In 1976, the Dutch composer Simeon ten Holt (1923-2012) finished his Canto Ostinato (‘stubborn song’). The piece consists of repetitive pulses and although the sequence of the separate components is continual and cannot be converted, the start and end of each component is not fixed. The amount of repetitions and components and their respective intensity are left to the performer(s) of the Canto. Because of its pulsating, repetitive and at times almost hypnotic characteristics, the Canto Ostinato is often included in the tradition of minimal music. It is performed in many settings, but was originally written for four pianos – which, in itself, is quite an experience. During a performance – which may take anything from an hour and a half to four hours, depending on the decisions of the performers on site – the pianists must stay in close nonverbal connection, because the Canto Ostinato never evolves in a fixed pattern. One of the pianists has a leading role, meaning he/she nods to fellow pianists when the next component begins.

After about a third of the piece has been played, a lyrical melody breaks through the undulating, repetitive, pulsating and strongly rhythmic flow. For the listener, this is a sudden and unexpected experience: the melody detaches from the staccato of the former (and latter) music and yet perfectly fits the pulse heard up to then. The unfolding of the melody comes as a complete surprise (even if one listens to the work over and over again) and may be experienced as a very moving, emotional moment.

The Canto Ostinato is characterized by the atmosphere described above, but requires immense discipline on the part of the pianists. They have to remain alert to one another continuously, as the course of the Canto Ostinato is never known beforehand. Playing the Canto Ostinato properly is much more than playing the right notes. It requires players’ ongoing tuning in to each other, staying in close nonverbal contact and being vigilant.
In a way, listening to the Canto may be experienced as demanding, too. At times there is peace; an almost meditative colour to the music. At other times the Canto Ostinato may be annoying because of its ongoing, stringent rhythm and its - at times - dark passages. Then, the melody is uplifting and evokes great relief as all parts seem to come together.

The Canto Ostinato has similarities with the process of dialogue in moral case deliberation. Constructing a dialogue is a disciplined, demanding practice. It evolves from a methodical stepped structure but has explicit room for the unexpected, for new directions, new perspectives and new searches. The process of a dialogue is never fixed or predefined, yet, like the Canto Ostinato, its method is crystal clear. Facilitating a dialogue requires well-developed skills on the part of the facilitator so that participants can experience the solid framework of a session by which they can find space to explore. In this process, the method of a dialogue and its characteristics require the alertness and vigilance of all involved. There may be moments of great annoyance, perhaps because the direction of the session may be (temporarily) unclear. The session may be experienced as irritating because the process is characterized by slowing down the speed of mutual exchange, or critically questioning presuppositions or convictions. Yet all parts of the conversation may come together subsequently and as a result a vivid dialogue evolves in which all participants stand out.

I experience my work as a moral case deliberation facilitator as an exquisite reflection of the Canto Ostinato. Throughout the dialogical process, I note enthusiasm, impatience, eagerness, involvement, disconnection, annoyance, pleasure. In my role I am eager for the moment I can hear the melody break through, knowing this is where all the efforts of the participants (and the facilitator) come together – if that happens at all. Facilitating moral case deliberation truly is an exciting process full of dynamics, surprises, boredom and, yes, music.

This thesis may also be read as a thick description of unexpected, new directions and perspectives on the issue of implementing moral case deliberation. We did not intend to write a handbook for implementation: quite the opposite, in fact. In this study, the impact and dynamics of moral case deliberation are described from the perspective of a range of stakeholders, resulting in requirements for its implementation. Still, the requirements depend on context and situation. Like the Canto Ostinato, requirements may be applicable or transferable and result in the evolution of a lyrical melody rising from a process of search, deliberation, dynamics, boredom and suggested stillness. This thesis is a reflection of those dialogical processes that are valuable steps in the proceedings towards the implementation of MCD.
Chapter 1

Introducing Dialogue at work
Introduction
As initiatives in Dutch healthcare to introduce MCD expand, questions arise how to implement MCD and make it into a durable, continuous practice. The qualitative empirical study presented focuses on questions related to the implementation of MCD. The aim is not to construct a blueprint that is applicable to any healthcare institution, but to point out important aspects of both the practice of MCD itself and its implementation in processes of mutual learning, shared development of deliberative clinical ethics and facilitation of conversations on controversial issues.

In this introductory chapter, we will first present an overview of the literature on the development of clinical ethics support. We will next describe an MCD session, so that the reader has a clear picture of the ins and outs of the deliberative processes within MCD. After this, the subject of implementing MCD is introduced, and the central research questions are presented. Next, the research context will be described; a mental healthcare institution in the eastern part of the Netherlands. This will be followed by an elaboration of the research method and related methodological issues. Finally, an overview will be given of the separate chapters in the thesis, providing a first glance at the content of the rest of this study.
Clinical ethics support

Ethics support in healthcare

Clinical ethics in Europe over the years has proved to be a dynamic field in which several kinds of clinical ethics support (CES) have been developed (Dörries et al., 2011; Reiter-Theil and Agich, 2008; Slowther, 2007 pp 527-34; Slowther et al., 2001; Steinkamp et al., 2007). Next to advice-based CES such as ethics committees and ethics consultants, deliberative ways of dealing with ethical issues emerge. Moral case deliberation (MCD) is an example of a deliberative practice dealing with moral issues. Deliberative methods of CES aim to stimulate professionals’ awareness of the moral dimension of their work and to foster reflective skills to deal with these moral issues in joint processes of deliberation (Abma et al., 2010; Parker, 2001).

The upcoming attention to ethics support activities in healthcare can be understood in the context of an increasing emphasis on cost control and increasing needs for accountability or transparency in healthcare. These changes require healthcare institutions to reflect actively on moral issues in terms of extending or limiting care, clarifying responsibilities, etcetera (Agich, 2013; Anderlik, 2001 pp.18-21). Also, there is a felt need among professionals to balance the requirements of the healthcare system and strong emphasis on economic and market values with room for interpersonal and moral values. Examples of those values are fairness and solidarity grounded in the life-world (Kunneman, 1998). Further, new moral issues are placed on the agenda of healthcare professionals, including multidisciplinary teamwork, the role of the family and network and the involvement and empowerment of patients and nurses (Gold et al., 1995).

Besides ‘big’ ethical issues, like suicide assistance and euthanasia, day-to-day dilemmas demand increasing attention, for example communicative and relational ethical issues, particularly in chronic care, care for people with disabilities and elderly care (Abma et al., 2012; Agich, 2001; Holstein et al., 2010; Pols, 2004; Smits, 2004; Van der Dam et al., 2012; Verkerk, 2001). Research shows these day-to-day dilemmas can have a disruptive impact on quality of care and job satisfaction among care givers (Erlen, 2007).

In line with international developments, ethics support is attracting growing attention in Dutch healthcare. In a context of increasing responsibility and transparency, moral reflection and moral competence on the part of healthcare professionals are required. Institutions are inspected regarding the availability of ethics support services. The Dutch government stimulates clinical ethics support by putting it on the agenda and steering care professionals towards more systematic moral reflection directly on the work floor. Dutch healthcare institutions and government aim to contextualize ethics support to promote the ownership of moral issues that arise in
daily care and the organization of care. This requires institution-bound ethics support initiatives which are related to the specific needs of the separate organizations (Dauwerse et al., 2011). In line with these developments, care organizations search for suitable ways to organize ethics in healthcare (Dauwerse et al., 2013).

**From expert advice to contextual deliberation** The development of MCD is part of a changing view on the role of ethics in Dutch CES since the mid-1990s. Previously, CES in healthcare organizations was generally exclusively ascribed to medical ethics committees (MECs) or hospital ethics committees (HECs). Ethical issues usually concerned medical-ethical issues (e.g. euthanasia, drip-feeding, suicide assistance, life-sustaining treatment, abortion), which were dealt with by a committee functioning as a group of external experts (Gjerberg et al., 2011; Onwuteaka-Philipsen et al., 2010).

Over time, MECs at times came under fire for being too detached from daily practice by virtue of their advice-based or expert-based position. The prominence of daily ethical issues in healthcare practice, increasing attention in the literature to moral distress in daily care and new ethical theories (particularly care-ethical theories) paved the way for the inclusion of practitioners in reflection on moral issues (Libow et al., 1992). Deliberative ways of working through ethical issues were acclaimed. Moreover, moral, deliberative and reflective competence gained ground in the profile of healthcare professionals (Aulisio and Arnold, 2008; Slowther, 2007; Slowther et al., 2002; Steinkamp and Gordijn, 2003a pp. 107-115; Van Dartel et al., 2002; Van der Dam et al., 2013).

The changing view on MECs was accompanied by new ideas about the nature of ethical expertise and ethical issues in healthcare. The idea that moral issues may also go beyond medical-ethical issues gained ground. Understanding ethical issues in this broader, day-to-day perspective strengthened the insight that practitioners also have a valuable and complementary input in ethical deliberation because of their practical wisdom and perspective (Abma et al., 2010). It was understood that ethical issues may concern relational, interdisciplinary, or organizational matters (Bolmsjö et al., 2006; Glenn, 1998; Van der Dam et al., 2012) and that day-to-day dilemmas arise within the direct practice and dynamics of healthcare. The insight grew that an application of predefined theoretical ideas on morality on these authentic cases detached ethics from actual experience and contextual knowledge on the validity of moral assumptions (Hoffmaster and Hooker, 2009). Therefore, it was recognized that the processing of moral issues should include attention to the context in which they arose.

People responded to these developments in the field of Dutch CES by changing or
expanding the tasks of the traditional MEC or HEC. New methodical initiatives related to CES came up, focusing on inclusion, practical experience and dialogue (Abma et al., 2010; Rudnick, 2007). MECs added the facilitation of MCD to their traditional consultative role.

In response to the changing practice of MECs and HECs in the Netherlands, several publications on the development of MCD and how to embed MCD in an organization appeared in the Dutch literature. The Dutch Healthcare Federation (CELAZ), at that time the umbrella organization for healthcare institutions in the Netherlands, published a document expressing the need for organizing ethics not only from an expert perspective by focusing on morality in the organization (Van Dartel, 1998). The document argued for an integrated way of facilitating ethics, including acknowledgement of those who encounter the moral issues. It made a plea for an integrated view on ethics, not only as useful for primary care processes or doctors but for other layers in the organization as well. In combination with changes in healthcare practice and governmental requirements, the document contributed to the feasibility of ethics activities throughout many institutions. MCD appeared an attractive additional way for CES to respond to this plea, next to (or sometimes instead of) expert-based CES.

Moral Case Deliberation
Before presenting our view on MCD and the ethical theories underlying it, we provide a closer look at the practice of MCD, and describe the process and dynamics of an average MCD session.

Moral case deliberation in practice
In an MCD session, participants from various backgrounds reflect on moral issues in their practice. Following methodical steps from one of the existing conversation methods (Molewijk and Ahlzen, 2011; Molewijk et al., 2008a; Steinkamp and Gordijn 2003b; Stolper et al., 2012), the MCD facilitator guides the group towards the sustainment of a dialogue. One participant brings up an authentic case (Verkerk et al., 2004) in which he or she encountered a moral issue. S/he describes the situation as clearly and in as much detail as possible, focusing on the particular moment at which her/his dilemma was experienced as most problematic. Focusing on that particular moment, s/he formulates, together with the group, a single moral question. This is the central question during the entire session, and needs to be answered by all involved. The group is then invited to ask further questions on the case, to clarify and under-
stand the situation. Throughout this process of asking questions, the presuppositions of those involved can be identified. Further questioning helps to check whether or not these presuppositions are valid, given the facts regarding the moral issue at stake. The discipline that is required to stick to questioning, rather than just opting for possible solutions (which are often based on a lack of factual information), is a demanding characteristic of MCD requiring discipline and postponement of judgments.

By the time all information is collected via questions, all participants have stepped into the shoes of the case-owner. At this point the case no longer exclusively belongs to the original narrator, but is owned by anyone joining the session. Besides other (dialogical) characteristics of MCD, this is an important distinction from other forms of group reflection, such as peer-supervision. All participants have to answer the central moral question, referring to critical facts from the case (rather than presuppositions concerning the case). They have to explain which facts were decisive in their answer, and how they will meet those values they did not mark as decisive. In this phase of the MCD session, differences between the separate answers are noted as learning possibilities and therefore acknowledged. Differences open up for deeper reflection on the issue at stake, stimulating participants to explore the case even further. Finally, the harvest of the deliberation is noted in terms of actions to be taken and assignment of responsibilities in that respect, and the group evaluates the session.

Throughout the deliberation session, dialogue is perceived as the means and outcome of a session. It embraces mutual learning, equal deliberation, inclusion of all voices, engagement, openness and frank speaking. These features are essential for the aim of dialogue, focusing on the identification of presuppositions that influence choices that are made or actions that have been decided. The aim of a dialogical encounter between various perspectives, focusing on a deep understanding and learning process, prevents the group from slipping into discussion, debate or conflict. In MCD, participants work towards understanding, rather than convincing one another of their own right answer or insight. The ‘weeding’ which brings out (hidden) presuppositions on a specific matter is the key to a learning process that is generated by the MCD structure. It helps participants to understand their core motivation, values or perceptions informing their actions and choices in practice, rather than to work from a ‘blind routine’. Uncovering underlying motivations contributes to mutual understanding and brings out crucial values in a moral case. Values differ for different participants. An exploration of the differences can lead to individual learning and mutual exchange. Examining these differences may create understanding among participants and in turn result in mutual openness, understanding and tolerance in cooperation.
By emphasizing mutual learning, equality, openness, inclusion of voices and frank speaking, MCD influences relationships between participants. The conversation about morality in practice is simultaneously a moral practice in itself, with an impact on relations.

**Theoretical foundations of moral case deliberation**

Under the heading of MCD, various methods have been developed which are based on different theoretical perspectives (or sometimes lacking a theoretical background). The MCD session described above is based on a specific theoretical perspective, focusing on dialogue. The approach of MCD as a dialogical practice implies a practical, methodical elaboration of theoretical foundations of moral practice based on dialogical ethics and hermeneutics.

Dialogical ethics is grafted on the epistemological claim that morality starts from concrete – moral – experience. The right thing to do cannot be determined in isolation from an actual experience (Kirklin, 2007; Wright and Brajtman, 2012). Pragmatism dictates that an ethical claim cannot be captured in generalizations (or theory), but must be approached as temporal, depending on the situation and context in which a specific case arose (Widdershoven, 2005 pp.57-76; Dewey, 1910/1997, pp.55-56). In other words, the morally right thing to do is not fixed or predefined. It is dynamic, evolving and developing. Dialogical ethics refers to a social interactive and deliberative process, which can be recognized in the methodical structure of an MCD session as described above.

To be able to weigh the moral aspects concerning a specific issue, those involved in the process of MCD must come to a full understanding of all contextual, situational and relational aspects of the case. In this understanding, the construction of the moral strain is uncovered. It requires detailed description, strong clarification, exploration of multiple perspectives on the situation and in-depth reflection on the complexity of underlying values. Dialogical ethics includes narratives (Abma et al., 2009b): sharing stories reveals details for a thorough understanding of the meaning of the experience that resulted in moral doubt. Narratives moreover support the ability to stick to the actual situation – the here-and-now –, rather than stepping into hypotheses. Narratives help fellow participants in the deliberation process to vividly picture the case at stake and focus on the particular moral friction at this particular moment, in this particular temporal-space location, with these particular persons and this particular culture and values (Råholm, 2008). Walking the path of dialogical ethics, in other words, people find their perceptions on the right thing to do come from a shared dialogue between stakeholders, reflecting on narratives from their concrete practice.
(Widdershoven et al., 2009). Along this dialectical path, a communicative climate is sustained in which all voices are heard and acknowledged which are important normative notions concerning dialogue.

The outcomes of this deliberative process refer to a hermeneutic approach to knowledge creation during joint deliberation that is based on the philosophy of Gadamer (1975). From a hermeneutic perspective, knowledge is always a social, dialectical construction of reality including conscious as well as preconscious interpretation (Widdershoven, 2005 pp.57-76). Interpreting reality is an ongoing dialogue, as the interpretation of a situation is based on personal experiences and societal traditions, which interact with one another in a dialogical way (Gadamer, 1975).

Hermeneutics refers to a practice that accentuates joint deliberation processes as a precondition of any moral claim. A moral decision comes from a joint interpretation process of the morally right thing to do – which can only be explored from the actual experience at stake. The start of any moral inquiry is the direct, concrete experience. A hermeneutical deliberation process implies the acknowledgement of the practical wisdom (phronësis) of all participants. Hermeneutics assumes that all humans are oriented towards the good life and that they carry preconceived ideas on what it is right to do. Exploring this orientation in the process of deliberation and in relation to the concrete case at stake explicates presuppositions underlying a case – thereby influencing the decision to be made. This explorative process is not a theoretical exercise, but a vivid dialogue that remains close to facts from practice and context, in direct deliberation with those involved.

Dialogical ethics and MCD in particular is ‘radically concrete’: it requires no hypothetical cases or hypothetical reasoning, only referring to real, experienced, casuistry and authentic thinking about the casuistry, not starting with definitions of moral concepts and answering the moral question closely related to the facts of the case (Abma et al., 2009a).

Implementing moral case deliberation

In healthcare institutions, MCD is mostly initiated and organized by ethics functionaries with different professional backgrounds (e.g. ethicists or spiritual counsellors). An initiative to start MCD generally meets with enthusiasm and a strong commitment on the part of institutions and ethicists or ethics functionaries. Yet it often appears difficult to ground MCD activities in an organization and to secure continuity. The potential of MCD is increasingly recognized in healthcare, and therefore questions concerning the implementation of MCD arise. This requires study at the level of the use, impact, added value, localization and (therefore) implementation of MCD. So
far, little is known about the implementation of MCD, and research has been scarce on this subject (Molewijk et al., 2008 b/c; Steinkamp and Gordijn, 2003a pp.129-137).

Implementation as a shared process  

Implementation strategies often follow the traditional Deming circle (Christensen et al., 2007 pp. 66-73), containing phases comprising plan, do, check and act. The primacy of this strategy is conducted by the technique that is to be implemented and the time-path that comes with it. A step-by-step design is developed to introduce the new technique and to support practice to understand, use and institutionalize this novelty. The implementation phase is supposed to be finished once the new technique is integrated in the general working processes in daily care. A top-down perspective on implementation may be very suitable for a one-dimensional, technical novelty (Pujo and Pillet, 2001). Using new techniques generally does not directly interfere with the normative structures of the organization, and implementation issues mainly refer to the correct technical use of the novelty to be implemented.

Over time, implementation as a self-evident top-down process for any initiative or change became criticized (Schieffer, 2006; Wierdsma, 2004), as the experiential standpoint of practitioners is frequently neglected in the process of implementation. Outcomes of implementation procedures result in practices in which employees are well-instructed, but the actual performance of the novelty is half-hearted. Insufficient communication, window-dressing, downsizing values and norms into rules and protocols, and only partial elaboration of the new ways of working are examples of shortcomings in implementation strategies, frustrating the results of the implementation process (Paine, 1994).

The current literature on organizational change and management strategies refers to the question of how to actively include practitioners in the process of implementation (Flynn and Anderson, 2012). Both manager and employee play an important role in the development and implementation of the novelty. This is particularly the case in implementation processes of novelties that interfere with cultural or normative issues in the organization (Verkerk and Leerssen, 2005). The aim of any implementation strategy is to support the ‘adapters’ to incorporate the innovation. At the same time, the novelty should not interfere too strongly with existing cultural climate (Raes et al., 2007), as this may result in the rejection of the novelty as a whole, or the experience of policy alienation from the practitioners (Tummers, 2012). Insights and developments in management practice make it clear that a radical change in routines may not be constructive or helpful here.
Implementation, given these insights, is a matter of so-called shared government, requiring a shift in the role of managers. Although managers obviously remain responsible for the evolution of an implementation process, they search for ways to include the users of the novelty in its realization. Current perspectives on management focus on a leadership-stakeholder relationship, rather than the traditional manager-subordinate relationship (Maak and Pless, 2006; Pless, 2007). Modern management strategies strongly focus on including stakeholders in the implementation process, in order to support the process of persuading practitioners to accept and particularly to merge with the novelty or intended change in practice (Raes et al., 2013). The idea is that employees become co-owners of the novelty to be implemented, therefore becoming active partners in the implementation (and development) process (Verkerk and Leerssen, 2005 pp. 86-93). In this process, not just the intention of including employees in the process of implementation is at stake, but the actual behaviour of all stakeholders involved (Verkerk and Leerssen, 2005 pp. 18-33). Much attention is paid to the valorisation of resources among employees, exerting shared and joint efforts to improve, sustain or change practice (Ghignatti and Dall’Agnol, 2011).

Implementing moral case deliberation These general changes in ideas on implementation fit neatly with the theoretical perspective on MCD as dialogical practice. From this point of view, MCD implies dialogical deliberation on moral issues in an institutional (healthcare) context, based on specific theoretical considerations on joint, contextual, moral reflection.

Nowadays insights into organizational development and implementation strategies emphasize that the process of implementation of a novelty should be congruent with the characteristics of the desired change in practice itself (Verkerk and Leerssen, 2005). Publications show an endorsement of participation and democratic leadership (Flynn and Anderson, 2012), particularly when ethics policy is at stake (Verkerk et al., 2001). It is essential to sustain an ‘ethical fit’ between the instrument under implementation and the several structures and culture in the organization (Jose and Thibodeaux, 1999), thereby automatically including organization-wide engagement that is top-down and bottom-up (Trevino et al., 1998). This implies top management must not only introduce and organize ethics activities, but also actively contribute on a content level and in terms of visible behaviour (Clark, 2003; Weaver and Trevino, 1999). This vision of leadership goes against a top-down regulated institutionalization of instruments that touch upon corporate climate, referring to a diminution of a purely hieratical or autocratic implementation. Leadership is indispensable, yet so is active bottom-up inclusion (Clark, 2003; Nel, 2008; Verkerk and Leerssen 2005).
Although the literature concerning ethics and implementation strategies mostly refers to the implementation of ethics codes (such as integrity policy, etcetera), we believe these strategies to be applicable to the implementation of MCD as well. As explained, MCD has the potential to interfere with organizational cultural elements that enable all involved to note critical issues concerning the quality of organization, the quality of care and the quality of cooperation. MCD is intended to mobilize and facilitate active involvement (if not interference) with questions that concern quality issues across the board of the organization. In our view, it does so by means of dialogue.

Reflection on normative assumptions on good care, cooperation or organization – which are central issues in MCD’s casuistry - is closely related to the individual attitude of healthcare workers and their ideas on how the organization as a whole is (or should be) functioning. A joint deliberation on moral questions requires dialogical space. In line with our theoretical foundations of the practice of MCD and current theories on change management, we assume that dialogue should also be part of the implementation process of MCD. But does dialogue suit and serve an implementation process? How can this be organized in such a way that implementation is actually fostered? This thesis presents an exploration of these questions.

Research questions
MCD as a dialogical practice assumes equal deliberation, mutual openness, frank speaking and recognition of vulnerability. In order to do justice to the dialogical character of MCD, we aimed to develop an implementation strategy that is explicitly based on a dialogical approach. To study the dialogical implementation process of MCD, we used a research design that also espouses dialogue as its central aim: responsive evaluation (see below). In line with this threefold use of dialogue, the following research questions were formulated:

1. What is the role of dialogue in MCD?
2. What is the role of dialogue in the process of implementing MCD?
3. To what extent does responsive evaluation as dialogue contribute to the implementation of MCD?
Motivation underlying the research questions

Research question 1

The role of dialogue in moral case deliberation  Dialogue is both the means and the outcome of an MCD session. Conversation facilitators focus on the dialogical quality of a session, following methodical steps. The first research question aims to investigate the role of dialogue in MCD, in order to gain more insight into the characteristics of the practice that is the object of our implementation strategies.

Research question 2

The role of dialogue in implementing moral case deliberation  In our studies, we investigated the meaning of implementation issues, without any preconceived idea on what implementing MCD might mean in practice. This is in line with the view that both MCD and implementation of MCD start from concrete experiences, providing a voice for those involved in this practice by active inclusion and dialogue, creating a learning vehicle through the confrontation of multiple perspectives. Practical learning (referring to contextual and experiential knowledge) and social learning (referring to the collective process of learning mutually) are core notions. In other words: implementing MCD was approached not as a distant technical injection in practice, but as an internal reflection of the values of MCD. Research question 2 investigates how dialogue can be a useful concept in the implementation process of MCD.

Research question 3

The contribution of dialogical research on implementation  In this thesis we presuppose that experiences with moral issues and with MCD are crucial for the development of MCD as a sustainable practice. The research process should enable an explication of those experiences and include them in a joint learning process. Given the importance of dialogue, no stakeholder group should be excluded from the research proceedings. Therefore a research design is needed that strives for inclusion of stakeholders, active deliberation, mutual learning, engagement and empowerment, and it should not merely reflect the management rationale (Niessen et al., 2009, pp. 377-378). These considerations require a research design that underlines dialogue as essential and most appropriate for research on the implementation of MCD. Responsive evaluation seems to suit these requirements for the research process best. Our third research question highlights the role of dialogue in the evolvement of the research process, aiming for optimum inclusion of stakeholders and diversity in roles and perspectives on the implementation process.
Research context
The implementation research presented in this thesis focuses on a mental healthcare organization in the eastern part of the Netherlands called GGNet. In this organization, a substantial MCD practice has been developed over the past years, providing an excellent learning context for implementation research. At GGNet, MCD as method for reflection and learning was introduced in 2004 as part of a programme aimed at reduction of coercion and restraint which was funded by the Dutch government for four years. Nine teams in the organization were included in the project. The teams were invited to write their own local project plan for coercion reduction. Concerning the issue of reflection, which was seen as important in the project, the teams could choose between peer supervision, coaching on the job, and MCD. Five out of the nine teams chose MCD as a reflection method. An ethicist was employed to coordinate and facilitate the MCD sessions throughout the organization, and to train conversation facilitators within the organization.

At GGNet, an MCD steering group of six people was established. They were all trained as MCD conversation facilitators and had various backgrounds: education, spiritual caregiving, quality management, research. In agreement with the board of directors and in line with the design of the project on reduction of coercion and restraint, it was decided not to impose MCD top-down. It was also decided to use evaluation questionnaires after every MCD session for quality procedures as well as a data collection strategy for the intended research that was planned to take off soon after the introduction of MCD.

In the teams which chose MCD, evaluation questionnaires showed that participants were enthusiastic about MCD. In the qualitative evaluation of the project as a whole, respondents mentioned MCD as an intervention that proved very helpful, as alternatives for situations of coercion and restraint were formulated (Sitzvast and Bogert, 2009). Overall, MCD appeared successful in terms of its applicability in practice and its space for thorough reflection on moral issues.

At that stage, research was initiated on the implementation steps of MCD and a researcher was included in the MCD steering group (mid-2008). This research was initiated in cooperation with VU University Medical Centre, Amsterdam. This was the starting-point for the research that is presented in this thesis.

When the project on reduction of coercion and restraint ended in 2009, the teams in which MCD had been organized as a tool for reflection all wanted to continue the MCD sessions independently of the project. Meanwhile, other teams decided to start MCD, generally initiated by managers. The practice of MCD at GGNet grew stronger and MCD became more of a ‘settled’ instrument for moral reflection, yet it was never imposed by the board. Overtime, GGNet became an exemplary practice for imple-
menting systematic moral reflection in all parts of the organization, striving for good quality and professionalisation of MCD in healthcare. Organizing over 200 MCD sessions annually, doing MCD in all segments of the organization (caregivers, Human Resource Management, board of directors, services, gardeners, etcetera), GGNet provides a solid context for studying the implementation of MCD.

**Methodology and methodological issues**

For the studies presented in this thesis a responsive evaluation design was used. Responsive evaluation systematically and insistently includes all stakeholders involved. Basic assumptions are the importance of dialogue as a means and outcome, fostering mutual learning processes and the acknowledgement of experiential knowledge as a valuable source of knowledge (Gouinlock, 1978). As issues always rise from and within (institutional) contexts, responsive evaluation is, like MCD, interested in the particular, the unique, the specific. Given these characteristics, responsive evaluation is closely related to the practice of MCD (Abma et al., 2009a; see Table I).

Responsive evaluation research is rooted in social constructivist theories, acknowledging pluralistic interpretations of truth or meaning and including experiences, values and narratives in research (Abma and Widdershoven, 2005 pp. 57-76; Guba and Lincoln, 1989; Stake, 1975 pp. 13-31/2004). It has a focus on inclusion, active involvement of stakeholders and democratic participation. This is in line with the paradigm of transformational research (Baur, 2010a; Baur et al., 2012; Mertens, 2009). Responsive evaluation starts from the assumption that individuals are active partners in the construction of meaning (ontological perspective) and sees reality as socially constructed (epistemological perspective) (Guba and Lincoln, 1989). These views are based on critique of traditional research designs, positioning both research and evaluation outside the dynamics of reality and using goal-oriented evaluation criteria rather than the context and experiences of those concerned (Niessen et al., 2009; Stake 1975/2004). The traditional external expert role of the researcher may ignore the experiential knowledge of the people involved, thereby neglecting the dynamics, fluctuation and influence of supposed truth, objectivity, knowledge, context and causality (Greene, 1998; Guba and Lincoln, 1981/1989; Schwandt, 1995/2004 pp. 31-44; Stake, 1975).

In the 1970s, Stake developed a responsive evaluation design focusing on the interpretative understanding of a plurality of the values and interests of as many stakeholders as possible. Later Guba and Lincoln (1989) developed a version of responsive evaluation that aimed at mutual learning and understanding among stakeholders.
Responsive evaluation is strongly inspired by a hermeneutic approach in which the interpretative understanding of sense- and meaning-making is included in the research process (Freeman, 2011). Starting with the acknowledgement of the complexity of life (Morehouse, 2012), exchange of viewpoints, perspectives and experiences encourages mutual learning and shared decision-making (Paulus et al., 2008). Exchanging experiences and perspectives, participants in research activities broaden their horizons on a specific subject. To this end, there must be an inclusion of all voices that are part of the subject of research, here: the implementation of MCD. And to obtain a research design in which all voices are heard equally, an ongoing dialogue is an integral part of a responsive evaluation process (Abma and Stake,
This automatically implies that the context in which the research takes place should be taken into serious account during the research proceedings, as, from a hermeneutic dialectical perspective, contexts are an integral part of the interpretation of meaning (Schwandt, 2000 pp. 2204-11).

Responsive evaluation is characterized by an emergent design: the research evolves by input from practice, and research outcomes are brought into practice to be used on the spot. The research design is co-constructed between stakeholders and researcher, and is based on the issues that concern the stakeholders. This co-construction is ongoing, so that an emergent design of the topics is created. The knowledge presented in the research findings is experiential knowledge, based on experiences of those in practice and written in an experiential language. The cyclical process of responsive evaluation supports both practice and research developments simultaneously. In this way, the cooperation between researcher and stakeholders and results are strengthened in a co-production on the development of both practice and research.

**A normative research design** Responsive evaluation is a value-driven, normative research design, because of its aim of contributing to equality and empowerment (Greene, 2001; House and Howe, 1999; Mertens, 2009). It concerns the process by which individuals develop a positive self-identity, gaining mastery and control over their lives and a critical understanding of their environment (Swift and Levin, 1987), being a voice for ‘silent voices’ or ‘invisible work’ (Leigh Star and Strauss, 1999; Nardi, 1999; Stutzki et al., 2013) and emancipation. Responsive evaluation, in other words, strives for democratic values by stimulating ongoing dialogue among stakeholders and takes that as a means and outcome of the research process (Abma et al., 2009a; Widdershoven et al., 2009).

Responsive evaluation is characterized by a critical yet appreciative and positive approach so that respondents are invited to have their say (Carter et al., 2007). In this process, power balances are challenged by working towards mutual understanding (Baur, 2010a). Responsive evaluation is particularly suitable in contexts in which controversies, ambiguity, power issues and/or doubts can be expected because of its appeal for empowerment and inclusion (Baur et al., 2010b; Abma, 2005). In this thesis, examples of included groups that might be easily overlooked are psychiatric patients/client participants, the work-floor/participants of MCD and nurses/the local MCD-coordinators, doing significant, but often invisible, work.

In line with the democratic values in responsive evaluation, research includes dialogues in both homogeneous and heterogeneous groups. Also, iterative proceedings
are used: findings from previous research steps are elaborated in research activities to further develop and validate the outcomes. Responsive evaluation research may be seen as an ongoing, cyclical process that aims at rich (thick) descriptions, inclusion, empowerment, reciprocal understanding and mutual learning and aims at practice improvement (Abma and Stake, 2001; Guba and Lincoln, 1981). In this sense it is similar to the practice of MCD (Abma et al., 2009a; also see Table I). The outcomes of a responsive evaluation do not aim for control or explanations of practices, nor can the process be seen as absolute or finite. Consensus is not an aim per se: perspectives and considerations change over time and generalizations are located and situated in a specific context (Chapin, 2010; Stake and Trumbull, 1982). Rather, responsive evaluation research can be seen as a vehicle for continuation of dialogue and as an inspiration for learning in institutions with comparable contexts (Stake and Trumbull, 1982).

The role of the researcher in responsive evaluation  

In responsive evaluation the researcher (or evaluator; we use both terms throughout the thesis) is an active partner in the practice studied. The researcher is a partner in the process of improving practice, facilitating occasions for the stakeholders to deliberate on the practice under evaluation. This implies the evaluator is present in two ways simultaneously: as evaluator and as partner. In the light of transformative research paradigm aims, the evaluator has multiple roles. These roles are: a researcher, an information giver, an adviser, a teacher, a facilitator and a Socratic guide facilitating dialogue (Greene, 1998; Schwandt, 2001). The explicit engagement of the researcher is focused on the process of the research as well as the development of practice. Hence the researcher may therefore be seen as a change-agent (Mertens, 2012).

Moreover, in this particular research, the evaluator not only had the multiple roles that come with the task of researching the implementation of MCD. In the institution where the case-study was done, she also functioned simultaneously as an MCD facilitator, an MCD coordinator (later, programme leader) and a member of the institutional MCD steering group. In those roles she was not only involved in the research process, but was a stakeholder in the implementation process of MCD herself. These different and also interfering roles deserve specific attention in this thesis and therefore will be addressed in a number of role reflections throughout the thesis as well as in the final chapter.
Quality criteria and procedures

As responsive evaluative research assumes that truth is socially constructed, specific validation criteria for responsive evaluation have been developed (Guba and Lincoln, 1989). These criteria comprise: dependability, credibility, transferability, authenticity and confirmability.

The dependability criterion indicates research should provide a credible view of the values and understanding of the stakeholders involved in the research process. This requires transparency on choices that are made throughout the research process. Peer debriefing challenges the evaluator to motivate methodological choices; peers act as devil’s advocate (Barbour, 2001). Multiple coding and check-coding are used to discuss analyses and interpretations by the research team. Finally, a log book helps to reflect on the researchers’ own filters.

