Moral injury and distress: influence of emergency services leadership and organisational dynamics

Abstract

This study explores how leadership behaviours and organisational characteristics influence moral distress and moral injury among frontline emergency services personnel. Fifty-four Australian emergency responders completed an online survey containing 6 open-ended questions addressing their experiences, influential organisational and leadership factors, alignment between personal and organisational values and recommendations for organisational change. Responses were analysed using thematic analysis. Organisational factors, rather than direct exposure to trauma incidents, were frequently described as primary drivers of moral distress and injury. Specifically, distrust in leadership and perceptions of procedural injustice commonly amplified respondents' vulnerability to moral distress or injury. Participants reported a disconnect between organisational and personal moral values and indicated perceptions of inconsistency between the stated and enacted values of their organisations. Empathetic and supportive leadership behaviours were identified as protective factors, while bullying, unethical actions and leader detachment were commonly perceived as exacerbating experiences of moral distress and injury. These findings underscore the potential importance of attending closely to leadership practices, organisational ethics and the alignment of organisational values.

Peer reviewed

Dr Greg Drummond[1,2]
ORCID: 0000-0002-2560-3700

Dr Joseph Cuthbertson[3,4]
ORCID: 0000-0003-3210-8115

Dr Kate Baecher[5]
ORCID: 0009-0007-8893-1940

Dr Matthew B Thompson[6]
ORCID: 0000-0002-5649-1203

1. iCinema Research Lab, University of New South Wales, Sydney, New South Wales.
2. Department of Fire and Emergency Services, Perth, Western Australia.
3. Monash University Disaster Resilience Initiative, Melbourne, Victoria.
4. School of Medicine, The University of Notre Dame Australia, Freemantle, Western Australia.
5. Elysium High Performance, Sydney, New South Wales.
6. Centre for Biosecurity and One Health, Murdoch University, Murdoch, Western Australia.

SUBMITTED
30 September 2025

ACCEPTED
16 November 2025

KEYWORDS
moral distress, moral injury, emergency services, leadership, organisational dynamics, workplace safety, mental health

DOI
www.doi.org/10.47389/41.3.25

Introduction

Firefighters, police officers and paramedics (collectively referred to as emergency services personnel) respond to confronting and traumatic situations. These responses often involve dire circumstances that pose risks to both the public and the responder, while also challenging personal ethical and moral frameworks (Cuthbertson and Penney 2023). The exposure to potentially psychologically traumatic events combined with the inherent and sustained stress of these environments is associated with increased risk of posttraumatic stress, burnout and suicide among first responders and frontline personnel (Lentz et al. 2021; Smallwood et al. 2021). Their work can require them to make morally challenging decisions, such as a paramedic having to determine which patient to treat where resources are insufficient. These decisions can affect their psychological wellbeing and contribute to adverse psychological outcomes (Cuthbertson and Penney 2023; Lentz et al. 2021).

Unlike posttraumatic stress that can occur following threat-based trauma, moral distress (MD) and moral injury (MI) can arise from situations, events and actions that go against a person's deeply held beliefs and values. While definitions vary in the literature (Čartolovni 2021; Griffin et al. 2019; Litz et al. 2009; Litz and Kerig 2019; Shay 2014), for the purpose of this study, 'moral distress' is defined as: 'When one knows the right thing to do based on deep moral beliefs, but institutional constraints make it nearly impossible to pursue the right course of action' (Lentz et al. 2021) and 'moral injury' is defined as: 'A particular type of psychological trauma characterised by intense guilt, shame, and spiritual crisis that emerge following perceived violations of deep moral beliefs by oneself or trusted parties' (Jinkerson 2014, 2016).

Although substantial MD/MI research arises from healthcare settings, this review focuses on emergency services personnel to preserve conceptual specificity. Where relevant, reference to adjacent sectors is used to contextualise convergent mechanisms (e.g. institutional constraints, perceived injustice) without extending beyond the study's scope.

The concept of MD is recognised as identified by Jameton (1984). Since then, MD/MI have increasingly been the focus of research within emergency services and first responder contexts. Lentz et al. (2021) conducted a systematic literature review examining MI, moral ambiguity, ethical decision-making, moral stress, MD, values, organisational betrayal and spirituality. Their analysis of 32 peer-reviewed studies (selected from an initial pool of 506) revealed that MD/MI were exacerbated when organisational protocols, procedures or requirements conflicted with a person's core values and beliefs. For example, moral conflicts arise when paramedics must follow medical protocols they believe may cause undue harm to patients rather than exercise their own clinical judgement. Similarly, police officers, whose ethos is to protect and assist rather than harm, are required to use physical force during crowd-control operations.

Emergency services personnel typically have a strong sense of pride in, and duty to, their service whereby their perception of identity blends with that of their role as a firefighter, police officer or paramedic. Within this context, the perception of organisational betrayal (e.g. lack of recognition or blocked career aspirations) and unfair treatment (e.g. unjust or overly harsh disciplinary action) can be a significant contributing factor to moral distress and injury. A systematic literature review by Beadle et al. (2024) analysed 104 studies and reports selected from an initial 1,689 sources and examined triggers and factors associated with MD and MI in health and social care workers. Their analysis revealed that MI emerges from a complex interplay of factors and workplace conditions and institutional limitations play significant roles in its development.

