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Exploring moral distress determinants in the healthcare missionary career

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Abstract

Introduction. Healthcare missionaries (HCMs) experience moral distress while serving in the field. Moral distress and subsequent injury prevention and intervention efforts may become more effective by analyzing the progression of practice experiences of Western healthcare missionaries. The purpose of this qualitative study is to analyze themes of experiences that may be associated with moral distress and potentially morally injurious experiences (PMIEs) among healthcare missionary careers.

Methods. A recent qualitative study of moral injury[1] included twenty-one healthcare missionaries being interviewed on the clinical, cultural, and spiritual factors associated with possible moral distress. Thematic content from that study was analyzed by high total frequency of participant responses and high variation among participants' years of service. Five resulting themes were analyzed by the respondents' years of field experience. Quotes were selected from the transcripts to provide key-informant perspectives on the themes. These themes and quotes were examined together to identify experience-based practice insights.

Results. The ratio of early career and advanced career missionaries experiencing each theme is listed. The qualitative analysis shows variations among five practice themes by participant's varied length of time in the field: (1) early career practitioners appear most likely to feel distress from personal responsibility and capability for care, (2) healthcare missionaries of all experience ranges rarely have patients ask for the reason for suffering, often due to patient fatalism, (3) early career practitioners appear most likely to personally react or have a spouse/family member react to a lack of boundaries rather than enacting preventative work/life boundaries, (4) early career missionaries may be slightly more likely than advanced career healthcare missionaries to personally confront unresolved ethical conflicts related to patient care, and (5) practitioners from both ranges of field experience (more frequently advanced career practitioners) noted having conflict with authoritarian leadership dynamics specifically with expatriate, rather than national leaders.

Conclusion. The relationship between moral distress themes across healthcare missionary careers is more complex than anticipated. This study identifies preliminary themes and insights that reflect possible moral distress in healthcare missions. These themes should be further researched to develop prevention and intervention methods addressing moral distress for healthcare missionaries and their patients.

Keywords: Moral Injury, Health Care Missions, Spiritual Determinants, Missionary Retention, Career Progression

Introduction

Healthcare missionaries encounter situations that require morally convicting actions and reactions.[1] Some attempts to resolve these situations pressure missionaries toward decisions where any choice has the potential of compromising their moral beliefs resulting in moral trauma.[2] This psychological phenomenon is known as moral injury or moral distress located on the moral trauma spectrum.[2] Moral distress or injury are potential effects of missionaries who perpetrate, fail to prevent, bear witness to, or learn about acts that transgress deeply held moral beliefs and expectations.[3]

Background

Moral injury is a construct that does not have agreement in the social, psychological, clinical, or spiritual disciplines. Studies have employed the concept of moral injury with varying methods often lacking a theoretical foundation.[4] Despite this lack of evidence from population-based studies of moral distress and moral injury, there remains an interest in understanding this psychological response to transgressions against one's assumptions and beliefs about what is good or right and wrong.[2] The definition offered by Vanderweele et al. (2025) for moral injury provides a helpful guide to understanding the experience of moral injury rather than the symptoms: "*persistent distress* that disrupts or threatens: a) one's sense of the goodness of oneself, of others, of institutions, or of what are understood to be higher powers, or b) one's beliefs or intuitions about right, wrong, or good and evil." This distress is identified as a broad concept of moral injury based on a continuum of trauma; it's persistence and severity. A moral traumatic experience is then defined as a specific experience that "disrupts or threatens" (a) and (b).[2]

Moral distress and injury have psychological, biological, social, behavioral, and religious/spiritual dimensions.[5,6] This multi-dimensional nature has implications for military, healthcare, psychology, psychiatry, social work, philosophy, and religious/spiritual fields.[6,7,8,9] Moral distress is like trauma in that both factors are individually processed uniquely. A human's past and current experiences dictate a wide range of experiential effects to potentially morally traumatic events. Moral distress effects may include guilt, shame, anger, betrayal (either target of, or perpetrator of), isolation, self-criticism, feeling damaged, feeling incompetent when responding to moral challenges, difficulty with trust and willingness to risk closeness, difficulty with goal-directed behavior, self-destructive and/or high-risk behaviors, fatalism, passivity, increased suicidality, and an overall disruption in moral dependability in self, others, and God.[1,5,10] Although the moral injury literature base has been informed by multiple disciplines with a focus on military and healthcare contexts, moral injury in medical missions has yet to be significantly researched. The medical mission context demands challenges unique to the already strenuous field of clinical healthcare; Western-trained medical ethics and culture intersect with norms from foreign, high-need, and often low-resource communities.[11,12] This complex understanding of moral distress and injury is of particular interest, considering it is an emerging cause of poor health and psychological conditions among healthcare missionaries.[1]

