2025, Volume 57, Issue 8, 1-4, e-ISSN 1938-3800

Family Medicine

COMMENTARY

Structurational Divergence: A Contributing Factor to Moral Injury Among Health Care Workers

LaKesha N. Anderson, PhD[a]; **Joshua Freeman, MD**[b]

AUTHOR AFFILIATIONS:

[a] Department of Health Professions Education, Uniformed Services University of the Health Sciences, Bethesda, MD

[b] Family and Community Medicine, University of Arizona, Tucson, AZ

CORRESPONDING AUTHOR:

Joshua Freeman, Family and Community Medicine, University of Arizona, Tucson, AZ, jfreeman3@gmail.com

HOW TO CITE: Anderson LN, Freeman J. Structurational Divergence: A Contributing Factor to Moral Injury Among Health Care Workers. *Fam Med.* 2025;57(8):1-4. doi: 10.22454/FamMed.2025.602498

PUBLISHED: 10 July 2025

KEYWORDS: academic environment, behavioral sciences, conflict resolution

ABSTRACT

To provide quality patient care, health professionals must be able to effectively communicate interpersonally and in team environments. While a lack of communication and conflict negotiation skills certainly can create obstacles to patient care, the organizational structures in which health professionals do their work also can obstruct communication or make it more difficult. Structurational divergence theory helps identify and explain the negative communication cycles that result when individuals must fulfill obligations from multiple competing systems, each with its own social rules.

The structure of health care delivery systems also can result in structurational divergence, as health care workers must often navigate the space between their clinician priorities of improved patient health and the corporate priorities of greater efficiency and profit. This divergence creates tension for the clinician that can lead to burnout and moral injury, especially when the clinician feels forced to act outside the patient's best interests.

Individual efforts to address moral injury are less likely to be successful than collective group action. However, medical education can take steps to prepare students with the knowledge and tools necessary to navigate competing role demands, systemic obstacles, and ethical dilemmas to ensure quality patient care.

WHAT IS STRUCTURATIONAL DIVERGENCE?

Structurational divergence (SD) theory helps identify and explain the negative communication cycles that result[1] when individuals feel "compelled to simultaneously fulfill obligations from multiple systems of social rules, each normatively sanctioned by its own structure."[2] In the health care setting, professionals must be able to effectively communicate interpersonally and in team environments to provide quality patient care. This communication involves sharing a mutual understanding of clinician roles as well as the goals and priorities of their work. An individual's lack of communication and conflict negotiation skills can create obstacles to patient care, but the organizational structures in which health professionals do their work also can obstruct communication or make it more difficult.

In health care, the official or *de facto* structures that exist and the work that management expects from clinicians are often different from, or even in conflict with, what clinicians identify as most important to their role. In the health professions, SD has been studied most often in hospital-based nurses,[1–4] exploring the communication among nurses trying to manage this divergence. Other studies have examined how SD affects other health care workers such as physicians, clinical technicians, and physical therapists.[5] As the landscape of medicine changes, physicians are moving from being predominantly self-employed[6] to being employees of large hospitals or health corporations.[7] This shift creates new ways for SD to emerge as clinicians' divergent interpretations of their individual roles and the meaning of being patient-centered conflict with their need to work within structures that may not be as patient-centered as they would like.

HOW STRUCTURATIONAL DIVERGENCE CONTRIBUTES TO MORAL INJURY

One component of SD between individual and structural expectations is the idea that care must be *sped up*. Speed is seen as increased efficiency and generally is viewed favorably by management both in the hospital, where clinicians are expected to provide care for more patients, and in the outpatient setting, where they are expected to see more patients more quickly. However, health care is not manufacturing, in which the goal is often to increase production. Health professionals are managing people and their health and illness, a complex and multidimensional endeavor that cannot be accurately

understood by a single measure, such as the speed of an assembly line. A manager may see an RN making a patient bed as wasting time doing a task that should be assigned to a lower-level staff member, but the RN may find that the interaction provides valuable insight that helps with patient assessment and treatment. Applying concepts from industrial manufacturing (eg, scientific management or Taylorism)[8] to the health professions can result in negative impacts on people's health. Focusing solely on efficiency can limit the communication between clinicians and between clinicians and patients that is imperative to understanding patients and their health decisions.