Credibility refers to the correspondence between experiences and interpretations. Prolonged engagement and persistent observation helped to build up solid rapport, as the evaluator was highly involved in practice, fulfilling a number of roles concerning (the implementation of) MCD. Next, triangulation as an aspect of the credibility criterion is used to verify findings of various methods. Finally, member checks are important measures regarding whether the interpretations of the researcher are in concert with the meaning that was expressed by the respondents (Guba and Lincoln, 1989 pp. 237; Meadows and Morse, 2001).

Transferability refers to the extent to which a research can be transferred to other contexts. We took care of this criterion by using so-called ‘thick descriptions’, offering detailed descriptions that provided insight into aspects of similarity and differences between the context described and the context of the reader (Abma, 2005; Abma and Stake, 2001).

Authenticity refers to a set of values that enables a fair, balanced presentation of diversity in terms of stakeholders and the contribution of the research to social justice (by its normative appeal to empowerment) (Abma, 1996; Lincoln and Guba, 1986). The values referred to include: honesty (a fair representation of underlying value systems among each stakeholder group and the inclusion of all stakeholders), ontological authenticity (an increase of the self-consciousness of individual respondents), education (the inclusion of numerous perspectives and bringing them to the attention of the separate stakeholder groups), catalytic authenticity (whether the evaluation process induced a change in practice) and tactical authenticity (whether the research contributed to empowerment and stakeholders were enabled to make their voice heard).

Finally, confirmability refers to the extent to which outcomes and findings directly originate from the data. Working from a normative design requires extra alertness
to the influence of these normative starting-points in the interpretation of the data. Confirmability also concerns the secure storage of data.

**Study relevance**

The aim of this thesis is to study the process of implementing MCD in mental healthcare. It aims to contribute to the development of MCD practices in general and to support and acknowledge practitioners searching their way through implementing MCD in particular. This research wishes to contribute to the published body of knowledge and experiences on implementing and institutionalizing CES, in particular to the implementation of deliberative and dialogical approaches of CES in daily healthcare practice. Up until now, little attention was given to implementation requirements for CES in general, and MCD specifically. In particular, the understanding of the specific dynamics of implementing MCD in a mental healthcare institution is missing. The contextual knowledge that comes from this thesis aims to combine theoretical ideas about the dialogical nature and value of MCD with insights into practical, organizational requirements. Furthermore, this thesis aims to contribute to questions and knowledge on role-diversity of the researcher who is also functioning as a partner in the MCD implementation process.

**Outline of the thesis**

Chapter 2 presents the results of a nationwide survey on CES in the Netherlands, providing background information on the development of CES in various healthcare domains. A distinction is made between long-term care (including mental healthcare, care for people with a disability and elderly care) and hospital care. The study highlights both explicit and implicit approaches of CES, and contains quantitative and qualitative data on the prevalence of specific kinds of CES and the development of CES in the context of specific healthcare domains in the Netherlands.

Chapters 3 and 4 deal with organizational perspectives on MCD and how MCD is organized. Allied to a management perspective on MCD (Chapter 3), we study a bottom-up way of implementing MCD. In this chapter, the MCD local coordinators are central (Chapter 4): nurses who are responsible for the preconditions of MCD on a daily practical level.

Chapters 5 and 6 focus on aims, ‘harvest’ and direct experiences of MCD. Aims (managers’ expectations concerning MCD) and harvest (experiences and lessons noted by MCD participants) show intentions, ideas and inspirations regarding MCD, thereby reflecting issues that are important in terms of MCD’s implementation. Direct experiences of MCD are presented in the study on client participation in MCD
(Chapter 6). The study highlights the relational precariousness that can occur in the process of deliberation and links the findings of the study to implementation recommendations.

Finally, in Chapter 7 (general discussion and conclusions), the findings of the earlier chapters are brought together and the central research questions are answered. The combination of findings results in an overview of the dynamics and processes of implementing dialogue in mental healthcare practice. The chapter marks the need for solid, concrete, managerial work in the domain of implementing MCD, as well as the institutional space that MCD’s dialogical practice requires. These findings are related to the philosophy of Hannah Arendt, and specifically to her concepts Labour, Work and Action.

Between the chapters, the dynamics in practice are presented in various interludes, focusing on the perspectives of the diverse roles of the researcher. The interlude at the start of this thesis provides a metaphor for the dialogical process in MCD by introducing the Canto Ostinato as a musical, auditory illustration, implying an ongoing inspiration for the dialogical work that is conducted for this research. A reflection by the researcher on cooperation with local coordinators follows Chapter 4 (local MCD coordinators). By means of personal log book memos, a glimpse of the diversity of roles of the researcher is spelled out. Finally, after Chapter 6 (client participation), a Socratic dialogue on the role of the MCD facilitator is given. The dialogue is intended to provide insight into the choices and doubts of facilitators in the midst of an MCD session.


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Chapter 2

Implicit and explicit clinical ethics support in the Netherlands

A mixed method overview study

Abstract
Internationally, the prevalence of clinical ethics support (CES) in healthcare has increased over the years. Previous research on CES focused primarily on ethics committees and ethics consultation, mostly within the context of hospital care. The purpose of this article is to investigate the prevalence of different kinds of CES in various Dutch healthcare domains, including hospital care, mental healthcare, elderly care and care for people with an intellectual disability.

A mixed methods design was used including two survey questionnaires, sent to all healthcare institutions, two focus groups and seventeen interviews with managing directors or ethics support staff.

The findings demonstrate that the presence of ethics committees is relatively high, especially in hospitals. Moral case deliberation (MCD) is available in about half of all Dutch healthcare institutions. Ethics consultants are not very prominent.

A distinction is made between explicit CES, in which the ethical dimension of care is structurally and professionally addressed, and implicit CES, in which ethical issues are handled indirectly and in an organic way. Explicit CES often go together with implicit forms of CES. MCD might function as a bridge between the two.

We conclude that explicit and implicit CES are both relevant for clinical ethics in healthcare. We recommend research regarding how to combine them in an appropriate way.

Keywords
Introduction
Since 1970, clinical ethics support (CES) has developed both in the United States and in Europe. In the context of hospitals, CES has generally increased over the years. In the last decades, the prevalence of ethics consultation services in US hospitals grew from approximately one percent in 1983 (Youngner et al., 1983) to 100% of hospitals with 400 beds or more in 2007 (Fox et al., 2007). In Europe, CES in hospital settings is also growing (Reiter-Theil et al., 2011; Slowther, 2007; Slowther et al., 2004). In the United Kingdom, the presence of ethics committees in hospitals increased from 4.5% (20/456) in 2001 (Slowther et al., 2001) to 100% in 2012 (Slowther et al., 2012). In Germany, the presence of ethics committees in hospitals has increased from 4% (30/795) in 2000 to 31% (149 / 483) in 2007 (Dorries, 2007). In Norway the first ethics committees were established in 1996; nowadays (2011) all hospital trusts (n = 23) have an ethics committee (Forde and Pedersen, 2011). In the Netherlands, an increase of ethics committees in hospitals is also visible; from 75% in 1991 (van Willigenburg et al., 1991) to 89% in 2002 (van Dartel et al., 2002).

In the context of elderly care, ethics committees have also been introduced over the past years (Brown et al., 1987; Cox and Roy 1985). In addition, other forms of ethics support have been developed, especially those with a focus on “everyday ethics” (Van der Dam et al., 2012a/b; Browning, 2011; Van der Dam et al., 2011; Horner and Kelly 2007; Bolmsjo et al., 2006) and on the quality of the relationship with clients in assisted living facilities (Powers, 2005). The same applies for various kinds of ethics support in mental healthcare and care for people with an intellectual disability (Weidema et al., 2013; Greenfield and Jensen, 2010; Roberts, 2004).

Over the past years, various kinds of CES have been developed. Ethics support within healthcare institutions not only includes ethics committees and ethics consultation but also moral case deliberation (MCD) and ethics rounds (Molewijk et al., 2008; Svanholt et al., 2008). Other CES activities or CES products include for example ethics education, written documents and policies, and ethical frameworks such as codes of conduct and protocols to assist professionals in dealing with and solving ethical problems (Van der Dam et al., 2012b).

Studies on CES in healthcare often focus on one setting (hospital care, elderly care, mental healthcare, or care for people with an intellectual disability). The subject is mostly one or two kinds of CES, such as ethics committees and ethics consultation (McClimans and Price, 2012; Forde and Pedersen, 2011; Fox et al., 2007; Slowther et al., 2001). The aim of the present study is to provide an overview of the various kinds of CES in multiple healthcare settings. We do not solely focus on instances of CES which have a formal position within the institution and provide professional guidance on a structural basis, like an ethics committee or ethics consultant. Next to these
kinds of CES, which we call explicit CES, we distinguish implicit CES – which refers to situations in which ethics support is not structurally organized and ethical issues are not explicitly put on the agenda. Examples are (team) meetings, spontaneous conversations, and educational or policy settings which are not primarily focused on ethics. Interaction with individual functionaries in the organization (such as spiritual caregivers) can provide a form of implicit CES. Research on the presence and functioning of implicit CES has not been reported earlier.

In this paper, we describe the prevalence of explicit and implicit CES in hospital care, mental healthcare, elderly care, and care for people with an intellectual disability in the Netherlands. We will also investigate the value of various kinds of CES as experienced by managing directors and professionals responsible for organizing CES. Finally, we will reflect on how to combine both explicit and implicit CES.

**Methods**

Through a postal mailing, we asked managing directors of all Dutch healthcare institutions (each of the 2,147 hospitals, mental healthcare institutions, elderly care institutions, and institutions for people with an intellectual disability) to participate in a national survey questionnaire. Managing directors included board members, directors, and location managers. Respondents were also asked to provide contact information of ethics support staff within their institution, if present, for a second national survey questionnaire (web-based). Ethics support staff are employees who organize ethics support like, for example, ethics committee chairs. Using interviews and focus groups, data input was also sought from a wider stakeholder constituency. Participants were representative for the wide variation of domains in healthcare and functionaries involved in CES (including staff employees, managers and bioethicists).

**Survey 1**

The first survey took place between December 2007 and December 2009. This phase started by developing and designing a postal questionnaire in close connection with experts in the field of CES (n = 7). The questionnaire was tested with nine participants. Considerable refinements were made to the survey tool (particularly to the length) and its introductory explanation. We sent two reminders. The main focus was on explicit ethics support (ethics committees, MCD and ethics consultation), but we also added the option of “other kinds of ethics support” in the questionnaire SQ1. This provided data on implicit ethics support.
Interviews and focus groups
Following the first survey in September 2008, the first author conducted five interviews with managing directors and ethics support staff to complement and get further insight on the data gathered from the first questionnaire. In addition, two focus groups with twenty-two managing directors and ethics support staff members were organized in June and July 2009 in order to complement and finalize the results of the first survey. In these focus groups, the advantages and disadvantages of explicit and implicit ethics support were discussed.

Survey 2
The second survey took place between September 2008 and September 2010. A digital questionnaire was developed, which was based on interviews and (e-mail) discussions with experts (n = 12). The questionnaire was designed via web-based, flexible, and secure survey development tool (enqueteviainternet.nl). It was pre-tested with twelve participants. The content of several questions on the second questionnaire was already tested in the pilot for questionnaire 1, which further supported the face and content validity of the questionnaire.

The second questionnaire included sections on explicit and implicit ethics support. The options concerning implicit ethics support were based on the analysis of the results on implicit ethics support in questionnaire 1 (see Table 1). We sent the second questionnaire to the ethics support staff members who were mentioned by the respondents of questionnaire 1. Two reminders were sent.

Interviews
After the second survey questionnaire, the first author conducted twelve individual interviews with ethics support staff members and managing directors from institutions with (1) an ethics committee; (2) moral case deliberation; (3) ethics consultation; and (4) implicit kinds of CES (such as peer-supervision). These interviews aimed to help interpret and reflect on the survey findings. The interviews focused on the experiences and views of the interviewees with regard to CES.

Analysis
Both questionnaires consisted of closed and open questions and the results were analyzed using quantitative and qualitative methods. SPSS 15 and Excel were used to analyze responses to the closed questions; responses to the open questions were explored through content analysis to identify common themes and key issues. Quantitative and
qualitative data were compared and discussed by the research team. Throughout this process, emerging patterns and hypotheses were developed and checked, resulting in a refinement of our analyses. To confirm our analyses, member checks were performed, both with interviewees and focus group participants.

Interviews were transcribed. Initial coding was performed in line with quality criteria described in the literature, remaining open, staying close to the data and keeping codes simple and precise (Mertens, 2010). We constructed short codes, compared data and involved team members in the coding when appropriate. We discussed differences in interpretation and the use of codes, revised codes if necessary, and made a codebook that included brief descriptions of each code which facilitated a constant comparative method of analysis (Mertens, 2010).

The first and second author collaborated in the phase of focused coding. This required decisions about which initial codes made the most analytical sense to categorize the data incisively and completely. During the analysis, all authors discussed the categories until consensus was reached.

Response rate
During data collection, it turned out that the initial 2,137 individual healthcare institutions were members of 864 legal bodies, or umbrella organizations with a legal status. As a consequence, there are two response rates for this first questionnaire, namely 30% (638 / 2,137) at the individual institution level and 56% (485 / 864) at the legal body level. Respondents included board members, directors and location managers. In this article we refer to them as “managing directors”.

The (digital) SQ2 was sent by e-mail to all the ethics support staff members (N = 515) designated by the respondents in questionnaire 1. The number of ethics support staff members was less than the number of respondents for questionnaire 1 (N=638) because not all respondents in questionnaire 1 designated an ethics support staff member. The response rate of the second survey questionnaire was 48% (247 / 515). Respondents included mainly ethics support staff such as spiritual caregivers, but in some cases also representatives from management.

Results
In this paragraph we present data on the prevalence and perceived value of explicit and implicit CES in various Dutch healthcare contexts, as well as data on the prevalence and perceived value of combined explicit and implicit CES. To assess prevalence, we used data from the second questionnaire, directed at ethics support staff. Ethics
support staff reported with a higher prevalence of CES than managing directors. We consider the data of ethics support staff more reliable because they know more about how CES operates in daily practice at their institutions. For the perceived value, we used data from interviews and focus groups with managing directors as well as ethics support staff.

Table I
Kinds of implicit CES, emerging from SQ 1

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implicit individual consultation</td>
<td>Interaction with individual person concerning the ethical dimension of (everyday) care</td>
<td>Spiritual caregiver (e.g., pastoral or humanistic), trusts person, member of ethics committee, physician, psychologist, behavioural scientist, psychiatrist, external expert, informal caregivers, complaints functionary, staff employee. ‘Physicians and spiritual caregivers play an informal role concerning ethical issues.’ (Un) asked advice from spiritual caregivers.</td>
</tr>
<tr>
<td>Group meetings</td>
<td>Existing work meetings in which ethical issues arise</td>
<td>Meeting (multidisciplinary, team, department, medical staff, management team, psychosocial caregivers, religious people). ‘Each department has group conversations about moral questions’</td>
</tr>
<tr>
<td>Policy / procedures</td>
<td>Existing policy/ procedures with an ethical dimension</td>
<td>Procedure for complaints, annual report, in quality standards, policy goals</td>
</tr>
<tr>
<td>Other committees</td>
<td>An organizational group who deals with ethical issues</td>
<td>Committee (medical ethical, value committee, education, identity, for professional attitude), council (for employees, clients, security, advice, nurses), department (ethics, philosophy and history, human resources), church</td>
</tr>
<tr>
<td>Education</td>
<td>Educational activities having attention for ethical dimension of care</td>
<td>Thematic session, in education of physicians and nurses (experience oriented care, own educational program on culture, values, norms)</td>
</tr>
</tbody>
</table>
Explicit clinical ethics support
Explicit CES concerns institutionalized structures with a formal role regarding ethical issues in healthcare. We found three kinds of explicit CES: ethics committee, ethics consultant, and moral case deliberation (MCD).

Figure 1
Explicit CES in Dutch healthcare institutions

Prevalence in Hospitals Overall, in 87% of the participating hospitals explicit CES is present (see Table 2). Respondents from a majority (76%) of the surveyed Dutch hospitals report an ethics committee. In over half (54%) of the hospitals, MCD is present (see Fig. 1). In one-fifth (22%) of Dutch hospitals, an ethics consultant is mentioned. In almost half (46%) of the hospitals, an ethics committee is combined with MCD. In almost one-fifth (17%), an ethics committee, MCD and an ethics consultant are available. In 9% of the participating hospitals MCD is available while there is no ethics committee (see Table 3).

Prevalence in mental healthcare Overall, in 65% of the participating mental healthcare institutions, explicit CES is present (see Table 2). Respondents of two-thirds (62%) of Dutch mental healthcare institutions report that MCD is present in their institution. In one-third (31%), an ethics committee is mentioned. An ethics consultant is present in a small number (14%) of the Dutch mental healthcare institutions. In almost one-third (28%) of mental healthcare institutions, an ethics committee is combined with MCD. In 7% an ethics committee, MCD and an ethics consultant are present. In 35% of the participating mental healthcare institutions MCD is available while there is no ethics committee (see Table 3).
**Prevalence in elderly care**  Overall, in 60% of the participating elderly care institutions explicit CES is present (see Table 2). Respondents from almost half (48%) of elderly care institutions report an ethics committee (see Fig. 1). In more than one-third (36%), MCD is mentioned. A few (8%) Dutch elderly care institutions have an ethics consultant. In almost one-third (27%) of the elderly care institutions, an ethics committee is combined with MCD and in 5% all three are present. In 9% of the participating elderly care institutions MCD is available while there is no ethics committee (see Table 3).

**Prevalence in care for people with an intellectual disability**  Overall, in 81% of the participating institutions for people with an intellectual disability, explicit CES is present (see Table 2). In most Dutch institutions for people with an intellectual disability, an ethics committee (61%) or MCD (58%) is present. Ethics consultants are available in 22% of the institutions for people with a disability (See Fig. 1). In two fifth (39%) of the institutions for people with an intellectual disability, an ethics committee and MCD are combined (see Table 3). In 19% of the participating institutions for people with an intellectual disability, MCD is available while there is no ethics committee (see Table 3).

<table>
<thead>
<tr>
<th></th>
<th>Absence explicit CES</th>
<th>Presence explicit CES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital care</td>
<td>6</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>13%</td>
<td>87%</td>
</tr>
<tr>
<td>Mental health care</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>35%</td>
<td>65%</td>
</tr>
<tr>
<td>Elderly care</td>
<td>52</td>
<td>79</td>
</tr>
<tr>
<td></td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>Care people with intellectual disability</td>
<td>7</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>19%</td>
<td>81%</td>
</tr>
</tbody>
</table>

**Comparing explicit clinical ethics support in various contexts**  Ethics committees are often available in hospitals (76%); in almost half of the participating hospitals an ethics committee is combined with MCD while in the other contexts, this combination is present in one-third of the institutions studied.
In mental healthcare, MCD is more often present (62%) than an ethics committee (31%), while in the other contexts it is the other way around. In elderly care, the prevalence of MCD is lower (36%) than in other contexts, in which more than half of the participating institutions organize MCD. In care for people with an intellectual disability, MCD (57%) is almost as prevalent as an ethics committee (60%) and, like in mental healthcare, MCD is relatively often used as an alternative for an ethics committee; that is, in half of the institutions without ethics committees, MCD is present. In comparison with elderly care (8%) and mental healthcare (14%), the prevalence of ethics consultants is higher in hospitals and institutions for people with an intellectual disability (22%).

Experienced value of explicit clinical ethics support

The interviews and focus groups with managing directors and professionals responsible for organizing CES indicate that explicit CES is valuable because it puts ethical issues in healthcare explicitly on the agenda. Respondents emphasize that, from an organizational point of view, explicit CES is important because it creates connections in the organization and guarantees continuous ethics support and systematic attention for the ethical dimension of care. Respondents also indicate that the multidisciplinary character of MCD fosters an equal conversation between various disciplines (with different hierarchical status) about the ethical dimension of care:

‘MCD realizes an equal ethics conversation between disciplines’ (Care for people with an intellectual disability; spiritual caregiver)
Continuity implies that CES is offered on an ongoing basis, and that practitioners know where to find assistance in dealing with ethical issues. A respondent says:

‘I attended a post graduate ethics course. Now, I am the functionary in our organization who knows about systematically dealing with ethical issues. In case of any incidents, I am being consulted’ (Elderly care; spiritual caregiver).

Explicit CES makes certain that the ethical dimension of care is structurally on the agenda. Respondents explain that without explicit CES, attention to ethics is superficial:

‘Other [not structural] ways of ethics support are often ad hoc, too much in a rush, and under pressure of finding a quick solution’ (Care for people with an intellectual disability; ethics support staff).

‘Ethics is an intrinsic part of our daily routines; therefore ethics support should be organized in a structural way. If ethics support is organized only incidentally, a good foundation is missing. We do not want to invest in that’ (Hospital; managing director).

Implicit clinical ethics support
Implicit CES concerns formal and informal structures in healthcare (like multidisciplinary team meetings and conversations with individual colleagues) in which the ethical dimension of care is addressed indirectly.

Prevalence in hospitals
Respondents from almost all (96%) hospitals report implicit CES (see Table 4). Mostly (91%), they mention individual functionaries (such as spiritual caregivers) as a form of implicit CES (see Fig. 2). Almost three-quarters (73%) of the respondents from the participating hospitals mention committees not directly related to ethics, such as a quality management committee, as an example of implicit CES. Furthermore, half of the respondents from hospitals mention other kinds of education (55%), policy (55%) and group meetings (50%).
### Table 4

Prevalence of implicit CES

<table>
<thead>
<tr>
<th>Setting/Prevalence</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital care</td>
<td>44</td>
<td>96%</td>
<td>2</td>
<td>4%</td>
<td>46</td>
<td>100%</td>
</tr>
<tr>
<td>Mental health care</td>
<td>28</td>
<td>97%</td>
<td>1</td>
<td>3%</td>
<td>29</td>
<td>100%</td>
</tr>
<tr>
<td>Elderly care</td>
<td>121</td>
<td>92%</td>
<td>10</td>
<td>8%</td>
<td>131</td>
<td>100%</td>
</tr>
<tr>
<td>Care people with intellectual disability</td>
<td>31</td>
<td>86%</td>
<td>5</td>
<td>14%</td>
<td>36</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Prevalence in mental healthcare** Almost all (97%) of the participating respondents from mental healthcare institutions mention implicit CES. For the most part (89%), this concerns group meetings like multidisciplinary team meetings. More than three-quarters (80%) of the mental healthcare institutions report individuals providing implicit CES and more than two third (69%) name other committees. Half of the Dutch mental healthcare institutions mention policy (54%) and/or education (50%) as implicit CES.

*Figure II*

Implicit CES in Dutch healthcare

![Bar chart showing prevalence of implicit CES in different settings](chart.png)
Prevalence in elderly care  
Respondents from elderly care note that implicit forms of CES are often (91%) available. Mostly, this concerns individuals (84%). More than one-third (69%) of respondents mention group meetings and about half of the respondents mention policy (55%) and/or other committees (46%). Almost two-fifths (39%) of the respondents mention education (39%) as an implicit kind of ethics support.

Prevalence in care for people with an intellectual disability  
In institutions for people with an intellectual disability, many respondents (86%) mention implicit CES. The majority (73%) mentions that individuals provide implicit CES. Almost three-quarters (74%) of respondents mention group meetings and approximately two-thirds mention education (62%) and/or policy (58%). Two-fifths (39%) of respondents mention other committees not directly related to ethics.

Comparing implicit clinical ethics support in various contexts  
In all participating institutions, implicit ethics support is prominent. Individuals like spiritual caregivers are often mentioned as providing implicit CES (see Fig. 2). In mental healthcare, group meetings are more often mentioned as providing implicit CES than individuals. In the other contexts, it is the other way around.

Experienced value of implicit clinical ethics support  
Our findings from the focus groups and interviews indicate that the value of implicit CES is that it provides an open, organic, and more narrative approach to the ethical dimension of care, which helps to evoke stories that might have been missed when ethics would be explicitly addressed:

‘I talked with nurses about good care. They gave examples of what they assessed as good care. At the end I asked: ‘do you encounter ethical dilemmas in your work?’ They answered: ‘No, we are not really interested in ethics.’ I said: ‘I just talked with you about ethics for 1.5 hours.’ They were not aware of that’ (Expertise centre of for long-term care; senior staff member).

In implicit CES, ethical issues may rise spontaneously. Care workers do ethics “on the fly,” in the immediacy of their relations with individual and groups of clients, family, and colleagues. This is seen as an important factor for a continuous attentiveness to ethical issues. As a consequence, implicit CES provides a low-key way to pay attention
to the moral dimension of everyday care and helps to prevent (often heavy-loaded) associations that care workers have with the vocabulary and methods of ethics. A participant explains:

‘Not everything fits moral case deliberation. A lot of what happens within institutions may not be openly qualified as ethical. Conversations or peer-supervision can have an ethical dimension’ (Association for long-term care; staff member).

**Combining explicit and implicit clinical ethics support**

Our qualitative findings indicate that institutions value explicit and implicit CES and aim to foster both:

‘It would be good to secure continuity of formal CES and guarantee the quality of informal CES’ (Hospital; managing director).

In several institutions, various forms of explicit CES are combined to embed ethics integrally within the organization. For example, MCD and an ethics committee are both available and offered depending on the goal of the specific CES request: MCD addresses ethical issues on the shop floor while an ethics committee deals with more general ethical issues in a formal group of experts. Other institutions combine various ways of explicit CES by changing the regular tasks of the ethics committee and making the committee responsible for organizing and stimulating CES in daily practice:

‘We transformed the ethics committee into an ethics steering group [organizing MCD in the organization]’ (Hospital; medical ethicist).

Respondents, while recognizing the importance of implicit CES, stress the added value of explicit CES:

‘Having conversations at the coffee-machine is fine, but some structure is also needed. One should learn to use a model to deal with ethical dilemmas’ (Hospital; managing director).

On the other hand, respondents also acknowledge the added value of addressing ethical issues informally and spontaneously during individual contacts or group meetings:
‘Structured peer-supervision provides an occasion to share problems that professionals come across. During these meetings people deliberate on the difficulties in their work. They reflect on their experiences. This implies an organic way of conversation in which often ethical issues are discussed’ (Mental healthcare; spiritual caregiver).

Hence, the results of this study reveal that institutions aim to offer various kinds of explicit and implicit CES. Explicit and implicit CES are both needed to make ethics part of the daily work of healthcare professionals:

‘This is an important issue about which we talk a lot: how to bring ethics in the veins of the organization?’ (Mental healthcare; managing director).

**Discussion**

Explicit and implicit CES address ethical issues in different ways. Respondents stress the importance of both and report that they can reinforce each other. Explicit CES puts the ethical dimension of care on the organizational agenda structurally and in a professional way, with formal tasks and responsibilities. This strengthens both the place and the professional quality of ethics in the organization. Implicit CES offers healthcare professionals the opportunity to discuss and integrate moral issues in their common practice in an organic and narrative way.

Explicit and implicit CES are complementary. Explicit CES facilitates systematic and structured attention for the ethical dimension of care. It thereby offers more possibilities for contributing to organizational learning cycles by transferring lessons from incidents and individual ethics cases to the organizational level. Implicit CES is needed as the ethical dimension of care emerges in a natural, more narrative way. It stays close to the actual experience of the ethics of daily care of healthcare professionals and provides answers to concrete issues, arising in specific settings. Many moral problems are continuous in nature and require explicit as well as implicit kinds of CES to identify them and deal with them.

Explicit CES is planned, structured, and has a formal character. As such, it is suited to deal with clearly identified moral dilemmas and decisions. However, when it comes to fostering moral awareness and a reflexive attitude, more is needed. Implicit CES helps to anchor values and norms which are addressed by explicit CES in the organization as a whole. Structure and culture need to correspond, and cultural change is as important as structural change. This view is in line with literature from organization studies (Flynn and Andersson, 2012; Martin, 2000). Change cannot be realized by policy alone, particularly when cultural change is at stake (Chapin, 2010).
Implicit CES might play a role in the ethical climate of an organization, as described in the literature. An ethical climate is defined as nurses’ perception of how ethical issues in their work environment are handled (Olson, 1995). It concerns organizational conditions and practices that affect the way in which ethical problems are discussed and decided (Schluter et al., 2008). Studies have shown that ethical climate influences nurses’ job satisfaction and feelings of moral distress (Chun-Chen et al., 2012; Silen et al., 2011; Goldman and Tabak, 2010). The presence of implicit CES, especially when combined with explicit CES, might contribute to job satisfaction and the prevention or decrease of moral distress.

**Recommendations**

Managing directors and ethics professionals underline the importance of both explicit and implicit CES and see the need for constructively combining implicit and explicit ethics support. This has consequences for organizing CES in healthcare organizations. When implementing CES, healthcare institutions should not merely focus on establishing explicit kinds of CES but use existing implicit kinds of CES and acknowledge them as valuable. Taking into account the activities and professionals involved in implicit kinds of CES not only creates a social basis for explicit kinds of CES, but also allows integration from the start. More research on how to combine explicit and implicit forms of CES in a constructive way is needed.

Moral case deliberation could play a specific role in combining and integrating implicit and explicit forms of CES in healthcare. MCD explicitly addresses the concrete experiences of healthcare professionals and aims at enhancing reflection on moral issues in the concrete working place (Molewijk et al., 2008). MCD thus stays close to the narrative characteristics and embodied experience of implicit CES. At the same time, by using a systematic approach and having a professional facilitator, MCD is an explicit form of CES that supports professionals to enlarge their moral reflection skills. Furthermore, results of MCD can be placed on the agenda of an institutional ethics committee when the issue has a broader importance. Further experiences with, and research on, the role of MCD in connecting implicit and explicit CES can help to find new ways to improve ethics support in healthcare organizations.

Additional research on the role of CES in relation to an ethical climate is recommended. For this purpose, results of explicit CES activities (such as policy documents, consultation reports and outcomes of MCD meetings) and indications of implicit CES activities (such as reports of team meetings) might be tracked and related to the ethical climate of the institution. This can be assessed by using the ethical climate questionnaire (Victor and Cullen, 1987) or the hospital ethical
climate survey (Olsen, 1995). Moreover, the influence of explicit and implicit CES on professionals’ job satisfaction and moral distress might be investigated. In this way, the impact (and the combination) of explicit and implicit CES on an organizational level might become visible.

**Strengths and weaknesses of the study** The strength of this study is the combination of quantitative and qualitative methods and the iterative way of analyzing the data, which aimed to verifying results and interpret them in various, complementary, rounds. Another strength is that all healthcare institutions were approached and a considerable number participated in our study. A limitation is that the respondents (i.e managing directors and ethics staff) may have given a more positive picture on the prevalence and importance of CES when compared to the non-respondents.

**Conclusion**
In the Netherlands, ethics committees are important vehicles for explicit CES, especially in hospitals. A second important kind of explicit CES is MCD, which can be found in half of Dutch healthcare institutions and in two-thirds of institutions for mental healthcare. Ethics consultants play a minor role in all contexts of Dutch healthcare. The perceived value of explicit CES is that it places the ethical dimension of care structurally on the agenda.

Implicit CES is found in all Dutch healthcare institutions. In mental healthcare, group meetings are more often mentioned as providing implicit CES than individuals. In the other contexts, it is the other way around. Implicit CES is valued because it fosters attention for the ethical dimension of care in a more organic and narrative way.

In Dutch healthcare, combining implicit and explicit CES is considered to be a good way to embed ethics integrally into the organization. This opens up to new perspectives on the meaning, positioning, and ownership of ethics in general and CES in particular. We recommend additional research, to investigate: (a) the functioning and quality of implicit kinds of CES; (b) the way in which implicit and explicit CES can be integrated, including MCD as possible bridge; (c) the tasks and roles of clinical ethicists in combining implicit and explicit CES; and (d) the impact of (a combination of) explicit and implicit CES on the organizational level.
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Managers’ views on and experiences with moral case deliberation in nursing teams

Abstract

Aims This paper contributes to management insights regarding moral case deliberation (MCD), from the experiential perspective of managers of nursing teams.

Background MCD concerns systematic group-wise reflection on ethical issues. Attention to implementing MCD in healthcare is increasing. No research has been published on the experiences of managers regarding their role in and experiences with facilitating MCD’s implementation in nursing teams.

Method As part of an empirical qualitative study on implementing MCD in mental healthcare, a responsive evaluation design was used. Using reflection on former research findings (iterative procedures), a managers’ focus group was organized: eight (out of 20) managers involved in the processes of implementing MCD attended.

Results Managers appreciated MCD, fostering empowerment and critical reflection among nurses—according to managers, core competences for professionals. Managers found MCD a challenging intervention, sometimes resulting in dilemmas due to MCD’s confidential and egalitarian character. Managers value MCD’s process-related outcomes, yet these are difficult to control / regulate.

Conclusions MCD urges managers to reflect on their role and (hierarchical) position both within MCD and in the nursing team.

Implications for nursing management MCD is in line with transformative and participatory management, fostering dialogical interaction between management and nursing teams.

Keywords
Introduction
The development of clinical ethics support (CES) is currently under increased scrutiny in international literature. Next to well-known approaches (i.e. ethics committees, ethics consultants), new approaches have been introduced focusing on supporting health professionals in dealing with their moral issues. Examples are: moral case deliberation (MCD) (Dauwerse et al., 2011; Widdershoven et al., 2009; Molewijk et al., 2008a), skills labs (Vanlaere et al., 2010) and ethics rounds (Svantesson et al., 2008; Bolmsjö et al., 2006a/b). These new approaches foster deliberation (rather than giving expert advice). They show attention to the context of care, and a focus on the experiences of healthcare practitioners involved in moral decision-making and deliberation. This study focuses on MCD.

In MCD, (multidisciplinary) groups of healthcare professionals reflect on ethical issues they encounter during their work (Stolper et al., 2012; Verkerk et al., 2004). In contrast to peer-supervision, MCD does not aim to help individual professionals to cope with technical or psychological issues, but invites all participants to reflect on their own values and moral concerns. MCD is radically concrete, focusing on the experiences and reasoning of participants (Irvine et al., 2004; Widdershoven et al., 2009), representing a rich spectrum of perspectives (Van der Dam et al., 2011).

An MCD session is facilitated by a specifically trained facilitator (Plantinga et al., 2012), focusing on one central moral question, using specific conversation methods (Molewijk et al., 2008a). A central MCD aim is to facilitate reflective and equal dialogue (Stolper et al., 2012; Weidema et al., 2011), implying mutual equality, speaking frankly and an attitude characterized by moral inquiry, rather than convincing others of the right answer (discussion, debate) (Weidema et al., 2011). The meaning of and choice for dialogue is based on our theoretical and epistemological understanding of clinical ethics, inspired by pragmatic hermeneutics and dialogical ethics (Widdershoven et al., 2009; Ruiz and Roche, 2007). Moral inquiry therefore not only focuses on analytical, logical reasoning, but includes emotions and experiential learning (Molewijk et al., 2011; Kolb et al., 2002).

