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Organizational Impact on Healthcare Workers' Moral Injury During COVID-19

A Mixed-Methods Analysis

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OBJECTIVE: The aim of this study was to explore relationships between organizational factors and moral injury among healthcare workers and the impact of perceptions of their leaders and organizations during COVID-19.

BACKGROUND: COVID-19 placed healthcare workers at risk for moral injury, which often involves feeling betrayed by people with authority and can impact workplace culture.

METHODS: Secondary data from a Web-based survey of mid-Atlantic healthcare workers were analyzed using mixed methods. Data were synthesized using the Reina Trust & Betrayal Model.

RESULTS: Fifty-five percent (n = 328/595) of respondents wrote comments. Forty-one percent (n = 134/328) of commenters had moral injury scores of 36 or higher. Three themes emerged: organizational infrastructure, support from leaders, and palliative care involvement. Respondents outlined organizational remedies, which were organized into 5 domains.

CONCLUSIONS: Findings suggest healthcare workers feel trust was breached by their organizations' leaders during COVID-19. Further study is needed to understand intersections between organizational factors and moral injury to enhance trust within healthcare organizations.

The novel coronavirus COVID-19 pandemic has had an unprecedented impact on the US healthcare system, rendering healthcare workers (HCWs) at a high risk for experiencing moral suffering to differing degrees, which can contribute to burnout and a poor ethical climate in the workplace.[1] Moral injury (MI), a concept originally studied in a military context, acknowledges a corrosive form of moral suffering that involves violation of a person's moral core.[2] The complex situations that contribute to MI among HCWs can diminish workers' overall capability and productivity by leaving moral wounds that are not easily healed.[3] Moral injury has gained acknowledgment in light of COVID-19, and recent studies have found interdisciplinary HCWs are now experiencing clinically significant MI symptoms as a result of fallout from the pandemic.[4]

Moral injury encompasses feelings of betrayal of moral/ethical values by either an individual or a group.[2,5,6] Those experiencing MI often feel betrayed by leaders or those with authority, particularly in high-intensity work environments.[7,8] Challenges brought on by the pandemic intensified preexisting organizational factors known to degrade HCWs' well-being, such as increased working hours, exhaustion, and limited logistical support.[9] These barriers have caused significant moral burden for HCWs delivering patient care during the last year, leaving many HCWs feeling betrayed by their leaders/organizations and broader

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The authors declare no conflicts of interest.

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society. Trust is built over time in the workplace, but as witnessed during the pandemic, it can be broken in an instant or degrade after multiple breaches. Breaches of trust by leaders intentionally or unintentionally through organizational policies/practices can erode employee satisfaction, work engagement, and attrition and can prompt some to leave their profession altogether,[10,11] all of which exacerbate MI-related symptoms. Therefore, the purpose of this study was to explore relationships between organizational factors and prevalence of MI among a multiprofessional sample of HCWs, and the implications of HCWs' perceptions of their leaders and organizations during COVID-19.

Methods

Design and Data Collection

A Web-based, cross-sectional survey was distributed from June 2020 to November 2020 via Qualtrics to elicit HCWs' experiences of MI and ethical stressors amidst COVID-19. For this secondary analysis, a subset of participants who responded to at least 1 of the following open-ended questions were included: 1) "What resources do you need to help you confront the ethical challenges in the pandemic?" and/or 2) "From your perspective, what do you believe is additionally important for us to know?" Moral injury was originally measured using the 10-item Moral Injury Symptoms Scale-Health Professional scale (α = .93), where higher scores indicate a greater number of MI symptoms.[12] The Johns Hopkins Clinical Research Network approved the survey for distribution within a network of 5 academic and community-based medical centers. The Johns Hopkins Institutional Review Board deemed the study exempt.

Participants

The survey yielded responses from a multiprofessional cohort of HCWs, including nurses, physicians, and chaplains, among others (Table 1). In total, 55% of participants (n = 328) from the original sample (n = 595) were included in this analysis as because provided responses to survey items and the open-ended questions. Sixty-eight percent (n = 223) of respondents indicated they were involved in providing COVID-19–related clinical care. Furthermore, 41% (n = 134) of the sample yielded MI scores of 36 or higher indicating clinically significant MI symptoms among those who provided anecdotal responses.

