MORAL HARM: FACILITATED DISCUSSION MATERIALS

Scenario 4: Porter

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 4 – the porter

Prompting discussion of common themes in scenario 4

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Suggested questions:

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

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Specific question 1

In what ways did the protocol contribute to the moral harm that the porter experienced?

Facilitator notes scenario 4 Q1

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- The porter had to push the parents away from their child and felt that in following the protocol they had not met the needs of the parents.
  - The protocol for this kind of incident is designed to ensure that casualties can be dealt with quickly, and the needs of any subsequent investigation, police or otherwise, are met. These imperatives can conflict other needs casualties have. This can create ethical tensions for staff between expediency under pressure, demands of justice and need for compassion.
  - The different requirements for different parts of the hospital, different staff and patients can pull in staff many directions, explore the merits of 'the best outcome for the most people' rationale and the possible problems it may create for individual staff members.
- Prioritisation – difficult when someone misses out, or someone cannot have the care or response they want in that situation.
  - If staff feel that someone has not received optimal care in a particular situation, that can be hard to deal with, explore how different competing interests need to be balanced and how that can be done fairly and appropriately.
  - Recognising that even if a decision is fair, it can still cause distress and sometimes there is no decision that does not result in someone 'loosing out'.

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Specific question 2

Could anything have been done to better prepare the porter for this situation?

Facilitator notes scenario 4 Q2

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- Recognise that there are good reasons to adhere to mass casualty protocols where scope for discretion very limited, therefore when staff do everything they reasonably can under given circumstances, they should not feel ethically responsible for not being able to do more.
- Draw out views on what is in or out of our control in circumstances like this
  - Discuss peoples' perceptions of what they think is in their control and what they think is out of their control when following protocols, and to consider why some workers may have more (or less) discretion in how protocols are applied.
  - Ask the group to consider how this affects moral responsibility for actions guided by adherence to protocols.
- There are different ethical tensions that staff are likely to feel. For example, treating as many casualties as possible as quickly as they can to minimise suffering vs providing and preserving evidence for subsequent coroner and other investigation vs taking time to give compassionate care to individuals.
- Explore the potential for involving staff at all levels in the development of protocols and giving staff some say in organisational policies, making tensions explicit and building a sense of 'buy-in' for policies and procedures.
- Potential value of simulation training.

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Specific question 3

How was the porter’s sense of professional identity compromised?

Facilitator notes scenario 4 Q3

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- Recognise here the importance of porter's professional sense of identity, being a 'people person' to his identity – he is motivated by building connections, helping families to feel at ease in difficult environment, chatting to, and engaging with them to make their time in hospital as comfortable as he can. In the context of this situation, the protocol is clear, the porter must act contrary to his instincts to be compassionate. This is particularly difficult for him, given the horrific nature of the events unfolding on the way to theatre.
- The nurse seems to sense the porter's discomfort and tells him to just go. This reinforces the importance of adhering to the protocol, even in these circumstances. Consider in the discussion the position of the nurse too, and whether in any debrief of this series of events it might help the porter for there to be a recognition that *neither of them* had any discretion to manage this difficult situation differently.
- Discuss why, reflecting on the common slides, thinking about the other's position might help each of them.
- The porter's encounter with the chaplain, which he found very helpful, was a chance encounter. Discuss how the hospital might ensure the porter received wellbeing support after such a critical incident. Maybe porters and similar non-clinical but essential support staff should be involved in the development/dissemination of policies/practices for mass casualty events? How might that work? What other staff might be similarly impacted by / powerless to control the sequence of events in a mass casualty scenario?
- Consider discussing whether the Chaplin was right to spend time with the porter under these circumstances and the ways in which healthcare workers may feel bad about having their needs met when patients/family members also have needs and how support workers might help them to resolve these feelings.

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