ResetEthics

THE MORAL HARM PROJECT

MORAL HARM: FACILITATED DISCUSSION MATERIALS

Scenario 2 - part 1: Consultant obstetrician

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 2 – part 1 – the consultant obstetrician

Prompting discussion of common themes in scenario 2 (part 1)

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Suggested questions:

1. **Moral harm**: What gave rise to moral harm for the consultant obstetrician?
2. **Responsibility**: What was the consultant obstetrician able to control in this situation? What was out of her control?
3. **Compassionate care**: How might the consultant obstetrician's sense of a professional values-based approach to her work been compromised in this scenario?

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Scenario 2 pt 1 specific question 1

How should differing opinions about the ‘right’ approach to treatment between professionals and patients be handled in these kinds of circumstances?

Facilitator notes scenario 2(1) Q 1:

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- Healthcare workers are professionally obliged to act in the best interests of the pregnant person, and the fetus (insofar as this is compatible with that person's wishes).
- Pregnant persons who have capacity to consent/refuse consent have the legal right to make treatment decisions, including those affecting the interests of the fetus.
- Healthcare professionals are responsible for ensuring all patients (including those who are pregnant) are fully informed about treatment options, and the relative risks/ burdens / benefits of each.
- Patients who have capacity (including those who are pregnant) may make treatment decisions for themselves (and their fetus) that healthcare professionals disagree with.
- Reasonable people can disagree. The course of action desired by the pregnant person and healthcare professionals may be regarded as acceptable, or even ethically required – from their own perspectives.
- Consider discussing whether the moral harm for healthcare workers may be ameliorated by recognising scope for reasonable disagreement, and understanding the legal protection given to all patients with capacity (including those who are pregnant) to consent or refuse consent to treatments offered to them.

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Scenario 2 pt 1 specific question 2

How might consulting with others – e.g. colleagues, MDT members – mitigate moral harm?

Facilitator notes scenario 2 (1) Q 2

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- MDT meetings:
  - Multi-disciplinary involvement can help to see things from other/different perspectives. This may usefully support existing clinical decision-making, question elements of decisions, or identify alternative responses/justifications.
  - The aim of this process is to invite peers from different specialities to critically consider the context of a case and potential courses of action/ outcomes. Peers use their different expertise to inform an assessment of the case and joint decision on the best patient care plan.
  - Regardless of the outcome, holding a case review / inviting shared decision-making and the hearing opinions of peers can lighten the responsibility felt by an individual professional.
- Impact of legal processes:
  - Legal assessments continue to prioritise capacitous patient autonomy in decision-making.
  - Legal protections such as detailed record keeping can feel like futile actions that fail to address the patient's situation or seem more about protecting professionals than supporting them to put patients first.
  - It can feel like the law in its impartiality is unable to support a 'resolution' – this can feel frustrating.
- Importance of everyone involved feeling like a rigorous process has been followed, can be as important as the outcome itself. Sense of being heard and having an opportunity to input into decision-making can lift frustration and aid understanding. This seems not to have happened in this case.
- Consider discussing whether wellbeing professionals can support healthcare workers to recognise the value of these consultations, even when they don't resolve the underlying situation. Consider the role they may play in sharing the ethical burden.

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Scenario 2 pt 1 specific question 3

How does the consultant's increasing seniority shape her experience of professional values-conflicts?

