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Moral Injury: alertering

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'Moral injury', in het Nederlands ook wel 'moreel trauma' genoemd, is een begrip dat verwijst naar de psychosociale klachten die mensen kunnen ontwikkelen wanneer zij ervaringen hebben meegemaakt waarin belangrijke morele verwachtingen en overtuigingen worden geschonden.

Elke maand zet de ARQ-bibliotheek nieuwe publicaties over *Moral Injury* op deze lijst.
Voor eerdere updates kunt u mailen naar de ARQ-bibliotheek.
Deze attendering hoort bij het themadossier Moral Injury.

1. Borges, L. M., et al. (2026). "Acceptance and commitment therapy for moral injury: conceptualizing and intervening on moral injury through the lens of contextual behavioral science." *Frontiers in psychiatry* Frontiers Research Foundation 17: 1923699. 10.3389/fpsyt.2026.1923699

Moral injury is at a critical juncture in its conceptualization. Current dominant approaches to conceptualizing and assessing moral injury are rooted in syndromal frameworks with implicit medical model assumptions. In these approaches, painful moral emotions and cognitions are often conceptualized as pathological symptoms to be reduced or corrected. Such approaches risk pathologizing deeply human moral responses and may inadvertently position clinicians as arbiters of which moral appraisals or emotional reactions are appropriate, proportionate, or adaptive. In this paper, we present Contextual Behavioral Science (CBS), the philosophical foundation of Acceptance and Commitment Therapy for Moral Injury (ACT-MI), as an alternative framework for conceptualizing and treating moral injury without pathologizing moral pain or requiring clinicians to adjudicate the validity of clients' moral judgments. Drawing on CBS, Relational Frame Theory (RFT), and evolutionary science, we examine the social functions of moral emotions, the human capacity to construct verbal moral narratives, and the implications of these processes for intervention. Building on these foundations, ACT-MI is described as an approach aimed at disrupting the behavioral patterns that maintain moral injury at both individual and group levels. Rather than targeting moral pain to reduce symptoms, using ACT-MI can facilitate transforming the individual's relationship to it. Through functional assessment, clients' efforts to avoid, control, or resolve moral pain are identified and addressed with core ACT processes, including acceptance, defusion, contact with the present moment, self-as-context, values, and committed action. Within this framework, individuals learn to hold moral pain while continuing to engage in values-based living and meaningful social functioning at individual and group levels of treatment. Assessment targets, methods, and hypotheses are identified to support testing the mechanisms and impacts of ACT-MI in future research.

2. Bornemann-Cimenti, H., et al. (2026). "Moral Injury Beyond Burnout: A Scientometric Review of Clinician Distress and Its Blind Spots in Critical Care. [Review]." *Healthcare* 14(18). 10.3390/healthcare14183075

BACKGROUND: Moral injury is increasingly used to describe clinician distress after perceived moral transgression, forced complicity, or institutional betrayal. Its distinction from burnout and its empirical organisation in healthcare remain insufficiently defined.
METHODS: We combined a conceptual review with a document co-citation analysis of moral-injury literature indexed in the Web of Science Core Collection from 1961 to 2026 (20 April 2026). The network comprised 1573 cited references and 5497 co-citation links and was clustered in CiteSpace.
RESULTS: The network contained ten communities and showed strong structure (modularity Q = 0.73; mean silhouette S = 0.74). Four findings were most relevant to clinical and occupational mental health: the definitional core remains unsettled; healthcare and veteran literatures have developed as partially parallel traditions; measurement and operationalisation papers occupy disproportionately prominent positions in the citation-burst and sigma rankings; and the healthcare instrument that the network identifies as structurally prominent, the Moral Injury Symptom Scale for Healthcare Professionals, retains religious or spiritual elements that require calibration in secular and confessionally heterogeneous settings. Anaesthesiology and intensive care medicine are present in the empirical literature, but as of the search date no specialty-specific work had become an organising reference for the field; citation lag accounts for part of this.
CONCLUSIONS: Moral injury should not be treated as a synonym for burnout or as a deficit of individual resilience. Future research should specify definitions, validate instruments cross-culturally, stratify by clinical role and specialty and empirically test interventions directed at the moral architecture of work.