Appropriate operational guidance is crucial in emergency services organisations despite being a potential operational constraint. Penney et al. (2022, 2024) note that inadequate doctrine, protocols or guidelines can lead to unfair criticism of decisions made by public service personnel operating in time-sensitive and complex environments. Further to this, the potential effects of organisational factors explored by Drew and Williamson (2024) reported that while there was no direct relationship between trauma, stress and burnout, organisational factors including perceptions of unfair treatment were solely responsible for police officer burnout.

These findings suggest that organisational and leadership factors play a greater role in the development of MD/MI than previously recognised. While research has examined various aspects of MD/MI among emergency services personnel, less attention has been given to understanding how personnel themselves perceive the influence of leadership and organisational factors on these experiences.

This study aimed to develop a better understanding of how organisational contexts shape moral challenges in emergency services work. The study examined the responses of frontline emergency services personnel to questions about the influence of leadership and organisational factors in exposure to MD/MI.

Method

While there are various approaches to structuring a methods section, for consistency and clarity this paper adopted the approach by Willis (2023).

Study design

The research question explored is: 'Do organisational and leadership factors play a significant role in the development of MD/MI?' The research team hypothesised that this was the case.

This study did not include clinical assessment of MD/MI. It elicited experiences via open-ended questions and the analytic focus remained on participants' reported experiences and meanings. Australian emergency services personnel were surveyed using 6 open-ended questions focused on their experiences with MD/MI, organisational values and leadership attributes. Responses were analysed using an inductive thematic approach to identify emerging patterns and insights from participants' perspectives. An online questionnaire distributed via STAT59[1] collected responses from frontline emergency services personnel in Australia between August and October 2024 regarding their perceptions of how leadership and organisational factors influence their MD/MI. The purpose was to understand and accurately report the views of intentionally recruited respondents, selected for their direct frontline experience. These specific constructs were explored using the questionnaire that aligned with established practices for targeted insight gathering (Check and Schutt 2011). Accordingly, findings should be interpreted as reflecting the perspectives of the participant group rather than representing the broader population of emergency services personnel. Participants were provided the study definitions of MD/MI and were asked:

1. Please describe an event or types of events that are most likely to cause moral distress or injury.
2. Do you believe the moral values of your organisation align with the moral values of frontline emergency personnel?
3. Do you believe that the values of your organisation are demonstrated by the organisation itself?

1. STAT59 Services Ltd, at www.stat59.com.

4. What are the leadership attributes from your immediate supervisors you have experienced, that (i) increase and (ii) decrease moral distress or moral injury?
5. What are the attributes or actions from your organisation that (i) increase and (ii) decrease moral distress or moral injury?
6. What changes do you believe would make the biggest impact to protecting Australian emergency services personnel from moral distress or moral injury?

Participants

Participation was invited from individuals who identified as frontline emergency services workers (paid and volunteer) in Australia, through the distribution of links to the study via social media (LinkedIn and Facebook). For the purposes of this study, emergency services personnel were self-defined by the respondent (i.e. they viewed themselves as an emergency services person). The rationale for this is the breadth of service providers who respond to emergencies and disasters and the desire to seek breadth of input across areas of practice. Participants were not required to have experienced MD/MI to participate in the study. No compensation was offered for participation in the study.

While 220 registrations of interest were initially received, 54 participants (65% men, 13% women, 22% undefined) completed the survey. Participants had a mean age of 50.12 (*SD* = 11.95) years. Respondents represented diverse emergency services backgrounds with some having served in multiple roles. The majority of participants (67%) had fire service experience, while others reported backgrounds in medic/ambulance/paramedical services (20%), policing (11%), State Emergency Services (7%) and Marine Rescue Service (2%). Additionally, 11% identified as having experience in other frontline emergency services not specifically categorised. The average number of years served was 22.83 (*SD* = 10.03) with a minimum of 3 years and a maximum of 47 years.

Data analysis

An inductive thematic analysis of the results was completed allowing for themes to emerge from the data as opposed to attempting to fit data into a pre-existing coding frame (Nowell et al. 2017). This approach provides a rich description of the overall data (Braun and Clarke 2006).

As free-text answers were permitted and respondents were encouraged to provide as much detail as possible, some answers contained multiple and, at times, unrelated elements. Where this occurred, the individual elements were coded accordingly and linked to different themes as appropriate. Not all participants completed all questions and, in very limited circumstances, provided responses that were considered unrelated to the question asked. This is important to note when interpreting the results as the number of elements coded for each question will not necessarily align with the total number of study participants. In addition, 'outlier' individual responses that were not thematically linked to others yet offered particular or noteworthy insights were identified.

To address potential issues associated with interpretation of responses to open-ended questions, analysis was completed using a process aligned to the method in Nowell et al. (2017). To mitigate potential bias, researchers separately reviewed the data, developed initial coding and searched for initial themes. Researchers then jointly consolidated the preliminary results with all differences resolved through discussion until consensus was reached. A draft analysis and reporting were completed, which was reviewed and confirmed. The fourth member of the research team provided critical review of the process and reporting for quality assurance purposes.

