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Moral Failure in Critical Care: Reflections on How We Teach Ethics

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Moral Failure in Critical Care: Reflections on How We Teach Ethics

Introduction

Critical care is one of the most ethically complex healthcare specialities. Nurses working in this already highly intense setting face additional stressors of high-tech interventions, resource scarcity and increased workloads. Evidence in both the United Kingdom (UK) and the United States suggests that these stressors are affecting patient safety and mortality, and nurses are feeling dissatisfion with their job and burn out. [1-4] Although we are able to keep patients alive for increasingly longer periods, a growing body of research suggests that in many cases, the life-sustaining treatments carried out in critical care settings are perceived by healthcare professionals to conflict with the patient's best interests, which in turn creates moral distress amongst healthcare professionals. [5,6] In addition, nurses in particular are often left out of decision-making processes, and yet are responsible for enacting decisions made. This, according to Liaschenko,[7] reduces nurses to 'artificial persons'; persons who speak or act for others, but whose priorities and concerns are subordinate to others.

In order to navigate this complex environment, nurses need to be taught how to recognise and respond to a range of challenging ethical situations. While we acknowledge that ethics training for nurses can be widely variable depending upon the institution, (and perhaps even country), we will explore a common approach to clinical ethics education in the UK. We argue that it promotes a particular, and problematic, approach to understanding and framing ethical issues in general, which we will argue engenders misunderstanding about what can be expected of a solution. One of the best ways to illustrate our argument is through a case study, describing an ethical issue arising in critical care. As we outline our argument, we will refer to the case study and use it to illustrate key points.

Case Study

Toby, a middle-aged male previously fit and well, was admitted to the Intensive Care Unit (ICU) with cardiogenic shock. He deteriorated rapidly and was sedated, intubated, ventilated and placed on veno-arterial (VA) extracoporeal membrane oxygenation (ECMO). After 40 days he remains dependent on VA-ECMO, he has a necrotizing pneumonia and is not a suitable candidate for a left-ventricular assist device (LVAD) or transplant. The healthcare team is uncertain how to best proceed with the patient's care. They are considering a pneumonectomy or complete removal of the necrotic lung but this surgery will not be possible until the patient is stable off VA-ECMO. The healthcare team feels they have optimized the heart and that VA-ECMO decannulation is now indicated. However, they are worried that removing the patient from VA- ECMO could lead to his death. They consider placing Toby on veno-venous (VV) ECMO in the interim period to support his lungs but it is not clear whether this treatment would be beneficial. The healthcare team is concerned that rather than increasing his chances of survival such a procedure could only serve to prolong his suffering before death. Toby's wife, Jenna, has been very involved in Toby's care, and has stated that if Toby deteriorates she wants the healthcare team to continue life-sustaining treatments, whether that is VA-ECMO or VV-ECMO. This dilemma regarding which treatment option to take, if any, is causing anxiety amongst the healthcare team. The team wants to give Toby every chance of survival but also does not want to cause unnecessary suffering and prolong the dying process. The bedside nurses, in particular, feel distressed because they have struggled to achieve optimal levels of sedation and analgesia for Toby and are sure that he has experienced pain during routine nursing care, and is suffering as a result.

Ethics Education

Ethics education in nursing tends to be practical – the focus is on the identification of challenging ethical situations and developing and defending a resolution. Our own experience of clinical ethics education in the UK (both receiving and providing) reflects this, where the aim is to enable the student/clinician to use ethical theory to identify and understand the ethical issues, begin to resolve them and find an acceptable solution. In the process, students/clinicians develop as competent moral agents and effective advocates. The development of the moral agent tends to be described in terms of developing an appropriate character, which enables them to challenge the 'silent curriculum' that might habituate clinicians into unethical practice. Rhodes and Choen [8] argue that:

> "[A]s medical educators we have to help our students to understand their professional responsibilities and be people who have the requisite character; and we have to enable them to do the right thing as the well-formed professional would do it." (p 50)