3. Cai, Y., et al. (2026). "Association of artificial intelligence literacy with moral distress and moral resilience among nursing interns: A cross-sectional study." *Nurse Education Today* 169: 107476. 10.1016/j.nedt.2026.107476

Background: Artificial intelligence (AI) is increasingly integrated into healthcare and nursing education, requiring new forms of digital competency among nursing interns. However, the associations of AI literacy with ethical and psychological outcomes among nursing interns remain unclear. This study examined the associations of AI literacy with moral distress and moral resilience among nursing interns.
Methods: This cross-sectional study included 300 nursing interns from three tertiary hospitals in China between December 2025 and April 2026. AI literacy was assessed using the 12-item AI Literacy Scale adapted by Reinhardt et al. Moral distress and moral resilience were assessed

using the Moral Distress Scale–Revised and the Rushton Moral Resilience Scale, respectively. Multivariable linear regression models and exploratory subgroup analyses were performed. Results: The mean (SD) age of the participants was 22.0 (1.2) years, 234 (78.0%) were female, and the mean (SD) AI literacy score was 3.98 (1.29). Higher AI literacy was associated with lower moral distress in both the unadjusted model (β = −0.64; 95% CI, −0.73 to −0.55; P < .001) and adjusted model (β = −0.63; 95% CI, −0.72 to −0.54; P < .001). Higher AI literacy was also associated with greater moral resilience in both the unadjusted model (β = 0.74; 95% CI, 0.66 to 0.82; P < .001) and adjusted model (β = 0.74; 95% CI, 0.66 to 0.81; P < .001). These associations were generally consistent across participant subgroups.
Conclusions: In this cross-sectional study, higher AI literacy was associated with lower moral distress and higher moral resilience among nursing interns. These findings suggest that AI literacy may be an important correlate of ethical adaptation during clinical training and warrant confirmation in longitudinal studies.

4. Clayton, A. and K. McDeavitt (2026). "Detransition, posttraumatic stress disorder, and moral injury. [References]." *Archives of Sexual Behavior*. https://doi.org/10.1007/s10508-026-03669-x

There are increasing reports of individuals who, after undergoing medical gender-affirming treatments (GAT) for gender incongruence/gender dysphoria, subsequently detransition and/or express regret regarding these interventions. Although detransition experiences are heterogeneous, some individuals who detransition describe substantial adverse physical consequences and psychological distress resulting from the GAT they received. The purpose of this article is to assist mental health professionals in their understanding and conceptualizing of detransition experiences within the existing Diagnostic and Statistical Manual of Mental Disorders (DSM) framework. It is posited that a diagnosis of posttraumatic stress disorder, as delineated in the most recent text revision of the DSM (DSM-5-TR) (American Psychiatric Association, 2022), may be applicable for some individuals who have detransitioned. Furthermore, the relevance of the moral injury concept-recently incorporated into the DSM-5-TR under code Z65.8 (American Psychiatric Association, 2025)-as it pertains to this population, is discussed.

5. Danac, E. and A. Bekleviç (2026). "The Relationship Between Moral Distress and Quiet Quitting in Intensive Care Nurses: The Mediating Role of Moral Injury." *Nursing in Critical Care*. https://doi.org/10.1111/nicc.70751

Background: Intensive care nurses encounter numerous ethical problems in clinical practice. When these morally challenging situations remain unresolved, they may lead to moral distress and moral injury among nurses and may ultimately result in quiet quitting behaviours. Studies

examining the relationships among moral distress, moral injury and quiet quitting among intensive care nurses within a comprehensive model are limited.
Aim: This study aimed to examine the relationships among moral distress, quiet quitting and moral injury among intensive care nurses.
Study Design: The study employed a cross-sectional correlational design. It was conducted between 1 April and 31 October 2025 among intensive care nurses working in a university hospital in Türkiye. The data were collected using the Nurse Introductory Information Form, the Moral Distress-Appraisal Scale, the Moral Injury Symptom Scale–Healthcare Professional, and the Quiet Quitting Scale. The relationships among moral distress, moral injury, and quiet quitting were examined using the Pearson correlation coefficient. The statistical significance of the mediating effects was evaluated using 95% confidence intervals from 5000 bootstrap samples.
Results: The study included 138 intensive care nurses. A moderate positive relationship was found between moral distress and moral injury among intensive care nurses ($r = 0.524$, $p < 0.001$). In addition, a low but statistically significant positive relationship was identified between quiet quitting and both moral injury ($r = 0.258$, $p < 0.001$) and moral distress ($r = 0.201$, $p < 0.001$). The mediation analysis revealed that moral injury played a full mediating role in the relationship between moral distress and quiet quitting ($B = 0.083$; 95% CI [0.003, 0.170]).
Conclusion: This study demonstrates that the relationship between moral distress and quiet quitting among intensive care nurses operates through moral injury. The findings indicate that moral injury constitutes a key mechanism that negatively affects nurses' professional engagement and organisational commitment. In this context, quiet quitting may be seen as an outcome arising from unresolved ethical problems. Strengthening ethical support mechanisms to prevent moral injury is therefore important for the professional sustainability of nurses.
Relevance to Clinical Practice: These findings highlight the clinical importance of recognising and addressing moral distress and moral injury among intensive care nurses, as early interventions targeting these ethical challenges may help reduce quiet quitting tendencies and support sustained professional engagement. Accordingly, strengthening ethical support mechanisms and improving working conditions may foster a more supportive clinical environment and help sustain nurses' engagement in intensive care practice.

