a recognized problem in the healthcare system. Alcohol abuse or dependence is particularly common, self-reported by 21.4% of female physicians and 12.9% of male physicians (Oreskovich et al., 2015, p. 32). Physicians abusing alcohol were more likely to also report depression, suicidal ideation, burnout, and a major medical error within the past three months. Between 6-20% of nurses have substance abuse disorders, with both prevalence and most commonly abused substances varying by nursing specialty (Ross, Berry,

Smye, & Goldner, 2018). Ross et al. (2018) suggested that nurses may be self-medicating to address the pain of structural violence.

Clinicians and Chaplains: Lives of Vow as Common Ground

Professional Vows and Codes

The soldier holds simultaneous loyalty to two ethical codes—professional and civilian; the healthcare provider does likewise. Acts which are permissible, even commendable, by the professional code may gravely offend civilian morality. A clinician or chaplain may locate their conscience, their innate drive toward integrity, solely within themselves. Alternately, the heart/mind of this voice may transcend the individual and draw from the wisdom mind of esteemed teachings or religious figures. Precepts and vows are movements of wisdom in life.

On entry into clinical practice, healthcare providers make a vow. For physicians, this is the Hippocratic Oath (see Appendix B). The initiate commits to "keep pure and holy both my life and my art ... help the sick, and ... abstain from all intentional wrong-doing and harm" (Hippocrates, trans. 1868, pp. 299-301). The Oath also contains prohibitions against providing harmful drugs, misusing others' bodies for personal gratification, and betraying confidences. Nurses swear the Nightingale Pledge, authored by Lystra Gretter in 1873 and modeled on the Hippocratic Oath (see Appendix C). Like his physician colleagues, the nurse invokes witnesses to his commitment to refrain from harm, provide benefit, respect the personhood of all, and maintain personal and professional purity (Gretter, as cited in Fowler, 2015, p. 12). The Pledge expands the proscription against harmful drugs to include taking them oneself. It also enjoins the nurse to aid the physician.

The Hippocratic Oath, its supplementary Precepts, the Nightingale Pledge, and the *Code of Ethics for Nurses* seek to elicit the same way of living Dogen (1243/2001) described as "The Bodhisattva's Four Methods of Guidance" in his *Shushogi*. The first method is Giving—in the sense of not being greedy or covetous, of not fostering a mind of poverty. Both physicians and nurses promise to fulfil their vows holding nothing back. The second method is Kind Speech. The physician should "never quarrel or jeer," instead practicing "help and quietness" (Hippocrates, n.d., "Precepts"). The nurse's *Code of Ethics* requires respect for decisions with which she does not agree and advocacy for vulnerable individuals and populations (American Nurses Association, 2015). The third method is Beneficial Deeds. The clinician is to give freely of her knowledge and skills without thought of reward. "If there be an opportunity of serving one who is a stranger in financial straits, give full assistance to all such" (Hippocrates, n.d., "Precepts"). The nurse pledges to give of himself. The fourth method is Cooperation. Dogen (1243) wrote: "The ocean does not reject any water; this is cooperation. It is because of this that water collects and becomes an ocean." The nurse swears to "aid the physician in his work and devote myself to the welfare of those committed to my care" (Gretter, as cited in Fowler, 2015, p. 12). For the nurse, there is only the ocean of work; physician and patient alike are not separate from the nurse as agents and beneficiaries. All are water. Hippocrates (n.d., "Precepts") noted the unity of patient and provider wellbeing. Clinicians must strive "to superintend the sick to make them well, to care for the healthy to keep them well, but also to care for one's own self." Nurses likewise owe "the same duties to self as to others" (American Nurses Association, 2015, p. 19). Clinician and patient are one, into which medicine or poison may enter. The duty to wholeness includes all.

Military critical care nurses described the spiritual underpinning of their work as essential; it provided a "refuge," a "source of strength outside yourself that feeds you," "a way to reconnect people to themselves, to really develop that ... that spiritual resistance" (Simmons, Rivers, Gordon, & Yoder, 2018, p. 65). Nurses in this study who experienced loss of empathy framed it as a spiritual transgression rather than as an occupational hazard. Western physicians and nurses responding to the 2014 Ebola outbreak cited their professional ethics as enabling them to overcome fear of death: "It was just the right thing to do. I had something I could do to help" (Gershon, Dernehl, Nwankwo, Zhi, & Qureshi, 2016, p. 6).

Bodhisattva Vows

In interdependence with the world, one's thoughts, words, and deeds are shaped by habit energy or by intention. Vow is a particular kind of intention. Okumura (2012, p. 25) described it as "a concrete and practical form of wisdom and compassion." The Buddhist chaplain has made the four bodhisattva vows and regularly rededicates herself to them:

> Creations are numberless; I vow to free them.
>
> Delusions are inexhaustible; I vow to transform them.
>
> Reality is boundless; I vow to perceive it.
>
> The Awakened Way is unsurpassable; I vow to embody it.
>
> (Four Bodhisattva Vows, n.d., p. 93)

For the chaplain, paradoxical vows that are simultaneously unfulfillable and already realized speak to a mystery. To a doctor or nurse, they can abrade the wound of moral injury. "A clever person cannot be a bodhisattva," Okumura (2012, p. 17) wrote. For a clinician, the vow to save the numberless beings is something held to be literally true. He is committed to saving the one

being before him and affliction arises when he cannot save even that one. He is committed to make no discrimination; he is ashamed when personal limitations, organizational policies, or social injustice force ugly choices. An example:

> *Cathy lies in the ICU, probably dead, although her heart still beats. A few hours ago, she was eating pizza with friends. A doctor and nurse seek out her family to break the news. Her mother Janine sits in the waiting room, accompanied by a large man whose eyes never leave her. Janine's own eyes are black, her jaw swollen, her arm in a sling.*

Who is going to be saved here? What is benefit and what is harm? Whose needs take precedence? "Our practice is to take one more step to the infinite, the absolute, moment by moment, one step at a time" (Okumura, 2012, p. 20). What is the "one more step" available in this situation right now? The clinician must release his fixed idealized view of how his part is to unfold. Being present moment-by-moment, different and seemingly contradictory responses may arise; each moment has its own response. For the Buddhist chaplain, this is familiar territory. It also offers the clinician an opportunity to begin again; though he has stumbled in the past, that does not pollute all future moments.

Bodhisattva Precepts

Precepts are "healing vows" (Halifax, n.d., p. 9). They reconcile the practitioner to her Buddha nature, to the oneness of all things-as-they-are. In *The Bodhisattva's Four Methods of Guidance*, Dogen (1243/2001) drew connecting threads among the precepts, illustrating how practitioners might lead and be led. The Buddhist chaplain undertakes to study and live the bodhisattva precepts (see Appendix D) from three perspectives: the literal, the subjective, and the intrinsic. The literal understanding is an unconditional, face-value application of the words.

The subjective view engages compassion and a sense of contextual appropriateness, both mediated by wisdom (Glassman, 2003, p. 114). Oneness is the intrinsic understanding. Distinctions disappear—"boundlessness is the nature of all things" ("The Heart Sutra," trans. 2003).

> *Mr. P's room was awash in blood; his estranged mother slipped from the doorway and did not return. Mr. P's ICU team wanted to intubate him before he drowned. "This is the end of my life, isn't it?" "Yes." "Then no." "We could try to keep you comfortable," the intern said, not believing her own words. "OK." The intern asked Mr. P's nurses what he would need and they told her. A few minutes later, Mr. P's bleeding accelerated and he was literally drowning. His blood pressure and heart rate were dropping, but he was still awake and terrified. A nurse stood beside him, connecting a syringe of sedation to the IV in his neck. "Are you ready to not wake up any more?" He nodded. The nurse gave the medication. Mr. P lost consciousness and minutes later he was dead.*

Moral injury arose for the clinicians in this situation. The physician and nurses had vowed through their professional oaths not to administer harmful drugs. Education in ethics and morality stops with clinician training, frozen at the literal understanding of vows and codes. The Buddhist chaplain considering the above situation through the precepts may conclude that the clinicians violated the letter of many of them. Moments of life were stolen and replaced with death. Harsh judgments were spoken against the mother's retreat. Reactivity may freeze the chaplain into that literal perspective alongside his physician and nurse colleagues. He may instead open to a subjective understanding and facilitate a more contextual compassion-based exploration. Acknowledging and peeling back layers of circumstances and intentions, what core

values are being expressed or suppressed? While the chaplain is no more virtuous than the clinician, he is a committed comrade whose spiritual training and ongoing formation bring a rich resource for co-discernment. As Glassman (2003) advised in *Infinite Zen*, precept study unfolds day by day, year by year, as the student's view stabilizes. The chaplain might invite clinicians to revisit cases from earlier in their own careers and reflect together how any wisdom gained in the interim has changed their understanding of them. Intrinsic understanding speaks to the fourth method of guidance—cooperation. "At such times self and other are without boundaries" (Dogen, 1243/2001, p. 92).

Healthcare providers hold conflicting views on how conscience should translate professional precepts. Freedom of conscience proponents state that active moral engagement rather than reliance on categorical imperatives is necessary to preserve integrity and to ensure the most appropriate action. "Compromise of personal moral integrity, of any kind or nature, will inevitably lead to an erosion of ethical behavior—a prospect not conducive to optimal provision of healthcare" (Genuis & Lipp, 2013, p. 5). Another stance prioritizes public well-being, particularly as it relates to equal access to needed services, over individual provider morality. The Buddhist chaplain's three perspectives—literal, subjective, and intrinsic—on her own precepts may be a helpful view for clinicians to adopt as well.

Methods

Three arrows cause the wound of clinician moral injury: the event itself, the clinician's overwhelming reaction, and the systemic factors that promote harm and inhibit recovery. The healthcare provider and Buddhist chaplain are both people of vow. They share core

commitments of non-harming, beneficence, and social justice. Vows, precepts, values, and relationships form the structure of what Moon (2019) described as a moral home. These homes can be damaged or destroyed by conditions outside their tolerance. "The shame and guilt and trauma of moral injury ... require a journey of rebuilding a positive sense of self, restoring patterns of relationality, and developing resilience through practices of compassion and resistance to evil that rebuild and sustain a sense of moral integrity" (Ramsay, 2019, p. 108). Buddhist principles and practices can inform this journey toward integrity, translated by Kazuaki Tanahashi as *whole one-ness* (K. Tanahashi, as cited in Rushton, 2018, p. 99).

