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SURVIVOR GUILT AMONG HEALTHCARE LEADERS DURING ORGANIZATIONAL TRANSITIONS

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Abstract: *Healthcare professionals are anchored by moral commitments to compassion, integrity, and fairness. Rapid organizational change—particularly mergers, divestitures, and workforce reductions—can place these commitments in tension with institutional realities, creating conditions for moral injury among healthcare leaders. Drawing on literature in moral psychology and organizational ethics, this article conceptualizes survivor guilt, a specific manifestation of moral injury, in healthcare leadership as an appraisal-driven response to perceived inequity and constrained agency during organizational transitions. This article outlines individual, organizational, and system-level contributors, and proposes practical, leadership-oriented interventions—including modified Schwartz Rounds, ethics rounds, and chaplain-led logotherapeutic support—to mitigate moral distress.*

Keywords: *moral injury, survivor guilt, termination, healthcare chaplain, leadership.*

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INTRODUCTION

Healthcare delivery is grounded in altruistic values: respect for human dignity, compassion, integrity, beneficence (in contemporary terms, quality), accountability, and justice—including fair resource allocation and timely access to care. These ethical commitments guide both individual clinicians and healthcare organizations. However, the rigidity of these standards can generate significant tension amid the rapid changes' characteristic of modern healthcare institutions, where economic pressures, technological advancements, and shifting roles frequently necessitate complex decisions.

Moral injury, initially described in military contexts, gained prominence in healthcare following the occupational distress of the COVID-19 pandemic. Despite contextual differences, both military and healthcare professionals possess specialized knowledge and require autonomy to act according to ethical principles.[1] Moral injury arises when a perceived legitimate authority—such as an organization—transgresses an individual's deeply held moral beliefs, producing a perceived betrayal and a dissonance between "what happened" and "how the world ought to work." In healthcare, clinicians can interpret institutional policies as betrayals, creating dissonance between lived events and pre-existing assumptions about how the world should function. This dissonance often manifests as guilt—a central symptom of moral injury—when clinicians interpret events as fundamentally inconsistent with their moral self.[1]

Survivor guilt is a related construct that emerges when individuals perceive themselves to be undeserving beneficiaries of an unjust outcome. [2] Rooted in trauma psychology, survivor guilt may be a persistent experience or an event-specific reaction.[3] In healthcare, it can be analyzed at the individual, organizational, and system levels, reflecting the multi-layered nature of ethical strain during institutional change.

This article examines survivor guilt among healthcare leaders during organizational transitions, situates it within broader moral injury frameworks, and proposes feasible interventions designed for healthcare leadership contexts.

MORAL INJURY AND SURVIVOR GUILT: INDIVIDUAL APPRAISALS IN CONTEXT

At the individual level, clinicians confronted with potentially morally injurious events appraise (a) which moral values are transgressed, (b) their own agency, (c) harm severity, (d) extenuating circumstances, and (e) possibilities for repair.[3] When conflicts between core values and specific events cannot be resolved, moral injury may result. Guilt then functions as a cognitive–emotional signal—often framed as "I did not do enough" or "nothing I did could help"—that consolidates the injury.

Certain personal characteristics may heighten vulnerability to survivor guilt, including fear of social confrontation or rejection.[4] Neurobiologically, guilt is supported by frontal-limbic circuitry—including prefrontal regions and heightened amygdala activity—consistent with its status as a conscious moral emotion.[2] Clinically, survivor guilt often accompanies mood symptoms and shares features with trauma-related conditions such as post-traumatic stress disorder, yet scholarly activity of survivor guilt waned after the Vietnam era and warrants renewed attention in healthcare settings.[4]

At the same time, business ethics—centered on honesty, fairness, accountability, regulatory compliance, stakeholder respect, and avoidance of conflicts of interest—require healthcare organizations to balance immediate patient needs with long-term enterprise sustainability. Market volatility, reimbursement pressures, and regulatory dynamics can necessitate difficult choices, such as service reductions and workforce downsizing. To frontline clinicians, these choices may appear to deviate from the mission and values, fueling appraisals of institutional betrayal. The coexistence of mission-driven commitments and market-imposed constraints can thus create mutually exclusive imperatives that catalyze moral distress. Foundationally, many clinicians enter the profession driven by a genuine desire to help others, and when business demands or organizational decisions interfere with that mission, it can create significant moral tension.

Concurrently, broader drivers—technological change, financial consolidation, shifts in professional roles, commercial pressures on the clinician–patient relationship, and the widespread availability of non-professional medical information—have transformed the clinical identity. The ethical frameworks that historically governed the practice of healthcare have struggled to keep pace, creating dilemmas not easily addressed by traditional principles alone, leaving clinicians and leaders without adequate tools to resolve emerging moral issues.

SURVIVOR GUILT IN LEADERSHIP ROLES

Between 2010 and 2019, the United States experienced approximately 1,537 hospital merger- and acquisition-related ownership changes involving acute care general and critical access hospitals.[5] Systemic drivers, including regulatory demands and declining reimbursements, have fueled consolidation to enhance affordability and sustainability for smaller organizations. Proponents of vertical and horizontal integration highlight benefits such as financial stability, quality improvements via capital investments, work efficiencies, knowledge sharing, and protocol standardization creating value-based care. However, four decades of research reveal limited evidence of enhanced clinical quality post-merger, alongside declines in patient experience.[6] In 2024, 30% of mergers involved financially distressed providers, and over 60% of divestitures entailed hospital closures or market exits, the collateral effects are workforce reductions—loss of employment, terminations, and downsizing—felt acutely by patient, clinical teams, and healthcare leaders.[7]