6. Doty, T. E. (2026). Morally resilient leadership: Compassion practices for addressing moral injury within law enforcement. *Dissertation Abstracts International*: Section B: The Sciences and Engineering. 87, https://www.proquest.com/dissertations-theses/morally-resilient-leadership-compassion-practices/docview/3349096990/se-2?accountid=28179

Law enforcement in recent years has become increasingly aware of traumatic stress injuries resulting from the occupational challenges facing sworn personnel and professional staff. As a result, programmatic solutions are currently being implemented to confront this issue. While these measures are working to address some concerns, they fall short of acknowledging the

impact of organizational stresses on the mental, emotional, and spiritual dimensions of individuals. Of particular focus is the organizational stress of ineffective leadership giving rise to feelings of betrayal and the moral injury resulting from it. This project explores solutions to moral injury through a morally resilient leadership model centered on compassion practices. An adaptation of Robert Quinn's Fundamental State of Leadership framework provides a guide for identifying the core dimensions of morally resilient leaders and the importance of compassion for leading in complex, high-stakes environments. This project and the leadership training to follow will effectively assist the workforce in achieving the performance demands required in law enforcement while fortifying the dimensions of well-being that protect employees from moral injury.

7. Ein, N., et al. (2026). "Psychometric validation of the French version of the Moral Injury Outcome Scale (MIOS). [References]." *Psychological Trauma: Theory, Research, Practice, and Policy*. https://psycnet.apa.org/doiLanding?doi=10.1037%2Ftra0002079

Objective: Moral injury is defined as the profound psychological, emotional, spiritual, and existential distress that arises from exposure to potentially morally injurious events-situations that violate deeply held moral beliefs and expectations. The Moral Injury Outcome Scale (MIOS) has emerged as a robust tool for assessing moral injury. The MIOS, initially validated in English-speaking military populations, was recently adapted into a 14-item French version.
Method: This version was evaluated in a sample of 390 French-speaking Canadian Armed Forces personnel. To assess measurement invariance, the MIOS was further tested in a comparative sample of 490 English-speaking Canadian Armed Forces personnel deployed on the same operation.
Results: The French version of the MIOS showed strong psychometric properties with strong internal consistency reliability, factorial validity, and convergent validity. The proposed two-factor structure was consistent with the MIOS English version, and measurement invariance testing confirmed that the French and English versions of the MIOS satisfied configural, metric, and scalar invariance within military personnel.
Conclusion: Overall, the French version of the MIOS is a valid and reliable measure, enabling robust assessment of moral injury among French-speaking populations and broadening its applicability in research and clinical settings.

8. Gabelmann, J. M., et al. (2026). "Military sexual assault and moral injury: The moderating roles of identity coherence and confusion. [References]." *Identity: An International Journal of Theory and Research*. https://doi.org/10.1080/15283488.2026.2726808

In the present study, we examined whether identity coherence and identity confusion moderate the association between military sexual assault and self-directed and betrayal-based moral injury among service members. Participants were 242 U.S. military members (159 males; Mage = 33.2 years, SD = 8.6) who had experienced one or more deployments. Multivariate multiple regression models tested identity coherence and identity confusion as statistical moderators of military sexual assault with self-directed moral injury and betrayal-based moral injury. Results indicated a significant interaction between military sexual assault and identity coherence in predicting both self-directed and betrayal-based moral injury. Specifically, higher identity coherence was positively associated with greater self-directed and betrayal-based moral injury among those who endorsed military sexual assault, but higher identity coherence was negatively associated with self-directed and betrayal-based moral injury among those who did not endorse sexual assault. These findings suggest the importance of developing a comprehensive conceptualization, which includes identity among recent-era veterans who indicate military sexual assault.