Data Analysis

Descriptive data were analyzed using SPSS statistical software (version 27.0; Armonk, New York). Number of responses and percentages were computed to characterize relevant demographics and MI scores.

Table 1. Participant Demographics (N = 328)

Question	Responses	n	%
Demographics of participants			
Profession	Nurse	188	57.5
	Physician	47	14.4
	Respiratory therapist	19	5.8
	Nurse practitioner/ physician assistant	20	6.1
	Other	53	16.2
Years in profession	0-10	123	37.6
	10-20	80	24.5
	20+	124	37.9
Highest level of education completed	Associate degree	52	16.0
	Bachelor's degree	128	39.3
	Master's degree	83	25.5
	Doctorate	63	19.3
Practice location	Emergency department	23	7.1
	Inpatient: critical care	76	23.4
	Inpatient: other	131	40.3
	Operating room	14	4.3
	Outpatient/ ambulatory care	81	24.9
Involved in COVID-19 clinical care	No	105	32.0
	Yes	223	68.0
Involved in COVID-19 research regarding their organization's response to the pandemic	No	271	82.6
	Yes	57	17.4
Spiritual/religious preference	Buddhist	3	0.9
	Christian/ Protestant	122	37.2
	Hindu	3	0.9
	Islam	4	1.2
	Roman Catholic	86	26.2
	Jewish	11	3.4
	Spiritual but not religious	47	14.3
	No religious preference	52	15.9
Moral injury			
Moral injury ≥ 36	No	191	58.8
	Yes	134	41.2

The template organizing style was used to organize qualitative data,[13] generating a spreadsheet of textual material, which was stored in Microsoft Excel. Data were open coded independently by 3 authors (K.E.N., C.D.L., and D.S.) following the general principles of interpretive phenomenological analysis and qualitative content analysis.[14] Codes and emerging themes were compared, and discrepancies were reconciled through consensus. The codebook was iteratively refined throughout analysis. Coded segments were sorted by frequency of codes to identify key

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areas warranting further exploration and then displayed to identify respective themes and subthemes.

Organizational Model for Analysis

The Reina Trust & Betrayal Model was used as an organizing model for data synthesis.[15] Although not selected a priori, this conceptual model presented a unique opportunity for further interpretation of findings within the concept of building and breaking trust in healthcare organizations. The Reina Three Dimensions of Trust: Trust of Communication, Trust of Character, and Trust of Capability provide a behaviorally focused framework for assessing where and how trust is built and broken in an organizational context.[15] Each dimension is broken into behaviors, which prioritize optimal leadership practices to bolster a positive work environment (Figure).[16]

Data Integration

Findings were mixed and organized in an integrative display (Table 2), which crosswalks qualitative themes and subthemes, frequency of comments, corresponding survey items, and quantitative results. Each subtheme was linked to relevant dimensions of the organizing model, which enabled a deeper understanding of quantitative survey results and insights for participants' responses, while concurrently examining the interplay among various organizational factors.

Results

Three major themes and 10 subthemes emerged from analyzing comments about respondents' experiences as HCWs during COVID-19. In order of frequency, major themes included: 1) organizational infrastructure; 2) support from leaders; and 3) palliative care involvement. Respondents also outlined organizational remedies, which were organized into 5 domains. Principal exemplars from major themes and subthemes are provided hereinafter.

Major Theme 1: Organizational Infrastructure

A need for stronger organizational infrastructure to support HCWs during the COVID-19 pandemic was the most prevalent theme to emerge from the data. Subthemes included: 1) availability of resources; 2) clear communication; 3) offering hazard pay and other incentives; and 4) consistent enforcement of policies, practices, and rules.

Availability of Resources

Healthcare workers highlighted the need for greater resources, including testing materials, personal protective equipment (PPE), treatments of COVID-19, mechanical ventilators, and adequate staffing, to treat patients with COVID-19 and keep everyone safe. They discussed the link between resources and personal safety, as 27 of the overall 67 comments explicitly pointed to concern that patients/staff were being placed in unsafe situations because of resource shortages. One respondent wrote, "The pandemic is not over so stop pulling resources to save your budget," showing congruence, as the survey showed 55% of HCWs experienced moral distress from working with limited resources (such as PPE, mechanical ventilators, etc).