Literature overview
A study showed that attention to day-to-day dilemmas has an impact on quality of care and job satisfaction (Erlen, 2007). Further an MCD evaluation study reported that professionals improved their dealing with moral dilemmas with respect to knowledge, skills and attitude (Molewijk et al., 2008b). Another study showed that MCD participants experienced MCD as relevant. Open, straight, constructive communicating and moral sensitivity increased; presuppositions, prejudices and
automatic responses decreased (Molewijk et al., 2008c). A recent study found that managers particularly asked for MCD in their teams to a) increase nurses’ moral sensitivity and critical attitude; b) improve (multidisciplinary) cooperation skills (Weidema et al., 2013).

It is unclear how managers view MCD and what they perceive as their role in implementing this as an instrument for dialogue in healthcare. Also, it is unclear whether MCD can be positioned in relation to specific (management) goals, given its deliberative, dialogical nature. Can MCD be used as an instrumental management tool, or does it have intrinsic value? Finally, it is unclear what role managers can or should play with respect to their participation in MCD sessions.

**Research questions**

As part of a study on the implementation of MCD, we focused on the question of how managers view MCD and their role in its implementation. We investigated the experiences of managers from a Dutch psychiatric hospital in which MCD has been implemented. Three central research questions were formulated:

1. What perspectives do managers have on MCD?
2. How do managers understand the process of implementing MCD?
3. What role do managers see for themselves regarding their participation in MCD?

**Research context**

This study was conducted in a large Dutch mental healthcare institution that is leading the field of MCD practice in Dutch healthcare, facilitating over 200 MCD sessions annually and covering 40 teams of professionals (caretakers, staff services, management teams, board of directors etc.). The coordination, quantity and quality of the sessions are facilitated and monitored by an institutional MCD steering group, consisting of five people (including the MCD programme leader) from various organizational segments. This group is embedded in the institutional Expertise Centre. While the practice of MCD developed, empirical research on implementing MCD was conducted alongside, to understand how MCD evolved (and expanded).

MCD was introduced in the institution in 2004 as part of a project on the reduction of coercion and restraint. Once the project had ended, the teams involved decided to continue sessions. Simultaneously, initiatives for MCD expanded organization-wide. Current MCD initiatives are demand driven; no team is obliged to do MCD and the
board does not impose MCD (although it encourages its use). Requests generally come from managers for sessions once only, in ongoing groups, or in a predefined number of sessions. When a manager requests six sessions or more, the MCD programme leader initiates a semi-structured conversation with the manager in which the motivations, aims, expectations and end terms of MCD sessions are explored and documented in an agreement. This is used to streamline further evaluations of MCD in the specific team.

Methodology
Responsive evaluation design A four-year responsive evaluation research project was conducted to monitor, facilitate and evaluate the implementation of MCD. Responsive evaluation considers qualitative, transformative research, in which both the evaluation and development of programmes are studied and facilitated (Stake, 2004). The essence of responsive evaluation is active inclusion of stakeholders in the research process, providing experiential knowledge. It makes embodied insiders’ perspectives explicit and stimulates the development of the subject under evaluation (Visse et al., 2012).

Responsive evaluation develops via an emergent design, refining findings by insistently examining and reflecting upon them in dialogue. Iterative proceedings are applied, using former data as input for further exploration, nuance and understanding by bringing them in during research activities. Simultaneously, stakeholders learn about and develop their practice by attending research activities (Paulus et al., 2008). This cyclical process supports both practice and research developments. It strengthens collaboration between researcher and stakeholders, resulting in co-production on the development of both practice and research.

Characteristics of the evaluation process A responsive evaluative research design is in concordance with values that prevail in MCD, also applying principles of hermeneutic ethics (Widdershoven et al., 2009; Lüders, 2004). The means and outcome of a research process concern: 1. active inclusion and participation of stakeholders; 2. sustaining a meaningful dialogue; 3. focus on mutual learning (Visse, 2012 pp. 132-141; Baur et al., 2010; Abma et al., 2009). Insiders’ perspectives are brought in by multiple data collection methods such as interviews and focus groups (Morgan et al., 2008). Issues, expectations and controversies of stakeholders are investigated in order to obtain a full understanding of the object of research (Ren and Langhout, 2010; Stake, 2004). Research participants have the role of information providers,
advisors and active partners (Mertens, 2009). The merging of perspectives from all stakeholders involved creates simultaneously a rich understanding of practice and a mutual learning environment (Abma and Widdershoven, 2006; Greene, 2001). Co-generating data, co-learning, cooperation and participation are important concepts in this respect.

Data collection
For this study, a two-hour focus group with managers was organized (October 2011). All of the 20 managers who were involved in the process of the organizational development of at least six MCD sessions a year were invited by e-mail. Lack of space on the managers’ agendas was the main reason for not joining the focus group. However, most managers mentioned they were interested in further organizational development of MCD. Eventually, eight managers attended, including both managers who were enthusiastic about MCD and managers who were critical of it.

The focus group, facilitated by the first and second author, was partly open, partly semi-structured (see Table I). Throughout the focus group, the facilitators aimed to create an atmosphere of mutual openness, frank exploration of the personal/professional relation with MCD, reflections and doubts. First, participants discussed their own issues concerning managing MCD. Next, to intensify reflection and exchange, participants reflected on five predefined statements coming from interviews and focus groups that were performed earlier in the study on implementing MCD. Finally, previous research findings concerning managers’ aims and participants’ outcomes regarding MCD were discussed.

Data analysis
With oral permission from the participants, the focus group was audio-taped and fully transcribed. This transcript was used as material for this study. We conducted an inductive content analysis following a hermeneutic-dialectic interpretation process (Anderson, 2012; Bernard, 2000; Guba and Lincoln, 1989), applying steps of exact descriptions, systemizing and abstracting, thereby meeting the criteria of credibility.

From the transcript, topics and issues concerning the managers’ perspective on MCD were derived independently by the first and second author (investigator triangulation; Creswell and Miller, 2000). This material was used to organize the data into subcategories and consequently clustered into three main categories: 1) managers’ perspectives on MCD; 2) managing MCD; 3) managers’ participation in MCD sessions. Within the main categories, subcategories were maintained in order
to hold on to the nuance of issues. Throughout the analyzing process, categorizations were regularly discussed among all four authors. Data triangulation was realized by referring to empirical material as well as experiences during the focus group (Flick, 2004). Discussions in the author team were repeated until the point of saturation (Morse, 2001).

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<td>Researcher notes the issues from managers on white-board</td>
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<td>What issues do you note in managing MCD in your team?</td>
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<td>Participants individually write their response on memos. They put their memos on the white board with the corresponding statement</td>
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Validity precautions Qualitative research has specific criteria to validate research outcomes: credibility, dependability, confirmability and transferability (Guba and Lincoln, 1989). In transformative research such as responsive evaluation, researchers are highly involved in the practice that the study is about. This ‘prolonged engagement’ contributes to credibility. To further foster credibility, we deliberately included managers who were critical of MCD in our study.

Dependability requires solid reflection on personal presuppositions to prevent bias. Therefore, interview guides and analyzing procedures were created in cooperation with all four authors. The third and fourth author had no involvement with the practice of MCD and the specific institution, respectively. An independent review of the analysis was done by all authors. To increase the trustworthiness of the results, direct quotations from the transcripts were selected to support the presented findings. Also, audit trail records were kept to exclude our presuppositions from the findings.

Confirmability refers to the plausibility of the interpretation of the data. Team meetings with the author team, reflexive journals and discussions of findings with the participants helped to represent the participants’ perceptions in a trustworthy way.

Finally, with regard to transferability, results from responsive evaluation research count as particular and unique. Generalization comes about when descriptions are used as learning material for understanding comparable practices (naturalistic generalization; Denzin and Lincoln, 2011; Hellström, 2008). To enable readers to draw comparisons with their own practices, the study uses thick descriptions so that outcomes may be transferable to other contexts.

Ethical considerations This study took into account ethical considerations in terms of respect for anonymity and confidentiality. All participants gave their verbal consent for audio-taping the focus group. As no patients were included in this research, the study did not fall under Dutch law concerning medical research with human subjects and approval from an IRB was not needed. Participants’ names, wards or any other detail that could reveal identity were removed. Participating managers were numbered from I to VIII.

Findings
In this paragraph the findings on managing MCD are presented. For a summary of the findings, please see table II.
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Table II
Summary of the findings of the study: main categories and subcategories
The ‘examples’ in the final colon summarize quotations that were given by the participants of the focus group.
Managers’ perspectives on moral case deliberation

Managers searched for the meaning of MCD sessions in general and for their nursing team in particular. Perspectives on the quality of MCD sessions were shared, including ways to secure or strengthen the quality of sessions. Because of its specific nature, managers noted MCD as a tool for stimulating reflection, thereby contributing to good care and communication.

‘[MCD implies reflection on] attitude to colleagues, to myself, how I should position myself in communication or cooperation... Yes, I believe ultimately all that influences quality of care’ (Manager I)

Leaving the comfort zone

According to managers, MCD required leaving the comfort zone and entering critical thinking. In-depth reflection (rather than just a shared talk about care practice) was preconditional to qualifying the session as ‘good’ and perceived as a precondition for improvements in care and cooperation. Yet, managers found it difficult to point out what factors supported the quality of the sessions.

‘When I’m part of an MCD session in which I really discover the reason behind someone’s resistance, then I have really accomplished my goal! (…) I then think: look how far we’ve got! We so much approached this issue from a different perspective, we left our comfort zone so bravely, that I truly discovered something new. And, we came to understand each other better’ (Manager IV)

‘What’s happening inside the MCD participants? I sometimes wish to have more of a grip on the quality of the sessions. About... did you really get to the punch line? Did you dare to, together?’ (Manager V)

Reflection as professional competence

Some managers were critical when it came to the team members’ capacity or willingness to reflect. They saw reflection as part of professionalism, but noticed that team members do not automatically reflect. So managers noted it was their responsibility to stimulate the development of reflective competences of the nursing team through MCD sessions.

‘Some caregivers have been working in the same unit for 25 years. They may have had dilemmas at first, but by now they have become so hospitalized, they
Managers mentioned that MCD sessions were necessary because nurses felt no a priori need for reflection. By enabling nurses to participate in MCD, managers wanted to institutionalize a reflective attitude among nurses.

‘Nurses, they feel they have to be with the patients! In their opinion, MCD does not directly touch upon the heart of their work’ (Manager III)

Managers’ considerations on implementing moral case deliberation
Underlying the question how to manage MCD’s implementation process, considerations on the extent to which the manager can steer on the MCD sessions arise.

Differentiating moral case deliberation from regular meetings
MCD differed from regular ward meetings. Some managers facilitated MCD through the pragmatic consideration that regular ward meetings remained clear from moral issues, thereby making regular meetings more efficient.

‘In regular ward meetings, I can postpone MCD discussions to the facilitated MCD sessions’ (Manager VII)

Regulating frequency
Managers said that for nurses, reflection was not as self-evident as managers would like. So regulating MCD was necessary in terms of timing, presence and duration per session. As attending the sessions frequently had little priority in the spur of the moment, managers said solid regulation was required. This could include shuffling the frequency and/or duration of sessions and launching a mandate to join.

‘We make sure we facilitate dates for MCD and we as managers state: I want you all to join at least two sessions a year’ (Manager VI)

‘At first, we did MCD for one hour a month. But in-depth reflection isn’t possible in one hour. So I worked towards doing it four times a year for one and a half...
hours per session. That really makes it more...special, incidental, extra. And from that, I do see the rewards’ (Manager I)

Streamlining moral case deliberation  Three managers pleaded for a firm statement from the board of directors, streamlining MCD organization-wide as an obligatory part of professional practice. Also, they wished to attribute accreditation points to those attending the MCD sessions. Top-down regulation could overcome an informal status of MCD and strengthen MCD as part of regular work processes.

‘A BIG registration [Dutch accreditation system] should be applied to MCD. Such a regulation should be considered for MCD since, as an organization, you want this to be an institution-related instrument. That would show that this organization deems it important that employees reflect on their work continuously’ (Manager III)

Moral case deliberation within or outside the plan-do-check-act cycle? Most managers did not expect MCD to provide clear substantial normative outcomes. This ‘elusiveness’ was taken as a characteristic of the inherent free space of MCD: MCD initiated processes that could not be grasped or steered. Many managers appreciated the process-oriented outcomes of MCD: openness, deliberation and joint critical reflection. They valued the process of deliberation. A few managers thought that the process-related outcomes of MCD were insufficient.

‘You cannot measure the outcomes. That makes it all the more difficult for me as a manager’ (Manager VII)

‘After two hours [of MCD] I can really think the togetherness and process that evolved in that session really are enough, without me thinking: oh my, now I do not have any concrete results’ (Manager IV)

Other managers did suggest concrete outcomes:

‘For example, look at health-related absenteeism. On our ward, that rate is really low. So maybe that’s an effect: people are able to differentiate and find a place to ventilate their issues so that they can professionally keep up with their job’ (Manager II)

At times, managers hesitated to quantify MCD’s outcomes in terms of management tools. This hesitation was related to how managers perceived or wished to use MCD:
as free space for the nursing team, exploring issues and talking about them frankly. These managers distinguished MCD from other meetings in terms of input, style and output expectations.

‘In terms of policy I’d find it hard to say how it relates, because...what’s MCD about? Communication, cooperation, attitude, bringing appointments on policy changes into practice... When I consider outcomes of MCD, I do not wonder: did this mean something for my policy? That really isn’t necessary, in my view’ (Manager V)

Managers’ participation in sessions
Managers had different views on joining the sessions or not. Some managers experienced dilemmas or precariousness. Considerations – pro and con – were related to the characteristics of MCD and the position of the manager within the team.

Hierarchical relations
Managers proved themselves to be conscious of their hierarchical position, while MCD suggests equality and frankness of speaking. Participating in sessions that strive for equal deliberation made hierarchical differences explicit. Some managers stated that this evidently excluded them from participation. Others said this hierarchy might obstruct frank speaking.

‘I’d consider not joining the sessions. I’d feel that I would obstruct the process because of my position [as a manager] and I’d certainly observe people not speaking from the heart’ (Manager II)

Interestingly, other managers referred to the same MCD characteristics, but in terms of diminishing hierarchical differences. They felt participating in MCD encouraged equality and shared decision-making. Joining MCD made them feel part of ward processes as partners involved from the inside.

‘I so much appreciate being present during the sessions. Because it creates togetherness, knowing: hey, we work together here, we focus on the same goal, namely good care for our clients’ (Manager IV)

‘I strongly believe in my participation, showing my team: this also concerns me, and I’m learning here, too’ (Manager III)
Shared contexts For some managers, joining MCD sessions made them active partners in ward issues. They reported that participating in MCD included them in relevant team processes, gaining an insider’s view on issues and team dynamics. They felt they became a partner in the team, showing involvement, interest, closeness.

‘I consider my participation as a way to see dilemmas in practice. What I hear during the sessions differs from what I hear in passing on the ward. And sincere dilemmas, which are experienced, for instance, when a client commits suicide, need my close attention and participation’ (Manager V)

Sharing vulnerability Managers participating in MCD sessions wondered to what extent they should participate. Since MCD is characterized by mutual equality and openness, thus requiring vulnerability, some managers experienced dilemmas concerning their position in the team.

‘I’d not like to raise my own dilemmas in MCD. Because I’d then show vulnerability that might have consequences. As a human being I might experience an issue as really moral, but I’d have to solve it as a professional. It certainly has something to do with me being a manager’ (Manager II)

Confidentiality Other managers mentioned different moral concerns related to their participation in MCD. They found it difficult to decide what to do with information they heard during MCD. This dilemma was related to the confidential characteristic of MCD.

‘I wonder: what may I do with the information that I’m hearing? Do I restrict this to the MCD session, or can I use it during work meetings later on?’ (Manager IV)

Responsibilities Negative aspects of participating in MCD were not only related to vulnerability and openness, but also to creating shared responsibility:

‘I’m convinced that my participation in MCD would obstruct its aims. The responsibility of the nursing team would disappear as soon as I joined. At that point the meeting would become...an instrument, part of business’ (Manager II)
Discussion and implications for nursing management

In general, managers were positive about MCD. They agreed that reflection was a part of professional functioning. Yet, according to the managers, nurses do not consider reflection to be a self-evident part of the nursing job. Therefore, managers felt it their responsibility to facilitate MCD and search for the right frequency and duration of sessions to optimize its (durable) impact. Some managers stated that MCD should be organized organization-wide and top-down, or be part of institutional accreditation programmes.

Our study also showed that managers could not easily integrate MCD in standard management approaches, since outcomes were difficult to define (how do we determine that a change in cooperation did take place?) or measure (when is cooperation ‘good’ or ‘improved’ and how can this be measured?). Most managers expected that MCD would positively influence team cooperation and team reflection on good care, and experienced that it did so. Managers also stated that MCD provides a platform for different ways of communicating: open, explorative, not primarily appealing to decision-making processes. They agreed that the quality of MCD lies in the process. Given this process-related character, regulating the quality of sessions or outcomes appeared impossible. MCD required a different attitude from managers because of the characteristics of confidentiality, vulnerability and frankness. This resulted in managers’ search on how to relate to MCD.

Findings showed that managers thought MCD did not fit traditional linear management cycles of plan-do-check-act (Christensen et al., 2007). Some managers connected measurable outcomes to MCD (reduction of health-related absenteeism), but most managers noted that MCD could not be captured in measurable outcomes. Except for one, all managers did not perceive this as problematic: findings showed managers did not search for straightforward utility in MCD.

Current literature on change management points out that a broadening of the concept of utility is necessary to optimize involvement and commitment from professionals (Martin, 2000). Optimizing commitment and involvement requires space for a (moral) orientation on personal ideals and values. It is therefore suggested to expand the concept of utility with that of meaningfulness (Karssing and Spoor, 2010; Carr and Oreszczyn, 2003). Meaningfulness refers to understanding personal and contextual values, their mutual relationship (Martin, 2000), and their embodiment in professional action (Flynn and Anderson, 2012). This requires reflection in action (Loughran, 2010; Martin, 2000). MCD makes these processes explicit, supporting professionals in articulating and understanding their relation with the context in which they work (Grill et al., 2011).
Managers had various views on their participation in MCD sessions. The characteristics of MCD – equality, confidentiality, frankness of speaking, and therefore vulnerability – raised questions or dilemmas concerning the managers’ professional identity. Some managers were in favour of participation, seeing opportunities for mutual openness and shared learning. They deemed togetherness, in terms of reflecting together and sharing uncertainties and concerns, as valuable. These managers stressed the value of sharing team processes that concerned them, too. They referred to collaborative practices and shared responsibility (Robinson, 2009; Alleyne and Jumaa, 2007) known from theories on value-driven transformational leadership (Tomlinson, 2012; Newman, 2011; Bamford-Wade and Moss, 2010). Transformational leadership implies that managers should change one-dimensional relationships with teams to three-dimensional relationships (Covill and Hope, 2012): not only informing or communicating, but actively sharing processes within teams (Covill and Hope, 2012; Atkinson et al., 2003), constructively managing expectations and sharing responsibilities (Ott and Ross, 2013; Gilbert, 2005). Nevertheless, managers wondered to what extent they should and could be equal partners and what their participation would mean for other MCD participants. Also, confidentiality was regarded as an issue, resulting in dilemmas on what and how information from MCD sessions could be used.

Other managers were against participation, since they thought hierarchical relations would compromise MCD sessions. They felt their hierarchical position in the team would disturb processes of frank deliberation. Also, because MCD invites to vulnerability, they felt participating in MCD would not fit their hierarchical role. Finally, they feared their nursing team might refer responsibilities to the manager, rather than picking up on responsibilities themselves.

From the conceptual framework of transformational management, leadership means focusing on, valuing and strengthening potential resources of employees (Bamford-Wade and Moss, 2010). In this process, environmental, relational and hierarchical aspects are part of an ongoing learning process that is nourished by experiences and sharing (Gustafsson et al., 2010; Caldwell et al., 2008). Participatory management not only includes active partnership of managers in team-related processes but also refers to self-governance of the team. Research on participatory management showed that nursing managers may function as a moral compass, enabling nurses to enforce and sustain ethical practice (c.f. Storch et al., 2002). This includes enforcement of nursing empowerment by stimulating self-reliant decision-making and taking up responsibilities (Bamford-Wade and Moss, 2010). This might lead to the conclusions that absence of the manager during MCD could be perceived as a sign of trust: facilitating space for team members to make their own responsible choices (‘semi-autonomous space’, Karssing and Spoor, 2010). Yet, managers not participat-
ing in MCD miss out on the opportunity to share learning processes with the team, essential from the perspective of shared governance (Bass, 2010; McGuire and Kennerly, 2006).

Limitations of the study
A limitation of our study is that only eight out of twenty invited managers joined the focus group. Furthermore, the researchers may have been regarded as being in favour of MCD, which might have resulted in a positive bias on the side of the respondents. Finally, this research took place in mental healthcare, thereby limiting the transferability of the findings.

Conclusions
In terms of nursing management, implementing MCD requires being open to investments in cooperation with the nursing team focusing on process-related outcomes. We suggest our findings may be of particular interest to other long-term care institutions with comparable characteristics in the way care is organized and in the managers’ relationship with nursing teams. Implementing MCD implies fostering reflection processes contributing to nurses’ professionalism and competence in dealing with moral issues. According to managers, MCD requires openness, vulnerability, and equality with (in) the team. These core features of MCD are relevant for managers on three levels. Firstly, managers should create room for systematic reflection by providing time and place for MCD. Secondly, managers should be aware that the implementation of MCD requires dealing with process-oriented outcomes and complex issues of utility and value. Managers cannot expect to linearly work towards predefined goals, because the outcomes of MCD depend on the direct experience of participants during MCD sessions. Finally, fostering MCD in a team requires that managers reflect on whether or not to participate themselves. Whichever choice is made, these reflections refer to identity-issues regarding their role and position towards the nursing team, and issues concerning hierarchy.

We conclude that the role of managers in implementing MCD can be seen as an example of participatory management and dialogical leadership. Fostering MCD may pave the way for shared governance and participatory management, particularly when managers actively join MCD sessions and share their view and vulnerability. In this way, MCD can contribute to establishing dialogical interaction between nursing management and nursing teams, resulting in a mutual encounter and further joint meaning-making in relation to ethical issues in healthcare.
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Enacting Ethics

Bottom-up involvement in implementing moral case deliberation

Abstract
In moral case deliberation (MCD), healthcare professionals meet to reflect upon their moral questions supported by a structured conversation method and non-directive conversation facilitator. An increasing number of Dutch healthcare institutions are working with MCD to (1) deal with moral questions, (2) improve reflection skills, interdisciplinary cooperation and decision-making, and 3) develop policy. Despite positive evaluations of MCD, organization and implementation of MCD appears difficult, often depending on individuals or external experts. Studies on MCD’s implementation have not yet been published. The aim of this study is to describe MCD implementation processes from the perspective of nurses who co-organize MCD meetings, so called ‘local MCD coordinators’.

Various qualitative methods were used within the framework of a responsive evaluation research design. The results demonstrate that local coordinators work hard on the pragmatic implementation of MCD. They do not emphasize the ethical and normative underpinnings of MCD, but create organizational conditions to foster a learning process atmosphere, engagement and continuity.

Local coordinators indicate MCD needs firm back-up from management regulations. These pragmatic action-oriented implementation strategies are as important as ideological reasons for MCD’s implementation. Advocates of clinical ethics support should pro-actively facilitate these strategies for both practical and ethical reasons.

Key words
Introduction

In moral case deliberation (MCD), a group of healthcare professionals meets to systematically reflect upon a moral question that arises from a concrete case in their own practice. A specifically trained conversation facilitator – often, but not necessarily, a philosopher or an ethicist – watches over the content, process and product of the MCD meeting. The facilitator is non-directive regarding the content, helping participants in the deliberation process to make the inquiry into a moral inquiry and to keep an eye on the focus and quality of the dialogue (Molewijk et al., 2008a). An MCD meeting addresses questions concerning good care (‘what is morally the right thing to do in this situation and how should we do it rightly?’). Philosophical or conceptual questions can also be investigated (e.g. ‘What is respect?’ ‘What does understanding mean?’). Three central, often co-existing, goals of MCD are: (a) to reflect on the case and to improve the quality of care within that case; (b) to reflect on what it means to be a good professional and to enhance professional’s moral competences, (c) to reflect on institutional or organizational issues and improve the moral quality of care at that level (Abma et al., 2009).

MCD is based on various traditions ranging from hermeneutics, dialogical ethics and care ethics (Arend and Gastmans, 2008; Irvine et al., 2004; Steinkamp and Gordijn 2003a; Manschot and Van Dartel, 2003; Verkerk, 2000; Kunneman, 1998). According to these roots, an MCD starts with paying attention to the history, circumstances and context in which a moral question occurs (Abma et al., 2009). Deliberating from this viewpoint implies starting with the concrete, contextualized and practical cases of caregivers, leading to experiential and contextual knowledge. Participants are urged to remain open and receptive towards new options, perspectives and possibilities rather than to fixed principles (Irvine et al., 2004). Pragmatic hermeneutics is sceptical about a theoretical approach of an ethical dilemma, as moral knowledge is and should always be embedded in the experience and (thus) the persons involved (Verstraeten, 1994).

Over the past years, there is a growing interest in ethics support in general and MCD in particular. The Dutch government stimulates MCD to assist professionals in the development of their moral competence on the work floor (Dutch ministry of Health, 2005). MCD implies an answer to this advice. As experience increases, evaluation studies report professionals and institutions highly appreciate MCD (Sitvast & Bogert, 2009; Molewijk et al., 2008b/c). Though interest in and evaluation of MCD as a specific kind of ethics support is increasing, little is published on how to organize and implement these activities (Molewijk et al., 2008b/c, Verkerk & Leerssen, 2005; Steinkamp and Gordijn, 2003b; Dartel, 2002). Practice shows organization and implementation of ethics support activities are vulnerable, often
depending on individual enthusiasm and expertise. Also, people responsible for organizing MCD struggle where to place MCD within the organizational structure. Successes and pitfalls in implementation have not been documented by solid data collection. This article tries to fill that gap by enhancing insight in the organization and implementation of MCD. It will do so by presenting a case example, concerning the implementation of MCD within an institution for mental healthcare. In this example nurses from the teams in which MCD is taking place, are actively involved in, and responsible for, organizing the sessions. These nurses are called the ‘local MCD coordinators’.

The article is organized as follows: first the institutional context for the implementation of MCD project will be presented. This is followed by a description of the research methodology. Subsequently, findings are presented and analyzed. Finally conclusions are highlighted.

Implementing moral case deliberation in a mental healthcare institution

Within GGNet, a large mental healthcare institution in the east of the Netherlands, MCD was introduced in 2004 as part of a project on the reduction of coercion. Within this context, healthcare professionals from diverse teams reflected upon the moral issues in restraint or coercion casuistry. Over the years, MCD expanded throughout the organization, also detached from the original project. MCD was facilitated on either an ongoing basis, in a serial sequence, or once only. Nowadays, sessions are being held in the context of healthcare professionals (multi- and monodisciplinary), with clients, family members, staff services and management. GGNet also facilitates an in-company course by which employees qualify to be professional facilitators of MCD. Furthermore, GGNet facilitates research concerning the implementation process of MCD together with the department of Medical Humanities of the Free University Medical Centre at Amsterdam. All activities are monitored by the GGNet MCD steering group. Since its start in 2004, hundreds of registered MCD sessions were held throughout the organization. By these MCD activities, GGNet built up a lot of experience and collected data concerning MCD’s content, organization and motivation for practice (Molewijk et al., 2008b). In this contribution, part of this data concerning organizational aspects in MCD is presented.

Typical for organizing MCD at GGNet is the involvement of the so called local MCD coordinator. The GGNet MCD steering group introduced this role as a means to support the organization and implementation of MCD and as a way of stimulating the co-ownership of MCD amongst team members. Every team initiating
six sessions or more, applies one member of the nursing team to take care of the practicalities concerning the sessions. Tasks of the local coordinators concern for example: reminding participants of a scheduled session, reminding the person who is scheduled to write a case, making sure evaluation forms and reports are being spread etcetera. Also, the local coordinator is the spokesperson between the ward and the GGNet MCD steering group, the researcher and the conversation facilitator. At the moment eleven local coordinators, appointed by the team manager, are actively involved in MCD. These local coordinators are subject in this paper, presenting their perspective on the implementation of MCD. As they come from the nursing team, focussing onto their perspectives on implementing MCD provides insights from the shop floor. Presenting implementation from this perspective shows what ethics can learn from this stakeholder group in terms of enacting ethics by experiential learning, leading into increasing co-ownership amongst nurses of both the implementation process and the activity involved.

Methodology

Monitoring and facilitating implementation through Responsive Evaluation

Theory and design

To monitor the implementation proceedings a responsive process evaluation was chosen. This design is driven by the same democratic, participative and dialogical values as MCD (Abma et al., 2009; Widdershoven and Abma, 2003). Using a responsive evaluation strategy, active inclusion of an optimum of stakeholders is obtained, thereby meeting democratic, dialogic and participative principles in implementation simultaneously. In responsive evaluation the issues (expectations, concerns, controversies) of all stakeholders are investigated to obtain a rich understanding of the evaluated practice from their insiders’ perspectives (Stake, 1975/2004). Responsive evaluation (compare Guba and Lincoln’s Fourth Generation Evaluation, 1989) insistently includes the voices of all stakeholders in the evaluated process; not only as information givers, but also as advisors and partners (Greene, 1988). Its aim is to enhance the mutual understanding between stakeholder groups as a vehicle for practice improvement. The process is cyclical: stakeholder issues are first gathered and discussed among groups with converging interests (homogeneous groups), and later used as input for hermeneutic dialogues between groups with diverging interests (heterogeneous groups). These dialogues do not aim to generate consensus per se, but to collect meaningful issues that rise for the stakeholders themselves. Also the meetings aim to stimulate people involved to mutual learning by
responding to the various perspectives presented during the gatherings (Abma and Widdershoven, 2006; Greene, 2001). Evaluation activities obtain several purposes simultaneously, including the collection of empirical data as well as facilitating mutual learning amongst stakeholders during these conversations. Therefore in the case of this research project, both the research process and the implementation of MCD are allied and both impinge each other.

Following a responsive methodology, the research design develops in conversation with the stakeholders using the same moral competences as in MCD such as learning from other perspectives and postponing personal judgements. And like MCD, responsive evaluation meets well with the principles of hermeneutic ethics using dialogue as the main vehicle (Abma et al., 2009; Lüders, 2004; Schwandt, 2001). Issues at stake derive from the given context and from the stakeholders themselves, emerging in dialogues that reflect diversity in perspectives, history and meaning. Acknowledgement of this plurality of perspectives results in a bottom-up formulated definition of – in this case – the concept of implementation, not from a preconceived view on the concept detached from practice or people involved. This way, congruence between conceptualization of the evaluated object (i.e. implementation of MCD) and the evaluation design (i.e. responsive evaluation) is aspired.

**Evaluation procedure**

On behalf of the responsive evaluation process five stakeholder groups were distinguished: MCD participants (including client participants), local coordinators, conversation facilitators, managers and policy makers involved in the implementation of MCD (such as: Board of Directors/ members of the MCD steering group). This article deals with the perspective of the local coordinators. Eleven of them are active within GGNet.

As stated, the hermeneutic dialectic process of responsive evaluation is cyclical and iterative, so that interviews enabled data collection as well as engaging respondents for both implementation and research activities.¹

First, five out of the eleven local coordinators for MCD were interviewed individually. The selection of respondents was based on the principle of variety: gathering as many perceptions as possible (Meadows and Morse, 2001; Guba and Lincoln, 1989). After five interviews the data collection ended because of a repetition of issues that occurred in earlier interviews (i.e. principle of saturation). Each interview lasted 1 to 1.5 hours and was semi-open. A topic list – based on informal conversations amongst people involved, evaluation forms, internal rapports on MCD and literature - was used to bring in issues, but the interview was primarily structured

¹ When referring to respondents, this word indicates members of the focus group or the interview. When referring to participants, this indicates the persons who take part in MCD on the wards.
Subsequently, all local coordinators were invited to join a lunch focus group (Morgan, 1988). They only once met in such a cross-organizational meeting before. The meeting aimed to validate and further broaden and deepen the issues derived from the individual interviews by stimulating dialogue and confrontation of viewpoints amongst participants. Upcoming issues included: motivating participants, providing a case, support, multidisciplinary compilation, client participation, compulsory attendance, responsibilities of the local coordinators. Some issues spontaneously came up during the focus group meeting, some issues were based upon the analysis of the interviews. After this data collection process, all audiotapes of the interviews and focus group were literally transcribed in order to conserve specific characteristics such as doubts, hesitation and enthusiasm (Evers and Boer, 2007).

The focus group was joined by five local coordinators, out of whom two respondents who were interviewed individually earlier. The gathering lasted two hours and was moderated by the MCD program leader of the GGNet MCD steering group and the researcher. The focus group was characterized by an informal atmosphere, to invite respondents to speak out frankly. All in all eight out of the eleven local coordinators were included in the process of collecting data.

Analyzing the data, themes that came up were listed related to the process of organizing and implementing MCD. Subsequently, the five individual interviews were reread in order to refine the analysis of the focus group. Finally, all respondents were asked to read the interview analysis to validate and criticize outcomes and conclusions drawn (member check / respondent validation; Evers and Boer, 2007). Their comments were included in the final analysis.

Findings
In this section, the local coordinators speak. In order to structure findings, quotes from the interviews were derived and put into three categories: (a) MCD as an activity with distinction (b) Tools for implementation (c) Implementation as work. For an overview: see Table I. The process of deriving these categories was subject of discussion amongst supervisors, respondents and the MCD steering group. Central question is: ‘what do local coordinators experience while organizing and implementing MCD?’ Themes will be illustrated by quotes from the interviews, a usual strategy in qualitative research. Remarks from the member checks are included.
A. Moral case deliberation as an activity with distinction

According to local coordinators, MCD has a status aparte amongst other regular ward meetings. As the structure and attitude during a MCD conversation differs from (local) conversation routines, MCD participants initially do not easily connect to MCD. Also the concept of moral deliberation brings about some questions amongst participants. So how does MCD differ from its fellow ward meetings, according to the local coordinators?

Image of moral case deliberation

The concept of MCD generates associations of distinction or weight amongst participants. This evokes attractiveness and exquisiteness as a presupposition, yet, the concept also evokes associations of heaviness and difficulty – especially amongst those having little experience with MCD. Due to this, a certain ambiguity is accomplished towards the image of MCD, in which the distinctive characteristic of MCD is ratified. For beginners, the word reflection brings about associations less heavy and reverses the image of MCD into a more amendable one.