Clinicians also are experiencing greater demands on their time from paperwork and other administrative tasks, such as navigating insurance questions and charting in the electronic medical record. These tasks are time consuming and can infringe on time spent with patients, as well as often require extra time to complete after hours. While health care professionals tend to put their primary emphasis on caring for their patients, a study of nurses[3] emphasized how other requirements put in place by administrators can compromise their ability to provide care. These tasks can lead to dissatisfaction with the job because much of their time is spent doing activities they do not see as improving patient health. This dissatisfaction contributes a type of burnout created by "high caseloads and patient acuity, long hours, interfacing with the electronic health record, and an inefficient practice system."[9]

While SD is related to burnout[4] and burnout has been a focus of health care research for more than a decade, more recently moral distress and moral injury have been proposed as more accurate descriptions of the SD problem clinicians face. Moral distress is said to occur when a person's integrity is compromised because they feel unable to act on their moral judgments.[10,11] Moral injury, however, moves beyond judgments to actions. Moral injury describes "the challenge of simultaneously knowing what care patients need but being unable to provide it due to constraints that are beyond our control."[12] SD describes the organizational tensions that lead to poor communication, diminished patient interactions, moral distress, and often, moral injury.

Opportunities for SD, and subsequently moral injury, increase as health care becomes more corporatized,[10] with top-level decisions about health care management being made by those who are removed from, and perhaps not primarily concerned about, patient outcomes. The corporatization of health care, a concern since the 1980s, encourages market-like behavior,[13] which creates divergence between patient care and corporate financial interest.[14] An administrative focus on metrics also creates friction among clinicians due to increased, and sometimes uneven, workloads.[9] This focus leaves clinicians to navigate a situation in which their personal ethics and patient care goals may be at odds with those of the executive whose job is to ensure the financial success of the organization, as well as their clinician colleagues who are working to meet administratively determined metrics for care.

The SD experienced by health care professionals is unlikely to diminish soon. Despite a call for more physician leadership in hospital C-suites,[15] these positions often are occupied by business professionals who lack experience providing health care. Private equity companies are concerned with profit, which may put them in direct conflict with efforts to provide the best patient care, such as when facilities are closed to improve profit despite the harm the closure causes patients and communities. Because health care corporatization can create structures that prioritize outcomes that diverge from clinicians' patient care goals, clinicians are likely to increasingly experience moral injury.

The corporatization of health care also impacts medical education. Gupta et al[16] explained that India's shift to commercial over ethical medical education has led to a greater focus on profit margins than on the social and humanitarian aspects of medicine. Educators have an ethical responsibility to help students identify and manage the SD factors that can lead to moral injury. This involves ensuring that students and residents understand the evolving structure of the health care delivery system and how it can impact patient care, specifically for low-income patients.[17] This responsibility also means making students and residents aware of the ethical dilemmas they may face as clinicians. This concern is an extension of the one expressed by former *New England Journal of Medicine* editor Arnold Relman that while clinicians may accept financial assistance from corporations and corporations often provide continuing education opportunities, these acts can blur the ethics of medicine and hamper clinician professionalism.[18] Medical educators must be aware of the impact that corporatization has on professionalism and of what it means to ethically and empathically practice medicine.[19–21] The involvement of corporations with medical education likely will only strengthen, because they see themselves as innovators and wish to train the future health care workforce. Educators have a responsibility to ensure that students and residents receive balanced, high-quality education.

WHAT CAN WE DO ABOUT IT?

While it is well understood that both systemic and individual-level factors lead to moral injury, interventions typically are focused on developing personal resilience. However, by focusing on individual-level strategies for managing moral injury, we "risk putting misplaced and undue burden on the individual" while failing to solve the actual problems that lead to moral injury.[10]

One way of addressing moral injury is to engage in open discussion during preclinical education about how SD is experienced, including the ways in which conflicts about clinician roles and values arise. While students must know about the appropriate management of people and diseases, they also must realize the obstacles they may face in providing high-quality patient care, including those created by organizational policies. They must understand the ethical dilemmas that exist in health care settings resulting from the tension created by attempting to meet both corporate and patient-care goals

and be equipped with ways to navigate those paradoxes. On an individual level, understanding that these dilemmas exist encourages students to ask questions about workplace culture, role responsibility, and clinician autonomy, which can help them choose where they will work. This knowledge can help clinicians develop internal alliances that can navigate the corporate hierarchy and oversee the development of partnership agreements and corporate alliances.