This section proposes a spiritual care model by which the chaplain and clinician together can work with moral injury. The chaplain establishes a wholesome orientation within himself and in the relational field with the clinician. He and the clinician consider the mirage-like nature of the perceived self, the difficulties arising therefrom, and a more permeable and inclusive alternative. Grounding in the transparency of their shared life, confession and repentance follow. Whether forgiveness or resistance to systemic injustice (or both) might be Right Action is uncertain. This section concludes with a portfolio of interventions. Some are adapted through a Buddhist lens from existing evidence-based approaches to military moral injury as well as to the types of clinician suffering described above. Others are completely new. Suggestions for research into their feasibility and efficacy are presented at the end of this paper.

Orientation

Internal Chaplaincy: Modeling Non-Harming

Bearing witness to episodes and recollections of wrongdoing requires rigorous internal chaplaincy. The chaplain's own moral home has its share of leaks and broken windows; it

requires attention and repair. The prelude to the Three Refuges reorients the chaplain to her fundamental purpose: "*Inviting all creations* into the mandala of my practice and *vowing to serve* them [emphasis added]..." (Upaya Zen Center, 2016, p. 14). All creations include the chaplain herself. Inviting is active; beings are not accidentally encountering her practice. Inviting carries a sense of hospitality rather than compulsion. Beings, including herself, might enter boisterously, lurk on the periphery, or not show up at all some days. She dedicates herself to the well-being of all of them nonetheless.

> Recognizing that I am not separate from all that is: this is the practice of Non-harming. I will not lead a harmful life nor encourage others to do so, and I will live in harmony with all life and the environment sustaining it. (Upaya Zen Center, 2016, p. 14)

If the chaplain does not practice self-stewardship, she cannot model it for another. For the Buddhist chaplain, who has vowed to maintain the precept quoted above, the pathologic altruism, burnout, and other edge states (Halifax, 2018) which she nourishes in her own life bear fruit in the lives of those she serves. She can instead cultivate stability and resilience through contemplative practice, her sangha, and her teacher or spiritual director. The chaplain caring for clinicians must have formal support for processing their war stories in order to minimize vicarious trauma. Splitting is a common response to moral injury; the social contract maintaining cohesion has been compromised by emotional contagion and moral outrage (Shay, 2014; Rushton, 2013). The chaplain confirms her situational assessment with a mentor or trusted colleague before being drawn into drama.

Non-separateness invites the Buddhist chaplain toward authentic practice in the clinician's spiritual idiom. Zen Peacemaker chaplain Mikel Monnett (2005) offered: "In times of

crisis people seek solace in their religious traditions ... the more familiar I am with those traditions, the more effective I am in helping them to use their beliefs in their own healing process" (p. 61). The chaplain should have a working knowledge of concepts of good and evil, preceptual frameworks, and sources of authority and forgiveness in other faith traditions. In her spiritual assessment, she opens a space for the clinician to teach her what meaning these beliefs have in his life, if any.

These fundamentals help put the chaplain's moral house in order so that she can serve in harmony with a troubled provider community. Litz et al. (2009) had therapists prepare for working with morally injured soldiers using a thought experiment. They imagined the things their clients might have done in order to "tolerate this kind of material while being able to genuinely embrace and accept their patients .... to model, implicitly and explicitly, the idea of acceptance" (p. 702). Using a sequence familiar from lovingkindness or tonglen practices, a Buddhist chaplain might imagine a clinician whose situation is somewhat problematic and build toward what for him feels most challenging. He might hold an empty-chair discussion with a first responder from 9/11 who is stuck on the dying person she passed over in order to help another more likely to survive. From there, the chaplain might consider the clinicians who piece together perpetrators alongside their victims, such as the surgeons from Doctors Without Borders. Can the chaplain remain grounded, resourced by equanimity and compassion as he immerses in those narratives? Is it possible to "explore the client's moral compass and the felt sense of crossing a moral boundary" without adding his own values and concepts (Dombo et al., 2013, p. 207)? If so, the Buddhist chaplain might then practice bearing witness to a clinician who believes she has strayed even further from shared vows. The nurse trapped in Charity

Hospital during Hurricane Katrina, intentionally overdosing her patient. The psychiatrist who assisted in the interrogation and torture of prisoners in Guantanamo. The Nazi doctor who didn't get caught.

The chaplain cannot bear witness from an imagined moral high ground. Dogen (1237/2005) instructed:

> Do not judge monks as deserving of respect or as being worthless, nor pay attention to whether a person has been practicing for only a short time or for many years. Without knowing where to find your own stability, how are we to know where someone else would be most stable? (p. 14)

Shay (2014, p. 188) challenged those working with morally injured persons to establish credibility as a partner rather than rescuer, bystander, victim, or perpetrator. For the Buddhist chaplain, this means being Buddha and recognizing that the injured clinician is Buddha. The intimacy required by this kind of non-separation renders the chaplain simultaneously vulnerable and protected. The chaplain has traded the Drama Triangle construct, in which she enables a persecutor or rescues a victim, for the Triple Treasure. Taking refuge in its vastness, she encounters this partner, already present. She actualizes the bodhisattva method of Cooperation. Moral injury is evidence of "strong ethical values and a capacity for empathy ... an example of character and resilience [that] should be treated as such" (Dombo et al., 2013, p. 207).

Meeting the Clinician as a Fellow Traveler: Buddha Recognizes Buddha

Recognizing the Buddha nature of the clinician, the chaplain models how the clinician might see it in himself. Buddha recognizes Buddha in that sense as well, and what might otherwise be a metacognitive exercise dissolves into integrity. This integrity is intersubjectivity,

whole one-ness (K. Tanahashi, as cited in Rushton, 2018, p. 99). Whole oneness includes the clinician, the chaplain, the patient, and the systems in which they are embedded. Opening one's self in this way also engages moral subjectivity—recognition of an ecology of well-intentioned, ethically sound, yet potentially-conflicting values. "Moral subjectivity may enable the provider to share the burden of moral responsibility with others in the care team, rather than in isolation, thereby reducing his/her own moral distress" (Prentice, Gillam, Davis, & Janvier, 2018b, p. 41). The groundwork is laid for future perspective-taking.

The healthcare environment comprises many cultures. An intersectional approach to healthcare chaplaincy recognizes that individuals bring personal and collective experiences with power and vulnerability that impact adversity response and meaning-making (Ramsay, 2019, p. 109). Healthcare organizations and disciplines are strongly hierarchical, with non-overlapping lines of responsibility and authority. Gender, race, nationality, age, and role are a few of the intersections coloring the way similar situations unfold and linger. Nurses are responsible for the actions of physicians but lack authority to determine those actions. A 60-year-old white male RN disagreeing with a 26-year-old Latina intern is one context in which a potentially injurious event could unfold. A 50-year-old Asian female surgeon questioning why a 30-year-old black male RN has not immediately implemented her order is different soil. Mindful curiosity about the undercurrents of the particular event while being alert to common patterns and mindsets is required.

In the military setting, "inner conflict" is sometimes preferred to "moral injury" because it carries no implication of wrongdoing (Nash et al., 2013, p. 647). It is possible that a clinician, especially one fearful of litigation, would likewise prefer a more neutral-seeming term. "Soul

wound" is another way moral injury has been described (Graham, 2017, p. 16). For some, the secular medical language of wound or injury will provide a familiar and non-stigmatizing opening through which to begin the work. Asking the clinician how they would describe this change in themselves shows engagement and respect. As the clinician's comfort zone expands during the course of their work with the chaplain, their own dominant paradigm—medical, social, psychological, or spiritual—around the event may shift.

Graham (2017) noted that "relational ability and authentic use of self are the foundations of pastoral care in providing moral guidance and healing moral injury"(p. 12). The chaplain's ability to see what might serve relies on moral attunement. Together the chaplain and clinician attend to the ethically salient details, noting their blind spots. Whose viewpoint is not heard? What don't we understand about this other person's concerns, commitments, and constraints? What might his conscience dictate? Rather than confirming biases, moral attunement seeks to uncover potentially transformative understandings (Rushton, 2018).

Providing spiritual care as colleague, sanctuary—a safe literal or figurative space for honesty and vulnerability—becomes important. The chaplain may serve as a metaphorical tenzo in the healthcare provider community. He approaches this service with the Three Minds: joyous mind, parental mind, and magnanimous mind. Instead of punching in and collecting a paycheck, the chaplain agrees with Dogen: "Considering the innumerable possibilities in a timeless universe we have been given a marvelous opportunity" (1237/2005, p. 17). The chaplain tenzo approaches his colleagues on the team with the concern of a parent for their only child. He treats them carefully and unselfishly. Magnanimous mind allows the chaplain to not be distracted by appearances or preferences, but to hold all things as they are. Grateful to serve,

and bringing a fierce and impartial compassion, the chaplain is prepared to engage moral injury. Doing so, he cultivates these qualities in the wider community.

Kleinman (2013, p. 1377) wrote that the clinical encounter, conventionally seen as a market activity, is an exchange of gifts between the care giver and receiver. As the Buddhist chaplain prepares, she may be reminded of the "Verse for Setting Out Bowls." "Now we set out Buddha's bowls. / May we, with all beings, / Realize the emptiness of the three wheels: / Giver, receiver, and gift" (Meal Verses, n.d., p. 5). She drops the illusion of distinction between herself and this injured clinician. Whose bowls are empty, who kneels to serve, what is the meal, and how much is *just enough*? Neither individual knows, but in unity the answer might be found.

The chaplain exercises humility. Although he is a partner, clinicians must do the heavy lifting in their own recovery. Chaplain-facilitated, peer-based programs addressing moral injury are discussed later in this paper. Humility uncouples the chaplain's efforts from unrealistic expectations while leaving room for hope.