Identification & Categorization of Missionary Career Development

Healthcare missionaries appear to navigate a series of phases through their careers. The content and approximate time for each phase is a growing topic in healthcare mission literature. One concept of health mission phases developed by Dr. Jason Paltzer identified four distinct service phases: doer, leader, barrier, & facilitator.[13] New missionaries were usually action-focused (**doer**). A directive change agent often becomes a **leader**. While some leaders may be highly effective in this stage, others who do not understand a field's culture or rationale for established systems may act as a **barrier** to objectives despite positive intentions. After mending possible damage from premature action and through active practicing of cultural humility, a missionary learns to become a **facilitator** of mission objectives. Analysis of

healthcare missionary careers in cross-cultural environments may help expand research on challenges and the overall career progression of healthcare missionaries.

Though organizationally secular, literature released by the United States Peace Corps can inform mission research work. The Peace Corps annually surveys volunteers and releases feedback in "Health of the Volunteer" reports.[14] These reports led to the "volunteer life cycle" concept, which projects common phases/experiences that either lead to sustained service in the field or early termination. The development of a *healthcare missionary life cycle* might similarly reflect sustainable or detrimental field experiences/stages.

Study Purpose

A recent study of potential moral distress and injury among Western healthcare missionaries[1] identified experiential themes from key-informant interviews. A signal that emerged during the study's analysis phase was the possibility of distinct missionary experiences associated with varied levels of field experience. This signal was later targeted as a possible area of exploration during the article's peer-review process. To understand the signal and expand on the qualitative parent study, missionary experiences were analyzed while referencing their years of field experience (YEX). For this paper, we do not assert that the missionaries participating in the prior study were experiencing a clinical diagnosis of moral injury; however, based on the responses, moral distress was present. In this paper, we view moral distress and injury on a moral trauma continuum. The purpose of this study is to highlight a possible factor of career length in how we understand moral distress among healthcare missionaries for sending and support agencies to have practical guidance in preventing progression of moral trauma. We will use moral distress throughout the paper to avoid overstating the experiences of the missionaries.

Methods

Parent Study Introduction

The parent study[1] used semi-guided interviews to explore the potential occurrence of moral distress and injury among Western healthcare missionaries. Twenty-six interview questions were generally categorized by medical, spiritual, and cultural content. Interview responses were analyzed with a qualitative inductive approach.[15] Recruitment sampling included a wide age range of participants to explore factors that relate to varied years of experience. Participants included twenty-one missionaries with field experience ranging from 2-32 years. The average of their years of experience was 10.58 while the median was 6.5. Thirteen participants had served in Africa, seven in Asia, and one had served in Eastern Europe. Regarding the participants' country of origin, seventeen were from the United States of America, two were from Canada, one from United Kingdom, and one from Germany. Participants were interviewed (within a range of 1-2 hours) through the video software, Zoom. These interviews were recorded and transcribed by two analysts for inter-rater reliability. Initial sample and eligibility criteria, interview procedures, and analysis methods are described in depth in the parent study.[1] The final stages of analysis prompted seven experiential themes, also available for reference in the parent study's[1] result section.

Present Study Methods

The median years of field experience among the participants was intentionally rounded to 7 to organize all participants within two convenient participant groups. The median-based <7YEX and =>7YEX groups help control outlier ranges that could skew data analysis and generalization of findings in comparison to using an approach with additional groups. Missionaries within the <7YEX group are referenced as "early career" HCMs while those in the =>7YEX group are referenced as "advanced career" HCMs.

The parent study's[1] main themes reflect the composition of multiple content areas that were covered in various questions in the semi-guided

interview. This data was analyzed by high total frequency (the sum of participants with criteria alignment per theme) and high variation by years of service (e.g., very few early career missionaries having alignment to a code with which many experienced missionaries aligned). This analysis prompted five new themes that demonstrate noteworthy grouping according to varied time of field experience. Table 1 lists the total number of participants who expressed interview content relating to each theme. Table 1 is further organized by the 7-year, field experience threshold. Key informant quotes that reflect the themes are organized by the 7-year field experience threshold. Observational analysis of the theme ratios and quotes prompted insights. These insights are listed below in Table 2 and alongside each theme in the qualitative results section.

