Moral harm - the interface between distress and injury - developing an ethical language

Professor Lucy Frith

Centre for Social Ethics & Policy
University of Manchester

TALK OVERVIEW

This talk will unpack terminology used in this area and explore how we can discuss this area in ethical language and how we can best support well-being professionals to support staff with these kinds of ethical dilemmas.

1. Discuss the continuum of moral distress to injury – and use a concept of moral harm.
2. Consider where the boundaries lie – i.e., what is above and beyond.
3. Consider sources of ethical codes.
4. How do we distinguish moral harm from other forms of distress, and do we need to?
5. Argue that we do as this leads to potentially different solutions.
6. Consider one possible solution – the organisational component and organisational ethics.

TERMINOLOGY

DISTRESS OR INJURY

- There is substantial debate in the literature about the definitions of both moral distress and moral injury, and the relationship between the two concepts.
- Sometimes used interchangeably or one favoured over other - e.g. military favour moral injury
- Distressing psychological reaction resulting from being placed in a position where one is unable to do the right thing:

  “one knows the right thing to do but institutional constraints make it nearly impossible to pursue the right course of action” (Jameton, 1984)
- Broader definition:

  “Moral distress is the psychological distress that is causally related to a moral event.” (Morley et al 2019)

Moral harm

- The term moral harm is useful as it encompasses moral distress and moral injury.
- Therefore, in this talk I will use Gosling et al's, conceptual model, developed from a counselling perspective, that plots moral distress and moral injury on a spectrum of moral harm.
- 'Both severity and frequency should be considered when determining whether an event falls under moral distress or moral injury.'
- From mild to severe based on the nature, intensity and duration of the "violation of one's ethical code".

DISTINGUISHING MORAL HARM

IS IT DIFFERENT?

What separates moral harm from other forms of distress/burnout?

Moral nature, dealing with discomfort over ethical decision-making.

So - What are ethical issues?

- Difficult question to answer as many problems seem to have a multitude of elements.
    - Supremacy - the guides for action that trump all others, final or overriding
    - Universality - should apply to all of us & be applied to all people (Kant)
- These two could make too many things count as moral so need another condition
    - Welfare - aim to promote the welfare of others

Healthcare and ethical tensions

- As a starting point - ethical tensions are inherent in healthcare (Draper & Frith).
- But when do these become forms of moral harm?
- Distinction between harms and wrongs can be used.
  - Harms have to do with how much worse off people are made relative to either how they were or would otherwise have been.
  - Wrongs involve violations of persons' rights. These rights give others duties owed to those persons, and when there is a failure to perform the duty the right-bearer may be wronged.
  - Harms can occur without wrongs (as when a storm destroys one's property)
  - Wrongs can occur without harms (as when we interfere with someone's privacy even as we benefit him). (Kamm, 2024)
  - So, times when HCPs are harmed but not wronged, but moral harm is a wrong and a harm

How do we decide where these lines are drawn?

- Some ethical tensions inherent in all healthcare roles.
  - Sometimes need to cause discomfort – e.g. removing dressings - causing discomfort but part of job.
  - Accepting informed patient choices with which one disagrees.
- Difficult ethical decisions do arise
  - Withdrawing treatment
- Areas where there are consensus
  - Ie., competent adults refusing life-saving treatment
- Areas where there are disagreements that are recognised
  - Conscientious objection