Healthcare commonly deploys a leadership model in which physicians, nurses, and advanced practice clinicians simultaneously deliver care and hold managerial responsibility. This dual agency obliges leaders to balance the best interests of patients with the sustainability of the organization—an inherently conflict-laden position. Following layoffs, employees frequently experience "survivor syndrome," characterized by guilt, anxiety, and reduced trust.[8] For leaders spared termination, the cumulative burden spans continuing patient care, increased operational demands, and realigned organizational objectives. Many leaders perceive responsibility for staff losses, service disruptions, and cultural erosion, and may vicariously experience unemployment- and finance-related stressors—among the highest-rated stressors for working-age adults.[9] Notably, approximately half of healthcare workers who witness a potentially morally injurious event report survivor guilt.[3]

Equity theory posits individuals prefer outcomes perceived as fair and deserved.[2,10] When leaders believe they have benefited unfairly by retaining employment or authority, guilt may consolidate. Anticipatory threat appraisals—fear of losing one's role, decision-making authority, or team members—can sustain distress. Survivor guilt is also associated with prosocial "helping" behaviors.[2] In leadership, this often manifests as overcompensation: devoting excessive time and energy to "repairing" perceived injustices. While prosocial, these efforts are constrained by structural realities (e.g., budget limits, position eliminations, and professional bandwidth) and power asymmetries between leaders and subordinates. The altruistic identity of healthcare leaders can intensify the cognitive conflict: despite best efforts, they cannot reverse layoffs or "make whole" those affected. High-casualty events, massive layoffs, further challenge survivors' belief systems, amplifying perceived inequity and moral strain.

Thus, healthcare closures and consolidations impose workforce reductions that position clinical leaders in structurally conflicting roles, elevating moral injury risk as they navigate potential harm to patients, colleagues, and culture. Leaders may intellectually recognize that layoffs were unavoidable, yet emotionally experience quilt rooted in accountability and fairness. Inequitable outcomes, coupled with perceived powerlessness to avert harm, may trigger survivor guilt, marked by a sense of unearned advantage and compensatory efforts to restore moral equilibrium by shaping leadership decisions to mitigate moral distress.

INTERVENTIONS

Organizational Dialogues: Schwartz Rounds and Ethics Rounds

Empirically tested strategies for addressing survivor guilt in healthcare leadership remain limited, underscoring the need for innovative approaches adapted from related ethical domains. Preventative and restorative interventions implemented pre- and post-morally injurious events, hold promise for supporting leaders during transitions. Because organizations understand the morally complex pressures that transitions can create, they share responsibility for fostering meaningful dialogue with stakeholders about the effects of those changes.

Schwartz Rounds, piloted in 1997, are confidential, multidisciplinary forums in which caregivers reflect on the emotional and social dimensions of care. While leadership-specific outcomes require further study, a growing body of evidence indicates reductions in psychological distress and improvements in well-being and coping among participants.[11,12] Organization-sponsored Schwartz Rounds tailored to transition contexts can provide leaders and teams with a reflective space to explore the "how" and "why" of workforce reductions, reinforcing a humanizing culture and mitigating self-defeating narratives.

Ethics Rounds offer a more structured, case-centered forum for analyzing ethically difficult situations—including service closures and divestitures. Sessions can include internal and external experts in law, medicine, philosophy, and religion, alongside community members with lived experience. These rounds clarify morally ambiguous questions related to access and continuity of care, the clinician–patient relationship, social justice, community engagement, and trust. A phased model aligned with pre- and post-termination timelines can support leaders through the stages of change, from anticipatory planning to aftermath reflection and learning.

Meaning-Making and Spiritual Care: Chaplain-Led Support

Chaplains are key interprofessional collaborators who model leadership-relevant skills—presence, empathic listening, and facilitation of psychologically safe spaces.[12] Leadership survivor guilt often includes existential elements: "I am not to blame, yet I feel morally responsible." Chaplain-led interventions draw on logotherapy, reframing suffering to find meaning—e.g., attributing circumstances (not individuals) as culpable, while reconciling accountability values with inevitability. By reframing inequity appraisals (e.g., "these circumstances—not my moral failing—produced the outcome"), leaders can reconcile accountability with humility and self-compassion. Integrating chaplains before, during, and after transitions can normalize moral emotions, reduce isolation, and promote value-congruent action within real-world constraints. Such peri-transition support reframes inequity appraisals and harmonizes conflicting moral values without deeming them inherently flawed.

DISCUSSION AND CONCLUSION

Healthcare is transforming faster than the moral frameworks of clinicians can readily adapt, amplifying cognitive dissonance and increasing the likelihood of potentially morally injurious experiences. Organizational imperatives—survival, consolidation, and strategic repositioning—sometimes render certain roles or services unsustainable. In this context, leaders shoulder a dual burden: stewarding system viability while honoring professional and relational commitments to patients and teams. Survivor guilt represents a core feature of the leadership moral landscape during transitions, arising from perceived inequity, constrained agency, and unresolved responsibility.

To meet this challenge, organizations should (1) institutionalize structured reflection for leaders and teams (Schwartz Rounds, ethics rounds), (2) provide meaning-making supports (chaplain-led, logotherapy-informed interventions), and (3) align these resources with the temporal arc of organizational change (pre-decision,

implementation, and aftermath). These steps preserve the humanizing principles at the heart of healthcare while acknowledging unavoidable organizational and systems constraints. Future research should develop leadership-specific measures of survivor guilt and moral injury, evaluate targeted interventions across diverse settings, and examine long-term impacts on leader well-being, culture, and patient outcomes.

By implementing compassionate, evidence-informed practices, healthcare organizations can help leaders transform survivor guilt from an isolating burden into a catalyst for ethical clarity, relational integrity, and sustainable stewardship.

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