9. Ikenoyama, Matthew U.S. Navy (2026) "Research & Debate—Moral Injury Is a Readiness Problem: The Case for a Chaplain-Led, Peer-Intervention Model," Naval War College Review: Vol. 79: No. 4, Article 10. https://digital-commons.usnwc.edu/nwc-review/vol79/iss4/10

Moral injury is not a clinical problem—it is an operational one. During the Global War on Terrorism (2001–21), an estimated 30,177 active-duty servicemembers and post-9/11 veterans died by suicide. In that same period, 7,057 servicemembers died in war operations. Thomas Howard Suitt, whose 2021 report for Brown University's Costs of War Project produced these figures, characterizes the 30,177 number as a conservative estimate derived from Veterans Affairs (VA) mortality data; the actual toll is likely higher.1 The ratio of suicides to operational deaths is roughly four to one. Moral injury also contributes to administrative and medical separations, retention attrition driven by mental-health conditions, and the compounding institutional costs of degraded unit cohesion. The force is losing far more people to what happens inside their own heads than to what the enemy does to their bodies.
Moral injury is not the only factor that drives this toll, but it is one that the services consistently have addressed too late, through the wrong channel, or not at all. A servicemember who witnesses or participates in a potentially morally injurious event (PMIE) during a deployment typically does not encounter any structured response to that experience until weeks or months later, when symptoms have already set in and have begun to compound. By the time behavioral-health professionals see the servicemember, the wound is not fresh. It has been carried, often alone, often in silence, and often interpreted through a framework of personal failure rather than moral injury. The current institutional arrangement places the diagnosis and treatment of moral injury inside behavioral health and the responsibility for spiritual care inside the Chaplain Corps, yet it gives neither community the authority or the positioning to intervene at the point of origin.

Behavioral health sees the patient when symptoms become disabling. The chaplain sees service members when they seek out pastoral care—which many do not. The point of injury and the immediate aftermath of a PMIE belong to no one. That gap is where the readiness problem lives.

10. Larsson, G., et al. (2026). "Combat Exposure, Moral Injury Symptoms and Mental Health Among Ukrainian Active-Duty Military Personnel and Swedish Military Personnel: A Comparative Study." *International Journal of Environmental Research and Public Health*. https://doi.org/10.3390/ijerph23111362

The aim of the study was to compare a sample of Ukrainian active-duty military personnel with Swedish military veterans in terms of combat exposure, moral injury symptoms and indices of probable PTSD, depression and anxiety. Data collection took place in 2024, and questionnaire responses were obtained from 308 Ukrainian active-duty military personnel and 504 Swedish individuals (288 active-duty veterans and 216 veterans who had left the armed forces) using established scales. All participants reported a qualifying morally stressful experience. The Ukrainian respondents reported higher combat exposure and higher mean scores on scales designed to measure severity of moral injury symptoms, probable PTSD, depression and anxiety. Linear regression analysis showed that nation, combat exposure and age (the Ukrainians were younger) contributed significantly to the explained variance and resulted in a nearly large effect size for probable PTSD, a medium effect size for depression, and nearly medium effect sizes for moral injury symptoms and anxiety. However, possibly the most important finding is that the majority of the Ukrainian participants scored below the limit for moderate severity regarding moral injury symptoms and below established cutoff values on the probable PTSD, depression and anxiety scales. A practical suggestion for military healthcare is that the moral injury indication scales and mental health scales may be useful components of stepped screening and assessment processes, with positive screens followed by clinical evaluation.