Clear Communication

COVID-19–related policies and practices have frequently changed. As such, HCWs expressed the need for more detailed communication about what was being done to ensure the safety of patients, visitors, and HCWs. Healthcare workers wanted "more streamline communication on specific actions leadership is

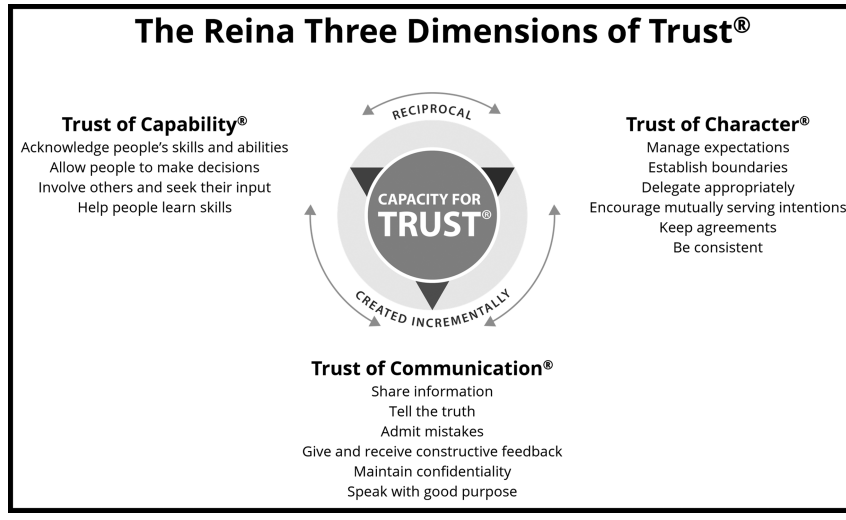

Figure. Key tenets of the Reina Trust & Betrayal Model.

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Table 2. *Integrated Quantitative and Qualitative Findings*

Subthemes	Link to Reina Three Dimensions of Trust	Qualitative Exemplar Quotes	No. Comments	Corresponding Survey Item	Quantitative Results
		Major theme 1: organizational infrastructure			
Availability of resources	Trust of Character • Manage expectations • Keep agreements	"Appropriate nursing staffing on COVID units. Ratios currently are extremely unsafe, cannot monitor or respond to patients. Stop treating COVID unit like a normal Med-Surg unit-acuity is so much higher. High nurse attrition is making it worse." "The pandemic is not over so stop pulling resources to save your budget." "Administration actually paying attention to what is actually happening and how dangerous short staffing is."	67	Q11: Given the pandemic crisis right now, to what extent are you experiencing moral distress related to the following situations? Working with limited resources (ie, PPE, COVID testing, staff, ventilators).	55%, a lot/a great deal
Clear communication (includes available resources)	Trust of Communication • Share information • Speak with good purpose	"More streamline communication on specific actions leadership is taking to serve us as staff, and the community." "Reasoning behind decisions to be explained."	31	Q8: Please consider how effective your organization is in providing the following: communication updates regarding system-based changes.	35%, not effective at all/slightly effective
Hazard pay and other incentives	Trust of Character • Manage expectations • Keep agreements	"Better Pay. When you are struggling to provide the best patient care in the midst of a pandemic but aren't paid well, this creates poor morale."	21	Q8: Please consider how effective your organization is in providing the following: information on hazard supplemental compensation.	75%, not effective at all/slightly effective
Consistent enforcement of policies, practices, and rules	Trust of Character • Manage expectations • Be consistent • Keep agreements	"We need CONSISENT, well thought out and logical policies for protecting staff and patients, and we need consistent enforcement of these policies." "Clear straight forward rules that are update and notified to each and every nursing staff. It is stressful coming into work with a new policy on how to handle COVID-19 every shift."	17	Q8: Please consider how effective your organization is in providing the following: policies regarding crisis response. Q11: Given the pandemic crisis right now, to what extent are you experiencing moral distress related to the following situations? Communication of new policies/practice that may forego interventions with patients/families.	46%, not effective at all/slightly effective 32%, a lot/a great deal
		Major theme 2: support from leaders			
Being heard and having concerns addressed	Trust of Communication • Speak with good purpose Trust of Character • Mutually serving intensions Trust of Capability • Involve others and seek their input	"I need to feel that I have a voice and that my concerns will be addressed and dealt with, not tucked away. Saying the words does not make me feel better. I want the problem fixed." "To be able to voice concerns and questions without being treated as if I am a problem." "...understanding that when I have a concern it is heard and not immediately dismissed or that everyone is so overwhelmed it will get dealt with at some point."	42	Q8: Please consider how effective your organization is in providing the following: Having forums with leaders to share concerns An environment that promotes speaking up without fear of retaliation	49%, not effective at all/slightly effective 49%, not effective at all/slightly effective