‘Moral case deliberation sounds so... heavy and loaded. That makes it all the lot heavier, actually’ (FG)

‘Moral case deliberation: what does it contain? Móral Cáse Deliberátion! Hm? Sounds very eh...severe, heated. (...) It is moral and it is deliberation, ouch, ouch!! (...) Yes, a fierce concept. Reflection has a different bite’ (Indiv. IV)

Moral case deliberation appeals to distinctive skills

Second, MCD requires skills by mouth, letter and attitude which differ from the daily skills applied to routines in mental healthcare and/or other ward meetings. Examples local coordinators present are: writing a case, talk to each other with a specific discipline, trying to understand a fellow participant and ask questions rather than trying to convince him or exchanging presumptions. According to the local coordinators, these skills can be experienced as strenuous by the participants, even in long-term, ongoing groups.

(...) ‘People who attend after a period of absence, or pupils and such, new colleagues, they find it really tricky. Afterwards they go pffftt, because [in moral case deliberation] one must ask questions and speak very open, and one is not allowed to simply state

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2 ‘FG’ refers to the abbreviation Focus Group, referring to the original transcript where quotes can be traced.
3 ‘Indiv.’ refers to the abbreviation Individual interview, followed by the number of the respondent, referring to the original transcript where quotes can be traced.
well, because!’ (laughter). You can see them sweat, thinking: hm, I don’t know what to think of this!’ (FG)

Thorough, in-depth investigation of casuistry A further distinction of MCD compared to other ward meetings mentioned by local coordinators, is the aim of gaining deeper insight in a case. The level on which an issue is discussed is qualified as in depth or going to the essence by local coordinators. They define depth as a strong focus on a small part of a concept in a presented case, gaining a glimpse on the essence of a case, and formulating an applicable transition towards daily practice. Depth helps professionals to come to a standstill on issues – typical for MCD and also part of its distinctiveness on the ward routines, according to local coordinators.

‘For example: take the word ‘respect’. What does that mean to you? Well, when you put ten people in a row answering that question, you gain ten different answers! So eventually you can see that often you think you are discussing the same subject, but [in moral case deliberation] it appears you don’t!!’ (FG)

The focus on clarification of concepts does not mean a turn to essences or large concepts. It rather requires valuing apparently small issues. Participants new to MCD often do not experience depth when they deliberate on small issues. When apparent trivialities are discussed during a session, participants feel they wasted time. Therefore, going to the essence or gaining depth requires active, personal involvement and willingness from participants: an attitude-related aspect of MCD. Therefore, individual experiences on the intensity of the session may differ:

[participants stated:] ‘Those trivialities, do we really have to discuss them!?’ Well, gaining depth: [as a local coordinator] try explaining to a group what that means! (…). Because exactly those small issues (…) weren’t experienced as ‘depth’ (FG)

Bringing together a variety in contexts According to the local coordinators, MCD also differs from other ward meetings because a variety of participants deliberates together on an equal basis. Most important is the variety in contexts of participants. This variety either can be reached by a mixture of disciplines, or a monodisciplinary compiled group with people working on different wards:
‘I think the surplus value in our group is located in the attendance of a variety of
disciplines. I believe if we would do our moral case deliberation solemnly with the nursing team, the usefulness of the sessions would disappear quickly. Because (...) we would linger onto our own viewpoint so to say’ (FG)

‘Many times only nurses attended our moral case deliberation meetings, but as we were coming from three different teams (...) we all brought in a different share’ (FG)

In sum, local coordinators typify the uniqueness of MCD amongst other ward meetings by four characteristics: concept and image, required skills, in depth reflection and compilation of the group. Combining an image of exquisiteness and heaviness, evoked by these characteristics, reflection becomes both illustrious and something very difficult at the same time. Local coordinators are not experts on these characteristics and cannot reply to all questions or hesitations they come across amongst their fellow-participants, especially when they are new to the matter. Although it seems that participants get used to the specific requirements of MCD sessions overtime, the distinctiveness of MCD always remains till a certain extent. Consequently, motivating participants to participate is not easy. To support this, and to persuade participants of the added value of MCD, local coordinators feel they need ‘tools’ and support from key persons at the ward. This is addressed in the following section.

B. Tools in organizing moral case deliberation: support in daily work

A local coordinator represents MCD amongst colleagues. Yet, experience shows he needs tools to support the activity and institutionalize continuity – an important aspect of implementation according to this respondent group. In the interviews, local coordinators mention a number of those ‘tools’:

Support by key persons Commitment to, and attendance during MCD of key persons (local manager, psychiatrist etc.) of the ward is of great value to the local coordinators. Their attendance contributes to the seriousness with which the sessions are being attended and appreciated, and to the positive interpretation of the concept of MCD. Attendance of key persons also strengthens the position of the local coordinator as he feels supported by these authorities showing approval for reflection.

4 Local coordinators can be male or female of course, yet in favour of readability only ‘he’ is used here
‘Precondition for the successes we had was the indisputable support of the psychiatrist and team leader. We needed their full support, yes’ (indiv. I)

‘In the beginning of the series the team leader always attended. Actually he did so in order to stress the importance and to stimulate continuity in the sessions’ (indiv. V)

‘I couldn’t help thinking she [psychiatrist – FW] had other priorities. And that the moral case deliberation meetings we had were not sufficient, not powerful enough’ (...)(indiv. I)

Scheduling for meetings: overtime hours and back-up assistance on the ward
Local coordinators focus on building up a routine in MCD. As routine builds up, MCD becomes a self-evident phenomenon on the ward. However, this requires scheduling sufficient personnel to cover the absence of colleagues during the meeting. Also, the manager must accept individual employees’ overtime hours. Local coordinators watch over these agreements and show active involvement when this becomes rocky.

‘No. Nobody feels responsible to settle assistance. No. So we [the team - FW] do it ourselves now. Because the team considers reflection of great importance. So yes, we do settle the problem ourselves’ (FG)

‘Well, in our case we do not even have to think about it any more. We just know on Mondays we need an extra day and evening shift’ (FG)

‘As a local coordinator, you must be able to make people enthusiastic (...) just by telling them – in accordance with your team leader – this is their time! They can record these hours at any time they like – that should be guaranteed’ (indiv. II)

Frequency of the sessions
Within GGNet, frequencies of the sessions of MCD highly fluctuate per ward and may vary from six times a year to every fortnight. Team leaders determine the frequency in their ward; there are no fixed guidelines. Local coordinators show loyalty towards direct colleagues who feel their available time with clients becomes under pressure by another scheduled meeting and towards regulations. They are therefore willing to listen to both stakeholder groups; if for example participants wish to adapt regulations they discuss this with the team leader.

‘In our case we decided to do a session once every four weeks. Everybody felt once
every fortnight was simply too much, especially the therapists and doctors said so. Well, then together we decided: from now on we will come together every four weeks’ (FG)

Compulsory attendance Despite local differences in organization, all team leaders who initiated MCD chose to obligate attendance of the meetings for all nursing staff on duty. Local coordinators experience initial reluctance amongst participants because of this compulsory attendance. To participants it is not always clear why MCD is initiated and why attendance is obliged. Local coordinators nevertheless report that they prefer this compulsory attendance as a regulation because it provides opportunity to participants to experience the surplus value of MCD instead of arguing about its value beforehand. Also, regulations like compulsory attendance help local coordinators to address to participants with stoutness and self confidence, regardless the eventual difference in status on the ward.

‘In our case attendance was obligatory. So people had to come back to work for it – sometimes for only two hours and this brought up a great deal of resistance’ (FG)

‘In the beginning there was a lot of struggle. People said: what is all that reflection about?! Well, as a local coordinator, you also have to motivate and activate people to arrive 45 minutes earlier, or to leave 45 minutes after duty’ (indiv. II)

Yet, provided that it is clear when the sessions are scheduled and who will be responsible to bring in the case to be discussed, this obligation is commonly accepted as MCD sessions proceed.

‘So people must be addressed! And as a coordinator, that is what I do. Yes, I think it part of my job (...). Well, I have no problem with that, no. And moreover, people simply know that I am right’ (indiv. II)

In summary, local coordinators state they need key persons from the ward openly or explicitly supporting MCD and supplying organizational tools to regulate attendance and continuity. These aspects justify the authority of the local coordinators they gain overtime. Without this support, MCD will never root into practice, they feel. While they take care of the preconditions in order to guarantee progression, they need the authority of the superiors to persuade people to attend.
C. Implementation as work
Local coordinators conduct the progression of MCD by taking care of preconditions, supported by management regulations. With this, they aim at continuity of MCD on their wards and they do this with vigour and consistency. Motivating participants is an important part of their job, they feel. Not so much for ideological, content related, persuasive reasons, but for pragmatic reasons (‘it is scheduled’) and on behalf of the creation of a social structure in which a learning process is realized. Creating this social structure is an issue throughout the interviews.

Content or continuity? The position of local coordinators comes with a number of listed responsibilities. Yet in practice, local coordinators decide individually and based on experience, personal insight and motivation, what responsibilities they add to, or remove from the original list. Differences in responsibilities can be detected, yet overall, local coordinators take their responsibilities very seriously. Efforts of local coordinators do not so much aim at the content or ideological background of MCD, but at the notice of embedding MCD in a ward routine. They function as floor managers of the organizational process. MCD as a concept might be associated with heaviness and eminence, yet organizing it means simply that there is work to be done! In doing so, they show great loyalty.

A: ‘(...) Well, one must adopt moral case deliberation as if it were your very own child, otherwise... eh... One must....’
B: ‘You’d better grin and bear it!’ (FG)

‘I consider my work as a local coordinator as a responsibility towards my team’
(indiv. V)

Local coordinators strongly emphasize on continuity and retention of the sessions. They do so in order to persuade participants to sustain social structures by getting people together. In their view, these structures are formative for participants in daily work situations. Their task is to establish conditions for these learning processes.

‘We just welcomed an interim social worker [on our ward] and she joins in, too. By attending, people become easy accessible. The same goes for her. (...) You hardly know each other, but (...) you already shared a dialogue together, well, that makes it
all the way easier to talk. Because (...) I like to hear the way she approaches a problem, and if we happen to share a shift in the future, well, I at least know a little bit of her way of thinking. I consider this to be... quite a plus of the matter’ (indiv. II)

Facilitating a learning experience  Local coordinators fulfil their responsibilities because of a number of motivational aspects. These are either personal or come from successful outcomes they link to the learning processes in MCD. Local coordinators recognize an increase of joint cooperation amongst multidisciplinary team members. This process is steered by appealing to learning experiences, joint communication and thorough reflection.

‘[Moral case deliberation] cultivated mutual understanding. And this understanding came from coming to know why a doctor, well, eventually had come to a certain decision. Because that isn’t always clear, is it?!’ (indiv. IV)

‘At some point a patient was admitted into hospital and one [of us – FW] said: (...) ‘maybe we should try doing it this way in stead of the other; we once discussed a situation like this within moral case deliberation!’ Well that really makes me feel: (clacks tongue) thát’s it!! This [transfer to practice – FW] is grèat!’ (indiv. II)

Bringing people of a variety of contexts together nourishes a sense of collectiveness amongst different disciplines working in one team. Solitary working disciplines meet support, understanding and (re-)connection to the nursing team. Also, reluctance in confronting other – mostly superior – disciplines is abolished by organizing a collective dialogue, based on and aiming at equality. Local coordinators appreciate this highly and report an improvement of team spirit due to the MCD sessions. This strengthens their efforts to do their job as a local coordinator.

‘I noticed (...) improvement of interaction with for example our welfare worker. It became easier to drop in, (...) to exchange thoughts on a specific client and to think jointly. And I believe this wasn’t the case in an earlier stage. At [name of the ward - FW] this process was very unambiguous. Very perceptible’ (FG)

‘In general, therapists work rather solitary at our ward. And therefore, they often feel they need to solve things on their own. But when they bring in a case on moral case deliberation, many times conclusions are: hey, give us a ring and we will send someone from the nursing team. Or: drop by so that we can discuss it a little to see if
we can do things differently (...). They think they work solitary, which in a way they do of course, yet still they are part of the team. And by the reflection meetings this bonding is fortified, certainly’ (FG)

‘(...) This doctor (...) stated: ‘I have been thinking about it and I decided to join you lot a bit more often to share a cuppa! Because I noticed that contacts improve and that the client is represented much better when discussing cases [in this setting]. Earlier, all this [consultation] happened from a mutual distance’. And this was him [the psychiatrist-FW] speaking!’ (FG)

Dealing with hierarchy Local coordinators highly value variety in participants. In this, they locate potential benefits from the MCD meetings. This implies a variety in hierarchical representation of the disciplines involved in daily care routines: nurses, psychiatrists, secretary workers, management, therapists; ideally all of them are involved in a scheduled MCD session. Given these asymmetries, the local coordinator focuses on creating conditions to provide a floor for a fair process: everybody should pin the gatherings; all are equal in that. No excuses are being made. Therefore, differences in terms of (hierarchical) positions do not keep local coordinators from addressing people when they do not show up or provide no casuistry when it is their turn. The MCD schedule provides authority in those cases and justifies action towards the person concerned. Participants then accept the authority of the local coordinator resulting in increasing self-confidence and a hint of stoutness. In consultation with the local manager, they even might decide in exceptional cases to exclude participation of certain team members when they obstruct the sessions for whatever reason.

‘Yes, I consider it a matter of principles : you should be there, shouldn’t you!? Everybody must return to work in order to attend, so at that scheduled time you should not have to discuss whether this counts as working overtime’ (FG)

‘Well in all honesty, when people start making a real fuss - like that psychiatrist who enduringly refused attendance, and he still does not join. Well, he simply accepts the outcome he is not welcome anymore. I spent so much energy addressing to him, and yes... there came a point at which I decided: okay, this is no longer my job’ (FG)
Personal involvement: feelings of pride and failure

Accomplishing and witnessing these successes, local coordinators become highly motivated to do their work. They show great willingness to make efforts in the conducting process for MCD. This willingness also brings about personal involvement concerning the amount of success or failure throughout this process. Succeeding in bringing people from a variety of contexts together and seeing the potential harvest grow as the group experience increases, local coordinators take great personal pride and pleasure out of this heart-felt success.

‘Well, I just love doing this! (...) I really like to conduct any process! (laughs). It’s just part of who I am. I just love (...) to activate and to cultivate enthusiasm, to activate participants slipping into the process ..!’ (indiv. II)

‘At some point I had a talk at an expertise meeting [on implementation of MCD - FW], and I told the audience as a local coordinator I saw our ward process was ahead of the plans of the expertise centre. (...) They are now talking about introducing moral case deliberation organization wide. But up here, all is settled! Why should they reinvent the process [elsewhere - FW] if we have so much experience over here they could use?’ (indiv. II)

Reversibly, local MCD coordinators take it as a personal failure for example when a set of sessions ends untimely. Also they feel responsible for a lack of input from participants during a session – also out of compassion with the conversation facilitator.

‘Somehow it slipped through my fingers... or actually it was pulled out [by lack of support from the psychiatrist -FW]. What a shame that was. A cardinal sin. I thought that was really bad’ (indiv. I)

‘I experienced the meetings as very dispassionate, and [as a local coordinator – FW] I felt responsible, thinking: okay, now I need to give a hint or an opening for conversation. Or I must head in something (...). And I watched the conversation leader pulling, pulling, pulling... which made me decide to interfere and bring another issue up or...’ (indiv. IV)
Practical responsibilities

Being motivated engages local coordinators to the process of organizing and implementing MCD. In order to keep up the continuity, they show great responsibility towards aspects that support this continuity in terms of preconditions and atmosphere during sessions. As an example of a precondition, providing a case is mentioned. Before the quality of a case is at stake, making sure there is a case is priority number one. It contributes to continuity and involvement of participants. Writing a case is one of the skills (by letter) MCD appeals to and therefore sometimes brings up hesitation. As routine in a group increases, participants usually need a simple reminder. But little experienced teams require active motivation of the local coordinator.

‘Usually, when no case occurred in time, I send a simple e-mail as a reminder: hey, won’t you forget? And this never results into any problem’ (FG)

‘(...) Our routine was to choose a theme in connection with the preceding session, resulting in a new case. And formally...someone from the team had to put that onto paper. But as a local coordinator, I had to pull real hard to motivate a team member to do so. Really hard’ (FG)
As an alternative, some local coordinators take it as their responsibility to write the cases themselves, leading to lower involvement of the participants.

‘I became crafty [in writing cases - FW]. And so I thought: oh, well, let me do it! But eventually [moral deliberation - FW] became my thing, while, well, it is a team thing of course. (...) And I think that is one of the reasons why MCD up here became a blind alley, eventually’ (indiv. I)

To sum up, local coordinators feel that by creating a social structure in which a learning process is realized, participants gradually become motivated for MCD. Local coordinators do not use ideological arguments for persuasion, but refer to management regulations and stimulate participants to experience the surplus value of MCD simply by undergoing the experience. Although this study does not focus on results of MCD, local coordinators state they see clear benefits, which motivates them to persist in their efforts. Yet, their personal involvement also makes them vulnerable towards feelings of either personal success or failure, especially when they do not feel support from key persons on the ward.
Discussion
This article deals with the organization and implementation of MCD in a large mental healthcare institution, perceived from the position of the shop floor. Local coordinators, coming from the nursing team, try to optimize conditions for MCD sessions, and thus allow insight into the process of enacting ethics support activities. In their work, they aim for continuity and bringing a variety of contexts together. To them, these are key elements of implementation and preconditions for a successful series of MCD meetings. In their eyes of the local coordinators, sessions bring forth a learning process with potential benefits like: changing social dynamics on the shop floor, lowering mutual thresholds and increasing mutual understanding. The findings illuminate local coordinators’ pragmatic style and their strong focus on the conductor ship that MCD meetings require. They know sessions would quickly come to an end if they would not do their diligent job, because participants need time to connect to and experience MCD’s potential benefits. MCD requires sustainable practice. Once the routine is settled, work is still needed to keep people motivated. Local coordinators can be typified as facilitators of the organizational process, rather than ambassadors with ideological reasons of MCD.

Care should be taken to generalize the findings from this study to the potentials of MCD in general. Although further research on results of MCD and a comparison with other forms of ethics support activities is desirable, the potentials local coordinators link to MCD are motivational strengths to them within their particular institutional setting. The findings presented are thus context-bound and an expression of the perspective of one stakeholder group. We do, however, believe that the thick description provided in this article enables readers to experience vicariously what it means to be responsible for the implementation of MCD in a mental healthcare institution. This vicarious experience may help readers to transfer knowledge developed in this context by this stakeholder group to their own context. We call this a naturalistic generalization (Stake, 2004), as it is based on informal ways of transferring knowledge, not by the researcher (who knows the studied context) but by readers who can compare their context with the studied context.

Amongst participants, MCD is initially associated with heaviness and trivial discussions about details. Ideological arguments to promote MCD might even work contra-productive and evoke resistance, because they might fuel these associations even stronger. MCD needs to be enacted: the actual meaning and implementation of MCD is revealed in concrete experiences by MCD participants. This pragmatic and action-oriented implementation strategy resonates with a key notion underlying MCD: action provides a valid source of knowledge (Niessen et al., 2009). Experiences of local coordinators in this research provide us with experiential knowledge
concerning the actual process of implementation in practice. Considering this, the pragmatic and sustainable work of local coordinators on behalf of the organizational process, could be just as beneficial to the implementation process of MCD as the efforts of ethics experts who stress the importance of this kind of ethics support for more ideological reasons.

Nevertheless, a pragmatic approach towards the implementation of MCD might conflict with initial ideological fundaments of MCD. For example, would a compulsory attendance of MCD meetings conflict with the basic notion of equal partnership and a free dialogue within MCD? Future research on organizing ethics support in a pragmatic way requires a thorough reflection upon this tension between pragmatism and idealism of the implementation of ethics support.

In terms of implementation theories, these often suggest a technical step-by-step procedure to introduce new routines. In the case of, for example, new techniques for using injection needles, this strategy seems appropriate. Yet MCD itself fosters methodical reflection amongst participants. Hence, the quality and success of both the MCD and the implementation of MCD is inherently depended upon its participants. Furthermore, MCD explicitly interferes with local cultural aspects. From a cultural perspective, actors in the implementation process are not rational beings which are automatically persuaded by a pre-defined set of ideological reasons for MCD or a technical step-by-step implementation set up. They are influenced by social contexts and personal values and attracted by alternative reasons as the process evolves (Boonstra, 2000). People involved in the implementation process actively relate to that process from different perspectives and backgrounds (Verkerk and Leerssen, 2005; Linge, 1998; Morgan, 1986). Therefore, specific attention should be paid to the local culture and to how people involved relate to the subject of implementation (van Dartel, 2003). Support of the implementation process depends on the possibility to appropriate initiatives and adjust them to the shared values, interests, needs and desires of participants.

In line with an organizational development approach (French, 1969) several authors stress the importance of synchronizing the strategy of implementation with the nature of the initiative that is to be implemented (Verkerk and Leerssen, 2005). Implementation of dialogical activities – such as MCD – therefore requires a dialogical and interactive process. Active participation of stakeholders requires inclusion, awareness and acknowledgement of ethnographic characteristics that help initiatives to fit into the local culture and increase co-ownership of the process without violating existing values and structures (Verkerk and Leerssen, 2005). A bottom-up strategy and active involvement of team members is crucial to successful implementation of new initiatives. Yet, top-down support is crucial as well (Honig, 2004; Argyris et al.,
1985). This is illustrated by the vital importance of support from key persons in the institution/on the ward. In line with this experience, implementation theories stress that new initiatives both need classic hieratical steering and a process of involvement and ownership of this initiative by its users over time (Argyris and Schön, 1978). In this research, this support is shown by presence of the key persons during sessions, but also by firmly stating management regulations such as compulsory attendance by all disciplines.

Table I
Overview of (sub)themes on implementing MCD

<table>
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<td>MCD appeals to distinctive skills</td>
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<td>Thorough, in-depth investigation of casuistry</td>
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<td>Tools in organizing MCD: support in daily work</td>
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Conclusion
Promoting ethics support services often refers to ideological reasons, rather than experiential meanings relevant for potential users. No matter how worthwhile these ideological reasons are, actual reasons for ethics support services (such as MCD) emerge in practice as all stakeholders define and re-construct its meaning. Ethicists working in clinical realities should not only be aware of this pragmatic process but should also pro-actively facilitate it. This can be done by paying attention to and creating space and co-ownership for those who are actually involved in the organization of the ethics support service.

Approaching implementation of ethics support activities like MCD from the perspective of local coordinators shows that organizing ethics support involves a lot of activities. These activities, like settling preconditions for a session, remain
invisible when focusing on ideological considerations only. Local coordinators reveal important experiential knowledge on how to do ethics support such as MCD. For example: realising what the meaning of a concept (like ‘moral case deliberation’) can do in practice. Local coordinators indicate, because of their practical involvement, apparent trivialities having impact on progression of MCD series. Ethicists initiating MCD should seriously take into account the organizational and practical side of the activity to be implemented. Initiatives are and should be translated to the particular context.

In implementing ethics support activities, meaning and organizational culture are crucial. The implementation process and its outcome are contextually determined in co-creation by those who will be actually working with the initiative to be implemented (Morgan, 1986). The process of increasing shared ownership flourishes by involvement of the users throughout the implementation process (Molewijk et al., 2008a). For this reason, we advice to include ‘tools of improvement’- meaning people from the section, ward or discipline at stake – rather than ‘tools of management’ exclusively (Verkerk and Leerssen, 2005). This is useful, not only for practical, but also for ethical reasons. MCD has potential impact on ward- or team culture. Including members of the team in the implementation process seems a fair choice as their local culture is at stake. Especially in ethics support initiatives, maintenance of democratic values in this process is to be respected, meaning: equality of voices, active participation and co-ownership of the process.

Acknowledgements
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References


References
Notes from the researchers’ logbook
25/11/2008
Today I phoned Eric [local coordinator – FW] again to make an appointment with him for an interview. I have tried to speak to him many times over the past weeks, but he never returns my calls. It annoys me, to be honest. Does he not understand that his experiences matter? He is just so new to MCD. It would certainly contribute to the aim of gaining a broad view on MCD and its implementation.

I wonder if something in me, or maybe in the reason for the appointment, is responsible for his lack of priority (is it lack of priority??). I hesitate to call him once more. I sort of feel I am a nuisance to his colleagues (when they answer the phone). There is a hint of shame or shyness.

27/11/2008
I have been thinking about how to approach Eric so that he is at least willing to consider participation in my study. There are many local coordinators at GGNet. Why am I so determined to talk to this particular person? That is another train of thoughts I reconsidered over the past days.

There is something Eric said to one of our conversation facilitators that triggered my curiosity. He said: ‘It’s okay for me to be a local MCD coordinator, but I know nothing about MCD. But hey, I’ll do it anyway’. Maybe he does not ‘have much’ with MCD? This would make it all the more interesting to include his perspective on MCD in the study on local coordinators! I think I will just drop by next week to see if he is in. It might be just the way – to do it informally?
02/12/2008

Today I drove to D. [location – FCW] to drop in and see if Eric was on shift. He was! Fortunately my timing was convenient; he could take a little time to show me around the ward. While chit-chatting about work and the organization, we had a nice meeting, really. I was very happy anyway, because I love being on the work floor. As I found Eric so talkative and welcoming, I wondered if this might have been the simple reason for not returning my calls and e-mails: just having to travel to my office at W. [location - FCW] to meet me? Isn’t it silly I did not think of that in the first place, how that could influence the rapport between us! Anyhow, we talked a bit and at one point of course we talked about the MCD’s that commenced at this location some months ago. He said he found it to be rather complicated if people from his team asked him about MCD, because he could not really explain what MCD was about. And all those heavy terms: ‘moral’, ‘deliberation’, ‘ethics’... But he also noticed there was something different about the MCD meetings. He described himself as ‘intrigued’. I told him I was curious about his experiences of MCD and I would like to interview him. Luckily, he agreed to do so. I will visit him at the location in two weeks’ time.

11/12/2008

Eric cancelled our appointment for next week. He could not make time for it. He said that he thought practice was more important than research anyway. I was a bit baffled by his bluntness. Yet I learnt in that moment that the perception of scientific research – even if it’s only based on presumptions – may not be urgent or even useful for Eric. I asked whether or not he would still be willing to make another appointment for an interview. He said yes – but I worry a bit if that’s only a gesture of politeness. We decided to meet at his location on January 9th.

09/01/2009

I have just returned from a rather dynamic interview with Eric! Although the start was a wee bit clumsy (we ended up in a very little room as we were constantly being disturbed in the other rooms) he really got into the interview once we could finally start. While listening to him I was so surprised to hear him say how loaded MCD for him was, just because of the concepts. He also said things about how his colleagues perceive MCD: as something difficult, because they have to write things down (casu-
istory), and have to think about small things from practice, and the conversation is just so slow! Eric seemed to speak completely frank to me. It was a pleasure, for that reason! I realise that I have never thought of MCD as something that requires efforts from participants. Writing, thinking, talking: these are things I love doing in life. I therefore completely overlooked the idea that these can be very demanding aspects of MCD. Eric and I had a very pleasant conversation. As I learnt a lot and told him so, he seemed to become more convinced that I was actually sincerely interested in his experiences. After a short while, his enthusiasm was plain and I felt quite happy about the contact we had.

14/01/2009
I invited all local coordinators for a focus group lunch next month. I realise, now that I have done quite a few interviews among this stakeholder group, that they all have the same task but because of geographical distances have never met. We have asked permission to audio tape the meeting.

24/02/2009
Today all local coordinators came to the focus group lunch meeting. Besides the semi-structure of the meeting, B. [colleague] and I decided to canvass the local MCD coordinators to see what issues they wish to put on our research agenda, and which issues can be discussed on the spot. We therefore facilitated a learning environment in which people could learn from each other’s experiences.

During the lunch, Eric particularly was eager about learning from the experiences of his MCD colleagues. He asked them all sorts of things and asked further questions when he got any tips or advice – his learning attitude was quite inspiring and brought in a lot of dynamics and focus. He also talked a lot about the resistance he felt in his team to MCD: again because of the ‘difficult terminology that goes with MCD’. The issue was confirmed by the others, yet at the same time this was noted as beneficial because the ‘heaviness’ contributed to a sense of seriousness of MCD.
30/02/2009
I worked through the transcripts of the focus group with the local MCD coordinators (and I immediately learnt that I should never ever again serve soup while audio tapping: the spoons hitting the bowls are really tumultuous!). I am intrigued when I read how vigour came up as the lunch proceeded. Starting off rather timidly, Eric really hit on some issues to which the more experienced local coordinators reacted. I am fascinated by his ability to question, listen and learn. He also raised the question on the usefulness of research for practice, larded with a hint of cynicism (my interpretation). This is confirmed by the others, particularly Elsa and John. I find it difficult not to be diffident about asking for their participation; my colleague B. is much more pragmatic and stresses the importance of shared ownership over MCD and the value of their experiences so researchers can learn from them.

Somehow it seems as if from that point a new confidence or expertise came up in the group. The participants started to raise issues that concern them regarding MCD. I think B. set the tone quite right, pointing out that it’s their practice and that their experiences help us to understand the practice to be implemented. By the time the focus group was over, the local coordinators agreed to stay in touch with each other, and they also requested for a follow-up meeting on the issue of client participation in MCD.

16/04/2009
It is now two months since we had our first local coordinators’ focus group and next month the follow-up meeting is scheduled (a focus group, including MCD facilitators at the request of the local coordinators). Over the past weeks the local coordinators mutually had quite some contact as I understand it. Also, they sent me lots of e-mails about how to organize MCD in their teams. I am so glad: it seems the lunch meeting helped them to confirm the importance of their job regarding MCD. They initiate contact with me, which shows that thresholds have lowered and that they pick up on their valuable contribution to the MCD practice. They also seem to consider me as a partner for their practice, as they readily contact me on issues from their teams related to MCD. In the oral evaluations we did over the past weeks with managers, conversation facilitators and local coordinators, they were much more up front compared with the evaluations before.
26/05/2009
Today we had the focus group on client participation in MCD with local coordinators and conversation facilitators. It was a very vivid, sometimes vigorous, meeting. I very much enjoyed the atmosphere of openness and the vigour with which I saw people interact. The perspective of local coordinators on MCD differs so much from the perspective of the conversation facilitators (I believe the latter approach MCD more from an ideological perspective, and the local coordinators more from a pragmatic perspective). The group is vital. The strength of their expressions makes me convinced they now perceive the MCDs in their teams as theirs. Any reservation towards me in the role of researcher seems to have disappeared. They included me in their practice – which I am.

13/02/2010
Last week I invited two of the local coordinators (who also participated in research activities) to give a workshop on this year’s Annual Dutch Working Conference on MCD. Responsive evaluation implies that I am not the expert but those who experience the object of research (implementing MCD). So I found it to be a natural choice to let the local coordinators do a workshop on organizing MCD bottom-up. They needed some time to think that over – one of them explicitly said she would not dare to, but she would consider it if her colleague decided to do it.

17/02/2010
They both confirmed they will do the workshop! Isn’t that just fantastic?!

29/11/2010
Annual Dutch Working Conference on MCD. ‘My’ local coordinators did just great in their workshop! They even gave an encore during the final phase of the conference, in a plenary ‘elevator pitch’ on MCD practices. I know the credits aren’t mine, but somehow I cannot deny I feel pride over these local coordinators: starting off with resistance towards research, modesty about their contribution to MCD’s practice and attending the local coordinators’ meetings out of politeness. I feel I really saw them grow in their role, picking up on initiatives and vigour. And now they are standing
here, between all the ethics experts from the Netherlands, representing their pragmatic, non-idealistic approach to clinical ethics. I do feel very, very content.

17/01/2011

Eric phoned this morning to let me know that the MCD’s at his ward were to end. He told me he himself made this decision, because the team members at the ward perceived MCD as his thing, rather than as a team thing. In one of my earlier interviews with one of the other local coordinators of MCD this issue also came up. As seems to be the case in Eric’s team, this local coordinator too picked up on all the responsibilities over MCD, had no institutional back-up from his manager and ended up writing casuistry himself. Eric told me that, over time, he had become very enthusiastic about MCD in his team. But he no longer liked his position in it: dragging casuistry from colleagues, month after month, really discouraged him. His colleagues just weren’t into it, although they appeared content during the MCD sessions.

I find it a bit difficult to deal with this. We decided in our institutional MCD steering group that MCD would never be compulsory – precisely for the reasons described above: MCD would never enable shared ownership if it were enforced top-down. When a team seems to have such strong resistance to MCD, obviously it should not be pushed. But, on the other hand, if they do experience value during MCD, should it then simply come to an end?

Anyway, Eric is right of course to end his task as a local MCD coordinator. Despite his enthusiasm and ability to learn from experience – which he showed so persuasively -, he is not responsible for the continuation of MCD in his team. That decision is to be taken in coherence with the team and the manager. But it is such a sorrow to let him go – his eagerness was so contagious. I must remember my prescriptive roles and make sure I do not feel responsible for him. Challenging...
Aims and harvest of moral case deliberation

Abstract
Deliberative ways of dealing with ethical issues in healthcare are expanding. Moral case deliberation (MCD) is an example, providing group-wise, structured reflection on dilemmas from practice. Although MCD is well described in literature, aims and results of MCD sessions are unknown. This study shows: 1) why managers introduce MCD; and 2) what MCD participants experience as MCD’s outcomes (‘harvest’).

A responsive evaluation was conducted, explicating MCD experiences by analyzing aims (N=78) and harvest (N=255). A naturalistic data-collection included interviews with managers and evaluation questionnaires of MCD-participants (nurses).

Findings note that for managers and participants, MCD appeals to cooperation, team bonding, a critical attitude towards routines and nurses’ empowerment. Differences are: managers aim to foster identity of the nursing profession, while nurses emphasize on learning processes and understanding perspectives.

We conclude that MCD influences team-cooperation that cannot be controlled with traditional management tools, but requires time and dialogue. Exchanging aims and harvest between manager and team could result in co-creating (moral) practice in which improvements for daily cooperation result from bringing together perspectives of managers and team members.

Keywords
Introduction
Healthcare practice comes with moral challenges. Internationally the awareness of the ethical dimension of healthcare is increasing and over the past years moral dilemmas in healthcare have become more prominent in international publications (Dubois et al., 2011; Walazek, 2009; Pauly et al., 2009; Schluter et al., 2008; McLean, 2007; Edwards and Street, 2007; Slettebo and Haugen Bunch, 2004). In response to this, various clinical ethics support activities have been developed, such as clinical ethics consultation teams or ethics consultants (Slowther et al., 2001; Boisaubin and Carter, 1999). In Dutch healthcare, moral case deliberation (MCD) is a widely used form of clinical ethics support. MCD aims to foster the active involvement of professional healthcare workers in reflection on moral issues from their own practice. MCD is expanding in Dutch healthcare institutions (Van der Dam et al., 2011; Dauwerse et al., 2011).