> Some moral challenges and injuries are simply too big and too complex for healing to come about in a straightforward or timely manner. Grieving losses and learning to live with what is 'left over' is sometimes the most we can embrace as a caregiving outcome. (Graham, 2017, p. 53).

Foundation

Studying the Self: A Lotus in Muddy Water

Exploring the interior landscape while not identifying with it, meeting it with equanimity and compassion, opens self-empathy (Sherman, 2014, pp. 230-231). Thoughts of blame or shame may arise, but the clinician can let them pass away rather than identify with them. The

chaplain models this in individual and group interactions. Self-empathy may be a prelude to self-forgiveness, might be a stopping point when there is no forgiveness to be obtained, or may serve as an ongoing way to work with moral residue.

Physician Arthur Osburn reflected back on his role returning soldiers to suffer on the front lines of World War I: "I felt a different person ... this sense of change has never left me. [It is] a change of vision, of spirit, of feeling" (Jones, 2018, p. 1766). Dr. Osburn had known himself to be a person whose faith called him to restore bodies to wholeness. In making soldiers just well enough to be ripped apart, he found himself routinely acting outside his moral framework. Who was this "different person"? A second-year resident reflected:

> When I'm walking to work, I try to be conscious of the fact that I'm gonna have to portray the kind of person I want to be for the next 12 to 14 hours or 24 hours. It's being your ideal self all the time." (Winkel, Robinson, Jones, & Squires, 2019, p. 187)

The resident has set herself an impossible task; at some point in her career she may find herself in Dr. Osburn's shoes, wondering how she became someone else. An opening for a chaplain might be to reflect with such a clinician on who that ideal self is. Gathering their attention, they recall their intentions (Halifax, 2014). Who is it that does the aspiring? The clinician is invited to find moments in the day to deliberately reconnect with that source of goodness. She connects with the core, the vow, not the trappings of her clinical role. Yandell (2019) wrote, "There were things germinating in me that a uniform had allowed me to ignore, but I could not continue to hide. I was ultimately hiding myself from myself" (p. 13). Those ignored things may include not just misdeeds but fundamental goodness.

The chaplain could facilitate a clinician's exploration of her values and commitments in order to gain understanding of how they relate to this self beyond the uniform. Which can flex and which do not? Which serve as her moral skeleton? Which are more like tendons and ligaments—holding the structure together but liable to tear if pulled too far? Which are the stretchy muscles, able to respond in many directions?

> That moral core of medicine may seem abstract, until you see health professionals passionately struggling to be useful, compassionate, responsive and responsible while working with the indifference of bureaucratic rules, the cold counting and costing of institutional audits, and the almost impossible-to-balance personal demands on their time and concern." (Kleinman, 2013, p. 1377)

Surfacing this struggle, the chaplain provides an opportunity for the clinician to articulate and appreciate his own efforts to thrive in adversity, to be the lotus in muddy water. The chaplain might inquire whether a feeling of compassion or tenderness toward that self is arising. What is the felt sense? A metta verse such as "May I recognize that I did my best" or "May I cut myself the same slack I give to others"—an expression of lovingkindness in the clinician's own voice—can be a touchstone recalling this feeling to conscious awareness.

Experiencing the deeper, more expansive self provides a refuge as the clinician begins to directly examine the injury. Wholeheartedly accepting appropriate responsibility requires a foundation of metta toward the self, otherwise the clinician may not be able to look deeply enough to truly differentiate their burden. "Developing resilience includes taking responsibility for one's behavior when warranted and externalizing shame and blame when these emotions arise from unwarranted assumptions of responsibility or control" (Ramsay, 2019, p. 114). One

clinician may feel clear culpability. Another resolves her genuine uncertainty by holding the dissonant views "there was nothing I could have done" and "it's my fault."

> *A device malfunction nearly cost Mr. Y his life, which is saved through the quick action of his nurse, Carol. When debriefing about the experience the next day, Carol did not mention rescuing Mr. Y, could not recall it. She was consumed with unearthing how she had failed her patient. Even "I wouldn't do anything differently" did not keep her from also saying "I'm somehow responsible ... I shouldn't take care of people that sick."*

A soldier recounted a similar self-appraisal: "I remember the shattered confidence ... questioning *everything* ... one day the mirror showed me a new kind of face, and I realized that I had become, in name and reality, *unfit* for duty" (Yandell, 2019, p. 5). An honest, compassionate look at oneself and one's behavior requires internal stability to maintain. Specific skills for nervous system regulation (Leitch, 2018) include sensory tracking, grounding and resourcing. These provide a safe structure for attending to and modifying potentially distressing internal states. Gaining a more nuanced view of the web of responsibilities and their place in it, the clinician establishes "contextually creative agency to revisit the harm they carry from a position of strength" (Graham, 2017, p. 98).

Confession, Repentance, Forgiveness

Through the facilitated appraisal process described above, the clinician begins to appreciate the aspirational self amid causes and conditions of moral adversity. Realizing these aspirations requires transforming harmful circumstances from hindrances into compost for growth. They are integrated rather than denied. Making that step releases habitual cherishing of the idealized self. Through confession and repentance, "we melt away the root of our

transgressions.... This is the pure and simple color of true practice" (Dogen, 1240/2013, p. 29). The Four Powers of Confession offer one structure for exploring a way forward toward integrity. As outlined by Patrul Rinpoche in *The Words of My Perfect Teacher* (trans. 1998, pp. 265-267), the four powers are bodhicitta, positive regret, resolve, and remedial actions. Bodhicitta involves actualizing I and all beings awakening together, as the Buddha saw under the morning star. It is the awareness that all beings are fundamentally free from suffering and its causes. It is a mighty dedication to clear away all impediments to beings, recognizing and abiding in their freedom. The next subsection, "The Power of Community," further discusses how bodhicitta might unfold for an injured clinician.

Expressing positive regret, the practitioner confesses without withholding. A brief yet comprehensive example is the Verse of Atonement: "All my ancient twisted karma / From beginningless greed, hate, and delusion / Born of body, speech, and mind / I now fully atone" (Upaya Zen Center, 2016, p. 14). The practitioner holds up even unremembered and unconscious misdeeds to be witnessed. Confession as an articulation of positive regret has been studied in the context of combat-related moral injury (Litz et al., 2009; Steenkamp et al., 2011). The format is an empty-chair dialogue. Seated in the empty chair is someone the participant holds in highest esteem. It might be a religious figure, a mentor, or their grandmother. To foster safety and honesty, the being must be "someone who does not want them to suffer and who feels that forgiveness and reparation is possible ... someone who has always had their back and will be in their corner no matter what" (Litz et al., 2009, p. 703). The participant confesses the event—what he witnessed, his own actions or inaction, the impact on his life, and what the consequences should be. Along the way, he pauses to listen to the responses of the benevolent

authority. How did they react? What did they say? Perhaps the chaplain is working with an individual unable to identify a powerful source of trust and support. Steenkamp et al. (2011) invited those participants to consider being such a fondly protective resource to a junior colleague. The participant placed the imagined colleague in the empty chair and heard his own confession with all its attendant emotions and judgments coming from the colleague's mouth. As someone who believes in that person and wants the best for them unconditionally, how does he respond? This approach may resonate strongly with healthcare providers. "By redirecting their own struggles to teaching others, [providers] align with altruism, a professional value they espouse." (Winkel et al., 2019, p. 184).

Having named what happened and their part in it, the clinician resolves not to continue or repeat it. The respiratory therapist who continued CPR on a dead child whose parents and physicians were shouting conflicting orders resolves not to surrender his moral agency to others. At the root, what do I stand for? What is it that is mine to do? He asks himself these questions and commits to abiding by the answers.

The fourth power of confession is remediation. The harm is not undone, but the fresh action is intended as medicine for it. "We have two forms of power available to us. The first form of power is agential power—the capacity to influence and initiate. The second form of power is receptive power—the capacity to be influenced and changed by what comes to us" (Graham, 2017, p. 125). In a moral transgression or betrayal, agential power has been misapplied. The clinician who has harmed a patient may recoil from stepping back into her own agency, believing it polluted. Another, led into harm by a senior colleague, may view his own agency as a fairy tale. Focus only on agential power centers the remedy within the particular

harm and may overlook more broadly beneficial ways of being. A critical care transport nurse explained:

> "I had to ask for forgiveness ... a lot ... I was in a system full of people that anyone could have said, 'Hey. Are we doing the right thing?' Nobody did. I will be that voice forever ... and it wasn't done for me.... Which doesn't forgive the action, but you know, it certainly might have changed the process ... afterwards." (Simmons et al., 2018, p. 65)

This nurse resolved not to be silent and instead to let the pain of these situations transform her into someone who would call that pause for conscience. This is the receptive power unlocked by repentance and vow.

Having undertaken the journey of confession and repentance, the clinician may find self-forgiveness or the ability to forgive one who has betrayed. Alternately, that may not be the most meaningful outcome.

> Deliverance from evil may require resistance rather than forgiveness.... Perhaps the gift we look for when facing an impasse about forgiving or not forgiving is the clarity and moral courage that emerge...." (Graham, 2017, p. 107).

The Power of Community

Healthcare providers, particularly those whose settings are permeated with suffering, share soldiers' lack of outlet for processing their trials and misdeeds. Finding peers with similar experiences can reboot a clinician's feelings toward himself, softening the grip of shame. In hearing a colleague share her story of struggle, he recognizes she is "just like me" and aspiration bodhicitta germinates (Rinpoche, trans. 1998, p. 222). He wishes wholeheartedly that this colleague might experience the same freedom from suffering that he seeks.