Ethics statement

Ethics approval was provided by Monash University (HREC #41738) with optional counselling support services for participants available should participation in the study and recollection of distressing events cause distress.

Results

Inductive thematic analysis of responses to the question, 'Please describe an event or types of events that are most likely to cause moral distress or injury' revealed 5 distinct categories of events with remaining responses grouped as 'Other'. Table 1 lists these categories and their commonality.

The analysis revealed that organisational factors dominated participant reports of events likely to cause MD/MI. Distrust of leadership emerged as the most frequently cited cause (24% of responses), followed closely by lack of procedural justice (20%) defined as the perception of fair process in organisational decision-making. Together, these trust-related themes accounted for 44% of responses and suggest that breaches of trust between senior leadership

Table 1: Events most likely to cause MD/MI – thematic analysis of coded responses.

Response	Percentage (%)	Total (n)
Distrust of leadership	24	13
Lack of procedural justice	20	11
Exposure to trauma	19	10
Public health control mandates (vaccination)*	9	5
Resource constraint	9	5
Other (combined)	19	10

* Enforcement of COVID-19 vaccine mandates and related disciplinary processes for those who declined to comply with the mandates.

and frontline personnel are a strong reported source of moral distress and injury.

Exposure to traumatic emergency response incidents was identified in 19% of responses. However, these responses lacked sufficient detail to determine whether the MD stemmed from the inherent trauma of the incidents or from conflicts between moral obligations and operational constraints. Two themes, public health control mandates (specifically vaccination requirements) and resource constraints, were each reported in 9% of responses. Both categories represent external constraints imposed by governmental or organisational policies that frontline personnel typically cannot influence directly, potentially creating a sense of powerlessness that contributes to moral distress.

Analysis of responses to questions addressing organisational values revealed a substantial disconnect between stated values and frontline experiences. Table 2 presents participant responses to: 'Do you believe the moral values of your organisation align with the moral values of frontline emergency personnel?' and 'Do you believe that the values of your organisation are demonstrated by the organisation itself?'.

The data revealed a pronounced pattern regarding organisational values in emergency services organisations. The majority of responses (78%) identified that an organisation's stated moral values did not align with the values held by frontline personnel. Only 2% indicated clear alignment, while 20% reported occasional alignment. Similarly, most responses (68%) indicated that their organisation failed to demonstrate values through actions and decisions. While 21% of responses reported their organisation consistently demonstrated stated values, 11% indicated that organisational actions only sometimes reflected stated values.

Notably, 6% of responses specifically distinguished between organisational levels of frontline and leadership, indicating that while frontline staff demonstrated behaviours consistent with organisational moral values, senior leadership did not. This distinction suggests a perceived gap between operational and leadership levels of emergency services organisations.

Table 3 shows participant responses to the question: 'What are the leadership attributes from your immediate supervisors you have experienced, that (i) increase and (ii) decrease moral distress or moral injury?'.

The presence or absence of empathy and support emerged as the most frequently reported leadership attribute affecting MD or MI with 20% of participants indicating that lack of these qualities increased MD/MI and 28% reported that their presence decreased MD/MI. Bullying (15%) and self-promoting or unethical behaviour by leaders (12%) were the next most commonly reported factors that worsened MD/MI. For factors that reduced MD or MI, good communication and willingness to listen were each reported by 8% of participants as the second most influential attributes. The substantial proportion of responses categorised as 'Other' (53% for factors increasing MD/MI and 56% for factors decreasing MD/MI) reflects considerable variation in participant responses. This variation aligns with previous research noting the highly individualised nature of ethical and moral perspectives (Cuthbertson and Penney 2023; Alhaidani et al. 2024).

Table 4 shows participants' most frequent responses to the question: 'What are the attributes or actions from your organisation that (i) increase and (ii) decrease moral distress or moral injury?'.

Participants reported organisational factors influencing MD/MI that paralleled with previously reported leadership attributes. Lack of support for staff emerged as the most frequently reported factor increasing MD/MI (21%), followed by leadership disconnect from frontline personnel (17%) and organisational failure to address poor behaviour or complaints (15%). Notably, the most commonly reported

Table 2: Alignment and demonstration of organisational moral values, thematic analysis of coded responses.

Value alignment	Percentage (%)	Total (n)	Demonstration	Percentage (%)	Total (n)
No	78	40	No	68	36
Sometimes	20	10	Yes	21	11
Yes	2	1	Sometimes	11	6

Table 3: Top leadership attributes from immediate supervisors that influence MD/MI – thematic analysis of coded responses.

Increase MD/MI	Percentage (%)	Total (n)	Decrease MD/MI	Percentage (%)	Total (n)
Lack of empathy / support for staff	20	12	Empathy / Support for Staff	28	14
Bullying	15	9	Good communication	8	4
Promotion of self at expense of others / unethical behaviour	12	7	Willingness to listen	8	4
Other responses (combined)	53	31	Other responses (combined)	56	28

organisational factor that could decrease MD/MI was 'nil - nothing can be done' (22%). Free-text answers indicated a perception that the leadership and organisational factors contributing to MD/MI were so systemic and entrenched that MD/MI could not be reduced regardless of interventions. Empathy and genuine care for staff were each reported by 16% of participants as the second most influential organisational factors that could reduce MD/MI. For both categories of organisational factors (those increasing and those decreasing MD/MI) a substantial proportion of responses fell into the 'Other' category (48% and 51%, respectively). This indicates considerable individual variation in participant perceptions of organisational influences on MD/MI.

