PERSPECTIVE

The Wounds We Dress And The Ones We Carry: Moral Injury In Modern Wound Care

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As professionals in the wound care sector, we are assumed to be experts in the vocabulary and in the observation, assessment, management and prevention of skin injuries. We can categorize wounds based on type and severity, and we are dependent on our observational skills. Wounds are measurable, billable and protocol driven. In today's health-care systems, wound care clinicians are not only treating tissue damage; we are navigating ethical fractures that create wounds that surpass length, width and depth parameters. The intersection of wound care and these fractures reveal a quiet crisis in modern medicine-one that not even the balsam of Gilead could soothe.[5]

Every day, wound care clinicians frequently encounter patients whose conditions reflect prolonged neglect, systemic inequalities and failures in continuity of care. Chronic pressure injuries, diabetic ulcers and infected surgical wounds frequently tell stories of delayed intervention, understaffing and fragmentation amongst care teams. Issues such as poverty, immobility, chronic illness, malnutrition and general institutional failure become focal points on wound care prevention and management. Clinicians begin to be the masters of wearing many hats, not only that of wound care specialist, but also social worker, nutritionist, and case manager.

To treat a Stage IV pressure injury is, in many cases, to confront the reality that it never should have existed. Wound care offers a unique lens into the deeper fractures of health care. A wound is a failure of integrity-of the skin, yes, but also of the systems meant to protect it. When a pressure injury develops, the question should not only be "how do we treat it?" but also "why did this happen, and what does it say about our capacity to provide ethical care."

Moral injury, a concept first developed in military contexts,[1] has gained traction in health care as clinicians confront situations that violate their ethical commitments. Moral injury is not burnout; it is not fatigue. It is the psychological, emotional and ethical harm that occurs when clinicians are unable to provide the care they know patients need because of systemic constraints.[2,3] In wound care, this collision between professional values and institutional realities is not abstract—it is visible, measurable and, often, preventable.

Quantifiers, much like diagnostic billing codes, look at the conciseness of moral injury origination: 1) Was there a 'betrayal' of what is deemed morally or ethically right. 2) Was that betrayal instigated by or encouraged by a person of authority? 3) Was this action/behaviour centred in a high stakes situation? 4) All three?[3]

I experienced this directly during the COVID-19 pandemic while working as a traveling Certified Nursing Assistant (or CNA, a US version of Nurse Aid/ Personal Support Worker in Canada) in New York City. Patient rounding–checking on patients at least every two hour–is a fundamental standard of care.

There is a recommendation of alternating purposeful rounding with Registered Nurses (RN) for a full scope of patient observation coverage. During purposeful rounding, patient repositioning for comfort or for pressure injury prevention is considered part of the 'Five P's', a guideline on rounding criteria.[4] On one shift, I was stopped by an RN and instructed not to enter any COVID isolation rooms, despite having proper PPE and training. The choice was clear; follow orders or risk termination. At that moment, my professional and moral obligations collided with institutional authority. This was just one of the moral 'injuries' I acquired during my health-care career.

Research links moral injury in health care to anxiety, depression, disengagement, and increased risk for suicidal ideation and attempt.[5-8] It is not just the witnessing of suffering that causes harm, but the forced participation or inability to intervene in systems that perpetuate it. Moral injury is not a failure of the individual. It is a signal of systemic dysfunction--the healthcare-industrial complex is septic. Many of us, as health-care providers, have shifted into survival mode. When individuals are operating in a physiological or physical sphere of survival, we cannot shift into healing mode-- the mode that we need to be operating in--to be stewards of care for members of our communities.

When HCPs Do Not Feel Safe, Paitents Are Not Safe

Jeanne Vanella, DNP notes that when health-care providers "do not feel safe, patients are not truly safe."[9] Moral injury cuts deep into our professional and moral ethics, in that it targets the very oath of care that we have dedicated our lives and careers to.[10]

How then do we begin the healing process when we have been morally wounded? Much like a physical wound, recognition is key. Having the framework and the vocabulary to describe the wound within a context is critical. We must be willing to start the hard conversations about our own professional wounds and how they may distort our frame of reference and our ambitions in healing physical wounds.
For organizations, prevention--how can executive leadership create safe work environments where the risk for ethical and moral violations-- are minimized? Does direct staff, including the nurse aids/personal support workers, feel supported in their role? Is there enough staff and resources for them to perform in their role in a way that aligns with their professional code and moral duty? As clinicians, we are charged with a bi-fold focus; prevention and healing.

Prevention for us looks different, it requires the courage to stand up as leaders against the systems that drive and perpetuate ongoing moral injury in our colleagues. Healing is the ability to take a step back and examine ourselves for signs of moral injuries. Are there memories of our careers that still elicit strong visceral reactions of anger, shame, regret? Healing also looks like acknowledging that our fellow colleagues may also have unaddressed wounds. We can collectively say "OUCH!" and begin our healing process.

Like physical wounds, there are suggestions for care supports: therapeutic techniques specific to moral injury and health-care worker trauma with trained psychological professionals, peer led support groups (such as www.dontclockout.org[11]) and/or removing ourselves from work environments that increase the risk for ongoing injury. The future of wound care depends on clinicians to be able to think critically, not only on skin integrity, but also on soul integrity.

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Additional Reading

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