> Second-person empathy, both the giving and receiving of it, may thus prepare a sufferer for first-person empathy; one gains an outside perspective of the self, a perspective that is qualitatively different from the punishing and shaming stance that has held the individual hostage. (Sherman, 2014, p. 229)

Second-person empathy engages resonance with another's suffering. This may be particularly helpful for the clinician who has silenced his own voice of conscience. Bodhicitta widens empathic bandwidth to include the other's aspiration for freedom. The clinician feels an altruistic motivation to lift that colleague out of the dark place. He begins to exchange self for other, and bodhicitta grows. An obstetrics resident explained:

> We're in this war. You're in battle with these people. You know them so well. I know when one of my co-residents is upset about something even if they are trying to hide it. I will pull them aside into a private room and cry, hug, vent, and scream or whatever it is. (Winkel et al., 2019, p. 188)

Communities characterized by acceptance and positive regard can help foster feelings of worthiness and wholeness. Discussing collegial support after adverse patient outcomes, one surgeon explained, "we can all talk about stuff and then we can look at stuff and people can have input from others" (Mallon et al., 2018, p. 5). The surgeons were not rehashing others' errors, they were confessing their own. They were not praising themselves at the expense of others, but humbly seeking a course correction. For the Buddhist chaplain, this recollects the sixth and seventh bodhisattva precepts, which encourage "taking responsibility for my own life" and holding "all beings in equal regard" (Upaya Zen Center, 2016, p. 15). In strongly hierarchical milieus such as healthcare and the military, all members are not held in equal regard. The

chaplain can overcome this by building ad hoc communities from near rungs of the ladder. Investigators of ICU moral distress (Forozeiya et al., 2019) found that nurses self-organized into junior-senior dyads for affirmation of worth, practical suggestions, and confirmation of trust.

The role of a chaplain involves facilitating wholesome function of existing clinician community structures—the provider sangha. She may also lead intentional groups such as the VA Search for Meaning (SFM) program. SFM is cofacilitated by a mental health professional and a chaplain (Starnino, Sullivan, Angel, & Davis, 2019). Over 8 weeks, veterans bear witness to each other's recollections, accept responsibility for their actions, grieve a lost sense of self, and rebuild agency. Experiencing Patrul Rinpoche's "just like me" has had a powerful impact on SFM participants: "...there's other people just like me that have the same, same thoughts ... I wasn't the only one traumatized by events, other people were traumatized also" (Starnino et al., 2019, p. 106). Mantra, journaling, and mindfulness practices complement group discussions. Cultivating present-moment stillness and reflection open a neutral field in which veterans are better able to differentiate context from personhood. "It's like moss growing on the side of a house," explained one participant (p. 109).

Attending to Systems

Veterans partially attributed their moral injury to specific organizational characteristics (Currier et al., 2015). Leaders were uncaring, self-serving, and out-of-touch with the frontline; rules of engagement did not meaningfully apply to their work. Similar phenomena are serially measured in healthcare organizations through tools such as the Gallup 12 and National Database of Nursing Quality Indicators (NDNQI) surveys. The chaplain has an opportunity to advocate for and participate in system changes which may prevent moral injury. For instance, surveyed team

members may express that senior leaders do not care about them as a person, are not present, do not provide necessary resources, and promote a culture of blame rather than proactive guidance. Leadership forms a remediation task force with clinicians; the chaplain could be included in the work group. In a teaching hospital, this would augment the clinical pastoral education experience and the results would be measurable over time by subsequent surveys. Chaplain engagement in creating a healthier work environment could be an entrée to more frequent and substantive support during situations of moral adversity. The chaplain would be a trusted colleague, on the ground to mitigate injury before it scars.

"When we practice with other people, we gather together small fires. Each one of us has a small fire, which alone will die out sooner or later. Together we become bigger than ourselves" (Okumura, 2012, pp. 42-43). For the Buddhist chaplain, healing a system is a moral imperative. To actualize her bodhisattva vows, she must work not just at the tip of the iceberg, but with the larger body. This is the way her work outlives her single life. Rushton and colleagues (2018) proposed transformational redesign using Conscious Full Spectrum methodology. A multidisciplinary group comprising clinicians, ethicists, and leaders of regulatory bodies developed a roadmap of strategies and tactics for fostering respect as a moral practice (Sokol-Hessner et al., 2018). The rigorous curiosity the chaplain applied in serving the individual clinician uncovers opportunities to effect change in the deeper layers.

Proposed Interventions

Having cultivated the orientations of self-stewardship and meeting the wounded clinician as a fellow traveler, the chaplain engaged with her around self-study, issues of repentance and

forgiveness, and finding refuge in a community. Interventions outlined here support and expand on those efforts. They involve core chaplaincy domains of assessment, support, counselling, education, and ritual. This list is not exhaustive, nor would every intervention suit every situation. The healthcare chaplain hears many cries and perhaps something offered here will serve one of them. May it be so.

Assessment

The FICA mnemonic (Puchalski, 2004) is used for clinician spiritual self-assessment. F (faith or belief) asks about spiritual beliefs, hope, and inner resources. I (importance) looks at how beliefs influence coping with adversity. C (community) has the clinician identify their faith community or other "group of people you really love or who are important to you" (p. 498). This might be family or a peer group who have supported the clinician's practice. A (action) invites reflection on what practices might meet the present challenge. A hypothetical emergency department (ED) physician might recount how he was raised to believe that being a good person means helping others no matter who they are. He is grateful that his job in the ED gives him a chance to embody that value. No matter how things turn out, there's at least some small thing he can do; he takes comfort in that when things are hard. He is not a church-goer and tries to protect his family from what he sees at work. He does have a colleague whom he considers his best friend and has known since medical school.

For mapping the moral contours of an index event, Graham (2017) suggested a threefold assessment: "who is responsible for the harmful action," "the harmful consequences of the actions both to the actor and to the recipients," and "without blaming the victim ... how the

recipient of the harmful actions may contribute to the harm by how they do or do not respond" (p. 15). The physician described above might share an experience like this:

> *A man came to the ED having a heart attack. I started him on nitroglycerin and he rapidly went into shock and had to be placed on life support. I almost killed him—a judgment angrily affirmed by his family.*

Per Graham's assessment model, this provider was responsible for the harmful action. The harmful consequence to him was a fresh belief that he was someone who hurt a person in his care. The consequence to the patient was an extended hospital stay and possibly permanent disability with its attendant role changes. His family experienced fear and loss of trust. Down the road there was probably material hardship. The patient's family compounded the physician's injury by their understandable anger and harsh words. He was ready to hear and agree with them. Pooling what she learned in the FICA assessment with this brief sketch of the event itself, the chaplain has material which may suggest next steps.

Exercising other forms of inquiry, a chaplain might sit on interview panels for trainee, staff, and leadership candidates. He could prepare by pausing to reflect on organizational and professional values as well as his own vows. The Zen Peacemaker chaplain might consider The Four Commitments:

> I commit myself to a culture of nonviolence and reverence for life.
>
> I commit myself to a culture of solidarity and a just economic order.
>
> I commit myself to a culture of inclusiveness and a life based on truthfulness.
>
> I commit myself to a culture of equal rights for all people regardless of race, gender, ability, and economic status. (Upaya Zen Center, 2016, p. 15)

The chaplain imagines how the culture described above might manifest through the position being filled and engages in perspective-taking regarding each candidate's possible relationship to such a culture. This preparation informs the questions he might bring and he is ready to listen deeply.

Support

Mindfulness increases interoceptive ability (Farb, Segal, & Anderson, 2013), which supports empathy, priming bodhicitta and compassion. An increasing number of medical and nursing education programs are incorporating mindfulness into curricula. Hospitals may have employee wellness programs. Both are opportunities for chaplain involvement, whether as an employee or as a volunteer. The chaplain can introduce mindful moments such as The Pause (Bartels, 2014) into potentially morally injurious situations. Centering Prayer, mantra practice, or metta meditation anchor present-moment awareness and may benefit clinicians unable to find their own still point.

At Jukai, the Buddhist chaplain received lineage documents depicting his entry into unbroken generations of dharma practitioners. He may have reflected upon the ingredients of his own life which nudged, carried or dragged him into his life of vow. These form his personal lineage, a handmade expression of these fortuitous conditions. Construction of a personal lineage may provide the clinician with a creative means to place herself in a larger context and enlist overlooked resources. Two of the many possibilities for lineage projects are the moral compass and tree of resilience. "[Moral compasses] arise within our souls from our past histories and our present contexts" (Graham, 2017, p. 3). The clinician might consider: "Where did my moral compass come from?" Meditation, discussion with spiritual friends, and reflective

writing inform the piece. The lineage could take the form of a poem, collage, or a literal compass; its expression is up to the clinician. Winkel et al. (2019, p. 190) envisioned clinician resilience as a tree. It is nourished by family, community, colleagues, connections with patients, and core values. What sources of resilience does this clinician draw on? Creating a resilience-themed personal lineage calls these resources into conscious awareness and leaves the clinician with a durable reminder.

The guilt and shame of moral injury are a trick lens; a defiled self fills the entire frame. Awe practices such as staring at the ocean, night sky, or a mountain range can rebalance this mental composition by shifting attention outside the self and into vastness. Piff, Dietze, Feinberg, Stancanto, and Keltner (2015) noted that a feeling of awe, as opposed to pride, was associated with believing that one is part of something greater. This recontextualization promoted ethical decision-making and prosociality.

Returning veterans have found personal affirmation and community-building through the organization The Mission Continues (Moon, 2019). Squad leaders identify local needs which teams of veterans then meet. The program leverages veterans' powerful service aspiration within the familiar context of an operational group. The veteran can reconnect to intrinsic goodness without being required to discuss traumatic events and feelings. Healthcare providers share this strong service orientation. They rely on team members to achieve goals and persist in adversity. A program modeled on The Mission Continues may be an effective system-level intervention. The chaplain could ally with frontline staff and leadership in advocating for, developing, and implementing such a program. Clinicians would have the opportunity to

reconnect with their Buddha nature—however they understand it in their own spiritual framework—to see the bodhisattva work of their colleagues, and to find refuge in community.

Counselling

An empty-chair dialogue with a trusted moral authority or junior colleague (Litz et al., 2009; Steenkamp et al., 2011) opens a safe way for the clinician with moral injury to express what happened, her feelings, and what consequences she believes should follow. She can hear an alternate perspective from the moral authority figure. She might imagine herself as the trusted resource of a colleague in similar straits. She draws out her own wisdom and articulates it for the chaplain-facilitator. A chaplain might also suggest these dialogues as written exercises.