(continues)

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Table 2. *Integrated Quantitative and Qualitative Findings, Continued*

Subthemes	Link to Reina Three Dimensions of Trust	Qualitative Exemplar Quotes	No. Comments	Corresponding Survey Item	Quantitative Results
Trustworthiness	Trust of Communication • Share information • Tell the truth • Speak with good purpose	"I would appreciate hearing the truth from hospital administrators—we are told that PPE is short, but we are fine. We are not fine. We also know that PPE supplies are limited. Please do not insult me by telling me that we are safe as we should be right now. Instead, please tell me what you are doing to get us the equipment we need. It does no good to try to convince me of something untrue instead of acknowledging the problem and explaining how we are trying to fix it." "...transparency of administration by sharing why decisions are being made." "...trust in coworkers and health care across the nation to provide us with actual facts instead of releasing info on 'studies' that have not been proven to the fullest extent possible." "Leadership that believes in and respects science. I will only feel better about the ethical challenges in the pandemic if I know that there is not an entity that is constantly spouting misinformation that directly goes against everything that I'm trying to do to help my patients. Furthermore, it would be nice if our patients had less skepticism regarding their care during the pandemic due to what they have heard from our leadership." "Scientific proof and knowledge of what is taking place."	27	Q8: Please consider how effective your organization is in providing the following: An environment that promotes speaking up about concerns without fear of retaliation Communication updates regarding system-based changes	49%, not effective at all/slightly effective 35%, not effective at all/slightly effective
Empathy, appreciated, and being valued	Trust of Capability • Acknowledge people's skills and abilities Trust of Character • Encourage mutually serving intentions	"...understanding what we are going through and that we are scared." "Feel appreciated and valued, but not through words of thank you but instead by helping them solve problems." "Nurses feel abandoned, we are taking care of these patients with limited resources, rotating staff and limited compensation. We feel under-appreciated and under compensated."	27	Not applicable	Not applicable

(continues)

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Table 2. Integrated Quantitative and Qualitative Findings, Continued

Subthemes	Link to Reina Three Dimensions of Trust	Qualitative Exemplar Quotes	No. Comments	Corresponding Survey Item	Quantitative Results
Being present and visible	Trust of Character • Manage expectations • Encourage mutually serving intentions Trust of Capability • Involve others and seek their input	"For my workplace to actually put in work to help support us rather than give blanket statements and call us 'heroes.'" "Executive leaders to be visible during the crisis. Executive leaders to involve the leaders and bedside staff in decision making because we are the ones actually doing the work and know what works in current practice." "Support from administration letting us know they know what we are up against/see them on the front line."	14	Q8: Please consider how effective your organization is in providing the following: Having forums with leaders to share concerns	49%, not effective/ slightly effective
		Major theme 3: palliative care involvement			
Advocating for dying patients	Trust of Capability • Allow people to make decisions • Involve others and seek their input	"Palliative support for those that are dying, they deserve a peaceful death, and many did not receive that." "Advocating for ethically dying for my patients, not prolonging COVID illness." "Do not keep people alive that should not be kept alive. Make sure family visits bedside when they want to in the event of end of life."	15	Q11: Given the pandemic crisis right now, to what extent are you experiencing moral distress related to the following situations? Not being able to advocate for patient needs due to resource constraints.	36%, a lot/a great deal
Dying alone	Trust of Capability • Involve others and seek their input Trust of Communication • Share information • Maintain confidentiality	"...need better communication with critically ill/ possible end of life with family—this is very distressing that patients do not get better when they are left alone in a room without family; staff are strained and have little time to call families to update on condition—make it hard to make good decisions especially when they cannot see their loved ones."	6	Q11: Given the pandemic crisis right now, to what extent are you experiencing moral distress related to the following situations? Not having access to loved ones.	64%, a lot/a great deal

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taking to serve us and the community." However, the survey showed 35% of HCWs felt their organization was "not effective" or "slightly effective" at communication updates regarding system-based changes.