Results

Table 1. Themes organized by participant time in the field

Theme	Total Responses	Early Career Responses	Advanced Career Responses
Feeling stress in the clinic	n=9/21	n=7/11	n=2/10
Patients don't ask about the meaning of suffering	n=8/21	n=6/11	n=2/10
Sabbath and family time as work/life boundaries	n=10/21	n=7/11	n=3/10
Personal confrontation of ethical conflicts regarding patient care	n=4/21	n=4/11	n=0/10
Authoritarian leadership conflicts	n=10/21	n=4/11	n=6/10

Note. Of the twenty-one participants, eleven are considered early career and ten are considered advanced career. The proportion of participants who expressed interview content relating to each theme is denoted with the (n=21) proportion. Each theme is further organized by responses of early career participants (n=11) and advanced career participants (n=10).

"Sabbath" is here referencing the Christian practice of intentionally resting and worshiping God. "Family time" is here referencing a practitioner distinctly spending time with family members aside from work responsibilities.

Table 2. Insights from Themes

Insight & Topic	Theme Explanation
1 - Stress	Less experienced healthcare missionaries appear more likely to feel stressed from personal responsibility/capability for care than more experienced practitioners. Language barriers were a focal stress element.
2 - Explanation for Suffering	Both ranges of missionaries reflected never having patients ask about the reason for suffering and noted the interview question might be too westernized and thus difficult for other cultures to consider. There was also unity in recognizing fatalism in the field.
3 - Work/Life Boundaries	Less experienced healthcare missionaries appear more likely to personally react or have a spouse/ family react to a lack of boundaries rather than enact preventative boundaries (Despite having ideas on which boundaries would work).
4 - Ethical Conflicts with Patient Care	Early career healthcare missionaries may be slightly more likely than advanced career healthcare missionaries to personally confront unresolved ethical conflicts related to patient care.
5 - Expatriate Leadership	Practitioners from both ranges of field experience noted having conflict with authoritarian leadership dynamics specifically with expatriate, rather than national leaders. Advanced practitioners expressed this dynamic more frequently than early career practitioners. Further, both ranges reflect tension from overly hierarchical leadership structures that feel disconnected/disjointed from the ground practitioners.

Note. Five insights organized by topic and content. The insight explanations result from theme analysis of the participant's years of field experience and key informant quotes.

Stress

Less experienced healthcare missionaries appear more likely to feel stressed from personal responsibility/capability for care than more experienced practitioners. Language barriers were a focal source of stress. This differs from more experienced practitioners who may have prevented language barrier stress with language training before practicing in the field and having more time for language acquisition in the field. Overall, 43% of individuals expressed some level of stress in the clinic. Participants noted the insufficient resources and knowledge to serve all needs.

> *Most of the time I feel fairly stressed. I normally feel like I need to be in more than one place at a time. I often feel like I don't have the resources I need to deal with what I'm seeing, be that, you know, physical resources or... also just my capacity as a doctor, my knowledge as a doctor is...inadequate for just the breadth and complexity of stuff I'm seeing all the time. (Early Career HCM)*

One early career participant reflected on the minimal availability of translation services, which created stress.

> *It's pretty chaotic in that we usually have just one kind of translator/nurse. He's not actually really a nurse but kind of acting like that, in a way, crowd control for everything; sometimes when attending and sometimes not even attending when there were two or three residents. So, it's kind of a zoo in terms of like everyone kind of vying for the one person to translate or to make sure that they understand what's going on and so yeah sometimes it's just a little chaotic. (Early Career HCM)*

An advanced career participant mentioned stress in the field could have been prevented through language training before practicing.

> *I hadn't been practicing for two years, because I had been in language school. (Advanced Career HCM).*

Another advanced career participant reflected upon feeling less stress while making important decisions with continued service and growing in faith.

> *I did feel stress from responsibility and decisions that seemed monumental. But that became less the longer we were there and as I grew my faith by showing me that the outcomes that I could see from these decisions were not the ones that He was going to bring. (Advanced Career HCM)*

Suffering

All ranges of missionaries reflected never having a patient ask about the reason for suffering. There was unity between a less experienced missionary and a more experienced missionary noting the interview question itself was Western and strange for other cultures to consider. There was also unity in recognizing fatalism in the field.