Okumura (2012, p. 15) noted that, while all bodhisattvas make the Four Vows, each also makes "special vows unique to his or her personality and capabilities." Regardless of the clinician's spiritual tradition, vows have meaning. What does this individual commit to bring into being (or to refrain from?) The Buddhist chaplain might assist or bear witness in the drafting and taking of personal vows.

Clinicians whose relationship to their organization or group has been damaged by moral injury have a discernment process ahead. "I had to put a towel over [dying premature twins] until they stopped floundering," said the provider in Larrson and colleagues' (2018, p. 181) study. Whether the action was a singular or routine expectation, such a betrayal may prompt the clinician to reconsider their role. Clarity and moral courage are spiritual care outcomes this chaplain/clinician dyad can work toward through collaborative discernment. Resistance to a toxic environment may involve conscientious withdrawal or system change from within.

As with The Mission Continues, healthcare chaplains can learn from their military colleagues by adapting the Search For Meaning (SFM) program. SFM chaplain and psychologist partners based in VA hospitals could adapt and pilot the program for clinical staff. Publication of qualitative and quantitative data can inform translation to civilian settings.

Education

The chaplain can collaborate with colleagues in clinical education programs to establish councils offering students and new providers a regular opportunity to study how professional precepts are unfolding in their practice. In addition to the literal understanding taught in the classroom, students would explore subjective understandings, mediated by equanimity and compassion. How do their professional duties align—or not—with what their religious, cultural, and family backgrounds have taught them is right?

Clinicians in settings of pervasive moral adversity benefit from emotional stabilization skills. These shift clinicians toward a more neutral initial appraisal and thereby lessen downstream sequelae. Intrusive re-experiencing and sympathetic/parasympathetic dysregulation may benefit from simple somatic techniques.

> *Andi had made repeated attempts to place a nasogastric tube for her patient Miss. B. Miss B had dementia and could not understand what was happening. She struggled with Andi. She bled all over both of them and Andi shouted at her to hold still. Another nurse removed Andi from Miss B's room. Over the ensuing weeks, the incident replayed itself in Andi's mind. She felt shaky and queasy in her body and began calling out sick to avoid the shame she felt around colleagues and patients.*

Hearing Andi's story, the chaplain may notice reactivity arising. She reorients to her own intention from the Three Refuges: "Inviting all beings into the mandala of my practice and vowing to serve them ..." (Upaya Zen Center, 2016, p. 14). She invites Andi to join her in sensing into the support of the floor under their feet and the chairs upholding their backs. The chaplain asks Andi to "identify moments in the day when one experiences peacefulness, beauty, calm, and love for others and oneself" (Doehring, 2015, p. 643). What is the embodied experience of those moments? What does Andi notice in herself as she describes them? The chaplain encourages Andi to check in with herself during their work together as well as during typically stressful situations and to notice what physical sensations are present. If signs of stress are noted, such as the shakiness and nausea Andi described earlier, she might briefly shift her focus to a moment of goodness for several mindful deep breaths. Have the physical signs softened? Doehring's approach is similar to the Social Resilience Model skillset (Leitch, 2018), which would also be relevant in a case like this. The chaplain and clinician track sensory cues indicating sympathetic or parasympathetic nervous system activation. They sense into a neutral source of support. The clinician identifies a resource, a being, place, or memory associated with security and comfort. She immerses in that resource and becomes aware of internal shifts suggesting ease or release. The chaplain alternates work with the challenging experience and engaging the resource. Without attentional and emotional stability, the morally injured clinician is unable integrate the event and is at risk of repeating it.

Once the clinician has cultivated the emotional stability to sense the suffering of herself and others without disintegrating into overwhelm, she may feel the aspiration toward shared freedom. The Buddhist chaplain might offer the practice of tonglen as a way to deepen this

intention. To begin, the clinician recognizes that she and her peers are experiencing the same suffering. She can breathe in their shared distress and on the exhale send out relief to everyone so afflicted, including herself (Chödrön, 2005, p 237). Relief could take various forms: ease, compassion, or forgiveness. The very thing the clinician so acutely lacks, she imagines giving to this co-worker. After engaging in this compassion practice, what physical sensations are present? What is the state of heart/mind? Attuned to the clinician, the chaplain may or may not proceed in the practice to ripening the other's suffering on the self. Doing so may not be appropriate. The chaplain may notice that staying with a shared experience of suffering fosters interoception within a widened field of subjectivity.

Schwartz Center Rounds (Lown & Manning, 2010) is a system-level education intervention. At Rounds, clinicians from all disciplines and levels of experience share their struggles in a confidential, accepting environment. Example topics might include caring for a homeless person, patient suicide, delivering bad news, or racism in health care. The focus is on uncovering the emotional and spiritual impact of cases rather than problem-solving them. This transparency shifts healthcare narratives away from mythology and toward realities, inviting transformation. Clinicians who participate in Schwartz Center Rounds show dose-dependent increases in coping, compassion, and teamwork while hospitals benefit from increased patient-centered care (Lown & Manning, 2010; Maben et al., 2018). The chaplain might lead a team to implement Schwartz Center Rounds at her facility.

Ritual

"The performative power of ritual practice assists those isolated by shame and guilt to recover access to communal and relational ties" (Ramsay, 2019, p. 115). The Blessing of the

Hands is an interfaith practice in which a chaplain enfolds a clinician's hands in her own while invoking grace. At UCSF Medical Center, one version of the Blessing is:

> May these hands be a source of reassurance, comfort and strength to all those you touch. May the work of these hands be a source of meaning and self-value to you as you go about your daily labors. And may you always connect to the source of caring that animates these hands, bringing healing to you as well as those they touch. (D. Joseph, personal communication, February 25, 2019)

A chaplain-led small group could design and enact their own ritual involving transformation of moral injury. If a clinician draws strength from a particular faith tradition, what prayers, scriptures, or rituals have been meaningful? For example, a physician might share this prayer from the Yom Kippur service:

> The day is fading; the sun is setting; the silence and peace of night descend upon the earth. Give rest now, O Author of peace, to our troubled hearts; lift up the spirit oppressed by guilt. Turn, O Loved One, to Your children; turn to every broken heart and every burdened soul. Let us at this hour be sure of Your forgiveness. (Liturgy Committee of the Central Conference of American Rabbis, as cited in Ramsay, 2019, p. 122)

The words are forms, transient manifestations of the universal. Rather than appropriate a hodgepodge of words and symbols, the chaplain instead touches into what is being called forth. This archetype manifests at the outer and inner levels of ceremony; the chaplain connects to it in a way that is beautiful and authentic (J. Halifax, personal communication, August 12, 2019). A chaplain's relationship to her own spiritual formation bears consideration. She may be invited

by clinician colleagues to shift back into a former tradition or into one that is completely unfamiliar. Developing the ritual is an opportunity for interfaith community-building.

Many healthcare organizations hold annual memorial services to remember patients who have died. A hospital could also offer a service honoring care providers, their sacrifices and challenges, and their vow of service. The Buddhist chaplain could work with an interdisciplinary and interfaith team in designing such a ritual. Clinicians themselves must be directly involved in shaping such a liturgy: "Then, interpretation of the practice and clarity about how it will unfold help all to enter with trust into what becomes holy space" (Ramsay, 2019, p. 123).

Writing and reciting gathas as mindful punctuation marks across the working day may facilitate reconnection with nourishing emotions and relationships. "Practices that empower compassion and gratitude intra- and interpersonally are crucially important in the recovery process in the aftermath of moral injuries" (Moon, 2019, p. 102). Gathas are mini-vows reminding the clinician of the larger moral context in which they practice. The Buddhist chaplain might use a Samu Gatha to spark individual or group creativity:

> May this work be done in a spirit of generosity, not driven by ego, greed, or delusion.
>
> May kindness sustain us and prevail in conflict, and compassion guide us and lead us to understanding.
>
> May we rejoice in the successes of others and remain unmoved by praise or blame.
>
> (Upaya Zen Center, n.d.)

What moments lend themselves to a gatha? "Waiting for the elevator, I rest in not-hurrying. May I and all beings learn patience." It could be that simple.

Pema Chödrön (2005) noted that "the bodhisattva vow is said to be like a golden vase; very valuable yet easy to mend when broken" (p. 81). This relates to clinician vows as well. It recollects kintsugi, in which shattered pottery is mended with gold. The cracks are highlighted rather than masked to show the beauty in restored integrity and to acknowledge that even this new form is impermanent. A clinician whose action or inaction violated a core value or precept may see that part of their moral selves as broken. One who has been betrayed may feel a global woundedness. A healing art project might be to transcribe what was compromised onto paper or ceramic (perhaps an old mug), then break the object. The clinician or group of clinicians pauses at this point to honor what was lost. Setting a fresh intention, the clinician mindfully reconstructs the object with glue that pleases the eye.

Discussion

Bernice was nearing the end stage of her end-stage disease, complicated by severe delirium. Her family met with the team to discuss options and plans. Dr. H offered a procedure which was risky but might buy additional time. Or not. Her daughter, the designated surrogate decision maker, declined. Dr. H said, "Perhaps we could do some watchful waiting and revisit this down the road if need be." Bernice's family went down to the cafeteria, relieved. Dr. H then had Bernice sign a consent. Her nurse and respiratory therapist objected but were overruled. They took her off the floor for the procedure, which was aborted when Bernice became unstable. She was placed on life support and her family returned to find her intubated and ashen.