Based on practical experiences and theoretical views, professionals involved in organizing MCD are convinced that MCD is valuable. Yet it is unknown which goals are aimed for and which effects are reached (Molewijk et al., 2008). In the literature, a surplus value of clinical ethics for (patient centred) care is suggested (McClimans et al., 2011; Gelhaus, 2011). Empirical research on why MCD is used and how the results are perceived by participants themselves, is rare (Molewijk et al., 2008). Studying these aspects of MCD practice can increase understanding of why MCD is initiated and what MCD means for its participants. In this study, which is a part of a larger PhD research concerning the implementation of MCD in psychiatry, the following research questions have been addressed: What aims are mentioned by managers introducing MCD in their team? What outcomes of MCD are experienced by the participants of the sessions? How are aims (of managers) and outcomes (as experienced by professionals) related?

Moral case deliberation
In MCD sessions, a group of healthcare professionals comes together to deliberate on concrete moral cases from their work, taking actual experiences as the starting point of dialogue (Bolten, 2003 -pp.14-56). MCD is a practice in which group-wise reflection is facilitated by a specifically trained conversation facilitator. Following a structured conversation method, this facilitator is non-directive in relation to the content of the session. The group starts an inquiry searching for moral issues within the presented case. Focussing on a single moral question, participants are stimulated to postpone their judgement. Whilst asking questions to the case owner, moral dimensions are being explored. The aim of MCD is to enable participants to express
and reflect on personal, moral considerations (Irvine et al., 2004; Gracia, 2003).

MCD not only addresses the content of the case at hand, but also aims at a dialogue between participants, and fosters listening to one another and reaching mutual understanding. Content and process are – although not always explicitly - under equal attention (Boers, 2003 - pp.79-96; Guinlock, 1978).

MCD is rooted in pragmatic hermeneutics and in dialogical ethics (Widdershoven and Molewijk, 2010; Widdershoven et al., 2009). From these theoretical perspectives, the means and outcome of a session is a dialogue among the participants. Habermas’ theory of communicative action is a leading concept featuring reciprocity and reasoning through arguments brought up by each participant, resulting in common understanding and a cooperative process (Habermas, 1984 pp. 85–101). The deliberative process aims at the realization of a learning environment in which co-learning is facilitated by the confrontation of different viewpoints (Gracia, 2003: Farrell et al., 2001; Bohm, 1996).

Research context
This study was done in a large mental healthcare institution in the eastern part of the Netherlands, called GGNet. This institution is prominent in the field of MCD practice in Dutch healthcare. At GGNet, over 240 MCD sessions are facilitated each year, covering 40 different teams of professionals throughout the entire organization (including caretakers, staff services, gardeners, spiritual counsellors and board of directors). While practice is developing, empirical research on implementation of MCD is conducted alongside, providing insight into the process of understanding how MCD evolves (and expands).

In GGNet, MCD sessions have been organized since 2004. At the start, MCD was part of a project on the reduction of coercion and restraint, allowing teams involved to reflect on moral aspects of coercion. By the time the project ended, the teams decided to continue their sessions on an ongoing basis. As time passed, initiatives for MCD expanded throughout the organization. The initiatives are demand-driven; teams are not obliged to organize MCD. Requests generally come from managers. MCD’s can be facilitated once only, for a number of sessions, or in ongoing groups. The coordination and quality of the sessions is facilitated and monitored by the GGNet MCD steering group, consisting of 5 professionals coming from various segments of the organization. This group furthermore provides in-company trainings for future MCD conversation facilitators. The MCD steering group is embedded in the GGNet Expertise Centre / Mental Healthcare Academy (ggz-academie).
Methodology

Responsive Evaluation design To monitor the process and outcome MCD, a responsive process evaluation was conducted. This design is driven by the same democratic, participative and dialogical values as MCD (Abma et al., 2009; Widdershoven and Abma, 2003). Using a responsive evaluation strategy, active inclusion of an optimum of stakeholders is obtained, thereby meeting democratic, dialogic and participative principles simultaneously. In responsive evaluation the issues (expectations, concerns, controversies) of all stakeholders are investigated in order to obtain a rich understanding of the evaluated practice from insiders’ perspectives (Stake, 2004/1975). Responsive evaluation insistently includes the voices of all stakeholders in the evaluated process (cf. Guba and Lincoln’s Fourth Generation Evaluation; Abma, 2005; Guba and Lincoln, 1989), not only as information givers, but also as advisors and partners (Greene, 1988). By systematically facilitating a dialogue among stakeholder groups, exploration into meaningful issues is encouraged. Evaluation activities aim at several purposes simultaneously, such as collecting empirical data and facilitating mutual learning amongst stakeholders during these conversations (Greene, 2001; Schwandt, 2001). In this process, the researcher functions as a facilitator, co-generating data together with the other stakeholders involved and facilitating co-learning, cooperation and participation.

Following a responsive methodology, the research design develops in conversation with the stakeholders, and focuses on moral competences such as learning from other perspectives and postponing personal judgements. Like MCD, responsive evaluation is in line with the principles of hermeneutic ethics using dialogue as the main vehicle (Abma and Widdershoven, 2006; Luders, 2004).

Practice improvement by research interventions In responsive evaluation, the actual ‘users’ of MCD get a voice. This study therefore provides insight in perspectives and experiences from practice, not from an ethics expert. A responsive evaluation researcher is not operating as an outside expert, but learns through the issues brought up by respondents themselves (Hensen, 2011). Research steps and findings inspire in turn practice to improve work where appropriate, constructing a cyclical, co-created practice. In this way, a responsive evaluation design encourages practitioners to actively contribute to the improvement of their daily practice.

In terms of generalization, results of a responsive evaluative research can be typified as particular, unique and meaningful issues coming from the stakeholders themselves, functioning as learning material for comparable practices (naturalistic generalization: Meyers, 2000; Denzin and Lincoln, 1994). Publications invite
the reader to derive similarities with his/her own practice, so that the described experiences can support practice improvements in ethics support initiatives in other contexts.

**Data collection procedures** The data collection for this article was conducted following a naturalistic data collection procedure (Lincoln et al., 2011 pp. 97-128). The data used for this particular research were originally collected for quality procedures within the GGNet MCD steering group. As part of the regular organizational procedures for MCD requests, every manager who requested for MCD in his team was invited for an introductory interview before the sessions in the allotted team commenced. In these interviews, practicalities, motivations and aims for MCD were listed and put into an agreement. For the introductory interviews a topic list of relevant items was created. This topic list was based on former (informal) conversations and interviews, internal reports and literature. In the years 2008 – 2010, a total of 35 interviews were held. After every interview, information was validated, checked, and if necessary revised by the manager. Every manager was explicitly asked for permission to use the (anonymous) information as data for research on the implementation of MCD.

The MCD steering group evaluated every MCD session on an ongoing basis, organization wide. Between August 2008 and April 2011, immediately after any MCD session, participants of MCD anonymously filled out a total of 1,067 evaluation questionnaires. This one-paged questionnaire consisted of 11 items (5- or 10-points scales, in 2 items combined with open questions) based on (informal and formal) interviews, focus groups and former questionnaires. Closed questions concerned the overall qualification of the session, the quality of conversation facilitator, the atmosphere, the relevance of the moral issue and the transferability of the results to daily practice. In the analysis of this study, we focussed on the answers to the open question ‘What changes would you apply to your practice after this session?’ As answers to this question refer to experienced change during the process of participation in MCD, rather than to preconceived outcomes, we preferred using the term ‘harvest’ in stead of ‘results’. Filling out evaluation questionnaires was a regular procedure for evaluating the quality of the MCD sessions within the organization. Participants were informed that the anonymous questionnaires might be used as data for further research on the implementation of MCD.

For this study, we used data from seven out of the forty MCD-active teams. The selection of teams was based on comparability: in all cases 1) the initiative to do MCD came from the manager; 2) the manager himself was not participating in the sessions;
3) the team had had MCD sessions for two years, in more or less the same frequency; 4) the participating professionals were exclusively nurses. Although responsive evaluation does not focus on direct generalization and therefore comparability is not a must, comparability in selected teams ensured approximately the same level of organization and experience.

**Analysis of the data** During the introductory interviews, the managers of the 7 selected teams formulated 20 main aims and 58 sub aims for the MCD sessions. So in total, 78 aims from the managers were included in this research (N=78). In the selected teams, we collected a total of 275 evaluation questionnaires. We excluded those questionnaires in which no qualitative answers were filled out, leaving a total of 255 responds to the open question ‘What changes would you apply to your practice after this session?’ The analyzing process consisted of three steps. First, every aim from the introductory interviews (managers) and every qualitative response on the evaluation questionnaires (participants) was characterized. Second, for managers and participants separately, characteristics which appeared closely connected were put together into sub-categories (38 sub categories). Step I and II were repeated independently by the second author. Third, the subcategories were clustered into a total of nine main categories (see table I). By using global titles for these main categories, we created structure in the data, without losing sight of the details shown by the sub categories. Throughout this analyzing process, all authors were consistently included in the content validation of the categorization.

**Validation procedures** The principle of triangulation was applied (Maxwel, 1998), using several sources of data and several methods of data collection. The analysis was supervised by two senior researchers from the university, and the head of the GGNet expertise centre. First, findings were compared with outcomes of a previously organized focus group among local MCD coordinators (nurses who are responsible for the daily organization of the MCD sessions in their own team; Weidema et al., 2012). The categorization of both aims and harvest (steps II and III) was repeated independently by the second author. Differences in insights were discussed between the first two authors, resulting in adjustments in categories. This procedure was repeated three times to check congruence and look for biases in the data interpretation. The fourth author monitored every step and participated in discussions about re-categorization, the third author commented on the pre-final version. Throughout the analysis, notes were made in a logbook by the principal...
researcher in order to make the process transparent and retraceable. Finally, in order to optimize internal validity, a member check regarding the analysis of the data was done amongst the stakeholders involved. In doing so, possible hiatus, blind spots or incorrect interpretations were adjusted. Participants in this study agreed voluntarily to use their input as data for scientific research. No information concerning names, locations or demographic identification was mentioned to guarantee confidentiality and anonymity.

**Limitations of the study** The data for this study came from ongoing quality procedures for practice improvement. For this study, we focused on the specific topic of transferability of an MCD session to practice. Using a naturalistic data collection procedure resulted in data that was written down in an experiential language referring to the direct experience of MCD in practice. We consider this a strength of this study.

The question at the evaluation questionnaire we used for our analysis was: ‘What changes would you apply to your practice after this session?’ (inviting a qualitative reply). The question suggests that participants should have learned something. This is taken as a limitation of our study, as the formulation of the question may have induced a positive outlook in the responds about the harvest of the MCD session.

**Findings**
In this section, the aims for MCD (managers) and MCD’s harvest (participants) is systematically presented. First, we will present the categories found among the aims of the managers. Second, we will present the categories found among the harvest of participants of MCD. Six categories were found in both aims and harvest, two categories are relevant for aims only, and three for harvest only. Consequently, in the third paragraph, congruencies and incongruencies between the categories are presented. Although this is a qualitative study, at points a descriptive comparison on the frequency of categories will be made in order to clarify differences and similarities. Names and locations have been removed for reasons of anonymity.
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Aims of moral case deliberation mentioned by managers
Managers formulate various aims they envisage with the introduction of MCD. Being aims for an instrument that is introduced in a team in order to accomplish something, managers focus on the outcomes they expect from MCD. Therefore, all aims are formulated in terms of ‘should’.

Developing a critical attitude towards practice  The most prominent category among aims for MCD, mentioned by managers, is the development of an attitude of asking critical questions, of curiosity and self-reflection. Often, routines in practice are a reason for starting MCD sessions in the first place. Managers expect that MCD will help to increase awareness of the complexity of the nursing practice. Reflection sessions should result in a deeper understanding of daily practice, rather than working from routines and on the bases of ad hoc gut feelings. According to many managers, MCD should lead to thorough thinking, evaluation and ongoing awareness of what is good care in a specific case.

‘Nurses work in terms of crisis-action-reaction-dispel: quick, short, and accurate. After that, the door is closed. No evaluation, no reflection on alternatives. This short-term attitude should change by introducing MCD’

‘By doing MCD, team members should learn to no longer state ‘this is how we always do it’ as a sufficient motive for good care’

‘Nurses should learn to discover presuppositions, and put these presuppositions under inquiry’

Cooperation  The second largest category of aims among managers for introducing MCD is to nourish cooperation within the nursing team as well as in the multidisciplinary team. Managers perceive the introduction of MCD as a way of refreshing and stimulating mutual consultation and actively discussing (potential) tricky situations, rather than acting from individual considerations only. This consultation should provide professional growth by consulting colleagues on expertise or experience in- and outside the sessions. Also, by facilitating MCD, a (re)connection either with fellow team members, or with the organization as a whole, is aspired to.

‘MCD should open up a climate in which nurses consult each other for advice on
cases in practice, also outside the MCD sessions’

‘Our nursing team is disintegrated. MCD should contribute to overcome this situation by rediscovering team-unity and focus and start working in the same direction’

‘Team members should learn to ask each other questions, rather than having an attitude of “I’ve been there, seen that, so I know what to do”’

Exploring policy, paradigms and vision Third, the implementation of a new paradigm on care, or new instruments for practice, is mentioned as a reason for introducing MCD. In the process of shifting from an old to a new way of working, managers consider MCD a suitable instrument to help professionals to detach from former working routines. Here, MCD is thought to function as a vehicle to explore new views on care by evaluating casuistry, and to establish an unequivocal vision among the team members.

‘Team members should no longer consider ‘control’ as the aim of their efforts. MCD should contribute to the humanization of our care’

‘MCD should open up and fill in hiatus in our vision on care’

‘By reflecting on casuistry, employees may start recognizing and adopt the new Illness Management Recovery-vision1 in their practice’

Care and inspiration for the nursing job Managers consider MCD as an occasion for rediscovering inspiration and motivation. Some managers explicitly formulate aims concerning care for employees or facilitating attention for day-to-day troublesome situations by providing MCD. It may provide acknowledgement of the heaviness of the job and appreciation for their work.

‘A series of MCD sessions should contribute to help nurses rediscovering the inner motivation for their job’

‘MCD facilitates care and attention for the team members’

‘Through MCD, colleagues may learn to address each others’ talents’
Empowerment and enhancement

Pride and emancipation of the nursing profession is also a motivation for introducing MCD in the team. Managers regard MCD as an intervention to reinforce the value of the profession and to improve the way in which nurses relate to other professionals. Also, awareness of the authentic, specific expertise of nurses is mentioned in this category. MCD in this respect functions as an instrument for recognition and increasing awareness of the uniqueness of the profession.

‘MCD should help nurses to pronounce the uniqueness of the nursing profession within the multidisciplinary team’

‘By doing MCD, the nursing team should become more powerful and strengthened from the inside’

‘MCD should inspire the members of the nursing team to have the courage to be vulnerable, without loosing their strength’

Transparency and straightforwardness

Managers also aim at increasing transparency and better communication among nurses within the (multidisciplinary) team. In such cases, MCD is introduced not primarily because of concrete moral topics, but in order to bring team members together to actually deliberate on their practice. Managers wish to see that MCD increases a climate of open, critical and positive feedback. This may be stimulated by the MCD method of plain communication and transparency.

‘I wish to see a continuation and improvement of both critical and positive feedback among team members’

‘Team members should come to understand by practicing MCD to be straightforward, rather than primarily express empathy or understanding’

Quality of care

A further reason for introducing MCD is to improve the quality of care on a daily basis. This may result from thorough reflection on challenging casuistry, leading to an exploration of the concept of ‘good care’. In particular, managers wish their teams to operate as advocates of their clients.
‘MCD should convince team members to contribute to multidisciplinary meetings by proceeding as advocates of their clients’

‘By MCD an open conversation concerning the question ‘what is good care in our practice, and can we define limitations of our care?’ should be facilitated’

**Innovation**

A final category among aims of managers is to foster innovation, related to the identity of the nursing profession. Managers wish to stimulate innovative ideas in the nursing profession in order to uplift their unique perspective on the client population. Managers tend to see MCD as a vehicle to stimulate new, fresh and profession-related insights and put them into action.

‘In MCD new, creative, nurse-related ideas should pop up’

‘Nurses should become inspired to come up with fresh ideas related to the identity of the nursing profession’

**Harvest of moral case deliberation perceived by participants**

After every MCD session, participants report what they learned for their practice. Because of its process-oriented character, we choose to speak of ‘harvest’ rather than ‘outcomes’: the harvest of an MCD session comes to the fore in the process, rather than reflecting a preconceived list of outcomes.

**Cooperation**

According to participants, MCD is primarily experienced as a learning experience on cooperation involving (re-)finding mutual support and consultation. Participating in MCD helps nurses to become aware that they are not alone in the difficult practice of mental healthcare. MCD appeals to a sense of togetherness in two ways: it inspires to ask for support and helps to see that a colleague might need support. Participants state MCD stimulates them to ask for each others’ advice and expertise and to explicitly experience they are not alone in their practice.

‘I learned I should not face difficult situations on my own without notifying and involving my colleagues’

‘Many times I felt alone in a certain opinion or matter, but the MCD sessions showed me this is not the case! I really appreciate getting this insight’
**Developing a critical attitude towards practice**  
Second, participants say they have become aware of the need for critical reflection. MCD leads to a shift from immediate action to thinking a situation through first (or reflecting upon it afterwards). By doing MCD they realise that routines prevent them from questioning or exchanging views on their practice. Through MCD, they experience that the complexity of their work requires reflection on difficult situations. Notes on the evaluation questionnaires also reflect an increasing awareness of personal involvement in professional work. Finally, reactions from the participants show sensitivity towards moral dimensions in their work. By this, routines can be detected, and put to test.

‘I became more aware of my personal attitude, values and norms’

‘Paying attention to the other side of our work: what does the client want and is it always right what we, as professionals, think best?’

‘I learned to more often verify facts and feelings in my job’

**Empowerment and enhancement**  
Nurses participating in MCD report an increase in empowerment on an individual level, as MCD provides growing assertiveness towards other disciplines. They formulate concrete intentions for new behaviour (i.e. being more straightforward, or more vigorous), appealing to an emancipative awareness and appreciation of their profession. In MCD, they learn to stand up as a nurse. To some extent, MCD also functions as an exercise for preparing a challenging talk with other disciplines.

‘After this session I can explain and motivate my perspective on the case at hand, and I feel able to express this to others. This makes me feel stronger’

‘I now feel more vigorous in how to solve this particular situation’

‘By doing MCD, I feel stronger in my contacts with other disciplines’

**Understanding**  
Participants report having become aware of different perspectives on a case, resulting in a broader vision on daily situations. Insight and understanding is expanded through confrontation with other perspectives. For nurses, MCD systematically introduces new perspectives and stimulates mutual understand-
ing. Insights from other participants or awareness of other viewpoints bring nuance to personal convictions. When a decision is unravelled during an MCD session, understanding for this decision increases.

‘I now have more understanding for the decision that was made’

‘I experience a little more understanding for all the separate responsibilities and visions’

‘I understand now that everybody takes another position in this situation’

Boundaries, limitations and self-care  Participants explicitly note in the evaluation questionnaires that they experience the latent need for moments of a stand still and reflection. Apparently they realise, by being facilitated in reflection, they need time for (joint) consideration of the challenges in their work to do their work properly, and to do it together. Praxis of MCD itself reveals the need for this opportunity, rather than noticing this need a-priori. In other words: participants discover their desire for reflecting on practice while actually undergoing the experience.

A specific and recurring subject on the questionnaires regards personal or professional boundaries in care-providing. Insights concerning personal involvement versus professionalism are mentioned many times. Respondents say they gain insight into their personal feelings of responsibility towards their clients, and are able to set new limits to this responsibility. In the experience of participants, MCD supports to find and justify boundaries on a personal (rather than solemnly professional) level. Here a discharge from feelings of responsibility can be discovered, preventing them from being (potentially) over-involved.

‘I should stop feeling responsible for my colleagues’ working schedule’

‘I learned to be more alert in terms of: whose problem is this actually? All I need (or have) to do is to do whatever possibly I can as a professional’

‘Next time I will refer family members to the medical attendant who is responsible’

‘I realise I need to question in my daily routines more often where to put limits to my responsibilities for a client’
**Transparency and straightforwardness** Participants formulate intentions concerning transparency and straightforwardness to colleagues, other disciplines, clients and/or family members. This includes showing vulnerability or being honest about not knowing, having doubts, being angry and so on. Transparency implies being open about what you can or cannot do. MCD motivates participants to be open about those aspects, and have the courage for straightforward and transparent communication about issues that can be precarious.

‘I believe we should increase our mutual openness and straightforwardness towards each other’

‘From now on I will try to address all colleagues honestly, even those who sometimes make me feel unsafe’

‘I intend to avoid conflicts. In the session I came to see that conflicts sometimes may be inevitable to get communication starting in the first place’

**No harvest** Confronted with the evaluative question ‘What changes would you apply to your practice after this session?’ a number of participants noted ‘no changes’. Due to the questionnaires’ anonymity, we could not identify the individuals who noted this down for further explanation. The word ‘no changes’ could have various meanings. Varying from a critical one (e.g. ‘I learned nothing, this MCD session was not useful’), to a neutral one (e.g. ‘it was a good MCD session but there are not specific lessons in my head right now’), to indifference (e.g. ‘I am not in the mood to think about this further’) or unawareness (‘I have really no idea’). In order to try to better understand this specific category, we checked the extensive annual evaluation questionnaires from the included teams (N=76) on which the usefulness of MCD for practice was questioned quantitatively. Seven participants noted a score referring to MCD as ‘neutral impact’ to ‘useless’ for practice. 69 participants scored ‘useful’ to ‘very useful’ for practice. Unfortunately, however, based on these quantitative findings, we cannot fully comprehend what ‘no harvest’ implies (compare Svantesson et al., 2008).

**Quality of care** Some participants explicitly noted they learnt in MCD how to improve quality of care. They formulate concrete intentions for practice improvement,
which generally concern a decrease in paternalistic attitude: a more prominent role for the client and a less prominent role for the (wishes of the) nurse. Also, participants noted that the intensified communication during MCD can be expected to contribute to an improvement of care.

‘I should think more from the perspective of the client and ask the client more questions’

‘The clarity we gain during the session supports the improvement of care for our patients’

‘From now on I will try to clarify things more for family members of our clients’

Exploring policy, paradigms and vision

The final category refers to uniformity in treatment policy and the approach of clients and situations in practice. Participants note that doing MCD reveals the lack of, and the desire for being unequivocal as a (multidisciplinary) team. Nurses urge for clarity on agreements in policy and among team members as well as among the separate disciplines, to be able to ‘speak as one’. In doing MCD, participants hear about the differences in approach within the team. This is inspiring on the one hand, yet raises the need for clarity and operating unequivocally on the other hand:

‘We need clarification between disciplines to realize better care’

‘MCD taught me that we need to make clearer policy arrangements’

‘I came to realise we should discuss casuistry more often in the team in order to be in line with each other’

Comparing aims and harvest

In the earlier sections, we presented aims and harvest of MCD. Aims show managers’ expectations of MCD in general. Harvest was noted right after the sessions and is therefore directly related to the experience of deliberation. As the overlap (see Table 1) shows, aims and harvest refer to comparable issues. Both managers and participants feel MCD appeals to mutual support and consultation; improves communication, quality of care and connection; stimulates critical reflection and brings assertiveness
or emancipation to the nursing profession.

For several categories, managers and nurses use more or less similar wordings. Yet differences can be noticed. ‘Quality of care’ in managers’ aims for example, stands for the improvement of care by standing up for clients in multidisciplinary meetings, whereas participants interpret quality of care as stepping back as a professional and allowing the client to be more upfront during direct client contact. ‘Care and inspiration to the nursing job’ in the eyes of the managers refers to the ability of rediscovering motivation for the job. Participants also note aspects of care in practicing MCD, yet they refer to the ability to set boundaries and share responsibilities. Many managers note the lack of mutual consultation as a motivation to introduce MCD, while participants appreciate the experience of being supported by their fellow workers in sharing and exploring practice.

Our findings also show more prominent differences between aims and harvest. First, participants appreciate getting to know more perspectives on a case. This is not mentioned in the aims of the managers. Second, managers aim for new inspiration, emanating the identity of the nursing profession. Participants do not refer to this. Third, a large category among aims concerns the implementation of new care insights and streamlining policy regarding treatment of patients. Participants also refer to the need to speak in one voice in direct patient approach, but this category is relatively less often reported in the answers of the participants than in the answers of the managers. However, participants emphasize the issue of empowerment more. Managers do refer to this issue also, but they report the subject relatively less frequently.

Discussion

Considering our findings, three issues stand out: (a) MCD’s appeal to process and dialogue; (b) few aims and harvest on quality of care and (c) MCD as a dialogical management practice. First, aims as well as harvest relate primarily to the process of deliberation, rather than to the content of the MCD sessions. The methodological and process-oriented features of MCD are clearly represented in both aims and harvest. Rather than focusing on solving ethical issues, both aims and harvest refer to exploring ‘good cooperation’ (Bokhour, 2006) by critical feedback, awareness and dialogical virtues such as asking questions, postponing judgements and generating curiosity. These are formulated in terms of dialogue, based on mutual equality, openness and cooperation (Van den Elshout, 2003; Greene, 2001; Walker, 1993). MCD provides a multilevel approach to dialogue: while deliberating on a concrete case from practice (content), participants simultaneously reflect on how the team communicates about the case (process). Participants directly learn how to cooperate and learn from each
others’ input (Baxter and Montgomery, 1996 -pp.239). They value the experience of working together within the framework of MCD. As a consequence, participants express intentions and concrete plans in order to prolong the positive experience during their regular work processes. Apparently, MCD is perceived as a way to strengthen the sense of a shared, multi-responsible practice. This is in line with dialogical ethics, according to which ethical issues are not solved by individual moral reasoning, but by joint deliberation and cooperation (Widdershoven and Molewijk, 2010; Irvine et al., 2004; Parker, 2001).

Second, aims and harvest show a relatively low number of outcomes related to quality of care (e.g. reduction of coercion, better listening to patients, etc). In harvest from participants, this could be due to the fact that the open question in our evaluation questionnaire refers to the experience of the deliberation session, rather than to the outcomes. Ethicists often use care improvement as an argument for introducing clinical ethics in general, and MCD in particular (Gelhaus, 2011; Hermsen and Ten Have, 2005; Irvine et al., 2002). Therefore, we expected to find more aims from managers referring to the improvement of care. We were surprised to find relatively few aims on this category. Considering our findings, aims and harvest suggest that MCD creates an atmosphere that is preconditional for the improvement of care in terms of mutual collaboration, the development of a critical attitude and breaking outdated habits. Further research nevertheless is needed to establish the impact of ethical reflection and moral deliberation on direct patient care (Den Besten et al., 2011). In such research, one should be aware of the distinction between MCDs’ utility on the one hand, and its value on the other. MCD might be valuable without concrete evidence on the level of patient care. This study shows that the value of MCD might lie primarily in fostering cooperation, not in directly influencing patient care.

Finally, the results have consequences for the way in which managers see the management process in general. Aims and harvest refer to processes which elude the traditional linear from A to B approach based on Demings’ quality cycle of plan-do-check-act (Walton, 1986). As such, MCD is not an A to B intervention; it does not fit into an input-output model, since its substantial output (i.e. in relation to the topic that is being reflected upon) cannot be predefined. Rather, it requires dialogical ways of management and an active partnership in the process of constructive cooperation-processes (Gumus et al., 2011; Morgan, 1992 pp.61-63).

Conclusion
Aims of managers who want to implement MCD in their teams, and harvest reported by nurses participating in MCD sessions show similarities. Both managers and par-
Participants report that MCD is related to mutual support and consultation; improves communication, quality of care and connection; stimulates critical reflection and brings assertiveness or emancipation to the nursing profession. Yet aims and harvest are also different. Aims are formulated in general terms, whereas harvest is concrete and related to experience – referring to a process-oriented, non-regulative character of the outcomes of a session. Managers aim to foster the identity of the nursing profession, whereas nurses report the importance of learning processes and getting to know more perspectives on a case. Managers stress the need for developing a critical attitude to routines, while participants note that they come to find the relief of sharing practice experiences. Managers describe improvement of care as advocacy of nurses for their clients during multidisciplinary meetings; participants say improvement of care is putting the patient more upfront during direct client contact.

Togetherness is a recurring issue in aims as well as harvest, expressing the eagerness and/or necessity to intensify cooperation and team bonding. Managers and nurses share the view that MCD provides a platform for exchanging ideas of and visions on day-to-day matters, in which participants can formulate their intentions and responsibilities in changing their working environment and practice. MCD enables the participants to communicate on various levels, addressing both care issues (content level) and cooperation issues (process level). Addressing congruencies and incongruencies between aims and harvest in the process of MCD, may provide a basis for co-creating a moral practice, motivating both managers and participants to develop a joint view on the meaning and value of MCD for daily healthcare practice.

Acknowledgements

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References


Client participation in moral case deliberation

A precarious relational balance

Abstract
Moral case deliberation (MCD) is a form of clinical ethics support (CES) in which the ethicist as facilitator aims at supporting professionals with a structured moral inquiry into the professionals´ own moral issues from practice. Cases often affect clients, however their inclusion in moral case deliberation is not common. Client participation raises questions concerning conditions for equal collaboration and good dialogue. Despite these questions, there is little empirical research regarding client participation in clinical ethics support in general and in MCD in particular.

This article aims at describing the experiences and processes of two MCD groups with client participation in a mental healthcare institution. A responsive evaluation was conducted examining stakeholders’ issues concerning client participation. Findings demonstrate that participation initially creates uneasiness. As routine builds up and client participants meet certain criteria, both clients and professionals start thinking beyond ‘us-them’ distinctions, and become more equal partners. Still, sentiments of distrust and feelings of not being safe may reoccur. Client participation in MCD thus requires a continuous reflection and alertness on relational dynamics and the quality of and conditions for dialogue. Participation puts the essentials of MCD (i.e. dialogue) to the test. Yet, the method and features of MCD offer an appropriate platform to introduce client participation in healthcare institutions.

Key words
Moral case deliberation – client participation – dialogue – inclusion – organization
Introduction
Internationally, interest in the active involvement of clients in daily healthcare practice is increasing. Research focuses on how and why to involve clients in practice and what surplus value can be found in their active participation (Agich, 1991; Schicktanz et al., 2008). Recent European publications articulate participation of clients in Clinical Ethics Consultation meetings (CECs), in which a specific case concerning a specific client is at stake. The client in the case at hand can either be involved in the deliberation process, or be absent (Fournier et al., 2009; Newson, 2009; Neitzke, 2009; Rari and Fournier, 2009; Førde and Hansen, 2009). Including client perspectives in moral decision making is motivated by ethical and political considerations (e.g. client autonomy, shared responsibility in decision-making, re-equilibration of the doctor-client relationship, empowerment) (Rari and Fournier, 2009; Fournier et al., 2009).

In the Netherlands, initiatives concerning moral reflection on the shop floor by healthcare professionals themselves are increasing (Weidema et al., 2011; Dauwerse et al., 2011). Moral case deliberation (MCD) is a particular example of such an initiative, differing from approaches such as ethics committees or ethics consultation (Aulisio, 2003). Within an MCD, a multidisciplinary group of healthcare professionals meets to deliberate systematically on a moral case from their own practice. The meetings are facilitated by a specifically trained MCD facilitator following a structured conversation method. The aim of an MCD session is to create a dialogue in which various perspectives on a case are presented and brought into dialogue (Van der Dam et al., 2010). Participants are challenged to explore both their thinking and the issues within the case in order to create a mutual learning process by the confrontation of perspectives (Bohm, 1996). An MCD session does not transcend practice, but systematically explores facts and values that are at stake in a case. MCD is radically concrete, focusing on the actual experiences and reasoning of participants (Gadamer, 1960; Irvine et al., 2004; Widdershoven et al., 2009).

Dialogue is seen both as a means and an outcome of an MCD session (Schwandt, 2001; Molewijk et al., 2008a; Greene, 2001; Abma et al., 2009a). To accomplish this, an attitude that fosters dialogical dynamics is required. Regulative conditions for this attitude are: equal participation and appreciation of mutual differences. These conditions support constructive relational dynamics. A dialectical process – the conversational space – opens up to the content of the session, aiming at creating a learning environment by exploring differences. In this way, experiential knowledge is constructed amongst participants (Kolb et al., 2002). Those involved in the organization of MCD sessions note these constitutional and regulative rules as essentials distinguishing MCD from other meetings in healthcare practice (Weidema et al., 2011).
Recently, clients are actively involved in MCD sessions in a number of Dutch healthcare institutions. Healthcare professionals as well as client participants are invited to bring in cases for deliberation. In such cooperation between professionals and clients (transdisciplinary groups), tensions due to differences in position, interests, language and communication style may arise (Holmesland et al., 2010). This paper discusses examples of client participation in two different MCD groups in psychiatry. Rather than arguing that clients should be involved in clinical ethics support activities, this paper explores the actual experiences of client participation in MCD, giving a voice to all stakeholders involved. In doing so, this empirical research is a way of contributing to the theme of client participation and working in transdisciplinary groups in clinical ethics.

Data presented are part of a larger study on the implementation of MCD. In this paper we aim at answering the question: What are actual experiences with client participation in MCD and how does client participation affect dialogical and relational dynamics?

Method
Setting GGNet is a large mental healthcare institution in the east of the Netherlands. MCD was introduced in 2004 as part of a project on ‘Reduction of Coercion and Restraint’. The GGNet Expertise Centre fosters an MCD steering group that monitors quality and development of the MCD activities organization wide (Molewijk et al., 2008b). By now, halfway 2010, MCD is a familiar concept within GGNet. Over forty groups have MCD sessions either in ongoing groups, within the context of a series of MCD’s, or incidentally in the case of a specific dilemma. Halfway 2008, seven out of these forty groups introduced client participation. Clients active in MCD sessions are either members of the client council, patient experts or, incidentally, clinically admitted clients. As part of a 3 year study on the implementation of MCD data were collected over the years 2008 – 2010. This paper is based on these data.

Theory and design To monitor the process of client participation in MCD, a responsive process evaluation was chosen as design. This design is driven by the same democratic, participative and dialogical values as MCD itself (Widdershoven et al., 2009; Abma et al., 2009a). Using a responsive evaluation strategy, active inclusion of an optimum of all stakeholders is obtained, thereby meeting democratic, dialogic and participative principles simultaneously (Widdershoven et al., 2009). In responsive evaluation the issues (expectations, concerns, controversies) of all stakeholders
are investigated to obtain a rich understanding of the evaluated practice from insiders’ perspectives (Stake, 1975/2004). Responsive evaluation (compare Guba and Lincoln’s Fourth Generation Evaluation, 1989) insistently includes the voices of all stakeholders in the evaluated process; not only as information givers, but also as advisors and partners (Greene, 1988). Its aim is to enhance the mutual understanding between stakeholder groups as a vehicle for practice improvement. The process is cyclical: stakeholder issues are first gathered and discussed among groups with converging interests (homogeneous groups), and later used as input for hermeneutic dialogues between groups with diverging interests (heterogeneous groups). These dialogues do not aim at generating consensus per se, but at collecting meaningful issues that are relevant for the stakeholders themselves. Also the meetings aim at facilitating mutual learning by responding to the various perspectives presented during the sessions (Greene, 2001; Abma, 2006).