Residency provides an opportune time for integrating this information into medical education. Patient care discussions during hospital rounds or in the outpatient clinic can help learners identify instances of SD, such as when a treatment or management that would be beneficial for the patient is blocked by institutional practices. Explorations of SD can be the topic of student didactic sessions or resident support groups as well. The traditional Balint group, for example, uses a case presentation to stimulate discussion of feelings and concerns that arise within the clinician-patient interaction (eg, countertransference) that are not part of the direct clinical management decision-making.[22] This approach can be modified, while still based on the case-presentation model, to explore the reactions and feelings engendered by the structural obstacles clinicians face in providing high-quality patient care. Civaner et al, for instance, suggested that case presentations can be used to introduce students to the relationship between health policies and ethical dilemmas, such as to examine the social and economic effects of cost-effectiveness policies.[20]

Another way of remedying SD between clinicians and an increasingly corporatized health care industry would, almost by definition, require structural change. This remedy could include creating universal health coverage, banning for-profit health care organizations, and making stricter (and enforced) standards for community benefit from nonprofits. These solutions already exist in many other countries. Students, residents, and faculty, as well as practicing clinicians, can collaborate with professional organizations to advocate for these goals as well. An example of this collaboration is the partnership between the Robert Wood Johnson Foundation (RWJF) and the advocacy group Physicians for a National Health Program (PNHP). RWJF is funding a study conducted by PNHP to examine physician moral injury, which may help identify its prevalence.[23]

While individual-level and small group interventions can help to mitigate or manage moral injury, effecting structural change is more difficult. Incremental change is much more likely to be successful when people work together, which has led to increasing calls for residents, fellows, and nurses to join forces to unionize in an effort to maintain autonomy and ensure quality patient care.[24,25] Collective actions can be taken by non-union professional organizations as well (eg, American Medical Association, specialty societies, student and resident associations). Many organizations (eg, American Academy of Family Physicians) have working groups aimed at creating changes to structures that invite moral distress and moral injury. The National Academy of Medicine has developed programs to address issues of well-being. The *National Plan for Health Workforce Well-Being* lists addressing compliance, regulatory, and policy barriers for daily work as one of its seven goals,[25] while the Action Collaborative on Clinician Well-Being and Resilience lists three goals around reducing clinician burnout and stress, improving challenges to clinician well-being, and caring for the clinician.[26] Educators can encourage learners to get involved with these societies, associations, and collaboratives.[27]

The corporatization of medicine is changing the landscapes of both clinician work and medical education. Medicine is more commonly being viewed as a business,[28] and medical schools are accused of increasingly selling "economic stability, professional status, and success," at the expense of character and critical thinking skills.[29] The corporatization of medicine has its benefits. Indeed, corporations play a role in innovations that can improve patient health; however, a focus on metrics and innovation can impact the clinician-patient relationship and erode clinician ethics and professionalism. This tension creates SD, as clinicians are primarily concerned with helping patients, regardless of the systems in which they provide care. As educators, we must prepare our students with the knowledge and tools they will need to ensure quality of care for their future patients.

Disclaimer: The opinions and assertions expressed herein are those of the author(s) and do not necessarily reflect the official policy or position of the Uniformed Services University of the Health Sciences, the United States Department of Defense, or the Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc.

REFERENCES

1. Nicotera AM, Zhao X, Mahon MM, Peterson EB, Kim W, Conway-Morana P. Structurational divergence theory as explanation for troublesome outcomes in nursing communication. *Health Commun.* 2015;30(4):371-384.
2. Nicotera AM, Clinkscales MJ. Nurses at the nexus: a case study in structurational divergence. *Health Commun.* 2010;25(1):32-49.
3. Anderson LN. Understanding hospital-based nurses' experiences of structurational divergence. *Qual Rep.* 2015;20(3):172-185.
4. Malterud AS, Nicotera AM. Expanding structurational divergence theory by exploring the escalation of incompatible structures to conflict cycles in nursing. *Manage Commun Q.* 2020;34(3):384-401.
5. Ford JL, Zhu Y, Barrett AK. Structurational divergence, safety climate, and intentions to leave: an examination of health care workers' experiences of abuse. *Commun Monogr.* 2022;89(1):1-24.
6. AMA examines decade of change in physician practice ownership and organization. *American Medical Association.* 2023. https://www.ama-assn.org/press-center/press-releases/ama-examines-decade-change-physician-practice-ownership-and.
7. Muoio D. Nearly 80% of docs employed by hospitals, corporate entities in continued shift away from independent practice. *Fierce Healthcare.* 2024. https://www.fiercehealthcare.com/

