ResetEthics

THE MORAL HARM PROJECT

MORAL HARM: FACILITATED DISCUSSION MATERIALS

Scenario 2 - part 2: 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 2 – the consultant obstetrician

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

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Suggested questions:

1. **Moral harm**: what factors were important in the Consultant recognising they were experiencing moral harm?
2. **Responsibility**: what actions was the consultant obstetrician able to take to help them in this situation? What remained out of their control?
3. **Compassionate care**: how have the actions taken helped the consultant obstetrician to re-establish their professional sense of identity?

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Scenario 2 pt 2 specific question 1

In what ways did the senior colleague lessen the impact for the consultant and wider team of the moral harms arising from the scenarios?

Facilitator notes scenario 2 (2) Q1

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- Support from senior colleagues offering space to listen, discuss, and reflect together can be instrumental in addressing distress, and recognising underlying moral harm.
- Support offered doesn't need to be 'directive' – note how helpful the consultant found their colleague simply listening to the situation and how they were feeling.
- Offering to review case notes in detail may be important for professional reassurance in decision-making; offers an opportunity to revisit and reflect on key decisions.
- Awareness of other forums for support – clinical ethics committees, getting the most out of MDT meetings, disseminating learning through grand rounds etc.

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Scenario 2 pt 2 specific question 2

How might discussing an ethically challenging case with a clinical ethics committee help clinicians?

Facilitator notes scenario 2 (2) Q 2

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- Role of clinical ethics committees:
  - Advisory; supports the identification of, and engagement with, the ethical issues present in a case.
  - Discussion and advice through a structured approach to decision-making.
  - Membership is multidisciplinary, including consultants, ethicists, junior doctors, nurses, a GP, representatives of faith communities and lay members.
  - Offers very different type of consultation than would be obtained through legal advice, or MDT meetings.
- Recognise the importance of professional consultation and reflection at all levels of seniority. Importance of everyone involved feeling like a rigorous process has been followed, can be as important as the outcome itself. Role of being heard and having an opportunity to input into decision-making and understand reasons for decisions being made as they have.
- Clinical ethics committee ability to re-frame the scenario in ethical terms, e.g. in this case as potential differences in opinions between reasonable people all trying to act in the best interests of the pregnant person and the fetus.
- Consider discussing how explicit engagement with an ethical assessment of this case seemed to help the consultant, including help her to reformulate her role and responsibilities in this case.

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Scenario 2 pt 2 specific question 3

How might a culture of team support, ethics consultation, and ethics training reduce the risk moral harms?

Facilitator notes scenario 2 (2) Q3

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- Sharing experiences can be helpful for supporting all staff in identifying and responding to the ethical dimensions to complex scenarios. They are also an opportunity to recognise and address situations that can result in moral harm – as seen in midwives' expression of unease in the second MDT meeting.
- Ethical importance of preparatory training:
  - Individual professional responsibility to engage in continuing professional development in ethics.
  - Organisational responsibility to provide opportunities for continuing professional development in ethics.
  - Recognises that healthcare professionals will encounter ethically challenging situations in their careers that are part of their professional role.
  - Identifying core ethical features of scenarios and reflecting on their relationship to day-to-day role of the HCP facilitates ethical preparedness to respond to situations that may arise in the future.
- Importance of continuing to reach out for support - realities of busy and overstretched department, can take more than one attempt to identify sources of support.

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