**Data collection**  The data collection was iterative and cyclical; input from former stages provided input for later stages (Paulus et al., 2008). First, informal conversations were held with representatives from all stakeholder groups: (client) participants, local coordinators (nurses responsible for the daily organizational aspects of the MCD sessions, and functioning as intermediary between team, manager, conversation facilitator and the MCD steering group of the expertise centre), managers, MCD facilitators and members of the institutional MCD steering group. The topics emerging in these conversations were used as input for semi-structured interviews in the next stage and incorporated in evaluation forms which were filled out by all participants at the end of every single MCD session.

Next, 15 semi-structured interviews were held; five local coordinators, five MCD facilitators and five managers were interviewed. The interviews lasted about 1.5 hours, were tape-recorded with consent, and fully transcribed. When no new issues were found, this phase was ended (principle of saturation; Charmaz, 2000). Based on these interviews another, refined topic list was created. This was used for a focus group with five (out of eleven) local coordinators and a focus group amongst the four client participants involved in MCD sessions. On request of the local coordinators, a heterogeneous group specifically dealing with the issue on client participation, amongst them three local coordinators (out of eleven) and four MCD facilitators (out of six), took place. The focus groups and heterogeneous group were moderated by the researcher (FW) and the program leader of the institutional MCD steering group (BM). The sessions were tape-recorded and entirely transcribed. Three (audio-taped) oral evaluations, held in every MCD group once a year, were also included in the data.
Furthermore, extended evaluation questionnaires taken amongst all MCD participants once every year, were used. These extended forms were also filled out by client participants, MCD facilitators and local coordinators. Also, e-mail contacts with stakeholders involved in the process of MCD sessions concerning the subject of client participation were taken into account within the analysis.

**Limitations of the study**

Throughout the data collection process, the largest body of data came from professionals in the MCD sessions. We collected less data among client participants in proportion to the data from professionals.

**Data analysis**

The data analysis was done inductively, allowing themes to pop up by studying the data closely. In order to approach the data and the practice in an open-minded way, no theory was applied to the analysis of the data on beforehand (compare grounded theory; Charmaz, 2000). The analysis was conducted following two lines: first, in the inductive phase both positive and negative aspects of client participation mentioned by stakeholders were assembled and clustered. It appeared that quotes from the groups on client participation referred to fundamental values within the MCD dialogue (such as: equality of voices, willingness to explore, frankness in speaking, postponing judgments, etcetera). Therefore, these values became a second focus in the analysis, comparing the practice of client participation in MCD with the aims and values of MCD. Following these two lines, an analysis was obtained focusing on the impact of client participation on dialogical and relational dynamics in MCD practice – and beyond.

**Quality procedures**

For this research, the principle of triangulation was applied (Maxwell, 1996), using several sources of data and several (both qualitative and quantitative) methods of data collection. All oral material was tape recorded and interviews were fully or partially transcribed. The analyzing process was done under supervision of three senior researchers from the university, in close contact with the manager of the expertise centre and the GGNet MCD steering group. Findings were shared and discussed in the research team. Throughout the analysis, notes were made in a logbook by the principal researcher in order to make the process as transparent and retraceable as possible. Finally, a member check was organized to optimize internal validity. This concerned the analysis of the data that was done amongst the stakeholders involved. In doing so, only incidentally, hiatuses, blind spots or incorrect interpretations were found and adjusted.
Research ethics

All respondents in this research participated voluntarily and were informed about this publication and gave their consent. The identity of the respondents is not made explicit. IRB approval was not required according to Dutch law.

Findings
Findings will be presented by describing two cases. In section 4, we will present a comparison between case 1 and case 2.

Case I
Management initiative and unequal participation
After a positive evaluation of the MCD sessions in the Reduction of Coercion and Restraint project, the manager of an acute admission ward decided to continue MCD sessions in his team on a regular basis. He decided to apply regulations for attendance more strictly: participating in MCD would become part of the annual, individual reviews for nurses. He also suggested the introduction of active and ongoing client participation in the MCD sessions, in order to provide the possibility of discussing a case on an equal level. In cooperation with the MCD steering group of the expertise centre, the manager decided to invite participants coming from the general client council at GGNet.

The members of the client council were eager to accept the invitation. Halfway 2008, one member became a permanent participant in the sessions. The client participant took part in all aspects of the MCD-process: providing casuistry to deliberate on, actively participating in the sessions by sharing his perspective, and being involved in organizational aspects and preparations of the sessions.

In advance: tensions about the idea
Despite enthusiasm and eagerness amongst client council members, the healthcare professionals were reluctant towards the initiative. The idea of involving client participants invoked strong feelings of insecurity and vulnerability. Professionals doubted reliability and integrity of (ex) clients. Furthermore, professionals felt uneasy when a client with a history (and maybe a future) of admissions on the ward would be involved. Client participants experienced the doubts concerning their reliability as particularly painful.
‘The team reacted with fear. The whole team did. They feared the appeal of MCD in showing your own feelings, your own weaknesses or pitfalls in relation to clients’ (ind. interview, local coordinator)

‘Even before we were introduced, our integrity was already questioned. Nurses said: ‘I do not dare sharing my deepest thoughts in their presence.’ I found that really hard in the beginning. Really hard’ (ind. interview, client participant)

Local coordinators were sensitive to the reticence of their colleagues and tended to postpone the participation of (former) clients. They stated professionals were not ready for client participation in their group, feeling unsafe and caught unprepared.

‘I tried to hold back for quite a while (...). At some point the manager started pushing that we should give it a go. But the nurses did not like the idea at all’ (indiv. interview, local coordinator)

‘It was a very precarious issue! We talked it over many times. People felt... distrust towards (...) the client participants’ (focus group, MCD facilitator)

The manager expected resistance would not pass spontaneously. Although he understood the reticence of the professionals, he believed client participation deserved a fair chance before a final judgment could be made. The MCD facilitator – allied to the MCD steering group - agreed with this viewpoint. After the decision to continue, the local coordinators became more cooperative. The initiative was announced in the local newsletter and soon after that client participation was regarded as a given fact.

‘Only by having the experience of [client participation in] MCD, (...) one can learn: ‘hey! Talking to [clients] actually is possible!’ (focus group, MCD facilitator)

Openness for positive lessons So the client participant joined the MCD sessions, actively contributing to the content. Also, casuistry was brought in by both professionals and the client participant. Evaluation forms of these MCD sessions showed appreciation for the added viewpoint the client participant brought in. The client perspective appeared much richer when brought in directly rather than portrayed by professionals, as was done earlier.

‘Listening to the viewpoint of the client council member is sometimes very clarifying,
because as professionals you might think you are at the right track and from their perspective this appears not to be the case’ (focus group, local coordinator)

The client participant in turn showed eagerness to learn by considering the viewpoints of the professionals. As a result, distinctions between ‘us and them’ were softened. The client participant expressed experiencing a great sense of emancipation by gaining a voice in deliberating on such precarious casuistry. Conversation facilitators considered this a big step forward in emancipating client contribution to good care. As time went by and routine built up, reluctance amongst professionals diminished and – under conditions – the client participant was accepted as a member of the group.

‘I came to realise some clients mean really hard work for professionals. With this, MCD taught me to perceive professionals as fellow-human beings. To me this awareness works out very connecting’ (group interview, client participant)

‘My participation in MCD really means to me a step towards emancipation of clients: we are communicating directly. We do not speak about each other, we all have equal voices’ (group interview, client participant)

‘I thought client participation really was [...] immensely emancipatory’ (indiv. interview, MCD facilitator)

Reticence Still, despite this appreciation and softening of the us-them distinction, doubts amongst professionals participating in the sessions still existed below the surface. At moments, some professionals noted on the evaluation questionnaires that they did not dare speaking out frankly. They felt vulnerable in the presence of client participants. Referring to (former or possible future) care relations with the client, they feared information from the sessions might be ‘abused’. Noticing this reticence of professionals, client participants realised that it would not be an easy process to become really accepted as partners.

‘We have been working on this for so long. It takes an enormous amount of perseverance because amongst the employees there is still so much fear concerning our reliability. By now we know this will take endurance and patience’ (group interview, client participant)
Negative sentiments easily return  When an incident in the group occurred, the ‘them and us distinction’ easily returned: information from casuistry from one of the MCD sessions appeared to be circulating amongst clinically admitted clients on the ward. Professionals immediately stated they knew where the information must have come from: they supposed the participant from the client council was leaking confidential information. Professionals felt confirmed in their previous presuppositions concerning lack of reliability and integrity of the client council member. According to the local coordinator, they judged the state of affairs firmly. A rush of reactions amongst subgroups of all stakeholders in the process – mainly via e-mail contact – resulted in a more explicit view on criteria for client participation:

‘[before the incident] things had settled just a bit, and now colleagues focus on client participation again. And I feel this is not fair towards our client participant. What do you mean ‘towards him’? Well... suspicion is coming back Are they afraid he is leaking also? Well, they are afraid information is being leaked by client participants in general’ (focus group, local coordinators)

Professionals proposed contra-indications for participating in MCD in terms of psychopathology (no personality disorder) or in terms of attitude (not too silent, not too prominent). Client participants should meet these criteria in order to be able to join sessions. On the other hand, MCD facilitators stressed the learning potential of critical situations such as the incident that occurred. They interpreted these hard moments as potentially constructive:

‘(...) We immediately said: we don’t want participants in our group who enter short after admission and have a personality disorder, well...(with such participants) you can expect problems!’(focus group, local coordinator)

‘I believe that by such trifles a group can mutually grow. I mean, dealing with those storms in the process contributes to surpassing us-them distinctions’ (focus group, MCD facilitator)

During the oral evaluation of these MCD sessions the manager appeared firmly opposed against the suggestion to postpone client participation because of the professionals’ reticent frankness. According to the manager, professionals should learn to
see clients as full-fledged conversation partners. MCD is the ideal platform to practice just that. The revived feelings of distrust and discomfort were not discussed amongst clients and professionals together. Driven by the managers’ ideal, MCD was continued including client participation.

‘Professionals did not appreciate my presence at all. They did not feel safe [after the incident - FW]. But no one asked how I felt. But I do sit there, alone, around the table amongst all professionals!’ (group interview, client participants)

‘[Participation] isn’t secured. The sessions simply continue, also if there is no client participant present’ (group interview, client participant)

‘I don’t think any of my colleagues would say: ‘they must be included!’ No one would shout if a client participant isn’t present: ‘this is unacceptable!’ (...) (focus group, local coordinator)

**Summarizing** In this case, client participation was induced by management. The introduction of client participation resulted in diminishing the initial reluctance amongst professionals. The addition in viewpoints was appreciated. Yet, professionals now and then kept reporting not to feel at ease, and to miss the frankness MCD aims at. As an incident occurred, reluctance revived. In this case, the balance between positive and negative aspects of client participation remained precarious and was easily disturbed. This disturbed balance did not become a subject in the sessions, so that participants remained talking about rather than with client participants.

**Case II**
**A focus on content and numerical equality**
The second case concerns a series of moral deliberations focussing on moral questions related to sexuality and intimacy in a mental healthcare institution. This issue was brought up by a study group of nurses, who brought it to the notice of the Board of Directors. The Board of Directors asked the nurses group to explore the subject and to organize this together with the client council and the GGNet MCD steering group. The goal of this project was on the one hand to stimulate dialogue on this subject and on the other to provide insights, viewpoints, principles, etcetera for making an institutional policy on the subject of sexuality. Ten moral case deliberation sessions were scheduled to explore the issues amongst people involved. The project group
openly invited healthcare professionals, members of the client council, and members of the family council to participate voluntarily and on an individual basis. Six out of the ten sessions took place in a fixed group, having the same participants. The representation of client participants, family members and professionals was more or less equal. In four out of the ten sessions, everybody was welcome to subscribe for participation. In these four open sessions, also clinically admitted clients participated.

**A shared interest in content** Because the subject of intimacy and sexuality in mental healthcare was something of a personal interest, participants committed to the MCD sessions. This commitment worked out positive: everybody joined for the sake of the subject, not as a member of an existing team but on an individual basis in a new temporarily group. Also, people came together because of a framed, clear goal: contributing to a proposal for a policy on intimacy and sexuality.

‘We did not know in advance who would be joining those sessions. But we did know the subject of the sessions and we shared an interest concerning this. Therefore, the tension was quite different from sessions in ongoing groups in for example a clinical team’ (indiv. interview, MCD facilitator)

‘We came together to sort out and explore our own main issues concerning policy on sexuality; what should be in it, and what not. This was a joint goal: creating building blocks together, sharing responsibility of what would come out of the sessions’ (focus group, local coordinator)

**Individuals rather than groups** Throughout the sessions, all groups were equally represented. Rather than blocks or camps or teams, people joined on an individual basis. Participants easily mixed because they did not know each others’ relation with the institution, or regarded it as irrelevant. The point was to join together and get to the heart of a case, without prior problematic relations or shared admission histories – although it was known some participants shared history in care.

‘I think it is of substantial importance (...): working towards a shared goal. That is so much a different situation from a client participant shoving on in MCD sessions in a clinical team’ (focus group, local coordinator)

‘There was no ‘block of people’. We were all individuals, all different people’ (focus group, local coordinator)
Within the sessions people worked in conformity with the MCD method: listening to each other, taking new perspectives into consideration. Also, throughout the sessions there was a lot of laughter amongst participants. Participants reported that they learned a lot. In the so called open sessions, they said the atmosphere was friendly, easygoing and willing.

‘I never learnt as much as I did in those MCD sessions. There was so much space to share experiences. The method created a safety to share those experiences in an atmosphere of safety. That was really positive’ (focus group, local coordinator)

The MCD facilitators tended to protect client participants to some extent. They felt that there was great emancipatory power in client participation and therefore it should be cherished. MCD facilitators suggested that, because of the equal numerical representation of all participant groups, client participants weren’t outnumbered by a possible intimidating group of professionals. In their perception, this was vital for the process of inclusion during the MCD sessions.

‘Within these [open - FW] MCD sessions, clients other than members of the client council joined in. Because there were five of them, it all went well. But you should not send them to a MCD on their own. They would not be able to maintain themselves. But once they are in the company of fellow-client participants, they are okay’ (focus group, MCD facilitator)

‘I realise it cannot be easy to join a relatively closed group all on your own. I mean: being the only client in a nursing team’ (indiv. interview, MCD facilitator)

Professionalism and diminished frankness Just as in case I, professionals reported they felt reticence in speaking out frankly. They explained this by referring to the presence of client participants (members of the family council are not mentioned by them in this respect), as well as the subject of the sessions, namely sexuality and intimacy. Interpreting this, MCD facilitators believed ‘openness’ was understood by the professionals as having to talk about personal experiences concerning sexuality. Therefore, during the sessions the MCD facilitators stressed that ‘openness’ meant receptivity towards perspectives and reasoning from participants (and not to personal sexual experiences). In other words, the reluctance in speaking out frankly was related to the subject of the sessions, not to the background of fellow participants. Just as in case I, conversation facilitators mitigated reticence or the feeling of not being safe. They said professionals tend to approach MCD as something big and personal,
in stead of just entering the dialogue at stake without preconceived notions. In evaluation forms, feelings of reticence diminished as time went on and experience grew.

‘In the beginning I missed frankness, because we did not know each other’ (evaluation questionnaire, participant - professional)

‘some reticence’ (evaluation questionnaire, participant - professional)

‘It is not the purpose to talk about personal experiences concerning sexuality (laughter). It is not the point to become less professional, but to be receptive to the subject in the context of professional practice. That’s what clients need!’(focus group, MCD facilitator)

Table I
Factual differences between case 1 and case 2 regarding client participation in MCD

<table>
<thead>
<tr>
<th>Main theme</th>
<th>Case I sub themes</th>
<th>Case II sub themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization of the MCD sessions</td>
<td>‘Ownership’ of client participation: manager</td>
<td>‘Ownership’ of client participation: GGNet nurses study group, Board of Directors</td>
</tr>
<tr>
<td></td>
<td>Obligatory attendance for profs</td>
<td>Voluntary attendance (invited by project leader)</td>
</tr>
<tr>
<td></td>
<td>Content: open</td>
<td>Content: sexuality/intimacy</td>
</tr>
<tr>
<td></td>
<td>Time path: ongoing sessions</td>
<td>Time path: slot of 10 sessions</td>
</tr>
<tr>
<td>Motivation for client participation</td>
<td>External, enforced by management</td>
<td>Intrinsic, decided by nurses and MCD Group together</td>
</tr>
<tr>
<td>Compilation of the group</td>
<td>History: just nurses in MCD, coming from one existing team/ward</td>
<td>Client participation from the start, group members from all over the organization</td>
</tr>
<tr>
<td></td>
<td>Sole client amongst healthcare professionals</td>
<td>Equal numerical representation by professionals, family members, client participants (formerly and clinically admitted)</td>
</tr>
<tr>
<td>Dealing with vulnerabilities</td>
<td>Homogenous talking about client participation outside MCD</td>
<td>Reflecting upon feelings of vulnerability related to content during MCD</td>
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</table>
Summarizing In this group, both the focus on a shared problem and the numerical equality within the group proved to be positive for client participation. Initially, as in case I, there was some reluctance towards working in this mixed setting. This resulted in reticence in meeting the principles of MCD such as ‘speaking frankly’. This attitude diminished as experience evolved. Focusing on the content of the sessions rather than questioning the composition of the group, all participants became full-fledged members of the group. The group cooperation developed positively, and there was even an open attitude towards participation of people outside the fixed group during the four ‘open sessions’.

Analysis: similarities and differences in the cases
In both cases a similar movement in group dynamics is present: first professionals show resistance or reticence, but as time goes by the differences in background of separate participants become less of an issue and the us-them distinction diminishes. Yet, the cases differ in terms of organizing structures, composition of the groups and attitude (see table 1). These aspects affect the dynamics in both the relations and the dialogue. In the next paragraph these differences are analyzed. Essential values related to the MCD method will be addressed, referring to dialogical and relational dynamics.

Organization of the moral case deliberation sessions
Ownership and attendance In case I, a top-down and pragmatic introduction of client participation is chosen by the manager to overcome reluctance of professionals by experience. Professionals experience little space to express, share, or explore feelings or ideas concerning this novelty. As attendance is obligatory, they have to accept the decision. Professionals deal with the given situation by formulating criteria client participants should meet in terms of psychopathology and their attitude during the sessions. This enforces stereotyping, so that client participants find it more difficult to become a regular member of the group and equal partner in the dialogue. In case II a bottom-up introduction of client participation results into a more reflective and receptive attitude, and the potential of constructing a solid group cooperation process. Space is available to explore possible feelings concerning the cooperation of non-professional participants in an atmosphere of little system pressure. As participants join the sessions voluntarily and on an individual basis, they develop a sense of joint ownership.
Content and time path In case I, client participation is introduced in an already existing, rather homogenous group with an open agenda. Beforehand, it is not clear for MCD participants what the surplus value of client participation might be. Also, nurses wondered what issues they can and cannot bring in during the sessions. From their perspective, the introduction of client participation disturbs the merits of the existing MCD routine. In case II, the MCD sessions come with a clear time path and a focus namely on issues concerning sexuality and intimacy in mental healthcare. There is a shared goal, and as a consequence clear structure: sharing experiences and working towards the formulation of policy items on the subject. The relevance of the added viewpoint from non-professionals is clear considering the aim of the sessions: learning to create a dialogue about a precarious subject. There are no questions about the value of their potential contribution.

External or internal motivation for client participation In case I due to the introduction of client participation by the manager, professionals were not intrinsically motivated for client participation in ‘their’ MCD sessions. After some time they do show appreciation of the added perspective of the client participant, but these positive findings do not result in them fully embracing client participation. Motivated by regulations, professionals endure client participation. This results into sustaining doubts about client participants’ reliability, capacities and remaining asymmetries, emerging when an incident occurs. In case II client participation is anchored beforehand and a known fact from the beginning. Also, participants join the sessions because of their involvement in the subject. So, participants are intrinsically motivated to attend, focussing on the content and the aim of the slot of the sessions.

Compilation of the group

History of a group An important factor concerning relational dynamics in case I is the fact that a sole client participant joins the sessions in an existing group of professionals – a nursing team. By a shared MCD and working history, this group of professionals already has its own culture, language, rules and codes. The client participant thus needs to tune into these habits, in order to become integrated in the group (Holmesland et al., 2010). In case II, more than one client participant joins in from the beginning. Thus, client participants are not as exceptional as in case I. Here, the cultural aspects are not as prominent as there is no group identity already. With this, equality of voices can be more easily accomplished. This equality of voices is an important principle and value within MCD, stimulating all perspectives to be taken into consideration.
Numerical representation: the odd one out? In case I, it seems as if the client participant does not fully overcome the status of being a (former) client. Stereotyping remains - to and fro - and asymmetries in terms of (former) care relations still affect relations now and then. Despite this, the client participant, being alone in a group of professionals, tries to become a full-fletceterahed member. It seems as if he keeps a guest status, remaining an exception in the group. When an incident occurs, client participation appears precarious, challenging and sometimes problematic. Moreover, when professionals outnumber client participants, equal input is at risk (Reiter-Theil, 2003; Newson, 2009; Neitzke, 2009), pointing at the importance of so called ‘proportional deliberation’ in which equal numerical representation of different backgrounds of participants is pursued (Karpowitz, 2009). Perhaps another social phenomenon pops up here: if a certain perspective (i.e. client) is represented by only one person, the risk might increase that his/her viewpoint is perceived as a ‘typical’ or a stereotype perspective of ‘the’ client in general, rather than an individual perspective. In the second case, a group of non-professionals joins the sessions, namely a number of client participants and a number of family council members. As voices are therefore more equally represented (proportional deliberation; Karpowitz, 2009), integration grows organically and relatively smooth.

Dealing with vulnerabilities
Client participation in both groups brings about uneasiness amongst professionals. The uneasiness is due to a sense of vulnerability or even fear. Abuse of the openness of professionals during MCD is feared. In case I, professionals tend to talk about this, potentially nourishing their reluctance. This results in a pragmatic decision of the manager to introduce client participation despite the feelings expressed. Caught in this decision, the issues of vulnerability, fear, and doubts remain latent throughout the sessions amongst professionals. Professionals tend to hold back in openness and frankness. Rather than raising this issue during the sessions, contra-indications for client participation are formulated outside the MCD meetings, behind the scenes. This brings about vulnerability in the position of the client participant: he does not feel part of the group, and feels he should stick to his position despite of the judgements he senses professionals make concerning his presence (due to limitations of the study the impact on client participants and their experience of vulnerability did not become fully clear. Future study on this subject would be desirable). In the second case there is little discussion about the background of other group members. Although the same issues concerning vulnerability come up, the issue on former or possible future admissions is not mentioned. Rather, participants feel uneasy to share
their thoughts on a case with people they do not know yet, be it clients or colleagues. Feelings of vulnerability are related to the subject of the sessions, and are relevant for all participants. No criteria for participation are mentioned, not even when, in the so-called ‘open groups’, clinically admitted clients join sessions. Reflection on positions and personal considerations is in concert with the principles of MCD. In this process, frankness increases and casuistry can be explored in an atmosphere of openness and transparency.

Discussion: dialogue on quality and conditions of dialogue
Both cases show that client participation in MCD is precarious, since it involves reluctance, vulnerability and even fear. Yet, this empirical finding is not in itself a contra-indication for the normative ideal of client participation in MCD. Feelings of fear and vulnerability may decrease over time. This indicates that a pragmatist approach is desirable: if we do not just do it, it will never be realized. Only talking about client participation seems to stifle learning, while actually undergoing the experience of client participation invites participants to confront both positive and negative feelings and disjunctions which trigger learning and dialogue. Ideally, judgments about client participation should be made after the actual experience of client participation in MCD. However, just starting the process in the expectation that reluctance will automatically diminish is not enough either. Throughout the whole of the process, space should be created to reflect on experiences, especially at those moments when sentiments (re)occur.

Equality in numerical representation (‘proportional deliberation’, Karpowitz, 2009) and a focus on a specific theme contributes positively to the quality of the dialogue. Secondly, a climate is required in which the group (professionals and client participants) can openly reflect on hesitations and fears regarding client participation. These hesitations should openly be addressed during the MCD sessions themselves, taking into account there might be feelings of reluctance in speaking frankly – an issue mentioned in various publications on client participation (Stidham et al., 1990; Neitzke, 2009; Rari and Fournier, 2009). As in every MCD, any normative ideal should not be taken for granted but reflected upon its concrete meaning for participants (as is the case with client participation).

By conducting our empirical research we learned that dialogue is an active verb. Just starting MCD (in which dialogue is a means and an end) does not automatically guarantee a dialogue. Like all transdisciplinary collaborations client participation seldom appears a smooth process (Abma et al., 2009b; Holmesland et al., 2010). Although it does bring in new and valuable perspectives (Cohen and d’Orazio, 1989),
we also need to be very alert that our own ‘academic,’ white, verbal and rationalist notions of dialogue and deliberation are not creating barriers for others to engage and involve with us (Abma, 2006; Barnes, 2008). Serious inclusion of newcomers in clinical ethics might also mean considering more embodied and creative forms of deliberation. Welcoming newcomers therefore needs careful consideration and process management. Client participation itself both requires and stimulates reflection as well as dialogue. The prima facie starting points of MCD (open dialogue and equal participation with respect to moral understanding) make MCD an attractive platform for establishing equality of voices, exploring and acknowledging reluctance and/or vulnerability, thinking through preconditions for cooperation and participation and opening up for new perspectives in order to sharpen individual presuppositions. The explicit and experiential learning processes in MCD make MCD a good vehicle for implementing client participation within healthcare organizations in a broader sense.

Conclusion
Client participation is a laudable concept or ideal, yet it requires pragmatist and dialogical work from the very start, constantly reflecting upon the meaning of (conditions for) a good dialogue. As such, MCD provides a good context for the introduction of client participation, as dialogue is its core feature. Likewise, client participation puts the essentials of MCD to the test by challenging the basic values of MCD such as safety, frankness, sharing power and control and inclusion. Regarding these founding values for a good dialogue, client participation creates extra challenges to the organization, preconditions and quality of the dialogue. The MCD values of equality of voices, being open and receptive towards fellow participants and postponing judgments can be demanding aspects of MCD. Fostering and maintaining a qualitative dialogue therefore requires ongoing care and attention throughout the introduction of client participation and the process of the actual deliberation. If these dialogical values are not met, client participation in MCD risks to turn into pseudo participation or participation out of politeness. Therefore, it requires a truly open conversation, providing space for feelings of vulnerability, inequality or even reluctance during the process of client participation on the spot. This cannot be done without a pragmatic attitude towards realizing participation of all voices and creating preconditions for good participation and dialogue. The pragmatic attitude consists of discussing actual challenges of client participation, not abstract (obstacles of) ideals. It also consists of starting with dialogue on dialogue from the very beginning, thereby preventing the paradox of talking about conditions for dialogue without having a dialogue. If this attitude is present, the ongoing dialogical process of joint learning concerning client participation is not a distant ideal anymore but starts right away.
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References


A Socratic dialogue on facilitating moral case deliberation
MCD facilitator: Allow me to share an incident with you that taught me a lot about the role of dialogue in moral case deliberation and my personal presuppositions. Would you be so kind as to help me explore the doubts and questions I had during that session?

Novice: It would be a pleasure! Although I read a lot about MCD, I still cannot fully grasp the process and the dynamics of such gatherings. So I gratefully accept the invitation to share your example; I believe an example would support my understanding of the matter.

MCD facilitator: Thank you kindly. Recently, I was an MCD facilitator in a multidisciplinary team. They had been struggling for years with a patient who had to be washed daily. He had to be washed for medical reasons, namely a bad skin condition which would deteriorate quickly if not taken care of, and because he was very keen on being well-groomed. But the resistance to this daily washing was generally immense, and as a result he was taken to the bathroom with quite some force by a number of caregivers on a daily basis. At the time, this practice was openly discussed with the family members.

Novice: I see. So family members were aware this was daily practice, and they agreed with it?

MCD facilitator: Yes, correct. And in this particular MCD, the nursing team, the treatment officer and the three closest family members of the patient were present. But I will not go too deep into the content of the case. The thing I am interested in is the
process and the evolution of the interaction.

Novice: I do not think the case is very complicated: if caregivers state they do not want to do it anymore, alternatives have to be considered that are more appropriate and workable. So I think it is good that they got together in order to find solutions to the problem here, particularly the inclusion of the family.

MCD facilitator: I agree on the importance of family members being present. But a quick solution would do away with the importance of the underlying implications of the matter. Here a team was presented that was sincerely struggling with the health of the patient’s skin (and their responsibility for it) and the humanity and dignity of care provided.

Novice: OK, I see. Can you then say something about the process that evolved in that session?

MCD facilitator: It would be a pleasure to do so, because that is the reason I wanted to bring this example in. You see, taking family members up into the process of exploration can be tensed.

Novice: Intuitively I can understand that, but can you explain it further?

MCD facilitator: The family was informed of all the details and actively agreed on forced washing on a daily basis. Still, they were obviously filled with emotion hearing about the treatment of their loved one. The caregivers, however, had to find the courage to clarify and explore their doubts about the practice even though they had agreed with it some months earlier. And they had to do this in front of the family.

Novice: You wanted to talk about what you learnt about dialogue, rather than describing the content of the session. So, considering your explanation of the tension of the family, what does that mean for the process of deliberation and your role as a facilitator?
MCD facilitator: Right you are. As a facilitator, I needed to be extra keen on the active inclusion of family members. I mean, not only to notice them observing the process, but actually joining in the exploration of the case by sharing their doubts and thoughts and considerations. In all honesty, I was tense myself even beforehand, because of the emotions that might emerge.

Novice: Can you say what you anticipated?

MCD facilitator: I was not afraid of people getting emotional and expressing that. I was afraid the emotions might seduce the participants to either discuss the case instead of exploring it or to remain distant and not enter the case wholeheartedly in order to escape from possible emotions. Also, I could not escape my personal resonance regarding what it must be like to hear about daily practices that put such a strain on the one you love. And these considerations were all vividly on my mind beforehand, before I even had met the group.

Novice: How did you deal with that in your position as an MCD facilitator? I thought you had to set aside your presuppositions?

MCD facilitator: Indeed, that was my problem! I presumed that as a matter of common sense emotions would be present among all participants, because of the strain and the permanency of the practice. That was already expressed in the written case I had received. But I did not know what emotions would go round and what they might mean in the process of deliberation, and I had to be wary of assuming the feelings in the room.

Novice: So, if I understand you correctly, you did already know participants were emotional about the matter. Can you explain how you knew?

MCD facilitator: Well, in the written case I received earlier, caregivers expressed a great sense of enduring powerlessness towards this patient. I guessed this powerlless-
ness was loaded, but obviously I had to check on that during the session.

Novice: And did you?

MCD-facilitator: Of course – sometimes one has to throw caution to the wind and jump after it. And the method of a Socratic dialogue requires you to express thoughts, action and feelings on the matter at stake. So on the basis of the methodology, I could comfortably ask about feelings that were involved.

Novice: Comfortably?

MCD facilitator: Yes and no. Yes, because I know from my expertise emotions are important ‘moral informers’ and they support in-depth reflection. This is, let’s say, the utility of emotions in MCD, there is no therapeutic reason to bring emotions up.

Novice: What makes you mention that? That there is no therapeutic reason for including emotions?

MCD facilitator: Good question! Talking about emotions may give rise to the impression that MCD is meant for therapeutic exploration on emotional bits and bobs. This would surpass the functionality of emotions in the light of MCD’s explorative aim.

Novice: And why would it be a problem to think that MCD has a therapeutic connotation?

MCD facilitator: Because it has not! This would bring up associations with MCD that are inappropriate, which do not coincide with its aims and which raise expectations that will not be fulfilled. MCD, in a way, uses emotions as moral informants to gain a deeper understanding of the layers in a case. Emotions moreover help to uncover hidden presuppositions or principles that are prescriptive regarding our choices or actions. And that, as you have probably read, is one of the theoretical aims of MCD. Uncovering presuppositions or underlying principles helps the participant to under-
stand his choices, and opens up to new, fresh listening to others. For that, one must notice the motivation and underlying values of his choices in daily routines. Emotions can be regarded as informants of those underlying motivations.

Novice: So, let me combine some of your expressions: you said you were tense before the session, because of the emotions that might come up resulting in either an obstruction of the deliberation or a discussion on an emotional level. And now you say these emotions are inevitably part of the deliberation process for gaining depth and uncovering presuppositions. Is that correct?

MCD facilitator: That is indeed correct, but are you suggesting a contradiction here?

Novice: Actually, no. But I do note your struggle of the necessity of exploring presuppositions through emotions as an inevitable, necessary part of MCD, and simultaneously your restraint in touching upon those emotions.

MCD facilitator: I guess that is correct. But I already told you: I felt I had to throw caution to the wind and jump after it. I knew if I left emotions out, this would result in a superficial MCD and would not answer the aim of a dialogue: opening up to presuppositions and retracing them in the current practice of this particular case. Leaving those presuppositions out would result in a meeting in which solutions would be formulated on the matter. It would not serve long-term mutual learning and genuine mutual understanding.

Novice: Can you say something about the process on this issue, please?

MCD-facilitator: The caregivers said that they felt extremely powerless about the recurring practice of forced washing. Exploring powerlessness, initiated by the facilitator, they said this powerlessness referred to the shame they felt over this daily practice.

Novice: If I understood the theory on MCD properly, this powerlessness and
shame would refer to presuppositions on the matter?

MCD facilitator: Indeed they did. Surprisingly, the mention of the powerlessness and shame opened up to a mutual willingness for deep understanding and curiosity among all of the participants. As soon as these emotions were mentioned, the atmosphere in the group became intimate in a sense that participants were courageous and started to ask each other questions, exploring the tracks of the emotions in terms of choices and action.

Novice: You say ‘surprisingly’. Why is this surprising to you?

MCD facilitator: Obviously, because this was the most tense part of the session. Asking for underlying emotions that come up while performing the forced washing immediately served as a connection to both the caregivers and the patient in the experience. The emotions that came with the daily practice made it more than just a story; the experience was sensed and emphasized in an urgent and inevitable way. In the session, this was the moment at which my twofold fear had possibly come true: would the group enter a discussion or would obstruction in the communication occur?

Novice: You did not answer my question about your surprise. Did your fears come true?