Moral injury's first arrow may be chronic—the "routine, incessant betrayals of patient care and trust" described by Talbot and Dean (2018, para. 10)—or an abrupt violation of a moral code, as in the above case. Beliefs regarding personal or collective goodness are shaken. Individual and team integrity is compromised. For some individuals, the second arrow of moral injury mimics a fight-or-flight pattern of anger, confrontation, and post-traumatic stress. Guilt prompts energetic attempts to fix or compensate for the wrong in order to relieve the clinician's distress (Chamberlin et al., 2019). For others, shame isolates them in a freeze or avoidant response, exhibited as depression, apathy, and burnout. The pattern of traumatic incident followed by uncompensated up- or down-regulation resulting in maladaptive emotional and behavioral responses is similar to the Social Resilience Model rhythm described by Leitch (2018). Witnessing or providing futile or potentially inappropriate care was the traumatic stimulus in Chamberlin and colleagues' (2018) work. The frequency with which this kind of care is occurring is well-documented in the literature. One in five ICU patients received care their own physician judged to be futile (Huynh et al., 2013). The moral injury risk is not just to the physicians ordering such treatment, but also to the frontline staff required to perform it.

Clinicians may experience both perpetration- and betrayal-based moral injury. The staff caring for Bernice witnessed the wrong done to her by Dr. H. They experienced his betrayal in requiring them to participate in the actions that followed. Witnesses and recipients of wrong action, these clinicians are at high risk for moral injury. Dr. H may recognize that he crossed a moral line, whether freely chosen or under perceived duress from colleagues or administration. The chaplain can provide preventive spiritual care before early guilt, shame, and anger harden

into complications such as depression, burnout, and bottom-up vertical violence. Figure 2 depicts how this model of moral injury may manifest in the clinical setting.

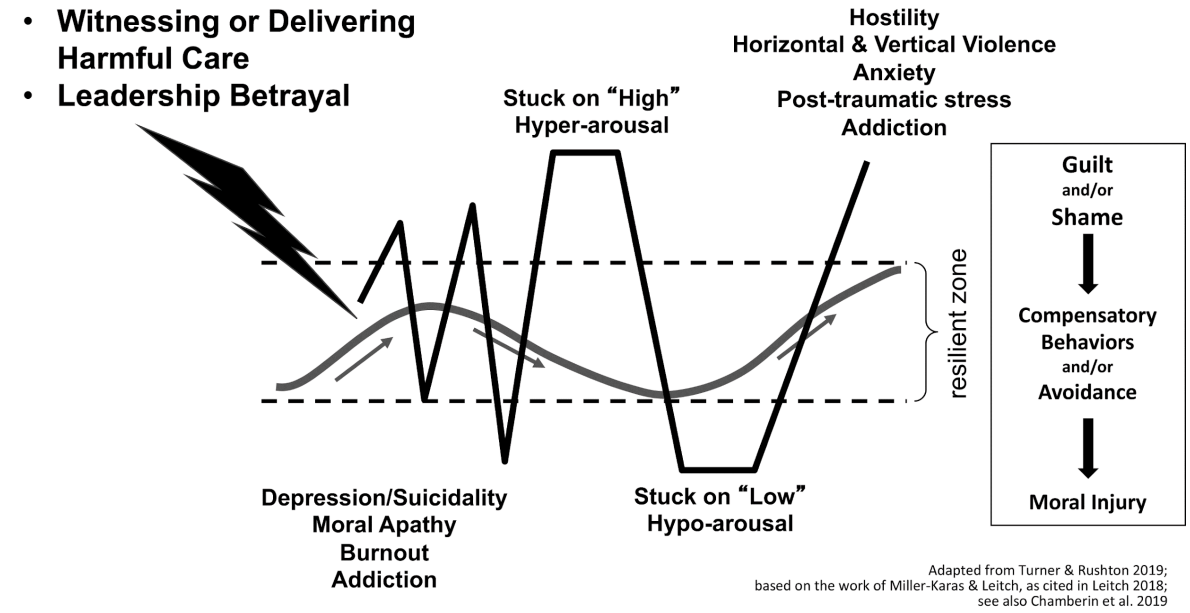

Figure 2: Proposed Mechanism of Clinician Moral Injury. Adapted by Turner & Rushton 2019; based on the work of Miller-Karas & Leitch, as cited in Leitch 2018; see also Chamberlin et al. 2019)

This model aligns with the previously described understanding of military moral injury. Research with military clinicians suggests there may be conceptual overlap with the civilian healthcare provider experience (Gibbons et al., 2013; Simmons et al., 2018). Insomnia, anger, grief, and sadness were symptoms of clinician moral injury in wartime. These providers' narratives were rich in plot details while lacking accessible meaning or purpose. Their experiences echo findings on psychological morbidity following errors and ethically compromising events in civilian settings. "I spent a lot of time just sitting in my office. Staring out of the office. I mostly internalized it. I drank a lot" (Gershon et al., 2016, p. 12).

Clinicians and Buddhist chaplains alike may be in the habit of seeing precepts as yardsticks against which they fall short, or as clubs with which to beat themselves and others. The chaplain and morally injured clinician may instead reflect together on precepts as healing vows, as described by Halifax (n.d., pp. 9-10). Their energy powers spiritual and clinical practice. For a clinician in a morally challenging situation, does vow drive this step, and the next, and the next, regardless of outcome? Remaining in the moment, actualizing the single step, requires softening and ideally releasing fixed ideas about who is the "I" that steps and what is the "right" destination. Instead, one works with what is there, open to incongruity and uncertainty. Zerach and Levi-Belz (2019) found that intolerance of uncertainty factored into the slide from moral injury to suicidality. Buddhism teaches that certainty and permanence are delusions while equipping the student with skillful means to live without them. The Buddhist chaplain is an ally in cultivating gratitude for the truth of impermanence and uncertainty as an alternative to believing oneself or one's environment to be irredeemable.

Recognizing that those all along the chain of command, as well as in the peer group, may hold conflicting yet still well-intentioned ethical perspectives and opinions requires moral subjectivity. The chaplain may facilitate perspective-taking among clinical team members, an exchanging of self for other. The leader of a clinical team acknowledges the moral consequences of her decisions on her frontline subordinates and accepts her measure of responsibility. A resident may come to appreciate that his attending physician herself feels constrained and conflicted, as in the reflection of this military troop leader: "There was only so much I could do to keep me and my guys from doing things that I thought were wrong. But, you know, I only have so much control and that's not very much control" (Currier et al., 2015, p. 112). Expanding

one's moral subjectivity does not carry the same emotional charge, the same righteousness, as moral outrage. On the other hand, it is not as injurious to self or others. A distressed frontline clinician may recognize his own moral responsibility, experiencing it as culpability, guilt, or shame, while being unable to see and release that which is not his to hold. He may become so distressed that he transfers the entirety of this perceived burden onto a colleague, patient, or family (Prentice et al., 2018b, p. 41). Moral subjectivity closely aligns with the clinician and chaplain's shared commitment to see clearly and not harm.

Persons with occupational traumatic exposures such as urban police officers (McCaslin et al., 2006), and healthcare providers (Declercq, Vanheule & Deheeger, 2010) may develop secondary alexithymia—a defensive response which cuts off access to unbearable internal states. The loss of interoception correlates with an inability to mount an empathic response to another's distress (Bernhardt & Singer, 2012). Inability to recognize suffering, attune to another, and experience empathic concern may hinder compassionate response to suffering and limit moral sensitivity. The clinician is at risk for further injuring himself and his patient. Alexithymia may place a clinician at risk for pathological altruism; McCaslin et al. (2006) noted that New York police officers with high degrees of alexithymia were more likely than their colleagues to engage in post-9/11 disaster work even if they were also experiencing PTSD. Though not a psychologist or psychiatrist, the chaplain may notice in her intimate work with a clinician that this person seems disconnected from their own interior landscape. The chaplain is charged with shepherding those in the edge states; giving, kind speech, beneficial deeds, and cooperation (Dogen, 1243/2001) guide her efforts.

Healthcare system research, monitoring, and interventions currently focus on far-downstream sequelae of moral injury such as provider attrition due to bullying and burnout, substance abuse, and lack of engagement. An increasing number of hospitals are responding by establishing peer-to-peer programs such as Caring for the Caregiver at UCSF Medical Center. Program director Dr. Kiran Gupta explained: "We weren't able through root cause analyses to ask in a meaningful way 'How are *you* doing?'" (K. Gupta, personal communication, August 2, 2019). Chaplaincy has a crucial contribution to make in reorienting institutional conversations back toward the moral heart that makes clinicians and healthcare as a profession fundamentally resilient. Spiritual care for the injured clinician aspires to restore and enhance this moral resilience.

Meeting the challenge of moral injury in healthcare, the engaged Buddhist chaplain is a change agent at multiple levels. She recognizes the truth of dependent co-arising, as expressed by Shantideva:

> All defilements of whatever kind,
>
> The whole variety of evil deeds
>
> Are brought about by circumstances:
>
> None is independent, none autonomous. (verse 6.25, p. 70)

Modern healthcare as a glorious triumph over illness, old age, and death and those who practice it as infallible paragons of compassion and self-sacrifice are delusions. As Yandell (2019) cautioned regarding the mythology of war: "We refine, polish, and admire [that story]....We take it and beat the hell out of people who have lived a different story....We let them fall apart, fall

through the cracks, fade and slip away, because we cannot bring ourselves to see it!" (p. 14).

Shantideva offered another target:

> Imagine that the steward of a king
>
> Does injury to multitudes of people.
>
> Those with clear, farseeing eyes
>
> Do not respond with violence even if they can.
>
> For stewards, after all, are not alone.
>
> They are supported by the kingly power .... (verses 6.127-128, p. 82)

How might the chaplain engage not just with the wounded clinician, but transform the kingly power of the healthcare system which set that individual up to harm patients and himself? In choosing how to strategically allocate his resources, the chaplain might consider the framework of primary, secondary, and tertiary prevention—familiar to his physician and nurse colleagues. Tertiary prevention aims to contain an established disease process, such as giving chemotherapy to a woman with cervical cancer. Secondary prevention identifies disease at the moment it manifests, when it may be most readily treated; this is her PAP smear. Best of all would be to prevent disease entirely. This is the primary prevention afforded by a vaccine.

