ResetEthics

THE MORAL HARM PROJECT

MORAL HARM: FACILITATED DISCUSSION MATERIALS

Scenario 5: F1 Junior doctor

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 5 – the F1 junior doctor

Prompting discussion of common themes in scenario 5

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Suggested questions:

1. **Moral harm**: what gave rise to moral harm for the F1 doctor?
2. **Responsibility**: what was within the control of the F1 doctor in the circumstances described? What was out of his control?
3. **Compassionate care**: how was the F1 doctor's sense of the being the doctor they wanted to be compromised?

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Specific question 1:

How do winter pressures and other resource shortages give rise to ethical difficulties for clinical staff?

Facilitator notes scenario 5 Q1

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- Professional codes of conduct stress that the professionals' primary duty is to protect in interests of patients. However, they are also expected to use resources effectively and efficiently, considering the needs of other patients. Acute resourcing problems exacerbate this existing ethical tension.
- Time with patients is also a valuable resource, but staff must ration and prioritise their time in ways that undermine their ability to deliver person-centred, compassionate care.
- Staff must make hard choices. They may feel – perhaps inappropriately – that they are then responsible for the poorer outcomes that result, even though no better overall outcome can be achieved. Their choices are constrained by the resources that are available.

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Specific question 2

How might continually working under extreme pressure undermine good practice?

Facilitator notes scenario 5 Q2

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- The doctor was trying to practice in line with training (which is based on best practice, e.g., adhering to NICE guidance & GMC guidelines). He tried to escalate care, consult with senior colleagues, spend time with patients etc. The senior colleagues were trying to offer help and advise, but this was brutally pragmatic – they seem to have (were perceived to have) normalised providing less than optimal care. Rather than supporting the junior doctor's sense that there is a mismatch with training, they encourage the doctor to adjust to their revised norms and become hardened to the realities. This is one approach and may have worked for them. But is does accept dilution of good practice.
- Circumstances of continuous pressure undermine training / consolidation opportunities for junior colleagues. It is unlikely that professional examinations/official norms will be changed as a result, leaving them unprepared for the exams that they must pass to progress in their careers.
- None of this is good for patients either. Obviously. This leads to a wider political question of whether expectations on all sides need to change or more resources need to be found/ a different system for healthcare delivery needs to be introduced.

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Specific question 3

To what extent do you think that moral harm contributed to this doctor leaving the NHS, and what support could they have been given that may have helped?

Facilitator notes scenario 5 Q3

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- Well-being services, more 'focused-on-reality' ethical training, better training for senior doctors in mentoring, team meetings etc. may have helped the doctor to feel less alone and shared some of their ethical burden. This case illustrates that a single event may not contribute to moral harm. Rather it may be a constant sense of professionalism being undermined and being powerless to change things.
- Greater involvement in, and understanding, of triaging higher-level allocation decisions may help staff whose job is to implement these decisions.
- A balance may have to be struck, however, between accepting that 'the system' or 'organisation' or 'colleagues' are partially responsible and the need for individuals to navigate how this these factors impact on their mental health and sense of professionalism. Leaving may have been the best outcome for this doctor, even if it seems like a loss to the same system (and waste of resources).

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