MCD-facilitator: Quite the contrary, as I have said. The participants became curious; the urgency of the matter was shared now that the emotional burden was clear. Particularly the psychiatrist was curious. She never thought of this practice as a strenuous thing to do – it was a completely new perspective on the washing decision she had initiated, after all. In the session, she stuck to the understanding of the shame. By asking questions, caregivers were able to see the shame they felt as an expression of the inhumane care they provided – as they explained the washing routine. That was the surprise I mentioned: I was so focused on my doom scenarios that I did not expect the group to pick up on the emotions so maturely, respectfully, equally and attentively.
Novice: Do I understand it correctly: you did not expect the group to be able to handle this delicate matter in a mature way?

MCD facilitator: Well, I feel awkward admitting that this is true, but yes.

Novice: Awkward? Can you be more specific?

MCD facilitator: I was ashamed too, as I realized that even in advance, I underestimated the group: their maturity, their wisdom. This essentially is one of the features an MCD facilitator must possess: to rely on the wisdom of the group. But the presence of the family discouraged me from offering this trust. The group – including the family members – in a sense overruled me by their willingness and ability to explore. I did not feel a good facilitator, in this respect.

Novice: You did not feel a good facilitator because you had underestimated the wisdom of the group?

MCD facilitator: Not in advance, and not even during the session. Because of the suggested precariousness of the compilation of this group – including family – I remained over-alert, and I might have obstructed the flow of the session.

Novice: Obstructed?

MCD facilitator: Yes, obstructed. Because my presuppositions (‘they probably cannot handle this’) disturbed my open listening and observation of the process, and made me interfere in the process more than necessary. So I obstructed the flow of the mutual exchange and exploration.

Novice: I do not understand that fully. You said the group asked questions, they got into the urgency and multi-coloured layers of the case at stake. Listening to you, I pictured the group going into in-depth reflection, exchange and deliberation, and now you are saying you interfered too much. Can you elucidate?
MCD facilitator: Looking back, I think I understand what happened. As I was blinded by my own presuppositions about the group, I did not dare to leave the group following their trace. Even not when they actually did – it took time before I could let go of my own presuppositions and I worked through that during the session, while the deliberation evolved. I felt extremely responsible for everybody’s comfort. As a result, I became too focused on the methodical steps. After all, this may have obstructed the natural process of the group. Because in fact I did not notice one single sign of discomfort among participants; the fear of discomfort was just ‘in my head’. They were all very open, very willing. They were not sparing each other, not convincing each other, etcetera. I should have left my interventions to some mild dialogical cues. That would have sufficed.

Novice: You started this dialogue by inviting me to share your experiences on an MCD session from which you learnt a lot about dialogue. How does that resound in the example you shared with me?

MCD facilitator: Obviously, I am not proud of this example. But it let me learn a lot about the practice of dialogue. Most especially, it taught me about the modesty of the role of the facilitator. Although the facilitator settles the boundaries of the session, and although the responsibility for the group members’ active inclusion and well-being is realistic, this responsibility must also be put into perspective. And this perspective is nourished by trust in the wisdom of the group. Relying on this opens up the dialogue to space, mutual openness and in-depth exploration. I learned that without this trust the facilitator can be seduced to perform too firm, unnecessary, interventions, obstructing the process. In other words, I learnt about modesty, the impact of presumptions on my choices and actions as an MCD facilitator, I learnt about the wisdom and courage of the group. That, for me, makes this example a truly uplifting learning experience, reflecting on my work as an MCD facilitator long-term.
General discussion and conclusions
Introduction
In this thesis, the process of implementation of moral case deliberation (MCD) in a mental healthcare institution was investigated. In this final chapter, we will answer the research questions presented in Chapter 1. First, we will present the main findings on the role of dialogue in MCD practice, the implementation of MCD and the research process. Next, we will reflect on these findings by using the concepts of Hannah Arendt’s Vita Activa as an excursus for deeper reflection. Finally, we will formulate recommendations for the practice of MCD and further research on its (dialogical) implementation.

A threefold role for dialogue
MCD aims to foster dialogue on moral issues concerning quality of care, cooperation and the organization of care. In line with the dialogical nature of MCD, we developed a dialogical approach to implementation of MCD. This dialogical approach entailed a research design enabling inclusion of various perspectives and room for experiences on (implementing) MCD. Therefore, responsive evaluation was chosen as a research design. Because of its focus on relations, communication, openness and equality, responsive evaluation resembles MCD (Abma et al., 2009). For this reason, responsive evaluation seemed a ‘natural’ design to choose for this study, allowing us to approach the issue of implementing MCD dialogically and to include various perspectives on the process of implementing MCD. Thus, we focused on dialogue in MCD, in implementation, and in the research design. The overall aim of the project was to investigate whether this threefold role for dialogue might be helpful for understanding and fostering implementation of MCD in healthcare practice.

Central research questions
In the introduction to this thesis, the central research questions were presented. In this final chapter, we will formulate an answer to the questions by looking at the lessons learnt in the study.
The research questions we formulated were:
1. What is the role of dialogue in MCD?
2. What is the role of dialogue in the process of implementing MCD?
3. To what extent does responsive evaluation as dialogue contribute to the implementation of MCD?
I Main findings
In this section, the main findings from our study will be presented and discussed. The findings are subdivided into three domains in the light of our research questions: (a) the role of dialogue in MCD, (b) its role in implementing MCD and (c) the role of dialogue in research.

a The role of dialogue in moral case deliberation
The findings from our study provide insight into stakeholders’ views on and experiences with dialogue, both inside and outside the actual MCD sessions. The following issues stand out: (1) MCD fosters a learning process that goes beyond the content of the moral issue at stake; (2) applying the method of MCD does not guarantee a sustainable dialogue; and (3) dialogue can be used as an educational tool.

1 Beyond the content of the moral issue
The study on local MCD coordinators (Chapter 4) and the study on client participation in MCD (Chapter 6) showed that an MCD session is valuable because a case is approached from various perspectives, providing multiple insights. It increases insight of the participants into the content level of the case at stake. This is in line with hermeneutic philosophy, which stresses the importance of a plurality of perspectives (Gracia, 2003; Heidegger, 1927/1998; Pamental, 2013).

Besides the importance of multiple perspectives on a content level, the studies also showed that multidisciplinary MCDs have impact outside the MCD sessions. The local coordinators remarked that regular multidisciplinary sessions lowered thresholds or barriers between the various professions in a team. Although the concept of a multidisciplinary team suggests that several professions work together, professionals generally view the situation from their own professional perspective, and little exchange takes place between the disciplines. MCD, according to local coordinators, positively influences the way in which disciplines work together in everyday practice: it fosters cooperation and particularly strengthens informal exchange on how to deal with dilemmas.

According to MCD participants and local coordinators, dialogue in MCD works on multiple levels. While deliberating on a concrete case from practice, participants simultaneously enhance their moral sensibility and moral insight (content level) as well as learn how to improve communication about the case (process level). Deliberating systematically and with a focus on equality also influences the mutual relations between the participants (relational level). All three levels are equally important (Wid-
dershoven et al., 2009). According to the local coordinators (Chapter 4), this is both fruitful and challenging. It implies that MCD is more than a technical method or an instrument for solving a moral case. In line with managers’ aims for MCD (Chapter 3), the MCD sessions are characterized by cooperative and communicative aspects, such as attention to power balances in the group and feelings of uncertainty, in line with the basic notions of openness and vulnerability.

The effect on the process level does not come about by itself. Work has to be done in order to make explicit and explore issues of cooperation during a session. The transfer of lessons learnt to daily practice (outside the sessions) requires efforts from all involved, for example an increase of informal contact during working hours between the various disciplines, or the courage to ask for assistance from other disciplines (Chapter 4).

2 Applying the moral case deliberation method does not guarantee dialogue

Our study showed that MCD is different from other kinds of work-related conversation (such as team meetings, peer supervision, etcetera). Distinctive aspects are: confidentiality (Chapter 3), openness, vulnerability (Chapter 6), relational challenges (Chapter 4) and systematic in-depth reflection (Chapter 2). According to the stakeholders, these aspects determine the impact or learning potential of an MCD session (Chapters 4 and 5). Some stakeholders were critical of the ability of MCD facilitators to foster these substantial aspects of MCD to create conditions for dialogue.

The study on client participation in MCD (Chapter 6) showed that the application of a structured method is not sufficient to realize a dialogue. Although all participants neatly followed the steps described in the MCD method, this did not result in a dialogue in terms of inclusion, postponement of judgments and mutual openness. In other words, a (transdisciplinary) group around the table and an intention towards dialogue do not guarantee an open dialogue. The method ensures a focus on the dialogical quality of the session, and is considered preconditional (Gracia, 2001; Steinkamp and Gordijn, 2003). Without a clear method, the session may result in a conversation without rules and focus. Yet a method alone cannot produce dialogue – at most it can suggest a dialogue.

The study on client participation provided insight into the complex and demanding role of the facilitator. The importance of care for, and attention to, relational issues during a session is in line with the theoretical hermeneutic notions behind MCD. From a hermeneutic perspective, dealing with an ethical issue requires understanding of various perspectives on the issue, both in the case and in the group. The efforts that
need to be made in order to include various perspectives require hard work in terms of solid guiding by the facilitator (Chapters 4 and 6). On the basis of our findings we can, tentatively, conclude that the MCD facilitator needs skills on a methodical, dialogical, analytical, explorative and group-dynamic level. We will elaborate these five domains, focusing on the work that needs to be done by the facilitator to meet with the dialogical - normative - aims of MCD. In table I, an overview of practical skills of these five domains is elaborated.

Methodically, the MCD facilitator needs to create a solid structure for participants to investigate the case and their perspectives. This methodical structure is essential for starting and sustaining a dialogue. It marks the space in which participants can explore the case at stake. As the subject of deliberation remains a single moral example from practice, the boundaries of the conversation are clear: this is what we are talking about right now. The methodical structure combined with sticking to a single moral issue provides a basis for investigating the moral issue.

Dialogically, the facilitator should pay attention to democratic characteristics of MCD such as inclusion of all voices and equal deliberation. The facilitator invites all to have a say and to be heard. Examples are: inviting all to ask questions, explicitly giving room to all participants during the session, and explaining that all should take a stance in the final phase of the session. Dialogical interventions include checking mutual understanding and correcting participants when they infer from presuppositions. The facilitator’s requests for alternative formulations of the participants’ input overcome the risk of taking side-paths that drift away from the issue at stake. In our study on client participation, we saw many occasions on which the client participant did not speak up by her/himself. The facilitator explicitly had to invite the client participant to articulate her/his point of view. It was also necessary to make sure that the client’s perspective was taken into account in the final weighing of considerations during the session. These interventions provide an opening for dialogue and foster the deliberative atmosphere of a session.

Analytically, the facilitator makes explicit the value-orientations of the participants. These are written down on a white board, so they are available to deepen and to focus the conversation. The facilitator keeps an exceeding view on both the content and process of deliberation. This implies that, as the session evolves, the facilitator refers back to value orientations that were brought in earlier. The analytical skills of the facilitator support the participants further to explore the issue at stake, and investigate their own value orientations and those of others in an in-depth way.

The facilitator acts exploratively by sticking to the Socratic principle of asking (native) questions rather than jumping to conclusions, and inviting the participants to ex-
plore further. A communicative attitude of exploration helps to deepen and intensify the process of moral reflection. Also, exploration by asking questions urges participants to try and understand the motivations of the speaker. It naturally fosters interaction as each remark invites further questioning. Our study on client participation showed that the Socratic attitude of the facilitator (‘I do not know’) supported active inclusion of the client participant in the process of deliberation, and invited participants to come to a genuine understanding of the standpoint of the client participant – and vice versa. The work of the conversation facilitator in this domain is to repeatedly ask naive questions. Such a Socratic attitude scrutinises implicit or preliminary conclusions or stereotyping of other participants (e.g. talking about THE client, THE nurse). Also, exploration reduces the speed of the conversation, for example by asking a question when one of the participants expresses presuppositions. This entails invitation to check whether or not the presupposition is valid.

Finally, group dynamically, the work of the facilitator is to note (hidden) power balances in the group and make them open for deliberation – either explicitly or implicitly. Examples are: stopping ‘experts’ or those with a hierarchical position (such as a psychiatrist) in the group from teaching or giving lectures, as this may give rise to feelings of inferiority among other participants and may underestimate the experience behind the case at stake; making explicit (non-) verbal reactions and questioning them; inviting the ‘silent voices’ to give their view on a case and Socratically exploring those in relation to other perceptions; noticing and questioning pauses or mumbling which could refer to silent comments to other participants.

The MCD facilitator needs to cover the five domains explained above. Together the domains support the democratic principles of MCD.
The facilitator is...

This implies that the facilitator...

<table>
<thead>
<tr>
<th>Methodical</th>
<th>... follows the steps of the MCD-method, providing a clear structure and a riverbed for frank speaking and safety. He keeps up the pace of the session in terms of its dynamics and in terms of time-keeping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialogical</td>
<td>... moves the group (in)to dialogue by insisting on good listening and checking on genuine understanding by disciplined dialogical interventions. He deliberately decelerates the process of deliberation</td>
</tr>
<tr>
<td>Analytical</td>
<td>... keeps a helicopter-view on the process and on the content, and is able to (literally) refer to former statements or process-related issues. He notes expression both by speech and non-verbally and inserts these observations into the deliberation process</td>
</tr>
<tr>
<td>Explorative</td>
<td>... invites and challenges MCD-participants to search for presuppositions in their thinking, and to postpone and question them. He functions as an example of a Socratic attitude (‘I do not know’)</td>
</tr>
<tr>
<td>Group dynamic</td>
<td>... observes (hidden) power balances in the group and invites to empowerment of ‘silent voices’, guaranteeing inclusion of all. Besides guiding the group towards dialogue, he trusts and relies on the group for its wisdom</td>
</tr>
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3 Dialogue as an educational tool

The study on managers’ views related to MCD (Chapter 3) showed that managers tend to introduce MCD primarily as an educational instrument, teaching participants to improve their mutual communication and cooperation. MCD as dialogue is then perceived as a learning tool for developing mutual relations and communication. The study on aims and outcome (Chapter 5) showed that managers start MCD primarily for this communicative and cooperative impact. Managers consider MCD as a means to improve the relations among (multi-disciplinary) caregivers and expect that dialogue is the path along which improvement of communication and cooperation can be fostered. Managers expect MCD to have an impact both on an individual level (motivating professionals to become more critical and to break with routines) and on a group level (fostering team-bonding and mutual understanding), as was shown in the study on aims and outcome (Chapter 5). MCD in this respect is regarded as a place where the skills that are necessary for good cooperation can be exercised. This is expressed in the term ‘educational tool’. Managers see MCD as a process aiming to facilitate a pedagogic area in which professionals learn on the job (namely while doing MCD together) to try out new, constructive ways of communicating. The manager expects participants to experience
MCD as communication training and to understand and apply the communicative lessons that are (implicitly or explicitly) provided by means of practising dialogue. So, although professionals do not mark MCD as an intrinsic part of their work (Chapter 3), managers note important work is done during MCD that is intrinsically connected to daily practice.

To optimize impact, MCD as an educational tool on a team process level requires the presence of a variety of professionals. Bringing a variety of disciplines together is not self-evident (Chapter 4). To meet the managers’ educational aims, MCD requires organization and effort. For this, local coordinators (Chapter 4) need to do work on a relational and organizational level.

MCD participants more or less confirm the managers’ educational aims as they mention that MCD is attractive because it has beneficial effects on everyday cooperation (Chapter 5). They describe how the process of dialogue within MCD bonds a team and fosters a cooperative climate in which the various professionals listen to each other and look for mutual understanding. They emphasize that a climate of mutual openness and learning is cultivated by regular MCD, but they do not formulate their insights in terms of ‘lessons learnt via dialogue’, as the manager suggests. MCD participants perceive MCD to have an intrinsic value that puts them on a track that relates to cooperative issues and climate. They come to these insights while doing MCD, rather than aiming at these issues beforehand.

Having a chance for dialogue on moral issues did not guarantee an improved cooperative climate. Time and experience were needed to transfer new insights to practice. The evaluation questionnaires showed that participants were sometimes surprised by their own insights. These insights needed time to settle before they could be applied in practice. As experience proceeded, examples of successful application of lessons learned became visible.

b The role of dialogue in implementing moral case deliberation
As mentioned before, the implementation project was designed in a dialogical way to ensure conformity with the characteristics of MCD. Throughout the studies, we included as many stakeholders as possible to understand their experiences and expectations regarding implementing MCD. We wanted to know to what extent their involvement was feasible, and how that worked out in the practice of implementing MCD. Based on the studies, the following main findings concerning the role of dialogue in the implementation of MCD stand out: (1) combining top-down and bottom-up involvement; (2) fostering co-ownership of MCD; (3) the role of dialogue in management styles for implementing MCD.
1 Combining top-down and bottom-up involvement

The field of implementation is generally regarded as the managers’ domain. Involvement of other stakeholders in implementation processes is not self-evident. Traditional hierarchical structures in mental healthcare moreover may obstruct the active role of other stakeholders (such as nurses or therapists, clients or family). Yet implementation of MCD in practice requires active mobilization of stakeholders, inviting them to share their experiences. Their involvement, experiences and questions are necessary for a ‘fit’ between the context and the instrument to be implemented (Chapter 3). Moreover, MCD requires openness from the participants. This may lead to a paradox when MCD is introduced as a top-down initiative. Therefore, active involvement of multiple stakeholders is necessary for successful continuous practices of MCD.

The study on the management’s view of MCD (Chapter 3) showed that top-down and bottom-up approaches need to be combined. A top-down decision to start MCD is necessary but does not automatically motivate the team in a durable way. Bottom-up actions are necessary once the sessions are up and running. Local coordinators (Chapter 4) can play an important role in this respect. The organizational work done by local MCD coordinators provides a precondition for participants of MCD to express the value, meaning and usefulness of MCD. Coming from the team, they form a bridge between team, management and MCD facilitator, helping the sessions to optimize outcome. A dialogical organization of MCD requires ambassadors on the shop floor. Pragmatically, ambassadors from within the team motivate colleagues to join sessions. Yet in this process local coordinators also showed the risk of adopting the MCD sessions as ‘theirs’. When a local coordinator does not share the responsibility of MCD with her/his team members, s/he becomes the sole owner of the MCD sessions (Chapter 4). When the manager does not explain the (top-down) aims for introducing MCD, the local coordinator may be perceived as a team member who is burdening her/his colleagues with extra work, without the back-up of the managers’ initiative.

Our studies on local coordinators and client participants (Chapters 4 and 6) also showed that the implementation of MCD was fostered by a combination of top-down and bottom-up involvement. All stakeholders had their share, either implicit (such as decisions regarding the organization of MCD based on experiences from participants) or explicit (for example a manager’s initiative to start MCD or the MCD steering group who adapted the quality procedures on MCD facilitators). Both top-down and bottom-up processes played a role in the process of implementing MCD.

The studies showed that from the introduction of the plan to implement MCD up to the organization of MCD meetings attention has to be paid to the expectations...
and experiences of all involved. MCD interferes with cultural dynamics and cannot be detached from its context. Aiming for dialogue inevitably touches upon communicative, cooperative relations in a team. MCD purposely makes explicit these dynamics in order to increase mutual understanding and expand perceptions on moral issues. For this potential relational impact to happen, MCD needs both top-down and bottom-up involvement and bridges to bring those levels together.

2 Fostering co-ownership of moral case deliberation Stakeholders’ ownership of MCD is fostered by the active involvement of the users throughout the implementation process (Molewijk et al., 2008). This adds to the applicability of MCD to practice and results in shared responsibility in the direction towards which MCD activities may be headed in the organization. Dialogue in the implementation process of MCD forms bridges between the various stakeholders, thereby fostering mutual understanding of the use, value and meaning of MCD. Merging stakeholders’ perceptions leads to a process of co-creation, characterized by both deliberative investigations and firm work. Such a process actively involves those who will actually work with the initiative to be implemented (Morgan, 1986).

The local MCD coordinators function as mediators between manager, team and MCD facilitator (Chapter 4). As they come from the team, their role proves important because it expands the ownership of MCD to the team: their inclusion and active participation in the process of implementing MCD keeps MCD closely related to the experiences of all involved and helps the implementation process move forward. Their contribution is dedicated to the continuity of MCD, and their critical attitude towards decisions from managers on behalf of MCD (Chapter 6) and MCD’s impact (Chapter 4) proves valuable. Adaptations on behalf of the organizational quality of MCD (frequency, participants, location, etcetera) strongly depend on their experiences.

The adaptations and the interference regarding the organizational quality of the MCD sessions (that are an integral part of the requirements for its implementation strategy) may come from any stakeholder’s experience. ‘Harvest’ of MCD (Chapter 5) contained concrete suggestions for practice improvements and the quality of MCD sessions. Dialogue between manager and team at this level can contribute to the enactment of MCD as participants and manager together determine the added value of MCD and possible policy adaptations that should be made to optimize harvest. It supports a sense of shared responsibility over the impact of MCD in terms of daily care, cooperation and organization (see Van der Knaap, 2006). If the manager is committed to a shared process for the complete team, efforts need to be made to explore the willingness and obstacles of both manager and team to cooperate in MCD’s imple-
mentation and during MCD sessions. This makes MCD into a shared team practice in which all stakeholders gain experiences of dialogue. In our GGNet MCD practice, we have seen examples in which the manager participated half-heartedly; dropping in halfway through a session, blurting out the ‘right answer’ to a moral issue, and then leaving because of her/his busy schedule. This attitude violates the characteristics of dialogue, and has little to do with a shared and equal deliberative process or with team bonding.

By sharing, exchanging and deliberating on how to implement and apply MCD, co-ownership of the implementation process can be realized. This process is enduringly contextualized and situated, as insights, experiences and meaning over the use of MCD will change overtime. Yet in the striving for joint cooperation in implementing MCD, the MCD activities need to be organized. Dialogue does not come spontaneously, but needs a solid framework embedded in time, space, method and facilitation.

3 A suitable management style for implementing moral case deliberation

The study on managing MCD (Chapter 3) showed that hierarchical, technical top-down implementation does not fit in with MCD’s democratic and dialogical nature. A hierarchical obligation to participate in MCD is inappropriate, forcing participants to meet with these dialogical characteristics. A steering approach might also undermine the credibility of the intentions that managers refer to: improving quality of cooperation, care and attitude in daily practice. Hierarchical obligation is also at odds with current views of management as participative or transformational leadership, inspiring employees to adopt the novelty to be implemented and to bring out co-ownership and shared responsibility of that novelty.

Notwithstanding the inappropriateness of technical steering in MCD, managerial and organizational efforts are needed to start and continue moral reflection, as was shown in our studies on managing MCD (Chapter 3), local MCD coordinators (Chapter 4) and client participation (Chapter 6). Both managers and local MCD coordinators emphasize that the need for reflection does not exist a priori among professionals (Chapter 3). From a pragmatic point of view, initiatives have to be taken, planned (managers) and organized (local coordinators). According to managers, a traditional management rationale of plan-do-check-act suits the implementation of MCD only to a certain extent. The first two steps (plan–do) can be organized in a traditional way. Yet the check-act phases require a dialogical approach, using insights from transformational management. Checking then refers to understanding the experiences from participants in the context of daily work and using them for practice improvements. Acting in this respect includes a dialogue on how to adopt these ex-
experiences within regular work processes, to secure and meet with the suggestions on practice-improvement that came out as a result of the MCD sessions.

Although a dialogical approach of implementing MCD is crucial, some stages of the process require work in terms of taking control. The aim for continuity of MCD in the midst of the everyday’s hassle may count as an example of the importance of direct steering: local coordinators calling upon joining sessions, managers who provide time and space and an obligation for moral reflection. Guaranteeing the quality of the conversation facilitators by means of organizing supervision and formulating quality criteria also counts as an example of control to overcome the risk of non-commital sessions, as shown in the study on managing MCD and client participation.

Our studies (Chapters 3 and 4) showed that aspects of both traditional and transformational management are necessary in the implementation process of MCD: MCD needs firm organization, but also attentiveness to the experiences of participants of MCD (Blantern, 2010; Verkerk et al., 2001). Traditional management styles alone do not do justice to the experiences of participants. Transformational management alone does not take into account the need for solid organization of preconditions for reflection. Both are necessary to make MCD valuable and useful for practice.

c The role of dialogue in research

The aim of responsive evaluation is to bring about a dialogical learning process between stakeholders. Our third research question addresses the attainability of this aim and the role of dialogue in the research process. In the study, the research process was not explicitly addressed, but indirectly insights were gained which may provide an answer to the third research question. In this section we present the following findings: (1) inclusion of all stakeholders in the research process is not self-evident; (2) interaction between research activities and practice improvements creates a cyclical process; (3) inclusion of stakeholders generates empowerment and involvement; (4) the various roles of the evaluator provide opportunities, but may also lead to tensions.

1 Inclusion of all stakeholders is not self-evident  During the studies, the evaluator consistently aimed to make explicit various perspectives on MCD and implementing MCD and bring them into the dialogue. The inclusion of all stakeholders manifests the particular values and democratic ideals that accompany a responsive evaluation design (House, 2002; Lincoln, 2003). These values concern inclusion, empowerment, active participation and equal deliberation (House and Howe, 1999;
Mertens, 2009). In order to live up to these values, we organized heterogeneous focus groups, inserting findings from earlier research into individual interviews or homogeneous focus groups. In this way, a mixture of voices was represented during our research activities, leading to a multiple view on the implementation process of MCD.

The studies showed that inclusion in the evaluation process is not a given. The study on local coordinators showed that it takes a lot of effort to build rapport, before stakeholders decide to join research activities. Local coordinators are reluctant to become partners in a research process, because they hold that science is too removed from their practice (Chapter 4). Inclusion of stakeholders requires work from the evaluator in order to build up trust and good relations (which, in turn, are not guaranteed).

In the managers’ focus group we presented findings concerning aims and outcome and asked the participants to respond. This resulted in an increasing awareness among managers of the potential of MCD for shared practice improvements and provided insight into the meaning of MCD in terms of shared responsibility. Separate findings from the diverse studies were brought together and shared with the various stakeholders, resulting in a merger of stakeholders’ perspectives and creation of a learning environment. Yet not all were included in the research process in an equal way. For example, the participants of MCD were only included via their evaluation questionnaires.

As the experiences of absent stakeholders were important for a full understanding of our research findings, we used naturalistic data collection in order to represent their experiences via iterative proceedings. The absent stakeholder group was given a voice by our taking note of and deliberating on their perspectives.

2 Interaction of research activities and practice improvements creates a cyclical process

Responsive evaluation facilitates direct active involvement in practice improvement (here: implementing MCD) by means of the research interventions (Van der Knaap, 2006). The studies in this thesis showed that MCD and MCD implementation were fostered by the research activities and vice versa. An example is provided by the focus group we organized with conversation facilitators and local coordinators. Besides a better understanding of the processes within MCD, this particular focus group underpinned the precarious relational balance between participants in MCD. The MCD facilitators joining this focus group learnt about the expectations of participants in MCD regarding the role of the facilitator. In terms of direct practice improvements and implementation requirements, the focus group showed the need for qualification of MCD facilitators and a solid quality procedure for selection of MCD facilitators.
In an emergent research design, stepping-stones for the implementation of MCD were found along the way. In this way, we gained insight into the role of the managers, the role of the local MCD coordinators and the optimal composition of groups. Responsive evaluation appeared to be a catalyst in this process, continuously keeping the reflection going and insistently introducing other perspectives in the implementation process.

3 Inclusion of stakeholders generates empowerment and involvement During all stages of the research process, the awareness of responsibilities and tasks in implementing MCD was fostered by active involvement of all stakeholders. Inspired by the model of appreciative inquiry (Carter et al., 2007; Gunderman and Chan, 2006), all research activities contained acknowledgement of the efforts that participants made to develop the practice and implementation of MCD. In the study among the local MCD coordinators, the research activity which was organized for and with them (i.e. a focus group interview) empowered the respondents. Their role became more visible and explicit, making them proud and enthusiastic about their own contribution to the implementation of MCD. After this focus group, many of them took up their task more vigorously – thereby directly contributing to MCD by being enthusiastic ambassadors.

Responsive evaluation appeared particularly suitable for studying the so-called ‘silent voices’ (Leigh Star and Strauss, 1999). This was for example the case in the study on client participation. We organized several dialogical research activities (interviews, focus groups, etcetera) during the process in which client participation in MCD evolved. We intensified our involvement with both the teams from the examples in the study, the client participants and the MCD facilitators, as we were fully aware of the rich yet tense relational atmosphere of the MCDs. The position of the client participants was strengthened by making explicit their ideas, ideals and doubts. Articulation of and shared deliberation about roles and responsibilities resulted in a more solid positioning of all stakeholders.

Without active support, however, these empowering dynamics did not always last. The client participants did not continue to participate in MCD without external help. We may conclude that empowerment requires work in terms of external stimulation. Our study on client participation showed that clinical teams do not take the initiative to invite client participants. Neither do the client participants invite themselves to MCDs. An organizational, sometimes vigorous, lead is required to achieve the inclusion of ‘silent voices’ (Leigh-Star and Strauss, 1999). If not, client participation may end untimely, as was shown in our study.
The various roles of the evaluator provided opportunities and resulted in tensions. In this study, the evaluator had various roles in the practice of implementing MCD. She not only functioned as an evaluator but also as the institutional MCD coordinator/programme leader and as an MCD facilitator. The fact that these roles were united in one person was beneficial in some respects. For example, practice adaptations that were proposed during research activities were applied quickly.

The multitude of roles of the evaluator supported the implementation process of MCD, and in turn led to new research issues and research activities. The work that was done in practice resulted in new research initiatives, and findings from research were processed in practice. The adaptations were monitored by the MCD steering group (of which the programme leader was a member) and brought into the dialogue again with other stakeholders. The prolonged engagement (Creswell and Miller, 2000) of the evaluator and her deep involvement in the implementation process appeared relevant regarding the continuity of a dialogical process of implementing MCD.

The number of roles of the evaluator also gave rise to tensions. Stakeholders perceived the evaluator both as a programme leader and as an MCD ambassador. Those who were critical towards MCD therefore probably felt less welcome to express their doubts concerning MCD or, on the other hand, were inclined to express their worries about MCD, engaging in a debate rather than a dialogue. In order to prevent this, work was needed, entailing explicitly inviting them to utter criticism. It was sometimes difficult for the evaluator merely to ask Socratic questions instead of entering into discussion.

Nevertheless the views of those who were critical of MCD were systematically used as input for interviews of focus groups. Particularly in the focus group with the managers (Chapter 3), this worked very well. Various managers expressed doubts concerning MCD, encouraged by the critical notes that were struck in earlier interviews with those who were opposed to MCD or did not consider it useful in practice.

The dynamic interaction between practice and research activities required the vigilant presence of the evaluator and the skill to shift between the role of the teacher, the Socratic guide, the advisor and the partner (Baur et al., 2012; Mackewn, 2008). This at times gave rise to tensions. Apart from acting as an equal partner in the process of implementing MCD, the evaluator had to make decisions at the level of policy on MCD. In formulating and holding on to quality procedures for the MCD facilitators, it was challenging for the evaluator to be straightforward about decisions. This implied a shift in the relations with the MCD facilitators. It took time and perseverance on both sides to get used to the combination of various roles in one person.

Apart from multiple roles, the normative aspects of the project caused tensions.
This was particularly visible in the study on client participation. The MCD steering group, including the evaluator/programme leader, was very keen on client participation: it was MCD optima forma, with an equal voice for all involved in the cases. It took time and reflection to accept that client participation may not be attainable in any circumstance.

II Theoretical excurse

Our study shows that dialogue plays a crucial role in MCD practice, in the implementation of MCD and in research supporting the implementation process. The increase of co-ownership of MCD could not have been realized without insistently giving voice to experiences of stakeholders. Dialogue played an important role in the process of understanding the potential and pitfalls of MCD. Yet our studies also show that dialogue is not a given, and that it does not always provide an answer to the practicalities that are met in the process of implementing MCD. The practice of MCD requires methodical steps and interventions (e.g. explicating power issues) to create a basis for dialogue and mutual learning.

Implementing MCD needs joint work by management, MCD steering groups and local MCD coordinators. The official initiative to start MCD (managers) and summoning participants to attend (local coordinators) are not dialogical per se, but serve as preconditions for dialogue. Thus, implementing MCD requires a pragmatic, top-down and not exclusively dialogical organization.

Finally, studying the implementation of MCD with a dialogical research design is not a given either. Involvement of stakeholders requires a clear and continuous message on the importance and appreciation of their experiences. A reflective attitude on the part of the evaluator is essential to prevent excessively highbrow ideas and ideals on dialogue, and to create openness for experiences of stakeholders, including negative and critical voices.

We may conclude that dialogue is crucial in MCD, in implementing MCD and in research, but organizational activities and care for solid preconditions are equally necessary. From the chapters of this thesis, it appears that the implementation of MCD requires active steering, ongoing pragmatic interference and letting go at the same time. The dynamic relationship between dialogue on the one hand, and organizational activities on the other, brings about associations with the work of Hannah Arendt. Her distinction between the processes of Labour, Work and Action can shed a new light on the dynamics between dialogue on the one hand, requiring free space, and the necessary organizational and preconditional procedures. The concepts of Arendt prove helpful to deepen the reflections on our findings. In the next section, we
will provide a short overview of Arendt’s concepts. Subsequently, we will investigate how the concepts of Arendt can add to the findings from our study. Reversibly, we will also explore what light the developments we have studied may shed on Arendt’s theory.

**Hannah Arendt’s Vita Activa**

In ‘The Human Condition’ (Arendt, 1958/1998), Arendt distinguishes three levels of the human condition and the human way of establishing a ‘good life’. The distinction of the three levels implies three elements of the ‘Vita Activa’ – the nature of human activities - subsequently Labour, Work and Action. According to Arendt, the tripartite division of Labour, Work and Action can be regarded as a hierarchical classification, reflecting subsequently more distinguished levels of freedom that refer to an ideal of a ‘Mundus’ (world) that is collectively constructed, and based on collectiveness.

*Labour* refers to the most basic need to sustain life itself, requiring quick, cyclical, recurring activities to support biological maintenance. It is the domain of the necessity (1958: pp. 28-32). Because of the inevitability of the need to sustain life, and because Labour appears in the intimacy of a separate (as opposed to public) area (Arendt describes it as ‘cloaked in privacy’ 1958: -pp. 71-72/179), Arendt qualifies this domain of the human condition as unfreedom (or even ‘dead to the world’) if not combined with Action (1958: pp. 176).

