Protecting against moral injury among healthcare missionaries

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As mentioned in the introduction of our study in this issue, *Moral injury among healthcare missionaries: a qualitative study*, the setting of cross-cultural medicine inherently produces moral injury. This moral injury occurs because different cultures have different deeply held values, and medical care intersects with some of the most emotionally and spiritually powerful values. Moral injury is one of the most common reasons for distress in healthcare missionaries, and the consequences can be severe and lifelong. Our study found seven core conflicts of values that can lead to moral injury. What can be done?

Preparation

Despite their ubiquity, the factors we identified are not inherently evident to new missionaries. Several programs have been developed to prepare missionaries generally for cross-cultural service. Still, a specialized education program can prepare healthcare missionaries to serve in this challenging setting. Based on our interviews, such a program should include the following components:

1. Familiarization with moral injury and its management. The concept of moral injury is new to many, but its relevance to cross-cultural healthcare should be obvious. Moral injury can sometimes be forestalled by better comprehension of our deeply held values. Putting words and definitions to experiences and feelings helps missionaries identify early when moral injury is happening. Moral injury can be managed with the help of appropriate support systems and through various spiritual practices, such as lament, confession, and receiving forgiveness, sharing with non-judgmental believers, taking time away, and acting to "right the wrong." Such practices should be integrated into a healthcare missionary's spiritual support systems, personal and professional, given the porous boundaries between the two.
2. Understand the medical implications of the host culture's values. Cultural integration involves more than greetings, clothing, and food. The clash of different moral beliefs produces profound consequences for healthcare delivery. Differing beliefs regarding the value of human life, sexual practices, gender hierarchy, authority for decision-making, and the use of money can lead to emotional conflicts. We would do well to work with new missionaries to explore those values and how they intersect with medicine. Such exploration should include the culture's leadership values and practices. Regular meetings should be held between members of both cultures to graciously explore and understand beliefs as

they are discovered, with the goals of humility, reciprocal learning, and unity.

3. Theological preparation to encounter great suffering and frequent, tragic death and understand the spiritual role of healthcare. Many HCMs felt underprepared to deal with these deeply spiritually challenging issues. HCMs may be well prepared in the technical aspects of healthcare, but their missionary medical practices can thrust them into spiritual disorientation without a theological rudder. Among the most critical issues: they must become facile wrestling with the great mysterious tension between God's sovereignty and our responsibility for our actions. Without understanding the truth of both, the HCM may not justify taking weekly, sabbath-like rest or contest circumstances that could be changed. Sending organizations would serve their HCMs well by considering such healthcare-related, theological preparation as a pre-departure competency.

Though an initial specialized education program is needed to introduce these ideas and competencies, we should be under no illusion that these complex and deep concepts can be thoroughly understood after one introductory training session. Throughout their careers, HCMs will experience new types of moral injury, surprising intercultural conflicts, unexpected betrayals, and different burdens of responsibility. Supporting organizations should provide or outsource an ongoing, HCM-specific, discipleship program to revisit and build upon these ideas and practices and to assist the HCM with their unique concerns.

Team and Institutional Boundaries

Several conflicting values found in our study include themes of work ethic, a sense of personal responsibility, overwhelming demands, and limited time. Developing helpful boundaries was identified as an essential measure to manage these conflicting values. Characteristics of successful boundaries included the following:

1. Prioritizing sustainable, managed, work schedules rather than allowing needs to dictate unpredictable work hours. A paradigm that prioritized "work until the work is done," such as allowing unlimited patient queues and keeping the same hospital workload despite losing staff, tended to promote burnout. In contrast, a paradigm in which a sustainable workload for the HCMs was determined first, then services were distributed or curtailed based on that workload limit tended to promote a perception of healthy service and effective navigation of conflict.
2. Development of a team approach to establish work boundaries and a spiritually healthy balance to life. If the HCM focuses on the acute needs in front of them, they may be unable to justify work boundaries. However, if the HCM team focuses on their long-term goals, sustainable service, and their holistic calling, they can more easily see the importance of boundaries. If they want to take care of patients, not just now but five and ten years from now, if they want their relationships with their loved ones to be healthy ten years from now, they need to structure life with balance. No one can be the ideal medic, parent, spouse, teammate, missionary, teacher, and cross-cultural leader all at once. There isn't enough time or human capacity. So, limitations in those ideals must be made, best made intentionally and collectively rather than accidentally and individually. Clinical work limitations should allow time for important personal relationships, meaningful spiritual interactions with patients and their families, practicing the spiritual disciplines, and other ministry duties or opportunities, for example,

with a local church or fellowship. Of note, decisions about healthy boundaries may be more easily developed after the HCM has become familiar with the management of moral injury and the theology of service, suffering, and God's sovereignty.

3. Institutional support for boundaries. Without guidance, support, and oversight, some HCMs may not be able to self-enforce boundaries or may conflict with the other HCMs' boundary preferences. If the institution (hospital or sending organization) facilitates the development of team boundaries, then endorses and supports the structure of those boundaries, the HCM team may be freed to practice without unnecessary guilt or shame and navigate conflict with hopefulness. Institution-supported boundaries could be introduced to prospective teammates or short-term visitors to unify expectations.
4. Team boundaries beyond work schedules. Team boundaries may address other value conflicts, such as Theme 4, "The professional value of practicing within one's training and competence conflicts with others' desire for the HCM to practice beyond those limitations." The team may adopt boundaries that either limit practice beyond one's training or may institutionally support practice beyond one's training due to legitimate need. Such boundaries could either support or redefine one's deeply held values to limit the effects of moral injury.

Overall implications

Though the term "moral injury" implies wounding, the outcome of this wounding need not always be predominantly loss. Moral struggle may lead to a greater awareness of truth, wisdom, and growth in relationships with others, self, the environment, and God. The core value conflict themes identified in this study and the implications of these conflicts may help us focus our efforts on better preparation for the challenging service of healthcare missions, toward more personal and spiritual growth and away from unexplored and misunderstood wounding which paralyses or undermines sustainable service.

A strength of qualitative research is identifying new areas for further investigation. Our interviews have identified many topics which would benefit from focused study, including cross-cultural leadership, the relationship between longevity and cultural integration strategies, understanding spiritual strategies of healthcare missions, integration of awareness of the supernatural in daily practice, and many others. We hope our findings will spark a broader interest in this research, and we anticipate great fruit from the ongoing study of the spiritually profound field of healthcare missions.