ResetEthics

THE MORAL HARM PROJECT

# MORAL HARM: FACILITATED DISCUSSION MATERIALS

## Scenario 1: Paediatric intensive care unit nurse

# Introduction 1

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**Intended use**

This slide-deck is intended for facilitator-led guided discussion of some of the contributory causes of moral harms.

The envisioned facilitator is someone with particular interest in ethics but not necessarily an academic ethicist.  It could be someone working in Trust with strong interest in ethics, who may have had some formal ethics training.

The materials are **not intended** to provide a comprehensive introduction to the moral harm, moral injury, or moral distress literature.

They are also **not intended** to capture the full range of scenarios that may contribute to moral harm in a healthcare  environment.

# Introduction 2

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**Intended audience**

Wellbeing staff supporting healthcare professionals/workers (not the HCP/Ws themselves but could be useful for this latter group).

Could also be used as part of pre-service training (e.g. counselling, clinical psychology, or hospital management).

**Terminology**

We use the term ‘moral harm’ to include moral distress and moral injury – this is a spectrum term that can go from very slight harm to severe distress or injury.

**Aims**

To promote open and respectful discussion of scenarios that can contribute to moral harm to stimulate reflection and learning.

To deepen understanding of core ethical features of moral harm, and how these arise in different scenarios.

To support understanding of the different levels of identification, and appropriate response to, situations of moral distress by a wide range of wellbeing professionals.

# Facilitator notes: How to use this deck (1)

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- We have presented facilitator guidance using PowerPoint
- Deck for each video scenario but **with some slides in common**.
- It is **not** intended that **all** slides are projected.
- Common slides, prompts for discussion of common themes and scenario specific question slides **are** designed to be projected
- ‘Common slides’ help with the identification of and response to moral harms – hence suggest look at these **before** showing video.
- No need to review and discussion common slides more than once if e.g. using more than one scenario per discussion session

# Facilitator notes: How to use this deck (2)

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- Suggested timetable based on a 60-minute session:
    1. Review and discuss common slides first (15 minutes)
    2. Watch a scenario video (5 minutes)
    3. Invite immediate reactions (5 minutes)
    4. Discuss answers to suggested questions about common themes (10 minutes)
    5. Discuss scenario-specific ethical dimensions (3-per scenario, 5 minutes for each)
    6. Wrap up discussion (10 minutes)
- The length of session and number of scenarios discussed can be adapted based on the time available.
- No need to start with scenario 1: scenarios can be discussed in any order.

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# Slides that relate to all the scenarios - 'common slides'

# Recognising moral harm

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- **Moral harm:** continuum that includes facing difficult ethical decisions, moral distress and moral injury. Term best captures this continuum, which arose out of the Reset Ethics research.
- **Healthcare work has an ethical dimension,** and **professional roles are often defined in terms of a common set of ethical values**. Moral harms arise when these are compromised. For example, compromise resulting in threats to an individual's sense of self as a professional.
- **Distinguishing feature** is that recognised signs/symptoms of distress result from **ethical tension or challenge**.
  - Moral harms tend to arise in exceptional (for the member of staff concerned) ethically challenging circumstances
  - Often occurs alongside signs of distress: stress, anxiety, depression etc.
  - But **distinguishing feature is the contributory ethical dimension**
- Vast literature - no single, universally accepted definition of moral distress or moral injury

# We are not responsible for things outside our control


- **Ethical responsibility implies agency/choice:** the person concerned **must** have a choice about how to behave. We are responsible for the consequences of the choices we make and actions we take.
  - e.g. do not regard babies as morally responsible beings
- This understanding of responsibility is often **core to definitions of autonomy**
- Where the scope for choice is very limited **people may be wrong** (in an ethical sense) **to feel personally responsible**.
- Recognising that '**ought implies can'** may help to lift burden of emotional responses such as feelings of guilt
- However, **high stakes moral decision-making almost inevitably feels uncomfortable –** precisely because stakes are high.
  - Nonetheless, the appropriate professional **must decide** what to do despite these feelings.
- If all possible outcomes are bad (genuine ethical dilemma), and no good outcome possible, then a bad outcome will happen regardless of how one chooses **– not to blame**.

# Compassionate care

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- It is assumed that the values underpinning practice at work reflect common healthcare values
- 'Care' as commonly understood has two elements:
  - Something akin to **compassion** – expressing and receiving care that is values-led; speaks to motivation of caring professionals
  - **Functional delivery of services** e.g. taking bloods, administering medications, providing bed bath, getting a patient from one place to another
- Moral harm can arise when compassionate care is prevented, and only functional delivery of services is achievable.