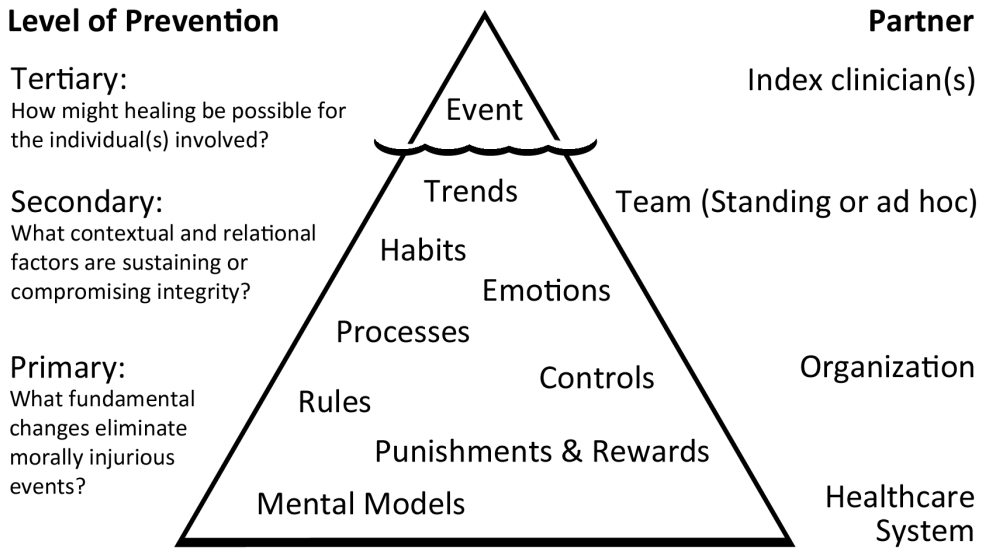

Figure 3: Chaplain Prevention of Clinician Moral Injury: A Systems View. Adapted from *Ways of Seeing: Systems Fundamentals* by J. Byrnes, March 20, 2019.

Seen through a systems lens (Byrnes, 2019; see Figure 3), a clinician overwhelmed with shame at his own transgressive act stands at the tip of an iceberg. The chaplain employs tertiary preventive measures to restore what wholeness is possible. If the chaplain is present near or at the time the event occurred, she is at the waterline, able to see some of what is arising as well as some of the precipitating factors. She has an opportunity to engage in secondary prevention, to lessen subsequent suffering while its seeds are small. She begins to map out patterns and engage potential allies. She facilitates or participates in working groups tasked with transforming mindsets and deep structures. These become an organizational vaccine. The orientation, foundation, and interventions proposed in this paper address the three levels of moral injury prevention from a spiritual care perspective.

Conclusion

Summary

Healthcare providers frequently find themselves in situations in which they, or those they trust, intentionally or unintentionally violate core values of nonharming, beneficence, and justice. Guilt, shame, and anger lead to mental and behavioral health problems including depression, burnout, and lateral violence. This is moral injury, similar in its formation to the first and second arrows from the *Sallatha Sutta*. Vows guide thoughts, words, and actions from training onward for chaplain and clinician alike. Meeting on this common ground, they examine the illusory nature of self and recall their shared aspiration to free all beings from suffering. They engage positive regret, confession, resolve, and remediation in finding a way forward. Not separate from the system which promotes morally injurious events, the chaplain identifies and moves on opportunities to prevent further harm. A suite of proposed interventions offers opportunities to work at small and large scales at the primary, secondary, and tertiary levels of injury prevention.

Next Steps

Where and how to begin will depend on the internal and external resources available to the chaplain. Initially concentrating on a particularly high-risk service area or situation may provide the small test of change needed to enlist additional stakeholders.

In selecting a service area on which to focus, the chaplain might choose the ICU, emergency department, labor and delivery, or perioperative services (K. Gupta, personal communication, August 2, 2019). Due to care complexity and high patient acuity in these areas, the frequency and impact of harmful events may be greater.

Many hospitals have rapid response teams, nurses and members of other disciplines who assist when a patient suddenly deteriorates. Members of the patient's primary team may be feeling responsible for the change, particularly if an error was involved. Before moral injury sets in, there is opportunity for the chaplain or trained rapid response providers to offer spiritual care. "You are a human being asked to provide perfection in an environment where the stakes are high and the system is flawed" (K. Gupta, personal communication, August 2, 2019).

Particular situations carry high risk for moral injury. Caring for violent patients is one example. A clinician feels that her organization disregards her well-being by placing her in harm's way. She is not able to refuse without risking her job or professional license. Her moral injury might arise from a feeling of betrayal. Another clinician manhandles and yells at the patient. He looks back on his shift and knows he crossed a line. Moral injury from transgression might occur. The patient kicks a pregnant nurse. She fears for her baby's well-being and blames herself for any ill effect. The hospital flags violent patients for security officers; these patients should also be flagged for chaplains. The chaplain can attend to the providers, facilitating emotional down-regulation, offering nonjudgmental presence, and reorienting providers to their intention to serve. Recognizing that she is not separate from even the worst-behaving patient, the chaplain also invites him into her practice.

The chaplain working in an academic medical center is a resource in teaching faculty and senior trainees to role model healthy skills and how to proactively intervene with colleagues at risk. Working in a smaller organization such as a community hospice, the chaplain could conduct inservices on the model of clinician moral injury and approaches to spiritual care outlined in this paper.

Future Research

Military chaplains draw on a rich body of literature to inform their varied approaches to perpetrator, witness, and betrayal origins of moral injury. Civilian healthcare chaplains need the same. How common are these subtypes of moral injury and how often are they occurring in healthcare settings? What variation exists across settings and what system factors might account for it? How do moral injury symptoms in civilian healthcare providers align or not with the military experience?

Validated assessment tools assessing the prevalence and symptom intensity of moral injury in veterans and active duty military personnel include the Moral Injury Events Scale (Nash et al., 2013, pp. 650-651) and Moral Injury Symptom Scale-Military Version (Koenig, 2018, pp. 10-11) (see Appendix E). No comparable instruments are presently available for civilian settings. Healthcare provider versions of these tools are necessary. The chaplain working in an academic setting may enlist interdisciplinary colleagues with psychometric expertise in modifying existing instruments or developing new ones.

Current understanding of the spiritual cost of moral injury comes through an Abrahamic religious gestalt. What dimensions are possibly being missed by this limited view? For instance, the Moral Injury Symptom Scale asks the respondent about feeling punished, unloved, and unforgiven by a personal God. These phenomena do not directly translate for respondents of other traditions. For example, a Buddhist practitioner may feel that what she did or what happened to her relate to her own and others' karma. While existing assessment tools focus on deeds, the Buddhist practitioner might experience moral injury also arising from thoughts or speech. The Buddhist chaplain is a resource in describing alternative expressions of spirituality.

It may be that filling the gaps which miss manifestations of moral injury in non-Abrahamic respondents uncovers these or similar manifestations in respondents of any faith.

Once assessment tools for healthcare are available, they should be incorporated into existing and future initiatives directed toward clinician well-being. Trainees should be a priority. As noted elsewhere in this paper, potentially morally injurious events (PMIEs) begin occurring at that time. Do clinical pastoral education participants experience moral injury? How is it similar or different to that of physicians or nurses? What aspects of chaplaincy training may facilitate or hinder progression of moral injury?

Moral injury was described by Feinstein, Pavisian, and Storm (2018) in an international sample of journalists covering the migrant crisis in Europe. In this group, the most common PMIE was witnessing the immoral action of another. Experiencing a negative reaction correlated with increase in workload, poor control over resources needed to do the job, and a belief that organizational support is lacking. Conducting similar analyses of moral injury in healthcare may uncover system hazards that could be flipped into leverage points for positive change.

Qualitative data will provide a more nuanced view of the lived experience of healthcare moral injury. For instance, do clinicians coming from community-oriented rather than individualistic cultures experience moral injury differently?

Cross-analysis of clinical moral injury event types and associated symptomatology alongside trait and process measures of resilience may suggest ways to build on clinician strengths with spiritual care.

As chaplains undertake spiritual care of clinicians with moral injury, what types of approaches are most effective? How is effectiveness defined and measured? Having a

healthcare version of the Moral Injury Symptom Scale (MISS) and looking for a decrease in symptom burden and intensity is a beginning. Qualitative research in which chaplains partner with clinicians themselves is needed in order to characterize meaningful outcomes.

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Appendix A

Ghosts That We Knew

You saw my pain, washed out in the rain
And broken glass, saw the blood run from my veins
But you saw no fault, no cracks in my heart
And you knelt beside my hope torn apart

But the ghosts that we knew will flicker from view
And we'll live a long life

So give me hope in the darkness that I will see the light
'Cause oh they gave me such a fright
But I will hold as long as you like
Just promise me we'll be alright

So lead me back, turn south from that place
And close my eyes to my recent disgrace
'Cause you know my call, and we'll share my all
And our children come and they will hear me roar

So give me hope in the darkness that I will see the light
'Cause oh they gave me such a fright
But I will hold as long as you like
Just promise me we'll be alright

Hold me still and bury my heart on the coals
Hold me still and bury my heart next to yours

So give me hope in the darkness that I will see the light
'Cause oh they gave me such a fright
But I will hold on with all of my might
Just promise me we'll be alright

But the ghosts that we knew made us black and all blue
But we'll live a long life
And the ghosts that we knew will flicker from view
And we'll live a long life.

(Mumford & Sons, 2012, track 5)

Appendix B

Hippocratic Oath

I SWEAR by Apollo Physician, by Asclepius, by Health, by Panacea and by all the gods and goddesses, making them my witnesses, that I will carry out, according to my ability and judgment, this oath and this indenture. To hold my teacher in this art equal to my own parents; to make him partner in my livelihood; when he is in need of money to share mine with him; to consider his family as my own brothers, and to teach them this art, if they want to learn it, without fee or indenture; to impart precept, oral instruction, and all other instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the physician's oath, but to nobody else. I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course. Similarly I will not give to a woman a pessary to cause abortion. But I will keep pure and holy both my life and my art. I will not use the knife, not even, verily, on sufferers from stone, but I will give place to such as are craftsmen therein. Into whatsoever houses I enter, I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm, especially from abusing the bodies of man or woman, bond or free. And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets. Now if I carry out this oath, and break it not, may I gain for ever reputation among all men for my life and for my art; but if I transgress it and forswear myself, may the opposite befall me. (Hippocrates, trans. 1868, pp. 299-301)

Appendix C

Nightingale Pledge

I solemnly pledge myself before God and in the presence of this assembly:

To pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous and will not take or knowingly administer any harmful drug. I will do all in my power to elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping, and all family affairs coming to my knowledge in the practice of my profession. With loyalty will endeavor to aid the physician in his work and devote myself to the welfare of those committed to my care. (Gretter, as cited in Fowler, 2015, p. 12)

Appendix D

Buddhist Precepts (Zen Peacemaker Order)

Three Refuges

Inviting all creations into the mandala of my practice and vowing to serve them, I take refuge in: Buddha, the awakened nature of all beings, Dharma, the ocean of wisdom and compassion, Sangha, the interdependence of all creations.