An early career participant noted the interview question was too Western to be cross-culturally appropriate.

> *I think that's a very Western question. In a Muslim context it's everything was Inshallah and so people don't ask that question at all, they just know that it's God's will whether someone lives or dies. People are actually sometimes upset that we're coding their family member because they're like 'They died. It's okay, like don't be upset they died.' And so, to be honest with you, I never have had that question asked. (Early Career HCM)*

Comments regarding fatalism in the context of suffering and cultural perceptions of "darkness" or evil forces describe the experiences of some healthcare missionaries.

> *There's just this darkness, you know, this sadness that's there that they don't really try to fix anything. So, they're less likely to ask for the reason, but I think*

you can bring up with them that God is in control and especially the ones who were so appreciative because they realized how close they were to dying, and they're getting ready to leave the hospital. (Early Career HCM)

An advanced career participant again noted the interview question's framing was too Western to be cross-culturally appropriate.

I don't know if anybody actually asked me that. I mean, I don't know even if the Nepali would ask that question. You know, I think that that's a very Western question. I think a Nepali would just be like 'You know, that's the way it is… why would you ask that? This is obvious, you know, life is suffering.' You know between the Buddhists and Hindus, I mean that's basically, you know they want to feel better, but they don't ask the question why. (Advanced Career HCM)

The concept of fatalism was also discussed for the theme of suffering.

[X Country citizens] are very fatalistic. This question does not come up as they are generally accepting that life involves pain. (Advanced Career HCM)

Work/Life Boundaries

Less experienced healthcare missionaries appear more likely to personally react or have a spouse/family react to a lack of boundaries rather than enacting preventative boundaries (Despite having ideas on which boundaries theoretically would work). This contrasts with a more experienced missionary noting a daily sabbath devotional as a preventive, rather than a reactive practice for work/life boundaries.

Among early career respondents who noted practicing the Sabbath and spending time with family as work/life boundaries (N=7/11), four expressed not actually using any strategies, but rather just working a lot.

Families were noted to help with awareness of a lack of work/life boundaries among early career participants.

Setting boundaries became much more important because it's not just me that's impacted by the lack of boundaries but also my family. And so, on the one hand, having a family makes me appreciate the need to have boundaries for their sake; It's not just about me, but it probably affects also where the boundaries should be. So, probably the boundaries that I need to apply to work should leave space for some rest for me, as well as some space for looking after my family. And I don't necessarily, you know, achieve that well. And so, my family helps me to recognize the need for boundaries, maybe, rather than making these boundaries a reality. (Early Career HCM)

If I was overextending myself at work, my wife would for sure let me know about it… (sabbath) was more theoretical… (we were not able to practice it in a way that was) restful for us. (Early Career HCM)

For one advanced career participant, Sabbath practice was an established work/life boundary throughout their career as a medical student and then as a practicing missionary.

Sabbath, but I don't mean… like a Sunday 24 hours; I used to do that before I went to med school. And I don't know how, you know, different people feel differently about this, but my Sabbath is really more my like devotional time in the mornings, where…there's not a lot of patient related stuff that happens… So, it's more kind of like a daily habit but not 24 hours all strung together. (Advanced Career HCM)

Personally confront unresolved ethical conflicts regarding patient care

Early career missionaries appear slightly more likely to confront unresolved ethical

conflicts related to patient care personally rather than appeal to an ethics committee or national colleagues.

An early career participant reflected on the difficulty of culturally assimilating, problems with other Western missionaries, and addressing ethical conflicts.

> *It's difficult because of power distance to get my partner to consider me as an equal. To consider me as worthy of being leveled with…Western partners actually that I've experienced the most conflict with ethically regarding patient care and things like that, where he or she has this desire to operate on everyone to do big cases, whether or not it's good for the patient to do things that I think, in the end aren't able to be justified medically, you know just from a clear standard of care, but also ethically, theologically, and culturally…Yeah conflict management, conflict resolution and all that, I mean I address it, I talk about it. I try not to talk about it behind that person's back. I try not to engage in tearing that person down ever… I've heard that from a variety of sources, you know somehow these African mission hospitals are breeding grounds for people with a God complex who think they should be allowed to do whatever they want. (Early Career HCM)*

An early career participant noted the ethical conflict of patients deferring medical recommendations.