Hazard Pay and Other Incentives

Twenty-one unique comments mentioned increased compensation for working during the COVID-19 pandemic. Healthcare workers delivering clinical care to patients with COVID-19 felt they should be compensated accordingly, given increased potential for virus transmission and limited resources. Several HCWs reported increases in staff turnover since the pandemic began. There was general agreement (75%) that organizations were providing insufficient information on hazard supplemental compensation.

Consistent Enforcement of Policies, Practices, and Rules

Comments regarding greater consistency in enforcing new policy and/or practice changes were mentioned 17 times. Policies and practices have been revised, as often as daily, since the start of the pandemic; however, unclear communication regarding these changes to frontline staff was frustrating for HCWs. A corresponding survey item revealed 32% of HCWs had "a lot" to "a great deal" of moral distress regarding communication of policies and practices that impacted interventions with patients and families.

Major Theme 2: Support From Leaders

An overarching theme of needing leadership support during the pandemic pervaded much of the data. Within this theme were 4 subthemes: 1) being heard and having concerns addressed; 2) truth, transparency, and trust; 3) empathy, appreciation, and feeling valued; and 4) being present and visible.

Being Heard and Having Concerns Addressed

Forty-two survey comments reflected HCWs' need to be heard and have concerns addressed by their leaders during COVID-19. Healthcare workers felt discouraged from sharing concerns, because they were either downplayed or not adequately addressed because of leaders being overwhelmed with external demands. One respondent discussed needing "to be able to voice concerns and questions without being treated as if I am a problem." These were consistent with the survey, whereby 49% of HCWs indicated their organizations were "not at all" to "slightly" effective at holding forums with leaders for sharing concerns.

Trustworthiness

The 2nd most frequently occurring subtheme, with 27 comments, was trustworthiness. Healthcare workers were not consistently receiving accurate information from their leaders. Several had questions surrounding what PPE was necessary, how much was available, safety protocols for reusing it, and what actions were being taken by organizational leaders to obtain additional items. One respondent expressed, "We are not fine. We also know that PPE supplies are limited. Please do not insult me by telling me that we are safe as we should be right now." Comments highlighted that HCWs tended to receive reassurances that resources were available, despite inadequacies, particularly amid national shortages that occurred during surges. In addition, HCWs reported feeling unsure that their organizations at large were receiving accurate guidance from government leaders and other public health organizations, such as the Centers for Disease Control and Prevention, fueling further issues of mistrust in leadership. This was largely reflected in the survey, whereby 49% reported their organizations as being "slightly effective" or "not at all effective" at creating an environment that promotes speaking up about concerns without fear of retaliation.

Empathy, Appreciation, and Being Valued

Being appreciated and valued was mentioned in 27 unique comments. Many HCWs wanted their leaders to value HCWs' contributions and efforts amidst heightened fear, exhaustion, and widespread resource shortages. Healthcare workers wanted more than only verbal praise; they wanted to not feel "abandoned."

Being Present and Visible

A desire for leaders to be visibly present was mentioned in 14 comments. Healthcare workers expressed having leaders present on the units was critical for provision of high-quality patient care, particularly during periods of such high stress. Several comments suggested this presence would not only enable tangible support but also increase opportunities for HCWs to provide input on organizational responses to the pandemic. One respondent described the importance of having executive leaders involve bedside staff in decision making because "we are the ones actually doing the work and know what works in current practice." Furthermore, greater interaction with frontline HCWs would provide a greater understanding for both parties, bolstering trust and recognition for the work both parties are doing.

Major Theme 3: Palliative Care Involvement

The 3rd major theme that evolved from the data was palliative care involvement for patients with COVID-19 and/or those who were actively dying. This included 2 subthemes, which were: 1) advocating for dying patients and 2) dying alone.

Advocating for Dying Patients

Healthcare workers expressed need for greater involvement of palliative care for patients in 11 unique

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comments, specifically to provide greater support throughout the dying experience. One respondent wrote, "They deserve a peaceful death, and many did not receive that." The survey found that 36% of HCWs disclosed feeling "a lot" to "a great deal" of moral distress over not being able to adequately advocate for their patients' unique needs throughout the COVID-19 pandemic due to resource constraints. In addition, some HCWs noted feeling ethically conflicted in patient situations where there was discussion of prolonging life via medical interventions despite a poor prognosis. Four comments indicated that palliative care involvement would have been particularly helpful in these types of complex situations.