Table 5 lists responses to question 6: 'What changes do you believe would make the biggest impact to protecting Australian emergency services personnel from moral distress or moral injury?'.

Improved education and training on MD/MI was reported by 20% of participants as the change that would have the greatest protective influence against MD/MI. Greater empathy and people focus was the second most frequently reported protective factor (17%) followed by improved recruitment and promotional processes (13%); increased accountability of staff (11%) and systems-level changes including restructures, external interventions or amalgamation of emergency services (9%). Among less frequently reported suggestions, 7% of participants indicated that increased compensation would reduce the effect of MD/MI. The remaining reported factors (30%) demonstrated considerable variation with low levels of agreement between participants.

Discussion

This study explored how leadership and organisational factors influence exposure to MD/MI by asking frontline emergency services personnel a series of open-ended questions about their experiences and perceptions. By analysing their responses, the research sought to capture the direct experiences and perceptions of these individuals to provide a rich, nuanced understanding of lived experiences. The central findings identified that organisational factors, particularly those pertaining to trust and procedural justice, were frequently reported as primary drivers of MD/MI. This suggests that the internal dynamics and systemic structures within emergency services organisations may contribute to psychological harm more than direct exposure to traumatic incidents alone (Bell et al. 2025).

Distrust and betrayal-based moral injury

The analysis of events most likely to cause MD/MI revealed a compelling theme. Distrust of leadership was identified as the most frequently cited cause (24% of responses) closely followed by a perceived lack of procedural justice (20% of responses). Collectively, these 2 themes intrinsically linked to trust within the organisational framework, represent 44% of all reported causes, more than direct exposure to traumatic incidents (19%). Respondent text provided vivid illustrations of this distrust and perceived injustice. One participant described a 'sense of betrayal' and a sub-standard psychologically safe environment stemming from a lack of validation and procedural injustice within their agency. Another described experiencing 'deep distrust' due to alleged fabricated stories and unfair dismissal processes orchestrated by senior officers. Other accounts described 'organised abuse from senior management', including instances of lying and gaslighting, which had profoundly affected them. These accounts underscore that breaches of trust between senior leadership and frontline personnel are a potent and frequently reported source of MD and MI.

Looking across the events reported to most likely lead to MD/MI (Table 1), similarities between several categories are apparent. Participant distrust of organisational leadership connects directly to organisational procedures such as the enforcement of COVID-19 vaccine mandates and related disciplinary processes for workers who declined to comply with the mandates. However, all responses, including those that appear unrelated at first glance (such as resource constraints and vaccine mandates) share 2 fundamental elements. The first is the presence of a deeply held moral belief by the participant. The second consists of (i) a reported event, action or circumstance that (ii) the participant perceives as sufficiently conflicting with their moral belief to cause intense shame, guilt or betrayal and (iii) that the participant cannot control or correct.

Applying this to the resource constraint and vaccine mandate responses, in both cases, we observed these elements at work. For element 1, emergency services personnel typically have a deep belief that their role as

Table 4: Top organisational factors that influence MD/MI – thematic analysis of coded responses.

Increase MD/MI	Percentage (%)	Total (n)	Decrease MD/MI	Percentage (%)	Total (n)
Lack of support for staff	21	10	Nil - nothing can be done	22	8
Leadership disconnect from frontline personnel	17	8	Empathy	16	6
Failing to act in response to poor behaviour or complaints	15	7	Genuine care for staff	11	4
Other responses (combined)	48	23	Other responses (combined)	51	19

Table 5: Changes that would have the greatest effect in protecting emergency services workers from MD/MI in Australia.

Category	Percentage (%)	Total (n)
Improved education and training	20	9
Greater empathy and focus on people	17	8
Improved recruitment and promotional processes	13	6
Increased accountability	11	5
Systems level changes	9	4
Other responses (combined)	30	14

a firefighter, police officer, paramedic, etc. is more than a job; rather it is a desire or even responsibility to help others (Lentz et al. 2021; Long et al. 2019). This satisfies the first element. Element 2 is satisfied in several ways. First, organisational resourcing constraints can result in responders being unable to help others to the level of their internal standards (Cuthbertson and Penney 2023). This is a complex and multi-faceted issue in the same way vaccine mandates prevent responders who object to vaccines being able to help others as they cannot enter the workplace. Second, being unable to do their job due to resourcing constraints was reported to cause emotions such as shame and guilt. Finally, both increased resourcing and the removal of organisational (and government) mandates are beyond the control of the individual. Conversely, empowerment and control over outcomes have been shown to improve a person's psychological recovery from injury (Brough et al. 2021).