> *But what I have started using now is 'if you don't do what I'm telling you it's no problem, this is not a prison, we can always refer you to the other hospital.' (Early Career HCM)*

Another early career participant reflected on nonresponse to ethical conflicts and how it can feel to try to solve ethical conflicts individually.

> *Poorly, a lot of time nonresponse. Others tried to resolve by self and when they couldn't, they quit…I mean a lot of times I don't feel like there was really any response… So, if it was a situation where I thought I could just do it myself then sometimes I would, for the sake of that individual. Other times, I mean you keep trying to find a way forward. I guess, because your question is when they were unresolved, so you keep trying to find a way forward and you can't, most of the time I would either quit doing that area of care, meaning I can no longer do this operation safely at this hospital, and I will not do it again here because there are bad outcomes, and it's more than I can do myself, and I have not yet been able to make the necessary progress to do it...to do it and have other people help me at the level that I need. I will not do certain operations at this hospital. (Early Career HCM)*

An advanced career participant commented on using an ethics committee to respond to ethical conflicts regarding patient care.

> *Ultimately, you can appeal to the ethics committee… everybody's going to have a different opinion on this (ethical dilemma and how to) resolve that within the colleagues, within the family, the family who's saying 'do everything' and, you know, the hospital… you have to appeal, you know, you cannot make a unilateral decision to come to consensus. How do you arrive at that? You've got to bring in the ethics committee to give you some guidance. (Advanced Career HCM)*

Another advanced career participant consulted national colleagues in their cultural approach to responding to ethical conflicts regarding patient care.

> *So, this this is an opportunity, a teaching opportunity to listen very closely, question the boundaries of this ethical problem, (and) listen to the national colleagues about their, the cultural natural approach to that… I wanted the*

people on either side of this, to know and understand the reasons or the process that I went through; more the process I went through to make a decision. (Advanced Career HCM)

Authoritarian leadership conflicts with expatriate leaders

While practitioners from both ranges of field experience noted having conflict with authoritarian leadership and overall practice with expatriate rather than national individuals, the signal was stronger among advanced career practitioners. Further, both ranges reflect tension from overly hierarchical leadership structures that feel disconnected and disjointed from the ground practitioners.

A participant suggests their leader does not model healthy work boundaries, thus creating a culture with an unhealthy work/life balance. The participant also reflects on conflict with expatriate authoritarian leadership.

So, I've appreciated our hospital director who has a good cultural understanding being present, and I have appreciated his work ethic and his, the responsibility that he takes for the work that he does, and for the hospital. The flip side of that is, I think that he would acknowledge himself, that he works too much and has, you know, basically given his life to the work that he's doing at the expense of his family. And he recognizes that as a negative thing, but is unable to escape from that cycle that he sees that he is in because of, you know, the demands of care placed upon him. And I think that actually has a really negative impact on the running of the hospital and creates a cultural environment where, where, you know, that I've been sucked into to a degree. And also, I think that it means that he's frequently exhausted, which I think is bad for patient care… what I have observed, I'm talking more about the expatriates now, yeah, as I said, seems to be quite authoritarian and actually not open to discussion and feeling very threatened by discussion. And I think that's very damaging to the leadership culture of the hospital. (Early Career HCM)

One participant noted a workplace with a hierarchical structure, a generational cultural norm of "not sharing things," and trouble specifically with Americans in leadership

The culture had changed them. They had become way more hierarchical… that combined with the generation gap (with) more of a mindset where you don't share hard things. We didn't realize that there was this big cultural thing that was different amongst our team until after it was well too late. I understand that the rules are different (here), and so my expectations are different. And I had a desire to sort of conform to their cultural expectations. I certainly wanted to do that with them too, but I assumed that their expectations were similar because they're American; I assumed that we are similar, but we weren't. (Early Career HCM)

An advanced career participant noted a disconnection between leadership and staff members, and that expatriate practitioners can be more difficult to hold accountable for their work than national workers because their funding is already established (For work tasks and time off).