A common pedagogic approach is to teach some initial theory (e.g. consequentialist, deontological, virtue and principlist approaches) and then encourage students and clinicians to identify cases from their own practice, apply their theoretical knowledge and develop their practical ethical skills through reflection. As described by Roff and Preece [9]:

> "[T]here is a consensus that students need to develop and use "moral compasses" to cope with real ethical and moral dilemmas that they face from their earliest training. And there is agreement that the students themselves can usefully generate the issues to be explored from their own growing exposure and experience. As students progress, and become clinically experienced, the use of case based scenarios that they can analyse from a combination of their evolving knowledge of principles and philosophies together with their own experience is recommended." (p 487)

For students, assessment of this style of learning will typically comprise some form of written case study where, for example, they will consider a case either given to them or drawn from their own experience, identify the key ethical issues in the case (drawing on theory), and then show, in a relatively limited number of words, how they would resolve the case – justifying their chosen resolution with reference to ethical theory. Our assumption is that, excepting those who go on to specialist study in ethics, the way that clinical students are taught about ethics will frame their approach to ethical deliberation throughout their clinical careers. Practising clinicians are encouraged, certainly in the UK, to document discussions around ethical issues, agreed solutions and reasons, in their clinical documentation – something that the models of assessment they encounter as students seems to prepare them for.

While there are certainly advantages to this approach, one risk is that it encourages students and clinicians to equate their development as competent moral agents with their ability to reduce a complex ethical problem to a series of concisely articulated ethical issues and tidy, theoretically neat, solutions –leading to a single satisfactory solution.

The problem with this model in clinical ethics education (both pre- and post-qualification) is that it risks encouraging a simplistic understanding of ethical analysis and offers little scope to explore complexity and uncertainty; and cannot prepare students for dealing with real-life ethical problems. It primes students to believe that identifying and resolving an ethical issue should be easy, and encourages the belief that:

1) If they cannot articulate and resolve a problem concisely and neatly then they are doing something wrong and perhaps lack the apposite moral character;
2) There is a correct resolution, and if they get it correct then they will and ought to be satisfied with it.

There are significant problems with promoting these beliefs, which we will outline briefly.

Challenging Ethical Issues are Complex

Ethical reflection permeates everyday clinical practice; for example, deciding whether to follow protocol and reposition your patient now or delay for half an hour to have your much-needed lunch break. One might easily overlook the ethical nature of this sort of decision because, all other things being equal, there is no complex ethical reflection required. The challenge lies only in finding the motivation to do the right thing; to put one's hunger aside for a few more minutes and reposition your patient. This sort of ethical issue is not particularly challenging and can be articulated and resolved neatly and concisely because it describes a case where although we might *want* to do one thing, we clearly *ought* to do another. We do not wish to ignore the everyday nature of ethics - the "microethics"[10] woven into the fabric of all our personal and professional interactions - but what we have in mind here are more challenging and complex situations, involving either dilemmas, restricted options or disagreement among moral agents (sometimes referred to as 'conflicts') which cannot be articulated or resolved simply or concisely.

A *dilemma* occurs when we are faced with two mutually incompatible and similarly weighted obligations and one must choose between them (for example a perceived obligation to save and preserve Toby's life vs. a perceived obligation to minimize his suffering, when the only way to minimise suffering is not compatible with preserving life).

A *restricted option* problem occurs when we know what we feel the right course of action is, but for some reason that course of action is not available to us (it is in fact a non-option), and so our options are restricted to a range of other less desirable options, none of

which we feel are morally optimal (for example, the healthcare team would ideally like to offer Toby a heart transplant but due to his necrotic lung he is not currently eligible).

A *disagreement* problem occurs when two or more agents who have a stake in the decision disagree over what the right course of action is, and action cannot be taken until a resolution is found (for example, the medical team does not want to offer VV-ECMO if Toby shows signs of deteriorating but want to continue other life-sustaining treatments such as continued invasive ventilation; the nursing team feel that they are prolonging Toby's inevitable death, contributing to his continued suffering and feel that all life-sustaining treatments are futile; whilst Jenna has requested VV-ECMO and wants to continue all life-sustaining treatments).