These findings resonate strongly with contemporary systematic reviews that underscore the critical role of workplace conditions and institutional limitations in the genesis of MI (Bell et al. 2025). It challenges conventional, individually focused interpretations of trauma by positing the organisational environment as a significant contributor to psychological harm. The concept of betrayal-based MI is particularly pertinent and aligns with observations in healthcare settings during the COVID-19 pandemic where a loss of trust in leadership and a fractured relationship with the organisation were identified as key factors (Bell et al. 2025).

The survey responses indicate that the organisational environment, characterised by a chronic perceived lack of trust and procedural justice, operates as a persistent stressor and a priming factor for MD/MI. While exposure to potentially psychologically traumatic events is an inherent and expected aspect of emergency services work, organisational failures represent a betrayal of the implicit social contract between the responder and their institution. This betrayal cuts deeper because it undermines the very support structures and ethical frameworks that individuals expect in a high-stress environment. This highlights that MD/MI in these contexts is less about the inherent dangers of the job and more about how organisations manage their people and uphold its values.

Disconnect between stated and enacted values

A finding of this study is a pronounced ‘values chasm’ within emergency services organisations. A majority of participants (78%) reported that their organisation’s stated moral values did not align with the values held by frontline personnel, with only 2% indicating clear alignment. This misalignment was exacerbated by the perception that organisations frequently failed to demonstrate values through actions, with 68% of respondents indicating this inconsistency and 21% reporting consistent demonstration. An observation was made by 6% of participants who explicitly distinguished between the behaviour of frontline staff and senior leadership, noting that while frontline staff often demonstrated values consistent with organisational principles, senior leadership did not.

Examples provided by respondents illustrate this disconnect. One participant noted that their organisation's stated values differed from its actions due to a ‘deficit of organisational courage’. Another highlighted a ‘huge divide’ between Annual Report data, which was perceived to be untrue, and internal member surveys, which were perceived to be truthful. It was perceived that there was no consequence for people in leadership roles who were believed to be responsible for the perceived inappropriate external reporting. There was sentiment that departmental values were ‘just words on a poster, just rhetoric’ and this further encapsulates this perceived chasm.

The ‘values chasm’ serves as a direct pathway to MD/MI as MD/MI is fundamentally defined by perceived violations of deeply held beliefs (Rimon and Shelef 2025). When organisational protocols, procedures or requirements conflict with a person’s core values and beliefs the experience of MD/MI is significantly exacerbated. This contributes to a recognised ‘loss of trust in authority’; a critical viewpoint within moral injury theory (Rimon and Shelef 2025).

A nuanced aspect of the values chasm is the paradox of competing priorities, which can lead to unintended MD/MI. For example, senior leaders in emergency services organisations must consider the distribution of resources in order to achieve the best outcome for the greatest number of people. Despite good intentions, this approach can be little comfort for frontline responders who believe they are being denied the resources they deem critical to do their job to the level they believe is both required and owed to the community. This tension between the singular, often life-saving focus of frontline personnel and broader organisational or government constraints (such as budget limitations or public health mandates) could inadvertently

lead to MD/MI as frontline staff feel betrayed or let down by the management. This tension may occur when both frontline personnel and managers genuinely believe they are acting in the 'right' way within their respective domains. This observation underscores that moral conflicts are not always born of malicious intent but can arise from structural and systemic pressures. This indicates a mismatch between the espoused beliefs and values of the leaders with their actions, given competing priorities.

A sustained values chasm can erode professional identity and organisational cohesion. Emergency services personnel often deeply integrate their personal identity with their professional role, viewing it as a fundamental 'desire or even responsibility to help others'. When organisational values are not genuinely demonstrated or when institutional constraints prevent responders from fulfilling this core moral imperative (e.g. due to resource limitations or mandates that restrict their ability to work, it can provoke intense shame, guilt or betrayal). This extends beyond job dissatisfaction and fundamentally challenges a sense of purpose and professional identity. The long-term implication of such erosion is a potential for disengagement, reduced effectiveness and, ultimately, a loss of dedicated and experienced personnel (Giwa et al. 2021). This has consequences for recruitment, retention and the overall quality and resilience of emergency services organisations.

Leadership attributes as catalysts and buffers

This study indicated that leadership attributes play a dual role in the experience of MD/MI and acts as both catalysts and buffers. The data shows that a lack of empathy and support from supervisors is the most frequently reported attribute increasing MD/MI, accounting for 20% of responses. Bullying (15%) and the promotion of self at the expense of others or unethical behaviour (12%) were also identified as significant contributors to worsening moral suffering. Participants reported instances of 'dark triad of traits' and a 'lack of moral courage' in leadership as well as 'bullying, use of quasi-military structure to control or manipulate situation', and 'corrupt persons in senior positions whose focus was on protecting their own interests'. Unethical or unsupportive leaders may create distrust that contributes to broader organisational betrayal. Conversely, the presence of empathy and support from supervisors emerged as the top attribute decreasing MD/MI, reported by 28% of participants. Good communication (8%) and a willingness to listen (8%) were identified as key protective factors. Responses illustrate the positive effect of such leadership, including 'servant leadership promoting a climate of psychological safety', 'open and honest communication' and 'empathy and genuine connection, care, concern for the people'. The findings are largely consistent with existing research that underscores the critical role of leadership in fostering a healthy work environment and mitigating moral suffering (Giwa et al. 2021). Engaged leadership, supervisor support and empowerment to make job-related decisions are recognised as protective factors against MI risk. Leaders are crucial in setting organisational values and providing support and perspective (Giwa et al. 2021; Woller et al. 2025). This highlights the imperative for leadership development programs to prioritise ethical conduct, empathy and communication skills rather than focusing on technical competence. The presence of a 'dark triad of traits' in some leadership is damaging and necessitates robust accountability mechanisms.