11. Mai, T., et al. (2026). "Moral distress and moral injury among nurses in German acute inpatient care–a cross-sectional study." *BMC Nursing* 25(1). 10.1186/s12912-026-05526-7

Background: Moral suffering in health care is increasingly a focus of research. The extent of and relationship between two distinct forms of moral suffering, namely, moral injury (MI) and moral distress (MD), has not yet been studied in nurses in acute inpatient care in Germany.
Objectives: This study aims to examine the severity of MI and MD in the context of organizational support, the correlation between the two constructs, and the variables associated with the extent of MD and MI.
Methods: We conducted a cross-sectional study including 1323 nurses employed in German hospitals. The data were collected in March and April 2023 in an online survey using the German

version of the Moral Distress Scale (MDS), the German Moral Injury Symptom Scale for Health Professionals (G-MISS-HP), the Perceived Organizational Support Scale (POS-s) and an additional questionnaire on the individual perception of ethical and structural conditions in the institution. The data were analyzed descriptively. Partial credit Rasch models were fitted to the item-level responses of the G-MISS-HP and the MDS to obtain interval-level measures of moral injury and moral distress for subsequent analyses. Median regressions with backward variable selection were performed for MD- and MI-Rasch scores to identify variables associated with the level of moral distress/injury. The associations between the MD and MI-Rasch scores were tested using Spearman's correlation test.
Results: A total of 68.6% (n = 907; 95% CI: 66.1%–71.1%) of the respondents scored above the validated G-MISS-HP screening threshold (≥ 29), which has previously been associated with impairment in family, social, and occupational functioning. Spearman's correlation analysis revealed statistically significant positive associations between the MD-Rasch score and the MI-Rasch subscores (guilt/shame subscore: r = 0.57, 95% CI [0.53; 0.61]; spiritual troubles subscore: r = 0.22, 95% CI [0.16; 0.27]; condemnation subscore: r = 0.39, 95% CI [0.34; 0.43], all p < 0.001). Median regression analyses revealed significant associations of both MD and MI with perceived organizational support (POS-s), satisfaction with the treatment team's consideration of own perspective, responsibility for staff, and participation in interprofessional case discussions.
Conclusions: Manifestations of moral suffering are common. Our findings highlight the importance of measures to promote an ethical climate and to address the negative consequences of moral suffering, particularly at the management level.

12. Midkiff, M. F., et al. (2026). "The impact of potentially morally injurious events on the effectiveness of evidence- based psychotherapies for PTSD." *Psychological Trauma:Theory, Pesearch, Practice and Policy*. 10.1037/tra0002187

OBJECTIVE: Morally injurious events are a more recent area of interest in the field of trauma psychology. Some suggest that current, evidence-based psychotherapies for posttraumatic stress disorder (PTSD) do not adequately address PTSD symptoms stemming from events perceived as morally injurious; however, this has not been clearly demonstrated in the literature. The goal of this study was to add to emerging evidence and explore whether current evidence-based psychotherapies for PTSD can adequately address PTSD symptoms resulting from both (PMIE) potentially morally injurious and (non-PMIE) nonmorally injurious events.
METHOD: The present study compared response to outpatient PTSD treatment in veterans who endorsed their index trauma as morally injurious (PMIE; n = 81) and those who denied viewing their index trauma as morally injurious (non-PMIE; n = 76).
RESULTS: A multilevel modeling analysis demonstrated that both groups experienced a significant reduction in PTSD symptoms over the course of treatment, as measured by the PTSD Checklist for DSM-5, B = -1.59, SE = 0.18, 95% CI [-1.94, - 1.24], t(98.64) = -9.03, p < .001. There was no

difference in treatment response between PMIE and non-PMIE groups, PMIE x Time interaction; B = .00, SE = 0.27, 95% CI [-0.54, 0.55], t(105.97) = .02, p = .985, after controlling for military sexual trauma, the only demographic variable with pretreatment group differences. CONCLUSIONS: These results suggest that for many veterans, current evidence- based psychotherapies for PTSD may effectively reduce PTSD symptoms even when PTSD results from an event they perceive as morally injurious.

13. Murphy, A., et al. (2026). "Caught Between Patients and Systems: Moral Injury in Trauma Practice." *American Surgeon*: 31348261493531. 10.1177/00031348261493531

Moral injury (MI) arises from conflicts with deeply held moral or professional values. Distinct from burnout, compassion fatigue, or PTSD, MI occurs when providers feel unable to provide care in alignment with their values due to circumstances beyond their control. This mixed-methods cohort study explored MI among trauma health care providers (THCPs) at a Level I Trauma Center. Study participants were trauma team providers who completed trauma-focused interviews and the Moral Injury Symptoms Scale for Health Professionals (MISS-HP). Clinically significant MI was common, consistent with existing literature. Qualitative analysis identified system-driven themes including prolonged care, resource scarcity, throughput pressure, compromised standards of care, and repeated exposure to violence. Mitigating MI in high-acuity settings requires greater alignment between leadership and providers. Findings emphasize the need for organizational reforms alongside employee mental health support to address MI effectively. Further studies should assess these system-level drivers across trauma roles and disciplines.