There was a big disconnect between, you know the flowery speech of the politician, and the on the ground needs of the staff. And the staff are either overworked or under resourced…and he would breeze in, give this talk like, it's like our politicians in the United States, you know, yeah. On the missionary's side, you know, missionaries are like herding cats. So, they're all volunteers, they all raised their own support, and… it was difficult bringing missionaries to task, or to get them to hold the standard when it's a charity. (Advanced Career HCM)

A participant noted a "Big man complex" when expatriate leaders do not know how to handle their perceived or actual power. A reflection on the overly bureaucratic committees follows.

> *Despite the most you know the most devoted Christian men, women, this big man in Africa complex is, you know, it's ingrained in our culture… there is a big man, you know, who makes the ultimate decisions, but there's also this everything by committee (dynamic). (Advanced Career HCM)*

Discussion

Stress in the clinic

This analysis suggests that it is more common for early career HCMs to feel stress in the clinic than advanced career HCMs. This may have important implications for HCM training emphasizing stress prevention, identification, and intervention to facilitate service retention. Moral injury is a stress-linked problem[16]; stress is correlated with the etiology and effects of moral distress and subsequent injury. If HCMs utilize evidence-based self-care strategies and receive support from their sending organizations to minimize this distress, it is possible that practitioners may navigate potentially morally injurious experiences in a more healthy and sustainable manner. Rather than interpreting this dynamic to indicate that early career HCMs are less resilient, this dynamic may reflect self-care growth areas that once established, allow practitioners to serve into advanced career lengths of time.

Patients not asking about the reason for suffering

Patient perspectives on the meaning of suffering may have significant implications for patient adherence to HCM medical recommendations. Since fatalism was acknowledged by multiple missionaries, the relationship between fatalism and moral distress may be worth studying. Fatalism within a medical context has been understood as a resignation of complete control over one's life; health, and illness are often associated with predetermination, pessimism, luck, passivity, and interaction with a higher power.[17,18,19] The majority of research on fatalism in a medical context relates to a patient's perspective on living with chronic diseases and is often associated with a patient's willingness to assent to palliative care recommendations.[18,20,21,22,23]

In medical missions where suffering is experienced at a high rate and intensity, awareness of the implications of varying perceptions on the meaning of suffering is necessary for a practitioner's appropriate appraisal of responsibility for outcomes. If a patient does not comply to HCM medical recommendations due to fatalistic beliefs and proceeds to have deteriorating health, an HCM may internalize responsibility for the outcome by over-assuming the extent to which they control patient outcomes. One etiology of fatalism in medical mission environments may be the willing adherence to religious/cultural norms. Individuals may also be situationally forced, where fatalistic beliefs serve as a coping mechanism for impoverished living. Patients with a spiritual mechanism for the reason of suffering may be more likely to adhere to HCM recommendations and, thus, heal with greater efficiency than patients with externally forced fatalistic beliefs that lead to non-compliance. Overall, stronger faith-based relationships among practitioners and patients/host community may help reframe poverty-forced fatalistic conceptions of the reason for suffering and with it, decrease distress related to fatalistic non-compliance. The relationship between fatalism and moral injury among healthcare missionaries has theological, philosophical, and psychological dynamics to be further explored.

Sabbath and Family Time as Work/Life Boundaries

Table 1 lists early career HCMs practicing either or both the Sabbath and family time as work/life boundaries more than advanced career HCMs. Advanced career HCMs noted exercise, not taking house calls, taking vacations, and having colleagues enforce boundaries as other

work/life boundaries. This information is useful for HCMs to critically consider what additional practices may facilitate healthy work/life boundaries.

Furthermore, it appears that early career HCMs tend to be reactive to insufficient work/life boundaries rather than proactive with work/life boundaries. The development of methods to guide HCMs' identification of insufficient work/life boundaries will facilitate healthy service delivery. HCM training programs may expand on self-care and work/life boundaries that other experienced HCMs have found useful. Mission-sending organizations may further develop peer-mentor programs where early career HCMs may be supported on-site or online through discussing practice successes and challenges.

When observing all participant responses on practices that help maintain boundaries for life on the field, 71% of all participants responded that they don't practice any strategies to help with boundaries, but rather just work a lot. When applying the experience categories used throughout this study, 82% of early career missionaries and 60% of advanced career missionaries noted working a lot rather than practicing boundaries.

Among the eleven early career respondents, seven noted practicing the Sabbath and spending time with family as work/life boundaries, while four expressed not actually using any strategies, but rather just working a lot. Similarly, among the three advanced career respondents who noted practicing the Sabbath and spending time with family as work/life boundaries, all three also expressed working a lot and not actually using any strategies.