Emergency services organisations are often characterised as high-trust environments that cultivate a familial bond among members (Yesberg et al. 2024). The contrast between espoused values and enacted leadership behaviour, frequently articulated as 'In writing yes, in action no', undermines this crucial bond. Authentic leadership, defined by integrity, transparency and genuine care, help to maintain trust within these organisations. To address this, organisations must transition beyond superficial 'box-ticking' exercises (as described by a participant) and genuinely invest in leaders who embody stated values rather than merely articulating them. This includes promoting leaders based on merit and moral character not solely on tenure or political acumen.

Organisational processes as contributions to moral injury

The data indicates that organisational processes affect the development and mitigation of MD/MI. The most frequently reported organisational factor increasing MD/MI was a lack of support for staff (21%). This was closely followed by leadership disconnect from frontline personnel (17%) and the organisation's failure to act in response to poor behaviour or complaints (15%). Examples provided by participants included 'lack of care of the Fireys actually on the ground', 'vexatious allegations … proven to be unsubstantiated yet no action was taken' and 'arrogance, stubbornness, and denial' as well as a 'disconnect from frontline personnel' within some services. When participants were asked about organisational factors that could decrease MD/MI, the most common response was 'Nil - nothing can be done' (28%). This implies that past interventions may have been perceived as ineffective, superficial (box-ticking) or disingenuous, leading to a pervasive distrust in the organisation's capacity or willingness to genuinely address these issues. Following this, empathy (8%) and genuine care for staff (8%) were identified as the next most influential factors that could reduce moral suffering.

A distinction emerging from the findings was the discrepancy between trauma and organisational harm. While direct trauma exposure occurs in emergency services operations, the data strongly points to organisational factors as primary drivers of MD/MI. This suggests that for many responders, psychological harm stems not from the inherent dangers of the job (for which they are trained) but from perceptions of unjust or unethical treatment experienced within organisations. This reframes the problem from one of individual resilience to one of organisational accountability and implies that current mental health support models, often focused primarily on trauma response, may be inadequate if they do not address the systemic sources of MD/MI (Drew and Williamson 2024).

The consequences of unaddressed MI extend beyond individual suffering, posing threats to workforce sustainability within emergency services organisations. Participants explicitly linked their experiences of MD/MI to their desire to leave the profession. One respondent noted a lack of follow-up once individuals leave the service, observing that 'which is when the issues raise their head'. Another stated that 'the amount of people leaving the job well before retirement speaks for itself'. The perceived lack of genuine care and support from the organisation was consistently identified as leading to burnout and a disconnect from organisational values. This finding aligns with existing literature indicating that moral distress is a significant factor contributing to professionals, such as nurses, leaving their careers (Giwa et al. 2021). MI is known to present considerable mental health challenges, leading to diminished self-esteem, isolation from and suspicion of others and spiritual distress (Knoblock and Owens 2024). The long-term consequences of unaddressed MD or MI include 'significant and persistent negative changes in behaviour or habits, mistakes, isolation, compulsive behaviour … and a weakened sense of empathy or compassion' (Rabin et al. 2023; Thibodeau et al. 2023), all of which degrade the overall performance and resilience of the workforce.

Among the diverse responses, one participant suggested that the most effective protection against MD/MI would be achieved by removing requirements related to gender, equality, diversity or inclusion. This suggests that the individual believed that these requirements actively contributed to their own MD/MI. However, removing these requirements would contradict the legal, and arguably moral, obligations of the respective organisations when their views are out of alignment with acceptable policy and practice. This highlights that someone can experience MD/MI when their views are out of alignment with acceptable policy and practice. Ultimately, just because an individual experiences MD/MI it does not make it appropriate to change desirable policy and practice. This poses challenges for leadership.

Findings of this study support the conceptual distinction between MD/MI and posttraumatic stress disorder (PTSD). While PTSD emphasises symptomatology following a traumatic event, MI is closely associated with the spiritual and existential aspects of an experience, often linked to feelings of betrayal and violations of deeply held values (Waller et al. 2025). One participant noted that 'many people diagnosed with PTSD are either incorrectly or mixed in with moral injury as a dominant feature in their conditions'. This aligns with literature that posits MD/MI and PTSD as distinct, yet often co-occurring, psychological constructs (Waller et al. 2025). MI is linked to cognitive and emotional outcomes such as lower self-worth, reduced perception of the reliability and trustworthiness of others as well as diminished capacity for forgiveness (Bell et al. 2025). Recognising this distinction is important to develop targeted and effective interventions that address the unique facets of moral suffering experienced by emergency services personnel.

