ResetEthics

THE MORAL HARM PROJECT

MORAL HARM: FACILITATED DISCUSSION MATERIALS

Scenario 3: Mental health support worker

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 3 – the mental health support worker

Prompting discussion of common themes in scenario 3

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Suggested questions:

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

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Scenario 3 specific question 1

How is the requirement to implement policy undermining the scope for providing care in this scenario?

Facilitator notes scenario 3 Q1

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- Professional judgement being undermined by policy requirements and enforcement – hampering ability to offer compassionate care to patients.
- Challenging professional identity:
  - Not what she went into the role for, i.e. not to police the ward environment and enforce policy.
  - Creating an environment of 'containment' where practices of constraint increasing.
  - Context on ward – high levels of temporary bank staff eroding supportive team-relationships within team. The status as support worker means she is unable to access reflective practice sessions to discuss her concerns / experiences with the team. This is turn negatively impacting her self-perception.
  - Changing nature of relationships with patients due to higher levels of temporary staff. Compromised ability to proactively de-escalate and respond to individual patients flexibly and compassionately .

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Scenario 3 specific question 2

How does racism exacerbate the experience of moral harm and undermine efforts to mitigate it?

Facilitator notes scenario 3 Q 2

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- Where professional and other hierarchies (like those wrongly based purely on ethnicity) exist, the views of those lower down the hierarchy are often ignored or go unsolicited. Expectations of behaviours within perceived hierarchies can make it hard for those at the lower ends to have the confidence to express their views, even when asked.
- Those with minoritised ethnicity are likely to have experienced repeated occasions (inside and outside of work) where their views have been ignored or discounted or talked over by those from a non-minoritised ethnicity.
- Healthcare workers are often on the receiving end of racism, and other forms of abusive and inappropriate language/behaviour from patients. One response to this behaviour is to ask staff to exercise a level of tolerance out of deference to the patient's illness, age or simply because patients themselves may lash out when they feel powerless. This may be an unfair ask of minoritised workers.
- Staff may also be expected to accommodate levels of violence at work that would not be tolerated in other environments. Yet not all staff in the same organisation are expected to be as accommodating nor are all equally likely to experience this kind of abuse.

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Specific question 3:

How does the cumulative impact of the ward environment, incidents, previous experiences, and daily micro-aggressions result in moral harm?

Facilitator notes scenario 3 Q3

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- Moral harm can arise from a single event or result from the cumulative impact of multiple events.
- Being powerless in the face of others' unethical behaviour can contribute to moral harm because it may undermine choice and moral autonomy / agency.
- Reflect on points raised in response to previous two questions. Consider asking participants to map the support worker's experiences to visually represent the factors leading to moral harm.

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