This seemingly contradicting dynamic of respondents noting that family time helps with work-life boundaries while also not actually practicing work/life boundaries is clarified with one early career HCM:

> *And so, my family helps me to recognize the need for boundaries, maybe, rather than making these boundaries a reality. (Early Career HCM)*

The HCM is reflecting on how their family time (or lack thereof) leads to awareness of their lack of work/life boundaries. Awareness of a lack of boundaries is helpful yet is distinct from practicing work/life boundaries. If this trend is reflective of a considerable sample of HCMs, targeting the encouragement and enforcement of healthy work/life boundaries could be significant in improving HCM wellbeing and service retention overall.

Missionaries are increasingly burning out from the field[12] from a wide range of causes. If HCMs are knowledgeable about and practice effective self-care practices including spiritual disciplines of prayer and repentance, and work/life boundaries, they may navigate potentially morally injurious experiences in less detrimental ways. Manageable workloads and support from fellow staff who role-model self-care and healthy boundaries may be key factors in sustainable HCM service.

Personal confrontation to unresolved ethical conflicts regarding patient care

This data analysis suggests that early-career missionaries appear slightly more likely to personally confront unresolved ethical conflicts relating to patient care rather than appealing to an ethics committee or national colleagues. Service to patients at the highest effectiveness and efficiency is critical to the missionary vocation. Taking personal initiative to solve ethical conflicts that are within a practitioner's competency may be the ideal course of action in some situations. In cases where the resolution of ethical conflicts may be outside a practitioner's competency, personal confrontation cannot be the best course of action to serve patients. Since not every healthcare mission environment has an ethics committee for HCMs to consult, supervisor or peer consultation may be effective steps when navigating unresolved ethical conflicts that should not be personally confronted.

How does the availability of ethics committees among healthcare missionary environments relate to an HCM's willingness to practice outside of their practice competency?

How does feeling required to take responsibility for things outside of an HCM's given practice competency relate to moral distress? Both situations may have significant potential of being morally injurious.

Authoritarian leadership Conflicts with Expatriate Leaders

The analysis appears first to identify that practitioners of all experience ranges may often have difficulty with authoritarian leadership dynamics and overall practice with expatriate leaders at some point in their careers. The analysis also suggests that the frequency of experiencing this issue is higher among advanced career practitioners than among early career practitioners. Furthermore, both experience ranges reflect tension from overly hierarchical leadership structures that feel disconnected and disjointed from the ground practitioners. If this reflects a larger sample of HCM experiences, these trends may have significant implications for cross-cultural leadership training. If HCM relationships with supervisors are marked with unaddressed conflictual leadership dynamics, the practitioner/supervisory relationship may be less effective in protecting the HCM from potentially morally injurious situations. Contrasting with the challenges with expatriate leadership, working alongside national colleagues was largely regarded as crucial to learning how to be a part of the serving machine of the environment. Though language acquisition and serving with cultural humility is a time consuming and complex process, learning how to learn from national colleagues appears to be a protective factor toward effective and efficient care.

Limitations and Strengths

Although participants were not tested with moral injury scales to prove the persistence and severity of moral distress and moral injury, they described double-binding psychological distressing situations that align with criteria suggesting to morally traumatic experiences and likelihood of progression to moral injury.

Though psychosocial researchers have yet to agree upon a standardized definition of moral injury and what constitutes a syndrome of moral injury, this study aligns with the definition that a potentially morally injurious experience entails "doing or failing to do (agentic) or directly experiencing or bearing witness to (nonagentic) acts that violate the social contract and transgress deeply held moral beliefs and expectations."[4] Participants experienced moral trauma relating to stress in the clinic, perceptions on, and discussion of the meaning of suffering, work/life boundaries, personal confrontation of ethical conflicts, and conflicts with authoritarian leadership. These early career and advanced career morally traumatic experiences were then thematically analyzed using qualitative inductive analysis. As such, we think this information can expand our understanding of moral trauma themes among early and advanced career healthcare missionaries.

While not having an a priori identification of moral injury can be considered a weakness given the existence of modalities like moral injury scales, a qualitative a posterori analysis can also motivate the possibility of moral distress among healthcare missionaries. Examining these details together, this article provides a thematic analysis of potentially moral traumatic experiences among early and advanced career HCMs.