Limitations

The purpose of this study was not to generalise findings to all emergency services personnel. Instead, the aim was to understand and accurately report the views of intentionally recruited respondents selected for their direct frontline experience. Respondent demographics are noteworthy: the majority were males with fire service experience and an average age of 50 years. This composition means care must be taken when inferring or generalising analysis to represent the views of emergency services personel as a whole. The findings should be interpreted as reflecting the perspectives of study participants rather than representing the broader population of emergency services personnel. Eliciting responses from a greater proportion of younger emergency services personnel, women, services other than firefighting, participants from diverse backgrounds and countries could yield different patterns of results. Nevertheless, the insightful and varied responses from these participants, along with the qualitative analysis approach, provide valuable contributions to understand frontline workers' experiences of MD/MI. These insights offer important perspectives that can inform interventions to reduce psychological harm in emergency services contexts.

The qualitative findings should be interpreted as participants' perceptions of influential factors. Quotations and themes illustrate the reported experiences and do not imply frequency in the wider workforce. While this study did not explore the influence of leadership demographics on MD/MI, this is considered an area for future research.

Conclusion

An online survey was used to explore how frontline emergency services personnel in Australia consider leadership and organisational factors that influence exposure to MD/MI. Organisational factors, rather than direct exposure to trauma incidents, were primary drivers of MD/MI. Specifically, distrust in leadership and perceptions of procedural injustice commonly amplified respondents' vulnerability to MD/MI. Most participants indicated a disconnect between organisational and personal moral values, highlighting widespread perceptions of inconsistency between their organisations stated and enacted values. Empathetic and supportive leadership behaviours were identified as protective factors, while bullying, unethical actions and leader detachment were perceived as exacerbating experiences of MD/MI. Some respondents expressed doubt that organisational actions could significantly reduce their moral suffering. These findings underscore the potential importance of attending closely to leadership practices, organisational ethics and the alignment of organisational value, as these factors are of central importance to the surveyed emergency services personnel.

Acknowledgments

Once the manuscript was written, the authors used AI co-pilot tools from Anthropic, Open AI and Microsoft to check author-created material for improvements to grammar and readability.

References

Afzal N (2022) Independent Culture Review of the London Fire Brigade. London Fire Brigade. London. UK. London Fire Brigade website, accessed 15 January 2023.

Alhaidani H, Al Halbusi H, Alharbi K and Alshaer W (2024) 'Navigating Organizational Justice and Ethical Leadership: Empirical Evidence from Saudi Arabia', *Sage Open*, 14(2):1–19. https://doi.org/10.1177/21582440241257378

Beadle E, Walecka A, Sangam A, Moorhouse J, Winter M, Wild H, Trivedi D and Casarin A (2024) 'Triggers and factors associated with moral distress and moral injury in health and social care workers: A systematic review of qualitative studies', *PLOS One*, 19(6):e0303013. https://doi.org/10.1371/journal.pone.0303013

Bell V, Murray E, Munoz L and Krahe C (2025) 'In harm's way: moral injury and the erosion of trust for emergency responders in the United Kingdom', *European Journal of Psychotraumatology,* 16(1):2513107. https://doi.org/10.1080/20008066.2025.2513107

Braun V and Clarke V (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology,* 3(2):77–101. https://doi.org/10.1191/1478088706qp063oa

Brough P, Chan C, Wishart D, Spedding J and Raper M (2021) *Psychological Response to Injury: Research to support workers' psychological responses to injury and successful return to work*. Griffith University. http://hdl.handle.net/10072/408465

Čartolovni A, Stolt M, Scott PA and Suhonen R (2021) 'Moral injury in healthcare professionals: A scoping review and discussion', *Nursing Ethics*, 28(5):590–602. https://doi.org/10.1177/0969733020966776

Check J and Schutt R (2011) *Research methods in education*. Sage Publications.

Clark B (2022) Independent Review of FENZ's Workplace Culture and Complaint Handling Practices. New Zealand Public Service Commission.

Cuthbertson J and Penney G (2023) 'Ethical Decision Making in Disaster and Emergency Management: A Systematic Review of the Literature', *Prehospital and Disaster Medicine*, 38(5):622–627. https://doi.org/10.1017/s1049023x23006325

Drew J and Williamson H (2024) 'Trauma, Critical Incidents, Organizational and Operational Stressors: The Relationship Between Harms and Psychological Outcomes for Police', *Police Quarterly*, 28(3):287–312. https://doi.org/10.1177/10986111241275048

Giwa A, Crutchfield D, Fletcher D, Gemmill J, Kindrat J, Smith A and Bayless P (2021) 'Addressing moral injury in emergency medicine', *The Journal of Emergency Medicine*, 61(6):782–788. https://doi.org/10.1002/jts.22362

Griffin B, Purcell N, Burkman K, Litz B, Bryan C, Schmitz M, Villerme C, Walsh J and Maguen S (2019) 'Moral injury: An Integrative Review', *Journal of Traumatic Stress*, 32(3):350–362. https://doi.org/10.1002/jts.22362

Jinkerson J (2016) 'Defining and assessing moral injury: A syndrome perspective', *Traumatology,* 22(2):122–130. https://psycnet.apa.org/doi/10.1037/trm0000069

Knobloch L and Owens J (2024) 'Moral injury among first responders: Experience, effects, and advice in their own words', *Psychological Services*, 21(3):500–508. https://psycnet.apa.org/doi/10.1037/ser0000838