providers/more-and-more-physicians-are-working-under-hospitals-corporate-entities-report-finds.
8. Braverman H. Labor and monopoly capital: the degradation of work in the twentieth century. *Monthly Review.* 1974;26(3).
9. Tanaka P, Hasan N, Tseng A, Tran C, Macario A, Harris I. Assessing the workplace culture and learning climate in the inpatient operating room suite at an academic medical center. *J Surg Educ.* 2019;76(3):644-651.
10. Beck J, Falco CN, Hara O, L K. The norms and corporatization of medicine influence physician moral distress in the United States. *Teach Learn Med.* 2023;35(3):335-345.
11. Morley G, Ives J, Bradbury-Jones C, Irvine F. What is 'moral distress'? a narrative synthesis of the literature. *Nurs Ethics.* 2019;26(3):646-662.
12. Dean W, Talbot S, Dean A. Reframing clinician distress: moral injury not burnout. *Fed Pract.* 2019;36(9):400-402.
13. Turner S, Wright J. The corporatization of healthcare organizations internationally: a scoping review of processes, impacts, and mediators. *Public Adm.* 2022;100(2):308-323.
14. Jacobs K, Nilakant V. The corporatization of health care: an evaluation and an alternative. *Health Serv Manage Res.* 1996;9(2):107-114.
15. Ray CE. Working with hospital administrators: strategies for success. *Semin Intervent Radiol.* 2023;40(5):441-448.
16. Gupta V, Gupta M, Gupta V. Challenges in medical education. *Curr Med Res Pract.* 2022;12(2):73-77.
17. Alayed TM, Alrumeh AS, Alkanhal IA, Alhuthil RT. Impact of privatization on healthcare system: a systematic review. *Saudi J Med Med Sci.* 2024;12(2):125-133.
18. Relman AS. Medical professionalism in a commercialized health care market. *Cleve Clin J Med.* 2008;75(6):33-36.
19. Balak N, Tisell M. Healthcare economics. *Neurosurgical Practice*;2020:73-84.
20. Civaner MM, Balcioglu H, Vatansever K. Medical students' opinions about the commercialization of healthcare: a cross-sectional survey. *J Bioeth Inq.* 2016;13(2):261-270.
21. Mckinlay JB, Stoeckle JD. Corporatization and the social transformation of doctoring. *Int J Health Serv.* 1988;18(2):191-205.
22. Roberts M. Balint groups: a tool for personal and professional resilience. *Can Fam Physician.* 2012;58(3):245-247.
23. Moral injury survey. *Physicians for a National Health Program*. https://pnhp.org/understanding-moral-injury-in-health-care.
24. Mayes R, Muir KJ, Pingali H. Not what we signed up for": nurse shortages, physician scarcity, and time for collective bargaining. *World Med Health Policy.* 2024;16(1):78-94.
25. Doyle T. Is unionization just what the doctor ordered? collective bargaining for doctors, nurses, and lawyers. *J Collective Bargaining in the Academy.* 2018;0(13):46. https://thekeep.eiu.edu/jcba/vol0/iss13/46.
26. *National Plan for Health Workforce Well-Being*. National Academy of Medicine; 2022. https://nam.edu/publications/national-plan-for-health-workforce-well-being.
27. Action collaborative on clinician well-being and resilience. *National Academy of Medicine*. https://nam.edu/our-work/programs/clinician-resilience-and-well-being.
28. Poduval M, Poduval J. Medicine as a corporate enterprise: a welcome step?. *Mens Sana Monogr.* 2008;6(1):157-174.
29. Lujan HL, Dicarlo SE. We used to get money to teach students, now we teach students to get money: medical education has become a market with credentials not knowledge the commodity!. *Adv Physiol Educ.* 2023;47(3):521-526.