Dying Alone

Six comments conveyed the heaviness of seriously ill and/or dying patients being isolated from family members during the COVID-19 pandemic. Accordingly, 64% of overall survey respondents felt "a lot" to "a great deal" of moral distress not having access to patients' family members due to the pandemic. Furthermore, some HCWs noted being too busy to keep families updated in a timely manner, causing even greater burden.

Organizational Support Remedies

Healthcare workers explicitly outlined resources and other sources of support that would have been helpful during the COVID-19 pandemic. Remedies outlined were organized within 5 domains: 1) counseling or other emotional support; 2) peer support (formal or informal); 3) education and ethics support; 4) wellness offerings; and 5) spiritual or faith support. Respondents' feedback and recommendations for healthcare leaders are outlined in Table 3.

Table 3. *Organizational Support Remedies and Recommendations*

Domain	Feedback From HCWs	Recommendations for Healthcare Leaders
Counseling or other emotional support	"A resource team of counselors and other support staff that staff can readily access to deal with difficult situations." "I feel that nurses all have a breaking point. It would be nice for healthcare facilities to emotionally support the nurses without them having to take time to do it themselves. Sometimes we just need to talk it out and everything will be okay."	• Humbly acknowledge and recognize suffering among HCWs • Provide formal and informal avenues for HCWs to share experiences and concerns at low or no cost to them; make counseling/mental health resources available during HCWs' shifts • Be vulnerable and express apology for any intentional missteps taken
Peer support (formal or informal)]	"Discussion groups regarding the shared trauma being in the ICU with 100% covid patients and a lot of death without families present." "Support from my teammates" "...talking through experiences with others that understand." "Time to allow for processing or debriefing."	• Express gratefulness to HCWs for personal sacrifices made • Make rounds to informally check in on staff on a human level without any administrative "agenda" • Bolster peer support and team-building activities for working through shared experiences; make accessible and relevant for all HCWs and staff
Education and ethical support	"More group discussion regarding treatment plans for these patients that we did not know how to treat." "Regular ethical rounds on COVID ICU patient who have been hospitalized/intubated…ethics and/or palliative should be pre-emptive, not brought in the last moment."	• Engage ethics and palliative care support for HCWs to debrief complex moral situations • Plan for institution of an emergency response communication plan from a centralized source that includes up-to-date education and information for all policy and procedure changes • Consider staffing ratios based on acuity of patients with COVID-19
Wellness offerings	"The pandemic has fundamentally dismantled many HCWs' perceptions of how they view their role in the future of healthcare. Many high achievers have abandoned personal goals and now operate at a 'bare minimum.' This is not the result of compassion fatigue or a loss of love for the profession but of sheer physical and emotional exhaustion." "I need to be at work less time to have time to rest, regroup and be present for my family."	• Provide evidence-informed wellness offerings that are accessible to all HCWs, including those rotating shifts • Develop a human resource policy for emergency situations, which addresses sick time, hazard pay, hiring incentives, and absenteeism expectations • Encourage staff taking time to truly disconnect from work when off the clock; revise policies for asking HCWs to fill staffing deficits to promote restoration during time off
Spiritual or faith support	"Making sure we are able to make difficult decisions from a place of inner peace. Having space to find that peace 'location,' having the courage to trust the God of my understanding when confronted with ethical challenges."	• Develop strategies for bolstering spiritual support • Carve out time and physical space in the workplace for HCWs to engage in their personal spiritual practices • Engage chaplains to support spiritual needs and facilitate team debriefing sessions

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Discussion

The field of organizational psychology is centered on the concept of trust as the crux of effective leadership and, in turn, positive work environments.[17] Of the sample included in this analysis, approximately 41% had MI scores indicative of clinically significant MI symptoms. Coupled with their detailed comments, it is clear HCWs perceived trust as being breached by their respective healthcare organizations and leaders, in major and minor ways, during a time of heightened vulnerability. The Reina Trust & Betrayal Model proved useful in synthesizing the impact of ways in which HCWs felt betrayed through use of the Reina Three Dimensions of Trust: Trust of Communication, Trust of Character, and Trust of Capability.