These kinds of decisions are never simple, and their ethical complexity can rarely be summarised or resolved in a short written piece of work or rote ethical analysis. By definition, a challenging ethical issue is complex and requires a great deal of thought and analysis, and so to assess competency as a moral agent/moral character, on the basis of a student's or clinician's ability to reduce and articulate a response in a short written assignment or verbal analysis sends entirely the wrong message and communicates unrealistic success criteria.

We suspect that most ethics educators are aware of this, and are aware that not all clinical ethics education follows this model. Nonetheless, there are two reasons why we ought to engage in this discussion. First, even though we are confident that most ethics educators will be aware of the shortcoming of this model, we are less sure that students or clinicians are – and so their own measure of success in dealing with ethical issues becomes associated with a concise and relatively sanitized written summary or analysis that demonstrates understanding and clear resolution – which seems quite unrealistic. Second, as clinical curricula become more crowded, and resource becomes increasingly competitive (as

is the case in most UK healthcare institutions), there is pressure to reduce ethics assessments to simple 'pass/fail' assignments, and to use multiple choice and short answers questions to assess ethics competency. The existence of this kind of pressure makes it important to reflect on the problems associated with this kind of assessment, and consolidate arguments against it, so that it might be resisted.

The Inevitability of 'Moral Failure'

Features of moral dilemmas, restricted options and disagreement are that (a) there may not be a clearly discernible correct course of action and (b) even if a course of action is identified that is morally preferable, it is quite likely the decision maker may still feel 'moral residue' after taking the seemingly preferable path. The best way to explain these two points is with reference to our case study, in which there is moral reason to withdraw treatment, but also moral reason to continue treatment. It is far from clear what ought to be done in this case, and no theoretical approach provides an answer. In fact an argument for either can be made from any theoretical perspective, and there are arguably many courses of action that could be considered ethically defensible and reasonable.

The point is that in a case like this there is no solution that is clearly or unequivocally correct, and it seems unlikely that we can select a course of action without also feeling we have done something wrong. This claim needs some unpacking.

First we need to explain the concept of 'moral residue.' 'Moral residue' is often used to refer, in the context of moral distress, to the build-up of negative emotions that occurs after we allow ourselves to be morally compromised. Webster and Baylis[11] characterize it as "that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised" (p 208), and Epstein and Hamric[12] describe moral residue as the painful feeling that remains after a morally distressing event, which, unless satisfactorily resolved, builds up over time

and amplifies negative responses to subsequent morally distressing events – creating a 'moral residue crescendo.' Importantly, in these kinds of argument moral residue arises when the agent feels there has been a wrong done – and so negative feelings are associated with a perceived moral failure and the logically necessary assumption that moral success was possible. We will not be using this definition of moral residue in this paper.

Rather, we will be using 'moral residue' as it was originally used (by, e.g.Williams[13]; Marcus[14]), to refer to the lingering feeling of having done wrong even when one has made a decision one feels is right. This concept was originally used to argue for the existence of genuine moral dilemmas: characterized as a special case of moral conflict where an agent recognizes she has moral reasons to perform two or more actions, cannot perform them all, and there is no overriding reason to choose one or the other. In such a situation, and assuming that a choice must be made, it seems impossible to avoid 'moral failure' of some kind, because in choosing one course of correct action we also fail to perform another correct course of action. 'Unavoidable moral failure'[15] is borne from the fact that we are forced to choose between these two conflicting moral requirements, thus violating one for the sake of the other. The presence of moral residue (a feeling of remorse or guilt) after having made a moral decision is taken to be evidence that the agent faced a genuine moral dilemma. Furthermore, this moral residue (the feelings of remorse or guilt) is an entirely appropriate response to this kind of situation. Referring back to our vignette, the healthcare team could feel completely justified making the decision to withdraw ECMO altogether and yet still feel they have wronged Toby and his wife in some unavoidable way, especially if it did then result in Toby's death. This would, arguably, be true. A wrong has been done, even though it was done in the process of doing something right. Exactly the same could also be said of the decision to continue to treat Toby. The decision is ethically defensible and arguably correct,

and yet in making it a wrong does seem to be done as there is a real possibility that all this will do is to prolong the dying process and associated suffering.