For more about this distinction, please see Chiumento, A., Fovargue, S., Redhead, C., Draper, H., Frith, L (2024) 'Delivering compassionate NHS healthcare: A qualitative study exploring the ethical implications of resetting NHS maternity and paediatric services following the acute phase of the COVID-19 pandemic', Social Science & Medicine.

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# The  five scenarios in whole training pack

# 5 scenarios with 5 different healthcare workers

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Scenario 1: Paediatric intensive care unit nurse

Scenario 2 - part 1: Consultant obstetrician

Scenario 2 - part 2: Consultant obstetrician

Scenario 3: Mental health support worker

Scenario 4: Porter

Scenario 5: F1 Junior doctor

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# Scenario 1 – the paediatric intensive care unit (PICU) nurse

# Prompting discussion of common themes in scenario 1

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Suggested questions:

1. **Moral harm**: what gave rise to moral harm for this nurse in this situation?
2. **Responsibility**: what was the nurse able to control in this situation? What was out of her control?
3. **Compassionate care**: how might the nurse's sense of professional identity have been compromised in this scenario?

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## Scenario 1 specific question 1:

## What were the different perspectives on the best interests of child in this scenario – e.g. perspective of parents and those providing medical services?

# Facilitator notes scenario 1 Q 1

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- Parents (those with parental responsibility) have the legal right to make treatment decisions for their children, in their best interests.
- Healthcare workers are professionally obliged to act in the child's best interests.
- No definitive 'test' of best interests: parents and healthcare workers/professionals can disagree about what constitutes the child's best interests
- Disputes can be amicable and well-motivated. Sometimes relationships between parents and staff disintegrate due to disagreement.
- Reasonable people can disagree. The course of action desired by both parents and HCWs may be regarded as acceptable, or even ethically required – from their own perspectives/values.
- In this scenario, **people had views on value of life: inherent value/sanctity of life vs value lying in a favourable balance of good over bad experiences in that life (from the perspective of the person whose life it is).**
- Consider discussing how recognising scope for reasonable disagreement may help in wellbeing support work.

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## Scenario 1 specific question 2.

## How might seeking a court judgment exacerbate or reduce the scope for moral harm for staff in a case like this one?

# Facilitator notes scenario 1 specific Q 2

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- It may be necessary to ask for a court judgement when parents and staff disagree about whether continuing with specific life-sustaining in interventions is in a child's best. This can be a lengthy process that can last for several weeks because e.g. second opinions may be needed (for both parents and Trust), parents need to have chance to appoint solicitors and prepare their case. In the meantime, the status quo regarding the care plan will continue.
- Having a court judgment can 'lift the ethical burden' of decision-making.
- Staff who are struggling with the current plan might feel that the pre-court process is prolonging the burdens for the child. This is especially true of staff providing day to day care.
- Preparing for court may lead to relationships deteriorating because the legal process may be regarded as combative. Staff working with children are generally committed to 'whole family' care as an ethical ideal. Staff can be affected by the distress felt by family members regardless of whether they agree with their perspective.
- Consider discussing measures that can be used to progress a shared understanding of best interests – e.g.  involvement of religious mediators such as chaplains, second opinions from outside trust, MDT meetings, clinical ethics committee referral.

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# Scenario 1 specific question 3

# What are the ethical implications of how sick leave is used in instances of moral harm?

# Facilitator notes scenario 1 Q3

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- Sick leave is sometimes used (formally and informally) as a sticking plaster to avoid addressing underlying concerns – basically leaving the responsibility with the individual to 'get better' and return to work. What may happen in practice is cycles of sick leave (not necessarily involving same person) being or being perceived as an avoidance strategy at the level of organisations.
- Feeling personally responsible for something over which one has little control can cause moral harm. Continuing to place the onus on the individual may hamper their recovery.
- High levels of absenteeism need to be explored at the level of the organisation and moral harm recognised explicitly as a potential factor in ill health if it is to be prevented or addressed.
- Support staff themselves may feel ethically conflicted by how moral harms are dealt with, leading to them to experience moral harm when managing high rates of moral harm amongst staff in their organisation.
- Sick leave is offered by the state to support workers during illness. Is tax-payers' money being used to best effect if healthcare workers are not being protected from moral harms, and having to take sick leave as a result?


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