Healthcare workers' feelings of betrayal were likely amplified because of the pervasive sense of uncertainty and fear that most felt working in healthcare during the pandemic. At a time when frontline HCWs needed support from leaders, many felt they received the exact opposite, which perpetuated feelings of pain, frustration, and anger.[4] An overwhelming lack of safe spaces to engage in open dialogue regarding issues of concern with leaders further eroded Trust of Communication, which encompasses the ability to be truthful and speak with good purpose. Patterns of dismissing or diminishing HCWs' concerns left some feeling like a "problem." Furthermore, unclear disclosure of the rationale for leaders' decisions regarding policies and procedures eroded trust among HCWs. Nationally, healthcare leaders were laser focused on prioritizing business operations, managing teams, and ensuring continuity of patient care.[18] However, failing to give equal attention to the relational support needs of the workforce opens the door to feelings of betrayal. These findings reinforce ways that leaders and organizations may intentionally or unintentionally break trust during high-stakes situations and the vulnerability that emerges when a break in trust goes unacknowledged or supported because of lack of transparent communication and diminished open dialogue.

Fundamental to the healthcare work environment is an implicit expectation between an organization and HCWs that a safe environment and adequate resources be provided to ensure delivery of high-quality patient care. This embodies Trust of Character, which was breached as HCWs were stretched thin with scarce PPE and limited staffing that placed them at a higher risk of exposure to COVID-19 than the general community.[19] Further contributing to perceived breaches in Trust of Character was lack of additional compensation for frontline HCWs working under such hazardous conditions. In addition, the fluidity of science regarding COVID-19 pathophysiology, immunology, and prevention practices in the care of COVID-19 patients rendered frequent policy and practice changes. The continued inconsistencies over time made HCWs perceive their organization as unreliable to varying degrees. This ultimately diminished capacity to trust leaders, which can contribute to betrayal and burnout.[15] According to respondents' feedback, leaders who actively problem-solved alongside HCWs providing care for patients with COVID-19 were perceived as more trustworthy than those who only provided "empty" words of encouragement. This highlights the importance of leaders and frontline HCWs operating with a shared vision to circumvent organizational challenges, which are often beyond even leaders' control during public health crises.

In addition to having clear communication and expectations, acknowledgment of people's skills and abilities and seeking their input in decision making, where possible, foster Trust of Capability. Many HCWs felt helpless caring for patients with COVID-19 and left out of discussions that impacted their scope of work. This erodes trust not only in leaders but also in one's own ability to trust himself/herself and successfully carry out his/her job duties.[15] Furthermore, as aforementioned changes to practices and policies were made, some reported feeling left out of opportunities to become more educated about COVID-19 treatment and prevention efforts. Thus, whereas healthcare leaders' actions and behaviors were seemingly innocent, "othering" of HCWs, in addition to the ebb and flow of these 3 dimensions of trust, contributed to heightened experiences of distrust in the workplace.

Moving Forward

Healthcare workers are experiencing MI symptoms because of myriad challenges encountered during the pandemic, all of which have impacted aspects of trust in leaders and organizations. Findings from this analysis highlight opportunities on behalf of healthcare leaders to learn and grow in leading HCWs holistically through trust. All human beings innately need connection—to be heard, acknowledged, and understood. It is important to recognize that maintaining connections and healthy relationships in the workplace is paramount to maintaining effective business operations and health of an organization. In planning for future public health crises of COVID-19 scale, healthcare leaders should be sensitive to the fragility of trust in the workplace and be equipped to address it, because it will make or break the organization's ability to respond effectively.

Limitations

This study has limitations that must be considered. First and foremost, the original study used a cross-sectional

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study design. This inhibited our ability to infer any causal relationships given the original survey was not designed to answer a specific hypothesis. Furthermore, our results represent a convenience sample of HCWs, and as such, findings are not representative and should be interpreted with caution. Finally, the Reina Trust & Betrayal Model was not selected a priori. However, it provided a more in-depth synthesis of findings, and its application offers a promising theoretical avenue for future research.

Conclusion

The COVID-19 pandemic has led to increased prevalence of MI in HCWs, which has contributed to feelings of betrayal by their leaders and healthcare organizations. Further research is needed to explore the intersections between organizational factors, MI, and trust in HCWs. A more holistic understanding will help inform the development of interventions to restore trust that has been broken in the work environment. More importantly, further inquiry will support collective healing from the pain and disappointment that have been brought about by this unprecedented crisis.

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