There is debate over the coherency of this kind of argument and whether moral residue, as defined above, can be used as proof of the existence of genuine moral dilemmas. It might be argued that it is nonsensical to suggest that one can do wrong in doing right, because the very fact that one has chosen option A over option B means that one has decided, all things considered, that A is the right course of action – so, by definition, all other actions would be wrong. Feeling guilt after having made such a decision, it might be argued, is simply irrational.[15]. Tessman,[15] however, argues that labelling this guilt 'irrational' assumes that all perceived wrongs can be compensated for by having done right overall. This, arguably, requires a hyper-rational agent who is able to endorse a conception of 'the right' such that the perception of having done right renders any contributing action or consequence similarly 'right', thereby avoiding feeling any regret or loss because of unfulfilled values.

People rarely, however, display that kind of rationality. Tessman[15] argues that because we often encounter impossible non-negotiable moral requirements, we ought to accept that we will unavoidably experience moral failure. In a dilemmatic situation, an ethically-sensitive person will always be cognizant of the fact that in choosing one moral requirement, one has failed to perform another. Even when a decision has been made in a way that is inclusive, fair and considered, it is rarely the case that one can (a) be absolutely certain it was correct or (b) shake off all feelings of doubt or regret. Doubt is a constant feature of ethical decision making in complex cases. In fact, certainty in the face of ethical complexity may suggest a failure to understand that complexity and a lack of moral character.

Nonetheless, we don't have to resolve these kinds of debate to learn something important from it and there are three key points we can take away that ought to inform approaches to teaching and learning about clinical ethics.

Learning Points

First, feelings of guilt, remorse or regret may be unavoidable features of being in an ethically complex situation and having to make a decision. Even when we feel we have done the right thing we might still have negative feelings about it – and so finding an ethical resolution is not the same as personal satisfaction or personal resolution. It is not a marker of ethical success or competency that one can arrive at a tidy solution that one is completely happy with. Rather, accepting these feelings as part and parcel of being a moral agent may ultimately mitigate the feelings that are associated with the accumulation of negative emotions and moral distress. Tessman[15] points out that while one may feel guilt or regret due to the unavoidable moral failure, unless the person is culpable they are in no way blameworthy. Culpability might flow, for example, from having failed to deliberate properly, listen to all relevant voices or create spaces for respectful discussion. There are, then, two kinds of moral failure: culpable and non-culpable. Culpable moral failure might arise when one has reached a decision that one regrets or feels guilty about because one knows one has failed to deliberate properly. Moral residue, as defined here, is always non-culpable – because it follows from having engaged in proper deliberation but nonetheless feeling one has done wrong.

Second, when faced with having to choose a course of action in response to a complex and uncertain ethical problem, sometimes the only way to move forward may be to find principled (i.e. integrity preserving) compromise. As Huxtable [16] has argued:

> "[C]omplexity and uncertainty, both in the realm of values and in the realm of facts (as far as these can be separated), are at the centre of the case for compromise. But so too are inadequate resources and the inability to honour every competing value, coupled with a prudent desire to ensure that one's values are voiced, an ongoing relationship with one's moral opponents and the need to reach a decision on a contested issue. The circumstances are ripe for compromise when such features are present in sufficient number or scale. The achievement of a principled compromise presumes communication and negotiation between the positions available and their respective defenders." (p 140, 141)

In our vignette above, this may mean that even though the clinical team feels that they ought to withdraw care from Toby they might nonetheless try other options that enable them to meet in part their obligations of beneficence to his wife - so they are able to take a course of action rather than continue to debate and discuss. Such a compromise may not represent a perfect solution, but it may be the best that can be achieved, and it seems that we would be expecting too much to find a perfect solution to such a complex problem. The problem with compromise is that it is often used and understood in a pejorative sense; for example when Webster and Baylis (above) talk about moral residue flowing from allowing oneself to be 'compromised'.