Though the parent study's[1] sample size of twenty-one participants is within the recommended range for qualitative data analysis,[15] the stratification of participants by experience led sample sizes to decrease. Results should be interpreted as exploratory. The results point toward a correlation between field experience ranges and themes; however, causation cannot be assumed. The data may be skewed by a survival bias where HCMs who might have endured the toughest practice situations/conditions may have burned out of the field quicker than others and may be less likely to accept an invitation to be interviewed as a study participant. The generational differences of participants and largely westernized bias overall may further limit generalizability. The stratification of early and advanced career practitioners creates generational grouping

with associated culture, education, research on best practices, and overall experiences and expectations of service. Having participants primarily from America leads the exploratory themes to potentially be less reflective of healthcare missionaries globally. Taken together, the following insights and interpretations should be regarded as exploratory observations that should be further examined to understand moral injury determinants across healthcare missionary careers. The study does not differentiate between professional and personal stress, potentially limiting awareness on how each factor correlates to the themes.

There are confounding variables that could influence field experiences. Each practitioner navigates unique interactions between the faith and culture of a given environment throughout their career; while general similarities may be abstracted, each are ultimately distinct. Common variables include expatriate co-workers, national co-workers, and patients speaking different languages and coming from varied spiritual/theological cultures, patient/provider ratios, baseline population health, and healthcare infrastructure/resources in a given setting. The extent of non-missionary healthcare experience before becoming a missionary varies widely among practitioners. Language, a factor relating to stress in the field, may be more challenging for an English-speaking practitioner to serve in a mission setting that utilizes neither English nor a European language than a practitioner serving in a field that uses a familiar language. Other language interaction options might be:

Field A: English is a national language understood by patients and professional colleagues.

Field B: English is a national language understood by professional colleagues but not all patients (or in general).

Field C: English is not a national language but another common European language (French, Spanish, etc) is at least professionally used.

Field D: Neither English nor a European language is present, and everything must be done in the host country's language.

Examining these possibilities together, language competency appears to correlate with cultural competency and reduced stress over long-term service overall.

This study continues the analysis of the rich data collected in a moral injury study[1] and contributes to the otherwise novel exploration of healthcare missionaries experiencing moral distress and injury. It provides insight into the experiences and career development or deterioration of a wide range of healthcare missionaries who serve in Africa, Asia, and Eastern European healthcare mission settings. This study's experiential themes, quotes, and analysis can contribute to the growing research interest in developing a *healthcare missionary life cycle* tool that reflects sustainable or detrimental field experiences/stages across missionary careers. This tool would be beneficial in informing preventative and intervention efforts for factors that jeopardize HCM service delivery, whether moral injury, burnout, PTSD, anxiety, or other complex challenges. The study's findings may also have implications in developing healthcare missionary and mission team training overall to advocate for missionary mental health. Sending organizations might utilize this information to develop policies regarding missionary support and what is expected of missionaries in clinical practice.

This study's results expand upon healthcare missionary literature seeking to identify career trends, experiences, and challenges. Topics for further research include stress identification, prevention, and intervention methods for HCMs, understanding the philosophy and theology of suffering among healthcare mission environments with particular emphasis on the role of fatalism, how to develop work/life boundaries that protect HCM well-being and the ability to serve, communication methods for responding to ethical conflicts, and how to navigate leadership conflicts across

multi-cultural environments. A theology of suffering is particularly relevant for Christian sending organizations to prepare and support missionaries. The moral stressor of suffering within the Christian context is aligned with how we relate to the suffering of Christ and, therefore, our own suffering and the suffering of others. Effort should be taken to consistently and frequently balance the distress of suffering with the eustress of suffering and the spiritual growth that comes from suffering with Christ in our circumstances. See Ritchie (2024) for an in-depth discussion of spiritual solutions to moral injury among healthcare missionaries. Other topics include a focus on both professional and personal stress in relation to potentially morally injurious experiences and the topic of anticipated and actual extent of autonomy of practice and humility among HCMs.

Conclusion

This explorative study identified themes relating to moral distress experienced throughout healthcare missionary careers. These themes may be indicators of where healthcare missionaries need specific organizational support in navigating stress, ethical dilemmas, work/life boundaries, and leadership structures. Further analysis of moral distress in the healthcare mission field will support the development of moral injury prevention and intervention methods to protect healthcare missionaries and their patients.

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