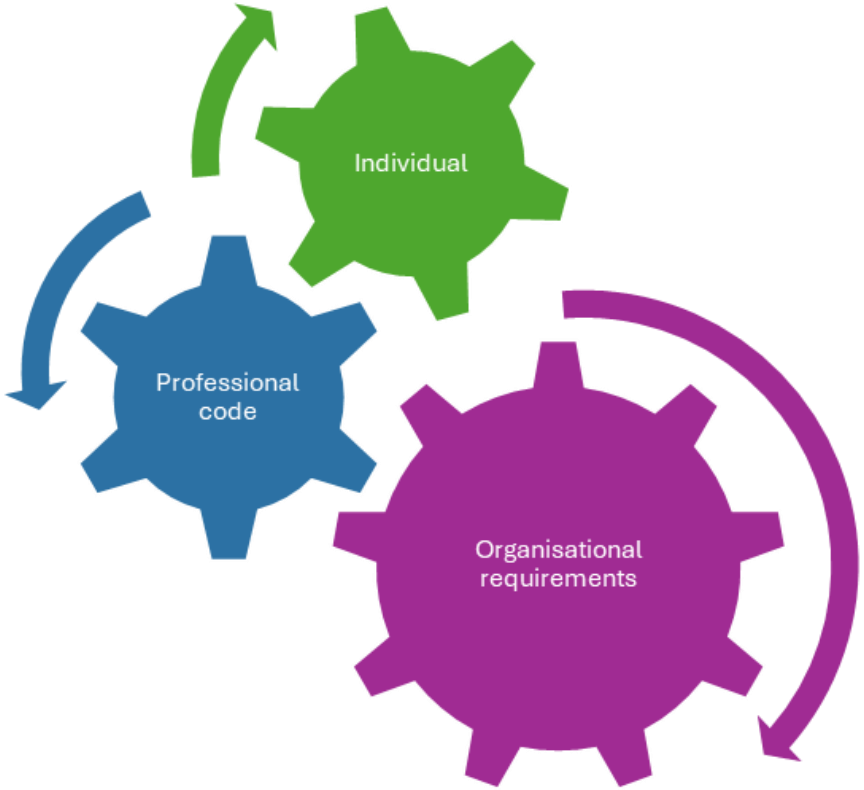
SOURCES OF ETHICAL BELIEFS

Three roots of moral codes:

1. Individual
2. Professional
3. Organisational

How do they relate to each other?

And what happens when these contradict each other?



Which moral code should guide HCPs?

And how are these different sources of moral codes reflected in moral harm?

Professionalism

- Concepts of professionalism, i.e., as healthcare professionals we agree to abide by our codes of practice.
- For example, Rosamond Rhodes when talking about medical professionalism, says, exercising professional autonomy is not the same as exercising individual autonomy, we do not expect clinicians to act according to their own personal moral codes, but the codes of the medical profession.
- Rhodes sees this as a kind of ethical standard of care, and this would be established, using the tools of public reason, by discussions drawing on the relevant evidence and ethical principles that all competent HCPs would recognise as relevant considerations on which to base their judgement.

- How individual moral codes fit in – ok if within contested areas (recognised in conscientious objection), however, have to abide by ‘professional codes’.
- So, if health care workers are out of step with their professional requirements, might see this as time to quit!
- If working requirements are out of step with professional ones then time for the organisation to rethink.

Moral harm is harm caused by not being able to act according to one’s (professional) ethics.

So, professional ethical standards key here.

Do we need to separate out moral harm?

Yes

- As different solutions are required.
- Organisations set the context in which people practice.
- Must allow people to practice according to their professional ethics.
- Moral harm needs organisational not individual solutions.
- As does burn out etc. but specific solutions that consider the organisation’s ethical operation.

Organisational ethics

It is increasingly recognised that much of health care professionals' moral behaviour is constrained, constructed and delineated by the organisational context in which they work

Attention should be given to the 'ethical culture' of organisations to ensure that the environment is supportive of good ethical practice, rather than just focussing on individual relationships and encounters

This is reflected in the growing body of work in the area of 'organisational ethics' (Spencer et al, 2000, Frith, 2018)

- The importance of organisational ethics is primarily because the organisational setting is what influences and, in some cases, determines how those within the organisation (both staff and patients) can and do act.
- The organisation sets the context for behaviour - the culture of an organisation can either act as a barrier or facilitator to good ethical practice.
- To aid this, an organisational ethics programme is desirable for any health care organisation and this can play the role of:

‘formulating and critiquing goals, determining the appropriateness and moral valence of alternative means to these goals, evaluating habitual behaviours and serving as an internal monitor for the way the institution conducts its activities.’ (Spencer et al, 2000:209)

- There is a need for a branch of applied ethics that focuses on the organisational aspect specifically, rather than expecting that these issues will be addressed by other areas of applied ethics, i.e. clinical ethics.
- Organisational ethics does not supersede clinical ethics but works alongside and extend this area of inquiry (Redhead et al, 2024).
- There are benefits of seeing the organisation as a moral entity. If the organisational level is taken as the site of ethical analysis, then the organisation can be conceptualised as a moral agent.
- This does not absolve individuals from moral responsibility in an organisational setting, but it means that the organisation can also be judged on whether it has acted morally or fulfilled its moral responsibilities: ‘organisational accountability is as important as individual accountability.’

Elements of an organisational ethics programme could include attention to

- Misson/values
- Ethics guidelines, e.g., organizational code of conduct, professional codes of ethics, accreditation standards
- Organizational policies, e.g., conflict of interest, disclosure
- Ethical decision-making frameworks, e.g., accountability for reasonableness
- Ethical leadership, e.g., clinical ethics committee, senior management champion, ethicist
- Evaluation, e.g., staff performance evaluation, quality review
- (Gibson et al, 2008:248)

But need a critical organisational ethic

- That will challenge organisations and could incorporate:
- Empirically informed ethical analysis;
- A recognition of the social context of HCOs and the power structures that operate both within and outside HCOs;
- A broader conception of stakeholder involvement – involving all staff, patients and the wider community and public – to ensure that HCOs operate in the best interests of the whole community – and to determine what these best interests might look like.

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THANK YOU