14. Nash WP (2026) Moral engine model: conceptualizing moral injury as a wound to the self caused by rupturing of defining and sustaining emotional attachments. *Front. Psychiatry* 17:1735274. doi: 10.3389/fpsyt.2026.1735274

A theory is elaborated illuminating the nature of moral injury based on evolutionary biology and psychoanalytic object-relations and self psychology, which explains how the betrayal of a moral trust can produce not only the negative moral emotions and losses of social and spiritual engagement characteristic of moral injury, but also the entire spectrum of adverse peri-and post-traumatic stress states. After stating the rationale for a few starting assumptions, three premises on which this theory is built are articulated, and their empirical support reviewed. The first premise is that morality is innate, evolving in vertebrates over a half billion years to enable the formation and evolution of cultures. The second premise is that pre-wired moral capacities comprise four concurrent moral modes serving a hierarchy of four moral imperatives: survive, be respected, love and belong, and seek the greater good. The third premise is that prosocial moral behavior continuously depends on the availability of secure and nourishing emotional attachments of three

types (valued, valuing, and kindred), and that the rupture of an important emotional attachment may cause a sudden loss of the functional integrity of the self, manifested as dissociation and the fragmentation of experience and behavior. A theory of personhood called the Moral Engine Model, based on these three premises, is then described, articulating the relationship between the availability of defining and sustaining emotional attachments and one's ability to become the best version of oneself and to contribute to the greater good through love, work, play, and creation. Two clinical vignettes are offered as frameworks for exploring the effects of betrayals of trust by oneself or someone else on the availability of diverse defining and sustaining, internal and external emotional attachments. Moral mapping is introduced as a graphical tool for visualizing changes in emotional attachments caused by moral injury traumas. Finally, a few thoughts about the possible application of the model to clinical treatment are offered.

15. Sahin-De Gier, N. and D. Boost (2026). "The (He) art of doing research with undocumented migrants: a duoethnography on positionality, emotion and moral conflict." *Journal of Ethnic and Migration Studies*. https://doi.org/10.1080/1369183X.2026.2742676

Building on the reflexive turn in migration studies, this article examines how ethnographic researchers negotiate moral conflict during and after fieldwork with undocumented migrants. As an important, yet often-overlooked, dimension of migration research, we conceptualise moral conflict as the tension between professional expectations, institutional and researchers' own moral convictions. To explore and examine this issue, we adopt the innovative methodological approach of duoethnography, treating the authors' dialogical encounters as the primary site of inquiry. Drawing on conversations about our experience conducting constraints, ethnographic research with undocumented migrants in the Netherlands and Belgium, we jointly analyse how moral conflict is negotiated across four interconnected domains: roles, care, knowledge, and change. Our findings show that moral conflict is not merely an individual emotional construct, but also a relational force shaping positionality, ethical decision-making, and knowledge production. Rather than treating emotions and vulnerability as threats to scholarly rigour, we argue that collaborative reflexivity can deepen ethical sensitivity and analytical insight. By introducing duoethnography to migration studies, this article offers both a conceptual vocabulary for researchers' moral conflicts and a methodological framework for more reflexive, caring, and ethically engaged scholarship.

16. Turner, B. F. (2026). "When Accountability Exceeds Agency: Executive Moral Injury and Organizational Fragility in Healthcare Leadership." *Military Medicine*. 10.1093/milmed/usag485

Moral injury in healthcare is most often discussed in relation to clinicians, but healthcare executives may also experience morally significant distress when they remain accountable for organizational outcomes without sufficient agency, information, trust, or voice. This commentary introduces accountability without agency as a potential pathway to executive moral injury. Drawing on scholarship on moral injury, moral distress, psychological safety, and organizational conditions, it examines how suppressed candor, routine bypassing of accountable executives, and persistent centralization of decision-making can harm leaders and weaken organizational coordination and resilience. Although evidence specific to healthcare executives remains limited, research among healthcare workers demonstrates that moral conflict can have consequences beyond occupational dissatisfaction. The commentary concludes that healthcare organizations can reduce these risks by aligning responsibility with decision rights, protecting executive voice, distributing strategic context, and developing leaders capable of exercising judgment in service of the mission.