Although compromise may not always be desirable in itself, it may sometimes be necessary. To borrow Benjamin's[17] characterization, it makes the 'best of a bad situation', and as Ives[18] has argued elsewhere:

> "[E]mbracing compromise… …points us back towards the pragmatic nature of the bioethical endeavour. Striving for coherence [in our ethical judgements] requires us to find the most [ethically] coherent picture we can – whilst accepting that perfect

coherence may be unattainable. Embracing compromise requires us to accept that the world is messy, with messy problems, and necessarily messy solutions." (p 310)

There is a potential problem arising from a combination of these two points, presenting a risk worth pausing to reflect on. Both might point to the value of the *process* of deliberation over the *outcome*, such that (1) it might not matter what the compromise position is so long as a compromise has been achieved and all stakeholders are willing to sign up to it and/or (2) that knowledge of having undertaken a rigorous process of ethical deliberation might in part, or in total, alleviate feelings of moral residue, because a person can have confidence that they have done the best they can. First, we would be wary of a focus on process as a justification for outcome. While process is important for many reasons, such as transparency, agency and accountability, it is hard to see how the process of ethical deliberation and agreement can confer justification for the decision itself. Huxtable's endorsement of compromise is not just a call for decision makers to reach agreement, it is for 'principled compromise', where agents are required to make compromises that can be justified by principles external to the process of compromise itself (i.e. the compromise position is not legitimate *just because* it is agreed to). This leads to the second point. Given our position on (1), a person for whom moral residue is alleviated from having been part of a robust process of deliberation seems to have misplaced faith in the justificatory power of process. Further, moral residue, as we have characterised it in this paper, would *survive* any feeling that the decision is justified, whether by process or principle. Moral residue, as used in this paper, is the residual feeling of having done wrong even though one is satisfied that the decision made is the correct one and that one has done the best one can to act correctly. If, conversely, one is unsatisfied with the process, it seems unlikely one would feel the decision was correct, and so the conditions for moral residue (as characterized in this paper) would not have been met. For these reasons we are wary of drawing the conclusion that a

focus on robust processes might be a panacea. While ethics education can and should facilitate learning about how ethical deliberation can take place, too much emphasis on process runs the risk of leading to an empty proceduralism, wherein the process of deliberation comes to replace justification.

However, there is still significant value in process, and this is derived from the importance of being able to distinguish culpable moral failure (about which we ought to feel bad) and non-culpable moral failure (about which we have no need to berate ourselves). Having confidence in a robust process can help guide us in determining whether we are experiencing non-culpable 'moral residue,' or culpable guilt.

Third, and finally, we suggest that clinical ethics educators need to incorporate the concepts of 'moral failure' and moral residue into teaching and learning. This is not to encourage indifferent or immoral behaviour but to better prepare clinicians for the realities of the experience of having to make difficult ethical decisions in the face of the complex and challenging ethical situations, and to better understand what a solution might look like. Specifically, that real life ethical decision-making does not mimic the sanitized assessments they are often required to undertake, and that expectations of what success might look like need to be adjusted to something more realistic.

Summary

As illustrated by the case study above, a complex, challenging case will often have multiple justifiable solutions, and it is unlikely that any single solution will feel completely satisfactory. Whatever the outcome of the case study, it seems likely that the actors would experience some form of moral residue. Assuming that they have deliberated properly, and arrived at a solution they believe is correct, they may still feel they have done something wrong. It is important that they recognize, however, that this feeling is moral residue, which is an unavoidable consequence of trying to manage the often impossible demands of morality

within critical care, rather than a culpable moral failure. It is a failure to reconcile the irreconcilable, and not a failure of moral character or a sign that one is an incompetent moral agent.

In summary, we believe that clinical ethics education should prepare nurses and other clinicians for the experience of moral residue and use it to help them distinguish between 'moral failures' that are culpable and non-culpable. This should better enable them to better interpret, and appropriately respond to, negative feelings that might follow from having made a decision in an ethically challenging scenario; and better manage expectations with regard to what an acceptable ethical solution might look, and feel, like.

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