Lentz L, Smith-MacDonald L, Malloy D, Carleton R and Bremault-Phillips S (2021) 'Compromised Conscience: A Scoping Review of Moral Injury Among Firefighters, Paramedics, and Police Officers', *Frontiers in Psychology*, 2:639781. https://doi.org/10.3389/fpsyg.2021.639781

Litz B, Stein N, Delaney E, Lebowitz L, Nash W, Silva C and Maguen S (2009) 'Moral injury and moral repair in war veterans: A preliminary model and intervention strategy', *Clinical Psychology Review*, 29(9):695–706. https://doi.org/10.1016/j.cpr.2009.07.003

Litz B and Kerig P (2019) 'Introduction to the Special Issue on Moral Injury: Conceptual Challenges, Methodological Issues, and Clinical Applications', *Journal of Traumatic Stress*, 32:341–349. https://doi.org/10.1002/jts.22405

Long S, Martin F and Owen C (2019) The shadow side of learning, leadership and culture in emergency services organisation. AFAC Conference 2019, Melbourne, Australia. https://hdl.handle.net/102.100.100/519360

Nowell L, Norris J, White D and Moules N (2017) 'Thematic Analysis: Striving to Meet the Trustworthiness Criteria', *International Journal of Qualitative Methods*, 16(1):1609406917733847. https://doi.org/10.1177/1609406917733847

Penney G, Launder D, Cuthbertson J and Thompson M (2022) 'Threat assessment, sense making, and critical decision-making in police, military, ambulance, and fire services', *Cognition, Technology and Work,* 24(3):423–439. https://doi.org/10.1007/s10111-022-00694-3

Penney G, Thompson M, Codreanu T and Launder D (2024) 'Insights into decision-maker's perceptions of good versus bad decisions in emergency services – A modified Delphi Study', *Journal of Contingencies and Crisis Management,* 32(3):1–11. https://doi.org/10.1111/1468-5973.12613

Rabin S, Kika N, Lamb D, Murphy D, Am Stevelink S, Williamson V, Wessely S and Greenberg N (2023) 'Moral Injuries in Healthcare Workers: What Causes Them and What to Do About Them?', *Journal of Healthcare Leadership,* 16(15):153–160. https://doi.org/10.2147/jhl.s396659

Rimon A and Shelef L (2025) 'Moral Injury Among Medical Personnel and First Responders Across Different Healthcare and Emergency Response Settings: A Narrative Review', *International Journal of Environmental Research and Public Health*, 22(7):1055. https://doi.org/10.3390/ijerph22071055

Shaw C (2019) Independent Review of Fire and Emergency New Zealand's workplace policies, procedures and practices to address bullying and harassment [PDF]. Fire and Emergency New Zealand.

Shay J (2014) 'Moral Injury', *Psychoanalytic Psychology'* 31(2):182–191. https://psycnet.apa.org/doi/10.1037/a0036090

Smallwood N, Pascoe A, Karimi L and Willis K (2021) 'Moral distress and perceived community views are associated with mental health symptoms in frontline health workers during the COVID-19 pandemic', *International Journal of Environmental Research and Public Health*, 18(16):8723. https://doi.org/10.3390/ijerph18168723

Thibodeau P, Nash A, Greenfield J and Bellamy J (2023) 'The Association of Moral Injury and Healthcare Clinicians' Wellbeing: A Systematic Review', *International Journal of Environmental Research and Public Health*, 20(13):6300. https://doi.org/10.3390/ijerph20136300

Willis L (2023) 'How to Write the Methods Section of a Research Manuscript', *Respiratory Care,* 68(12):1763–1770. https://doi.org/10.4187/respcare.11437

Woller S, Hall K, McGrew S, Anderson-Fletcher E, Norman S and Vujanovic A (2025) 'Examining moral injury and posttraumatic stress among firefighters, emergency medical services personnel, and emergency dispatchers', *European Journal of Psychotraumatology*, 16(1):2510019. https://doi.org/10.1080/20008066.2025.2510019

Yesberg J, Sargeant E, Fenn L, Murphy K and Madon N (2024) 'Fairness in policing: how does internal procedural justice translate to external procedural justice?', *Policing: A Journal of Policy and Practice*, 18:126. https://doi.org/10.1093/police/paae126

About the authors

Dr Greg Drummond is an Adjunct Professor at the iCinema Research Centre at the University of New South Wales and is Superintendent with the Department of Fire and Emergency Services in Western Australia. His research interests are decision-making, judgement, ethics and complex systems

Associate Professor Joe Cuthbertson is the Program Coordinator of Paramedical Studies within the School of Medicine at the University of Notre Dame Australia. His expertise extends to prehospital response, aeromedical retrieval, disaster health management and governance roles. He is also a researcher with the Monash University Disaster Resilience Initiative.

Dr Kate Baecher is a clinical psychologist specialising in trauma in high-risk, complex environments. She combines this with psychology and specialises in high-performance coaching, research and consulting on mental health risk in wilderness activities and austere settings.

Dr Matthew B Thompson is a senior lecturer in cognition at Murdoch University. He investigates human perceptual expertise.