The Three Tenets and Three Pure Precepts

Taking refuge and entering the stream of engaged practice, I vow to:

- First, do no harm: I vow not to harm others or myself, and to live in not knowing as the source of all manifestations.
- Second, do good: I vow to bear witness to the joys and pain of all life, and clearly see what is, without attachment or judgment.
- Third, do good for others: I vow to invite all hungry spirits into my life, and commit my energy and love to the healing of the earth, humanity, and all beings.

The Ten Pure Mind Practices

Endeavoring to actualize my vows, I engage in the practices of:

1. Recognizing that I am not separate from all that is: this is the practice of Non-harming. I will not lead a harmful life nor encourage others to do so, and I will live in harmony with all life and the environment sustaining it.

2. Being satisfied with what I have: this is the practice of Non-Stealing. I will not take anything not given, practicing contentment by freely giving, asking for, and accepting what is needed.
3. Encountering all creations with respect and dignity; this is the practice of Chaste Conduct. I will give and accept love and friendship without using or clinging.
4. Listening and speaking truthfully with kindness: this is the practice of Non-Lying. I will compassionately and constructively speak the truth as I perceive it, deceiving and harming no one.
5. Cultivating a mind that sees clearly: this is the practice of Not Being Deluded. I will embrace all experiences directly, without the many intoxicants of this world.
6. Realizing kindness: this is the practice of Not Talking About Others' Faults and Errors. Accepting what each moment offers, I vow to realize that I am not separate from any aspect of life and will abstain from criticizing others, taking responsibility for my own life.
7. Cultivating humility: this is the practice of Not Elevating Myself and Blaming Others. I will not blame or judge others, nor compete with others or covet recognition. I will hold all beings in equal regard and practice inclusiveness.
8. Being generous: this is the practice of Not Being Stingy. I will not foster a mind of poverty in others or myself, and I will use all the ingredients of my life, giving my best effort and accepting the result.
9. Transforming suffering into wisdom: this is the practice of Not Being Angry. I will not harbor resentment, rage, or revenge, and I will let anger teach me.

10. Honoring my life as a source of compassion and wisdom: this is the practice of Not Disparaging the Three Treasures. I will recognize that all beings, including myself, are expressions of oneness, diversity, and interdependence.

(Upaya Zen Center, 2016, pp. 14-15)

Appendix E: Assessment Tools

Moral Injury Events Scale (MIES)

Instructions: Please circle the appropriate number to indicate how much you agree or disagree with each of the following statements regarding your experiences at any time since joining the military.

		Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
1	I saw things that were morally wrong	1	2	3	4	5	6
2	I am troubled by having witnessed others' immoral acts	1	2	3	4	5	6
3	I acted in ways that violated my own moral code or values	1	2	3	4	5	6
4	I am troubled by having acted in ways that violated my own morals or values	1	2	3	4	5	6
5	I violated my own morals by failing to do something that I felt I should have done	1	2	3	4	5	6
6	I am troubled because I violated my morals by failing to do something that	1	2	3	4	5	6

	I felt I should have done						
7	I feel betrayed by leaders who I once trusted	1	2	3	4	5	6
8	I feel betrayed by fellow service members who I once trusted	1	2	3	4	5	6
9	I feel betrayed by others outside the U.S. military who I once trusted	1	2	3	4	5	6

(Nash et al., 2013, pp. 650-651)

The Moral Injury Symptom Scale—Military Version

Introduction: The following statements/questions may be difficult, but they are common experiences of combat Veterans or Active Duty Military returning from battle. They concern your experiences while in a combat or war zone and how you are feeling now. Just do the best you can and try to answer every question. Circle a *single* number between 1 and 10 for each ("strongly disagree" to "strongly agree"):											
Guilt											
1.	I feel guilt for surviving when others didn't.	1	2	3	4	5	6	7	8	9	10
2.	I feel guilt over failing to save the life of someone in war.	1	2	3	4	5	6	7	8	9	10
3.	Some of the things I did during the war out of anger or frustration continue to bother me.	1	2	3	4	5	6	7	8	9	10
4.	It bothers me sometimes that I enjoyed hurting/killing people during the war.	1	2	3	4	5	6	7	8	9	10
Shame											
5.	If people knew more about the things I did during the war they would think less of me.	1	2	3	4	5	6	7	8	9	10
6.	I feel ashamed about what I did or did not do during this time.	1	2	3	4	5	6	7	8	9	10
Betrayal											
7.	I feel betrayed by leaders who I once trusted.	1	2	3	4	5	6	7	8	9	10
8.	I feel betrayed by fellow service members who I once trusted.	1	2	3	4	5	6	7	8	9	10
9.	I feel betrayed by others outside the US military who I once trusted.	1	2	3	4	5	6	7	8	9	10
Violation of Moral Values											
10.	I am troubled by having witnessed others' immoral acts.	1	2	3	4	5	6	7	8	9	10

11.	I am troubled by having acted in ways that violated my own morals or values.	1	2	3	4	5	6	7	8	9	10
12.	I am troubled because I violated my morals by failing to do something that I felt I should've done.	1	2	3	4	5	6	7	8	9	10
Loss of Meaning											
Introduction*:* Circle a *single* number between 1 and 10 that describes how true each statement is for you ("absolutely untrue" to "absolutely true"):											
13.	I understand my life's meaning.	1	2	3	4	5	6	7	8	9	10
14.	My life has a clear sense of purpose.	1	2	3	4	5	6	7	8	9	10
15.	I have a good sense of what makes my life meaningful.	1	2	3	4	5	6	7	8	9	10
16.	I have discovered a satisfying life purpose.	1	2	3	4	5	6	7	8	9	10
Difficulty Forgiving											
Introduction: Circle a *single* number between 1 and 10 that describes how true or false each statement is for you ("almost always false of me" to "almost always true of me"):											
17.	Although I feel bad at first when I mess up, over time I can give myself some slack.	1	2	3	4	5	6	7	8	9	10
18.	I hold grudges against myself for negative things I've done.	1	2	3	4	5	6	7	8	9	10
19.	It is really hard for me to accept myself once I've messed up.	1	2	3	4	5	6	7	8	9	10
20.	I don't stop criticizing myself for negative things I've felt, thought, said, or done.	1	2	3	4	5	6	7	8	9	10
21.	I believe that God has forgiven me for what I did during combat.	1	2	3	4	5	6	7	8	9	10
22.	I have forgiven God for what happened to me or others during combat.	1	2	3	4	5	6	7	8	9	10
23.	I have forgiven myself for what happened to me or others during combat.	1	2	3	4	5	6	7	8	9	10
Loss of Trust											

Introduction: Circle a *single* number between 1 and 10 that describes how much you agree or disagree with each statement ("strongly disagree" to "strongly agree"):											
24.	Most people are basically honest.	1	2	3	4	5	6	7	8	9	10
25.	Most people are trustworthy.	1	2	3	4	5	6	7	8	9	10
26.	Most people are basically good and kind.	1	2	3	4	5	6	7	8	9	10
27.	Most people are trustful of others.	1	2	3	4	5	6	7	8	9	10
Self-Condemnation											
Introduction: Circle a *single* number between 1 and 10 for each statement ("strongly disagree" to "strongly agree"):											
28.	On the whole, I am satisfied with myself.	1	2	3	4	5	6	7	8	9	10
29.	At times I think I am no good at all.	1	2	3	4	5	6	7	8	9	10
30.	I feel that I have a number of good qualities.	1	2	3	4	5	6	7	8	9	10
31.	I am able to do things as well as most other people.	1	2	3	4	5	6	7	8	9	10
32.	I feel I do not have much to be proud of.	1	2	3	4	5	6	7	8	9	10
33.	I certainly feel useless at times.	1	2	3	4	5	6	7	8	9	10
34.	I feel that I'm a person of worth, at least on an equal plane with others.	1	2	3	4	5	6	7	8	9	10
35.	I wish I could have more respect for myself.	1	2	3	4	5	6	7	8	9	10
36.	All in all, I am inclined to feel that I am a failure.	1	2	3	4	5	6	7	8	9	10
37.	I take a positive attitude toward myself.	1	2	3	4	5	6	7	8	9	10
Introduction: Below are feelings that combat Veterans often have due to combat experiences. How much have you? Circle a *single* number between 1 and 10 for each statement ("a great deal" or "very true" to "not at all" or "very untrue"):											
Spiritual/Religious Struggles											
38.	I wonder whether God had abandoned me.	1	2	3	4	5	6	7	8	9	10

39.	I felt punished by God for my lack of devotion.	1	2	3	4	5	6	7	8	9	10
40.	I wondered what I did for God to punish me.	1	2	3	4	5	6	7	8	9	10
41.	I questioned God's love for me.	1	2	3	4	5	6	7	8	9	10
42.	I questioned the power of God.	1	2	3	4	5	6	7	8	9	10
43.	I wondered whether my church had abandoned me.	1	2	3	4	5	6	7	8	9	10
Loss of Religious Faith/Hope											
44.	*Compared to when you first went into the military* has your religious faith since then… ("weakened a lot," "weakened a little," "strengthened a little," "strengthened a lot")										
45.	How hopeful are you about the future? ("not at all" to "very hopeful")										

(Koenig, 2018, pp. 10-11)