Facilitator notes scenario 2 pt 1 Q 3

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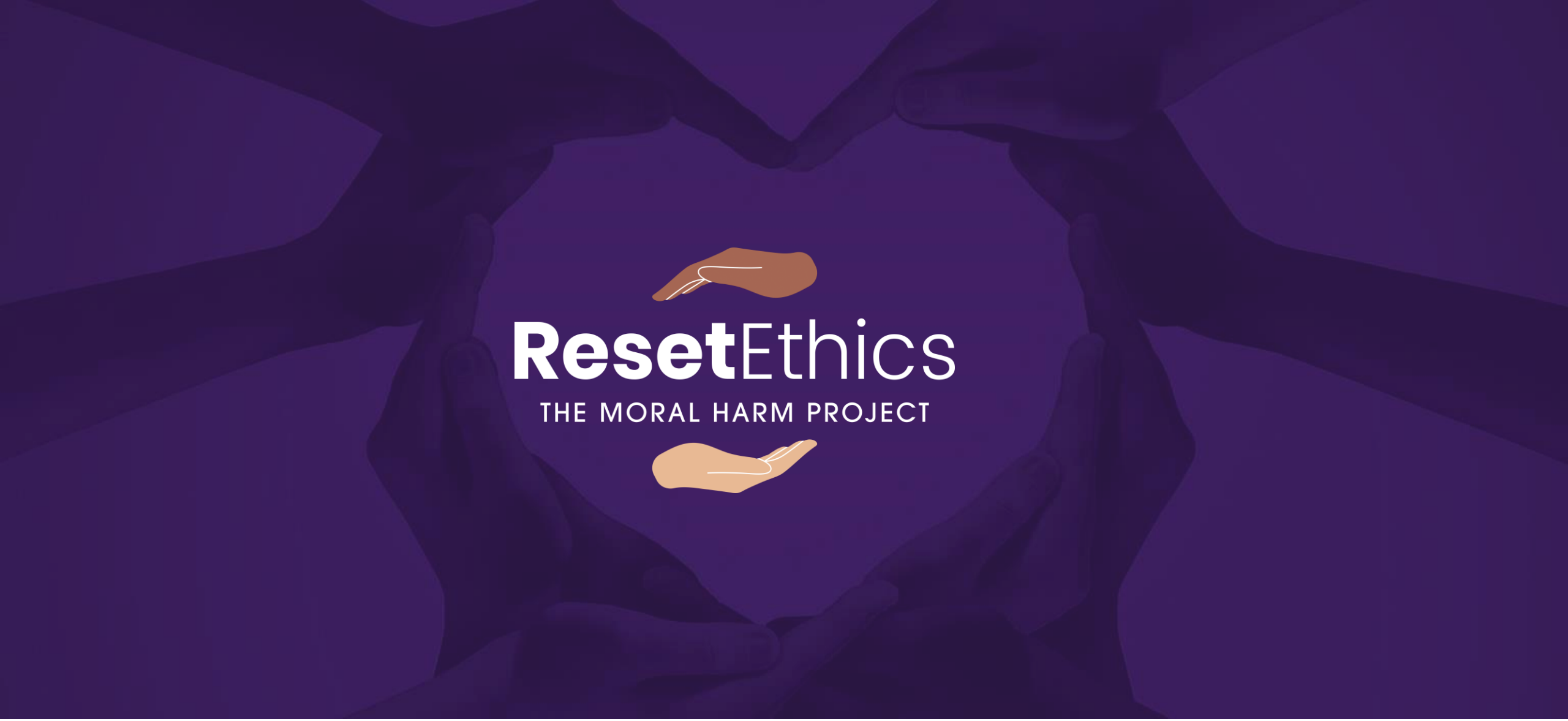
- Build from common themes question to revisit what professional values are being compromised for the consultant in this scenario. The consultant feels that there is greater responsibilities that come with seniority.
- As healthcare professionals progress in their career, they are likely to face decision-making that can challenge their sense of professional-self, and lead to questions about their capacity to undertake the role.
- ‘Imposter syndrome’ or questioning professional abilities is common across all career stages and for all professional groups.
- Senior roles such as a consultant do come with higher levels of decision-making authority and responsibilities. Many years of training, professional development, and mentoring are built into the career progression of medical professionals to equip them for this additional responsibility. This should include appropriate ethics training.
- Seniority in a team doesn’t require suppression of emotional response to challenging situations. Recognising and articulating emotional reactions in appropriate forums can support the wider team in acknowledging how they are feeling also.
- Consider discussing how wellbeing professionals can support healthcare workers to adapt to increasing seniority and equip themselves to carry out this role in ways that align with their professional sense of self.



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