*Work*, according to Arendt, means the creation of non-natural artefacts in the human world; more specifically she refers to those creations that separate humans from each other such as houses, walls or claimed domains (1958: pp.137). Arendt refers to Work as underpinning the technical and/or instrumental character of this domain. She classifies this Work as distinguishing humanity from animals (1958: pp.121), offering a greater amount of freedom in which humans show sovereignty and control over (natural) life (1958: pp.144-148). Arendt qualifies Work as a public function, with an impact on public relations and influencing perceptions of the world the community needs to relate to. This impact is not per se a positive impact according to Arendt, because of the division it may bring between individuals (1958: pp.159).

Finally, Arendt distinguishes *Action*. This concept refers to community life, a shared responsibility for the quality of life of all humans. In Action absolute freedom is established. *Action* refers to community. Pure freedom, according to Arendt, is never established by individuality, but always situated within a context of shared humanity and community sense (1958: pp.181-190). *Action* insistently refers to the unexpected, to completely fresh and unpredictable initiatives (1958: pp.234/244). This in itself – the novelty of action – means freedom, as it does not logically refer to history or past
occasions but to fully new and fresh ideas on how the good life can be obtained.

Action is never good (or bad) in itself, but should always be judged from the perspective of the collective: public life (1958: pp.180). Action results from relations with other humans and is always experienced in public. Essential for Action is both performing and speech (1958: pp.175-180). According to Arendt, this is the human condition: political life in its essence. Meaning is created by the exchange between individuals, and is thus unique expression in words, serving understanding and the birth of new ideas (1958: pp.178). Through human Action, communities can be built in diversity (1958: pp.68). Arendt refers to this as ‘the paradox plurality of unique beings’ (1958: pp.176), requiring deep exploration of the attempt to truly understand the other and creating a field of trial and error in order to come together, find compromises or (dis)agree.

Applying the concepts of Arendt to the process of implementing moral case deliberation

For Arendt both dialogue and reflection are important concepts. Reflection is referred to as an attitude of reconsideration, a second opinion, and tested in a mutual encounter by speech (Arendt, 2003 pp.150; Kristeva, 2001). Dialogue and reflection are central notions in the process of implementing MCD, as described in this thesis. Next to the distinction between Work, Labour and Action, this is relevant for a reflection on our findings and strengthens our choice to use Arendt’s work for this.

Arendt does not intend just to map human activities. She aims to describe and understand complex (historical) processes, and to contribute to the development of ideas about an ideal world - often referring to the Greek philosophers, in particular Aristotle. She developed her political-philosophical ideas around World War II, in response to the atrocious and incomprehensible events she encountered. Our application of Arendt’s ideas on dialogue and dialogical practice to the process of implementing MCD may be considered as limited, and certainly does not fully do justice to the intricate nature of her philosophical work. Nevertheless, we believe that, because of the focus on dialogue, joint reflection practices, inclusion and equal deliberation, MCD and its implementation process can be interpreted in a political sense. Addressing power issues and the need for solid work as a precondition to realize a dialogue, make MCD a process which is based on presuppositions similar to those of Arendt’s work.
Labour, Work and Action: freedom and regulation in modern healthcare

The context of a healthcare institution can be regarded as a community, in which all involved are oriented on the good life, with a focus on caring for others and ourselves. Care is both a moral and political activity which is always embedded in relations and community (Tronto, 1993). In healthcare, these relations imply elements of power. In the context of care institutions as moral and political communities, the concepts of Arendt may shed new light on our findings.

Arendt’s conceptual model refers to the keywords ‘freedom’ and ‘regulation’. In modern organized healthcare practice, both Labour and Work are processes that are strongly regulated. Labour should be understood as all those actions that are related to the sustainment of ongoing, basic processes in healthcare: the cyclical work of the primary process in terms of washing, bathing, feeding, comforting, nursing patients. These skills and tasks are perceived by caregivers as a natural part of their job. They are regarded as self-evident activities between patient and primary care worker. They generally remain invisible, and, as a side-effect, are low-paid and socially little appreciated.

Work in the context of healthcare institutions should be understood as following protocols and regulations for an (economically) healthy organization: making sure beds are full, cutting down on personnel, optimizing care by introducing new technical interventions, supplying preconditions for good care (by protocols or regulations, etcetera). At times, these aspects appear alien to professionals yet are necessary in order to make sure an institution can survive financially. Both Work and Labour are examples of processes that require top-down regulation, referring to measurable output in terms of quality, work routines and production.

Action in healthcare refers to the domain of freedom. In this area, initiatives are created from joint deliberation based on practice experiences. In MCD, speech, expression and consequences of the deliberation process are central. MCD claims free space for unexpectedness and freshness, and recuperation in terms of togetherness and the sense of shared practice, not only in terms of the MCD session as such but, as shown in this thesis, also in terms of the implementation process around MCD.

Reflecting on the implementation of moral case deliberation from the perspective of Arendt

We concluded above that MCD requires the active support of management. Preconditions such as well-qualified conversation facilitators and time and space for MCD must be guaranteed. Reflection should be organized as part of professional functioning, since professionals do not automatically reflect:
they see it as an obstruction to their regular work although they do feel the desire to discuss casuistry (Chapter 3). The managerial preconditions for organizing and implementing MCD represent artefacts (Work of managers) in which a particular experience can evolve. Organization of meetings and preconditions is needed to motivate participants to actually join in (Labour of local MCD coordinators). Depending on the ability of the managers to ‘let go’, participants experience free space to explore and come to new insights for practice improvements (Action of participants).

Action understood as ‘letting go’ does not only refer to managers’ attitude towards organizing MCD, but also to their active participation in MCD. Participation may strengthen a credible implementation once MCD is understood as a joint practice of practice improvement, based on equality and shared responsibility. Action invites equal deliberation in a collective, shared search for learning from and the meaning of practice experiences, thereby being inherent in (the potential of) MCD’s credible implementation. Once participants are brought together (Labour), with a qualified MCD facilitator (Work), and provided with coffee or tea (Labour), reflection can commence (Action), and bring about shared learning on moral issues and team processes.

So, the three concepts Work, Labour and Action are represented in the process of implementing MCD. These concepts can also be applied to evaluate MCD’s utility, value and meaning. In Labour, utility prevails: behind the scene, local coordinators try hard to bring together various disciplines to make the MCD session fruitful. They remind participants of the scheduled session, they make sure a moral case is available, and take care of the circumstances and attributes that are necessary (a room, white board, coffee, tea, etcetera). These pragmatic preconditions are necessary to ensure the session will take place.

Work in implementing MCD refers to the value of MCD: its expected impact on team bonding, cooperation, communication and attitude. Managers introduce MCD to accomplish these aims. Work refers to the investment in terms of time, people, training and money, combined with a set of strong expectations concerning the value of MCD.

Action refers to the meaning of MCD, experienced by participants during a process of developing new ways of communication and deliberation, leading to new and creative ideas. In terms of implementation, Action refers to the willingness of the manager to let the process evolve and accept that steering on a content level is inappropriate.

To sustain the Action-practice of MCD, Work needs to be done: openness towards new ideas on practice must be systematically present and processed. This implies that findings and experiences lead to decisions on how to change daily routines, resulting in agreements on further cooperation and communication: how do we wish to handle disagreements, mutual differences, etcetera? What was learnt from the MCD
experiences and how can we transfer this to daily practice? Can conclusions be drawn on that level?

Action in the implementation process of MCD also refers to openness to barriers. By focusing on issues concerning quality of care, cooperation and organization (Chapter 2), MCD can play a part in developing new ideas on practice improvements. This may strengthen shared responsibility and openness in daily cooperation by including stakeholders in the process of decision making.

Reflecting on our evaluation research from the perspective of Arendt

Throughout the research process, we learnt that the exchange of experiences and ideas on MCD required coordination. A dialogical approach to research did not come about spontaneously, but needed organization and explanation. Referring to Hannah Arendt, we may conclude that Action needs Work and Labour. In responsive evaluation, Labour and Work are involved in developing relations and sustaining positive dynamics in (and among) stakeholder groups (Abma and Widdershoven, 2011; Visse et al., 2012).

Labour was particularly at stake in the process of creating confidential relationships with the stakeholders, stimulating them to speak openly and honestly. Much effort was needed, for example, to create and sustain positive liaisons with the local MCD coordinators, who at first doubted the practical use of research. Informal talks, e-mails and meetings on the wards were needed to make the coordinators believe that their experiences and expertise were crucial in our research (also see: ‘Notes from the researchers’ logbook’ earlier in this thesis).

Work in the research process meant good planning and inviting stakeholders to participate in research activities, underpinning the value of their experiences and ideas. A lot of work was also done at the level of informing stakeholders about responsive evaluation and being appreciative about their contribution to (the implementation of) MCD. The guidelines of responsive evaluation described in the literature (Denzin and Lincoln, 2005) needed to be followed in order to guarantee reliability. They functioned as a framework (‘artifact’, in Arendt’s terms. 1958: pp.8/204) in which the process of dialogue could emerge.

Obviously, the research activities also entailed Action: room for the unexpected, for not knowing what our efforts might result in. They implied a shared search for meaning, risks and possibilities of MCD, requiring postponing of normative ideals. To give an example: during the focus group with local coordinators (Chapter 4), we expected to meet stakeholders who would have an intrinsic motivation for MCD. Yet their task-oriented way of organizing MCD had little to do with enthusiasm about clinical ethics. Rather, they were proud of their ability to get people around the table. This
shed new light on organizing clinical ethics, making us aware of the role of Labour. It showed that successful organization of clinical ethics requires a pragmatic approach. During this process, Action resulted in Work in the form of developing documents to instruct new local coordinators, based on Labour of experienced MCD coordinators who had developed ways of fulfilling their task in an explorative, experiential way.

Reflecting on Arendt in the light of our study on the implementation of moral case deliberation

For Arendt, Action is more important than Labour and Work. Our study underlines the crucial role of reflection and dialogue in transforming healthcare institutions as moral and political communities, by democratizing relations and communication. It shows that MCD can be regarded as a vehicle for realizing Action in healthcare. Yet, our study also shows that MCD, as an enclave for Action, cannot be sustained without Labour and Work. Moreover, Labour, Work and Action are not separate elements of human life, but refer to each other and are interrelated. We will briefly explain what these insights add to Arendt’s theory.

In the literature, Arendt’s conceptualisation of Labour, Work and Action is criticized, as it presents Action as the ultimate aim and the final stage of the human condition, and undervalues Work and Labour. Arendt is indeed particularly critical regarding Labour, describing a fear of people becoming ‘machine men’ (1958: pp.145-147) without distinctive, individual characteristics that mark the space between Labour and Work. In the view of Arendt, this space is necessary to obtain the first steps towards freedom (1958: pp.116-119). Several feminist authors have criticized Arendt’s view on Labour, as it may reinforce gender roles that have traditionally excluded women from public life (Curtis, 1995; Dietz, 1991; Honig, 1995). Furthermore, Arendt writes in The Human Condition that those working in the Labour domains should (or even must) emancipate (2003: pp.129/134). The critics note that Arendt underestimates the value of Labour, interpreting this as merely a functional part of the human condition, situated in individual, enclosed and non-public (or non-political) life.

Our study showed that Labour as part of the implementation of MCD, is essential for MCD as dialogical practice (Action). Making explicit the role of Labour and those who take care of this (particularly local coordinators and participants in MCD) helps us to understand the dynamics of organizing and implementing MCD.

Our study not only shows the importance of Labour as a separate activity, it also shows that Action is not the final stage of implementing MCD. Although dialogical processes are important, they are not ends in themselves but serve as means for improving practice, for implementing MCD and for studying the implementation process of MCD. The role of MCD in care practice, and the role of exchanging experi-
ences in implementing MCD, show that dialogue is not merely worthwhile in itself but can contribute to new ways of organizing practice; it can help to develop new forms of Labour and Work. So, our study suggests that Work, Labour and Action are interdependent. Action cannot come about if Work and Labour aren’t well taken care of, and Work and Labour lack direction and meaning when Action is missing. Our study shows that the three levels need each other and are intertwined. The evaluation of the utility, value and meaning of MCD requires a dialogue between management and team, which cannot come about without Work and Labour. Work and Labour serve Action, but findings coming from free deliberation require Labour and Work to find their foundation in practice and to help the instrument of MCD to develop further. Thus, the study on the implementation of MCD shows that the concepts of Labour, Work and Action are interrelated in a continuous, cyclical, and dynamic movement. Implementing MCD should be based on a cyclical process in which Work, Labour and Action each have their part, resulting in solid frameworks for an ongoing, shared search for and deliberation about practice improvements.

III Methodological considerations

Reflection on methodological issues is necessary in order to be transparent and justify the steps that were taken and the choices that were made throughout the research process. A qualitative research paradigm contains specific quality criteria which foster accountability. The qualitative research paradigm presupposes that reality is socially constructed. This implies that there is no final answer or one single perspective on reality, but many realities exist alongside each other and all at the same time (Gergen and Gergen, 2000; Paulus et al., 2008). This assumption does not necessarily imply a relativist position: certainly conclusions can be drawn as perspectives on reality meet and merge.

The criteria for evaluative qualitative research were developed by Guba and Lincoln (1989). They cover dependability, credibility, transferability, authenticity and confirmability. These criteria are addressed in the following sections.

**Dependability** Dependability refers to the interference of the evaluators’ assumptions that may reflect on the outcomes of the studies. The criterion of dependability is an answer to the risk of subjectivity in research, as the evaluator is the principal person collecting the data and analysing them. The criterion prevents the evaluator from framing the findings from personal normative assumptions. Regarding her diverse roles in the practice of (implementing) MCD, the evaluator in this
study took particular care of this criterion, being an engaged stakeholder in the implementation process of MCD herself.

To meet the criterion of dependability, most of the collection and all of the analysis and interpretation of the data were accomplished by more than one person. Analysis and interpretation were discussed in the research team and in cooperation with other authors included in the study. These multiple coding proceedings (Barbour, 2001) were particularly focused on differences in insights into the interpretation of the findings. The starting point was that differences would expose blind spots, hiatuses and new perspectives.

In our research, the data analysis and interpretation were performed along the lines of content analysis in close quarters with all authors involved. In the chapter on CES (Chapter 2) and the chapter on aims and harvest (Chapter 5), the data were independently read and interpreted by the first and second author, after which findings were brought together. All authors then interpreted the separate data findings and deliberated on these findings until consensus was reached by the complete research team.

Multiple coding not only prevents blind spots in data interpretation but also tracks down personal normative assumptions about the practice under research. This appeared particularly important in the study on client participation (Chapter 6). The first and last authors were also members of the MCD steering group in the institution. This institutional MCD group cherished the idea of client participation in MCD from principles of inclusion and equality. The data still showed many obstacles faced by professionals, local coordinators, managers and client participants. We had to be open to the perspective of practice experiences and downplay our normative presumptions, realising client participation is not attainable under all circumstances and may in fact obstruct the process of equal deliberation, the essence of MCD. These personal reflections were part of the discussions in the research team, employed in order to understand the impact of the presumptions in the interpretation phase.

**Credibility**  Credibility in the qualitative research paradigm refers to the trustworthiness of the research. Several actions were taken to meet this criterion. First, rapport between evaluator and stakeholders was created through prolonged engagement and persistent observations. Participating in MCD sessions, facilitating MCD sessions, meetings with managers, MCD facilitators, directors and the board, sharing lunch with local MCD coordinators and client participants were all examples of actions intended to sustain good relationships. As a result, good two-way relations were established and interviews and focus groups were well visited. In preparatory,
informal encounters the accent was on appreciation of experiences, ideas, critical notes and expertise in MCD. Obviously, because of the evaluators’ mixed roles within the institution, this attitude of interest remained throughout the research and is relevant today.

Second, member checks were done with most stakeholder groups. The interpretation of our findings was shared with the stakeholders and was open for critique or comments. This not only contributed to the trustworthiness of our studies, but also stimulated active involvement of stakeholders. Since scientific research can meet with some reticence, particularly among nurses, this was an important procedure in the construction of the relation of cooperation between practice and research.

Next, multiple data collection methods were used. Individual interviews, group interviews, focus groups and a naturalistic data collection method were used throughout the study. Also, the separate data sets and findings were used as input for data collection activities in latter stages of the research (iterative procedure), to refine our findings, bring nuance to the outcomes and include different perspectives in different stakeholder groups. This latter point also met with responsive evaluative normative ideals on inclusion and empowerment, giving a voice to stakeholders who might not automatically be heard in research.

**Transferability** The criterion of transferability refers to ‘the empirical process for checking the degree of similarity between sending and receiving contexts’ (Guba and Lincoln, 1989, pp. 241). Responsive evaluation focuses on the unique, the local and the particular (Stake, 2013) by providing thick descriptions, which are detailed descriptions of context, stakeholders and meaning. This is important for generalization issues. Because of the use of thick descriptions the reader can note comparable items from the research to other contexts. Those comparable practices support the transferability of research findings. For example, the chapter on managing MCD (Chapter 3) provides a detailed description of dilemmas from managers participating in MCD. Managers from other contexts may be inspired to reflect on those dilemmas and with those insights decide how to position themselves in their own organization.

The issue of generalization also contains learning potential for those contexts struggling with issues concerning the implementation of MCD. The studies in this thesis function as an inspiring example of implementing MCD, based on (organizational) recognizability of details from our study. During the many workshops and presentations that we conducted, participants noted new insights, ideas and inspiration concerning (implementation of) MCD, resulting in vivid discussions based on comparable issues from the many contexts they came from.
**Authenticity**   The criterion of authenticity (or ‘fairness’) refers to a set of values that enables a fair, balanced presentation of diversity in terms of stakeholders and the contribution of the research to social justice (through its normative appeal to empowerment) (Abma, 1996). We met this criterion by including all stakeholders during the research and the implementation process. We took care not to overlook the so-called ‘silent voices’ (client participants, participants, local coordinators) and explicitly asked about their experiences of (implementing) MCD. We also used these experiences throughout further research proceedings; for example, for iterative procedures introducing their experiences in other stakeholder groups.

We aimed for inclusion in terms of the research data, but also actively involved all stakeholders in the implementation process in practice. The intention was to support them to co-own MCD in the organization – to prevent the idea that implementing MCD was solely our mission or our instrument. Practice adaptations that were based on findings from research were always communicated to the stakeholders who initially generated the data for this change.

**Confirmability**   The criterion of confirmability refers to the extent to which outcomes and findings directly originate from the data. The criterion focuses on the plausibility of argumentation and the structure of the study. First of all, we took care when structuring, organizing and storing our raw data and transcribed most of our data sets. During analytic procedures, a constant interaction with the raw data was done to check if the findings were indeed a plausible reflection of the expressions of our respondents. Next, the analysis and interpretation of the data were performed continuously by a team of evaluators and other authors. In this way we were prevented from getting carried away by interesting thoughts that could not be traced back to the original data.

Another important way of meeting the criterion of confirmability was to exchange reflections on interpretations and relate them to underlying principles in the research team. To make this process traceable to the reader, we included quotations of respondents in all studies.

**Strengths and limitations**
This study intended to provide an insider’s view on implementing MCD in a mental healthcare institution. Strength of this study is the wide representation of stakehold-
er groups. By including participants, local coordinators, MCD facilitators and client participants in our research we added new perspectives on practices of implementing MCD, painting a more complete picture of MCD dynamics. Through this procedure, the research design prevented an approach to implementation as a technical injection top-down. Also, by underpinning the value of the contribution of every individual stakeholder in the research process, our approach not only generated valuable information but also created durable relations that supported further development of the implementation of MCD in the institution. The large (geographical) size of the organization meant the research contributed to liaisons between stakeholders who were colleagues yet appeared to have never met before. Research interventions therefore helped to pull down invisible walls in the institution.

Among some stakeholder groups an increase of empowerment became visible. This was particularly the case among local coordinators – typically the group doing the ‘invisible work’ for MCD (and, considering our democratic orientation, of particular interest). The appreciative approach to their important contribution to implementing MCD provoked zeal among this stakeholder group. The importance of their role was capitalized during the annual Dutch Working Conference on MCD, in which some of the local coordinators conducted a workshop on bottom-up involvement in implementing MCD. This gave a true and lasting impression of the value of their role of which the institution still perceives the benefits.

Our research also had limitations. First, our research is located in the Netherlands and in a mental healthcare organization. International correspondence, meetings, workshops and presentations made clear that MCD particularly suits the culture of Dutch healthcare. Compared with many other (European) countries, Dutch healthcare is organized horizontally, and mutual openness, directivity and negotiation are common. This can give rise to deliberative ways of ethical reasoning more than in other countries. Although responsive evaluation does not aim for generally applicable findings, we note this as a possible limitation of the relevance of the findings in other international contexts.

The fact that this research is situated in a long-term care context may also limit generalizability. It is suggested that mental healthcare organizations particularly provide a context in which joint deliberation or discussion is a common concept. Referring to Chapter 2, we suggest that the increase of MCD in mental healthcare may be owed to this characteristic. The organizational structure of curative care institutions (such as hospitals or revalidation centres; compare Stolper et al., 2012) may differ to such an extent that the applicability of our findings remains fairly limited.

Throughout our studies, we worked with small sample groups. For pragmatic
reasons – mainly a lack of space on agendas – not all managers were able to join the focus groups we organized. We consider this a limitation, since not all voices are heard in the research process. We tried to compensate for this by organizing repeated meetings with the diverse stakeholders (detached from research activities) to include as many separate voices as we could in the progression of the implementation of MCD in the organization.

Finally, the number of heterogeneous focus groups we organized was low. Apart from one focus group of local coordinators and conversation facilitators, all focus groups were homogeneous. We regret that, especially from the standpoint of our democratic, empowering ideals. To compensate for this, iterative proceedings were used so that a mixture of perspectives was represented. Yet a direct confrontation of different viewpoints was not accomplished to the extent we intended.

Future challenges and directions for practice and research
In the section below, we present future challenges and practical directions for research. The challenges and directions are divided into three parts: the practice of MCD (1); the implementation of MCD (2); and research on the implementation of MCD (3).

1 Practicing moral case deliberation
MCD is a demanding practice which requires the ability of speech and expression. In the light of experiences in our MCD practices at GGNet, we may conclude particularly that participants with little educational background may initially experience MCD as difficult because of the need for a mastery of language. Searching for ways to improve the capability and accessibility of the ‘silent voices’ by introducing alternative ways of MCD resonates with the aim of empowerment that is crucial to MCD.

Further research is desirable to determine whether other forms of moral reflection, including embodied and artistic expressions of moral orientations, may be helpful. The possibilities in this respect are numerous (using metaphors, painting or, as in this thesis, music) but need to be in line with the principles underlying MCD. Further research is also necessary on the competences of the MCD facilitator, as these are only addressed in passing in this thesis. The listed competences raise questions about who will be able to learn these competences, how they can best be taught (if at all) and how they can be addressed during the training. Findings from that research can be used for building a curriculum for training MCD facilitators.
As regards practice, the study from this thesis emphasizes the importance of solid and continuous training of MCD conversation facilitators. This training should cover the five domains identified. As training in becoming an MCD facilitator requires learning by doing, the facilitators should be offered sufficient chances to practise their skills, ongoing peer supervision and supervision by senior MCD facilitators.

Further, in practice the participation of so-called ‘silent voices’ in MCD should be considered, such as clients or family participants. Our study showed that inclusion of these often overheard voices adds valuable viewpoints to a case. MCD contributes to democratic values by putting them forward in dialogical activities. We recommend that practice should continue to encourage client participation in MCD practices, yet doing so without losing sight of the vulnerable, fearful, worried and (as always) honourable position of all participants. This requires reflection on preconditions for dialogue and participation, preventing the ethics of an over-optimistic and formally ideological introduction of MCD.

2 Implementing moral case deliberation

This thesis showed that theoretical views and convictions are not enough for a successful implementation process of MCD. Added value in more measurable terms is important, such as improvements in quality of care (Gracia, 2003), decrease of health-related absence and lessening of moral distress (Erlen, 2007). Research on outcomes and impact of MCD and the meaning of MCD for daily practice is a necessary complement to the research presented in this thesis, as it could contribute to the expedience of MCD and support implementation of MCD in institutions.

Research on the effects of MCD should, however, do justice to its dialogical aspects. Outcomes – or rather: harvest - should not merely be interpreted in terms of utility but also in terms of value and meaning. Outcomes should not be defined separately from the views of the stakeholders involved. Thus, dialogical processes are needed to determine desirable outcomes, in line with the way we studied the aims and harvest of MCD. Dialogical processes are also needed to interpret results of research on harvest and effects of MCD and help to explain them. Thus, qualitative and quantitative studies should be combined in a meaningful way, strengthening each other.

This perspective on studying and applying outcomes of MCD also has implications for the practice of implementing MCD. Research on the effects of MCD may pave the way for an instrumental approach and use of MCD. Having measurable outcomes at
hand may result in convincing management of the usefulness and managerial prof-
its of MCD. Implementing MCD comes with room for unexpectedness on the basis
of experience. Outcomes or harvest cannot be predefined and certainly cannot be
fixed beforehand. Dealing with this requires a dialogical, joint approach to the im-
plementation of MCD as suggested in this thesis. Not only would we sincerely regret
an instrumental approach of MCD focused on expedience only, we also believe that an
instrumental approach to MCD would obstruct a genuine or credible introduction of
dialogue as a means and outcome of MCD. This, in fact, is at the heart of this thesis:
putting MCD forward as a practice that relies on and supports joint practice improve-
ment and shared ownership.

3 Responsive evaluation
Responsive evaluation was very suitable for this
study. One reason for this was that the multiple roles of the researcher worked out
well. Being part of the processes in practice made her a partner rather than a distant
expert. This worked particularly well for those groups that were often little heard,
such as (client) participants and local MCD coordinators. Further research is recom-
ended on how participation in research, organizational processes and/or dialogical
activities contributes to empowerment. Although we have seen examples of increas-
ring empowerment among specific stakeholder groups, a more systemized study on
this topic is desirable.

Further, more detailed research on the multiple roles of the researcher is neces-
sary. We therefore recommend a qualitative study in which the experiences of role
differentiation of the researcher are central, as well as the impact of the separate roles
on the research context.

Conclusion
This thesis dealt with the implementation of MCD in mental healthcare practice. As
the practice of MCD is directed towards the sustainment of a dialogue among par-
ticipants with various backgrounds, we approached the issue of implementation of
MCD dialogically. To do so, we used a dialogical research design – responsive evalu-
ation – to include as many perspectives on and participants in the implementation
of MCD, including and acknowledging experiences that come with (implementing)
MCD. Thus, our study was based on a threefold role of dialogue.

We conclude that a dialogical approach to implementation is appropriate for
MCD, as it remains close to the characteristics of the instrument under implemen-
tation. This does not imply that steering on organizational aspects of MCD is not
allowed. The practice of MCD cannot be approached in isolation from traditional implementation strategies: theoretical views and convictions alone do not provide sufficient grounds for successful implementation of MCD. Implementation also requires work: practical thinking and organizational skills which relate to a pragmatic approach to clinical ethics. Our studies showed that both elements are necessary and should be combined.

In terms of the philosophy of Arendt, we concluded that MCD, its implementation and its evaluation typically require an intertwined combination of Labour, Work and Action. Labour and Work are necessary to provide grounds for safe investigation of presuppositions concerning moral issues. They provide the base for Action, accomplishing dialogue and exchange. Yet Action is not a final goal. Sustaining a dialogue provides a starting-point from which stepping-stones can be determined – again requiring Labour and Work in order to be realized in practice. In other words, Action serves Work and Work serves Labour, etcetera. This cycle is continuous, and illustrates that the implementation of MCD is not a process that ends at some point. Implementing MCD implies an ongoing dialogue on how to systematically organize joint reflection and deliberation in order to durably foster quality of care, cooperation and organization in a healthcare institution. In this way, MCD and its implementation provide eminent examples of dialogue at work.
References


References
Samenvatting

Dialoog
in Bedrijf
Samenvatting
De afgelopen decennia, in het bijzonder sinds de opkomst van de zorgethiek in de jaren ’90, zijn er veranderingen merkbaar in de wijze waarop klinische ethiekondersteuning in de gezondheidszorg wordt uitgevoerd en georganiseerd. Hierbij wordt in toenemende mate van belang geacht dat er niet alleen sprake is van een moreel oordeel vanuit experts (zoals commissies ethiek), maar dat de ervaring en morele expertise van degenen die bloot staan aan de morele kwestie intrinsiek onderdeel vormen van het proces van morele oordeelsvorming. Ten gevolge van deze veranderingen gaan steeds meer gezondheidszorginstellingen over tot het faciliteren van deliberatieve vormen van ethiekondersteuning, zoals moreel beraad. Moreel beraad (MB) is in het bijzonder een opkomende vorm van morele reflectie binnen de Nederlandse gezondheidszorg.

Dit proefschrift volgt en beschrijft het proces van implementatie van MB in een grote instelling voor geestelijke gezondheidszorg (GGZ) in Oost-Gelderland: GG-Net. In het onderzoek komen, langs dialogische weg, aspecten van implementatie van MB over het voetlicht. Hierbij wordt steeds de weg gevolgd van de directe ervaring van belanghebbenden die met deze praktijken te maken hebben. De directe ervaring doelt op zowel deelname aan een MB, ondersteunende praktijken, faciliteren van MB, als de organisatie van MB.
Hoofdstuk 1
Introductie Dialoog in Bedrijf

Het inleidend hoofdstuk geeft een weergave van ontwikkelingen op het gebied van de klinische ethiekondersteuning (‘Clinical Ethics Support’; CES) in de afgelopen decennia. MB is een voorbeeld van relatief nieuwe vormen van klinische ethiekondersteuning, welke binnen de Nederlandse gezondheidszorg terrein wint. In dit proefschrift wordt het MB gestoeld op een hermeneutische, dialectische visie waarin de totstandkoming van een dialoog doel en middel is. Dat betekent dat de concrete ervaring van de morele kwestie, de gezamenlijke exploratie van diversiteit in perspectieven, het onderling leren en een gezamenlijk proces wordt nagestreefd, samengevoegd in de term ‘dialoog’. Het MB wordt gekenmerkt door de volgende aspecten: het is een groepsgesprek over één waargebeurde casus, en één morele vraag uit die casus. Via een methodische en gedisciplineerde werkwijze, onder begeleiding van een specifiek getrainde gespreksleider die neutraal is ten opzichte van de inhoud van de casus, wordt toegewerkt naar de totstandkoming van een dialoog. De dialoog onderscheidt zich van debat, discussie, conflict of tribunaal doordat alle interventies en stappen erop gericht zijn dat men elkaar leert horen en begrijpen middels vragen stellen. Er wordt dus nergens overtuigd, en er bestaat onder de deelnemers geen morele hiërarchie. Vooronderstellingen worden systematisch opgespoord en uitgevraagd, om te checken of die geldig zijn in relatie tot de feiten uit de casus. Het MB kenmerkt zich door vertrouwelijkheid, onderlinge openheid en (morele) gelijkwaardigheid.

Gelet op de dialogische kwalificaties en karakteristieken die het MB omkleven, was de startoverweging van dit proefschrift dat ook de implementatie van dat MB dialogisch van karakter moest zijn. Reden hiervoor is trouw te blijven aan de karakteristieken van de dialoog. We veronderstelden dat een top-down opleggen van MB niet passend zou zijn, wat overeenkomt met veranderende inzichten omtrent leiderschap, waarin aandacht wordt geclaimd voor actieve betrokkenheid van professionals bij implementatieprocessen. De argumentatie daarachter is dat een technische innovatiestijl (top-down opleggen van veranderingen) niet altijd wenselijk of haalbaar is, of zelfs contraproducentief kan zijn.

Vanuit bovenstaande overwegingen is ervoor gekozen om ook het onderzoeksdesign aan te laten sluiten op de dialogische karakteristieken van het MB. Responsieve evaluatie sluit nauw aan op de kenmerken van het MB zelf. Langs deze denkwijze werd een drievoudige toepassing van het begrip dialoog zichtbaar in het onderzoek: in de praktijk van het MB, in de implementatie van het MB, en in het onderzoek naar die implementatie van MB. Op basis van deze initiële overwegingen formuleerden we de volgende drie centrale onderzoeksvragen voor dit proefschrift:
Hoofdstuk 2
Impliciete en expliciete ethiekondersteuning
In dit hoofdstuk wordt een overzicht gegeven van de vormen van klinische ethiekondersteuning in de diverse Nederlandse zorginstellingen. Deze vormen kunnen expliciet zijn (structurele en geïnstitutionaliseerde aandacht voor morele kwesties, met professionele begeleiding) of impliciet zijn (organisch ontstane aandacht voor morele kwesties die tot stand komt in de wandelgangen, intervisie, of tijdens andere overlegmomenten). In de studie is diversiteit van zorginstellingen ontsloten door zowel ziekenhuizen, GGZ, ouderenzorg als zorg voor mensen met een beperking op te nemen. De uitkomsten van de studie tonen aan dat commissies ethiek relatief veelvoorkomend zijn in Nederland – in het bijzonder in de ziekenhuissector. Circa de helft van alle Nederlandse zorginstellingen heeft MB, met uitzondering van de GGZ: hier heeft bijna 2/3 van alle instellingen MB. De consulent ethiek is in Nederlandse instellingen een relatieve uitzondering.

De bevindingen in de studie laten zien dat expliciete aandacht voor morele kwesties belangrijk wordt geacht, maar dat tegelijkertijd erkenning nodig is op het niveau van de impliciete omgang met morele kwesties. Expliciete klinische ethiekactiviteiten worden vaak gecombineerd met impliciete vormen. Het MB, met haar heldere structuur en tegelijk specifieke kenmerken die veel ruimte laten voor eigenheid en een zoektocht, zou hierin een brugfunctie kunnen spelen.

Hoofdstuk 3
Managers en moreel beraad
Het derde hoofdstuk gaat in op de verhouding tot, en ervaring van managers met het MB dat zij initiëren in hun teams. Meestal gaat het dan om managers van verpleegkundigenteams, hoewel binnen GGNet ook HRM, dienst Services en de Raad van Bestuur aan MB doen. Het artikel beschrijft om welke reden de managers MB inzetten, wat zij ervan verwachten en hoe zij zich tot de uitkomsten en de praktijk van het MB verhouden. Via een managersfocusgroep werd gekeken naar hun eigen kwesties met betrekking tot (de organisatie van) MB.
Uit de studie blijkt dat managers MB zien als een oefengelegenheid om teamleden anders met elkaar te leren communiceren. MB is een training in kritisch denken over het werk, en kritisch te spreken met elkaar. Het is de plek waarin geofend wordt elkaar niet te sparen, maar eerlijk en open feedback te geven. Al deze werkpunten samen zouden naar de verwachting van de managers invloed moeten hebben op de wijze waarop de teamleden met elkaar omgaan (teamcultuur). Gelet op de oefenruimte die MB biedt en de kwetsbaarheid die het MB onvermijdelijk vereist van de deelnemers, beweegt het MB zich tussen een vrijblijvende oriëntatie op morele kwesties en een gerichte communicatie- of samenwerkingstraining in. Dit leidt ertoe dat managers zich zoekende tonen in de wijze waarop zij het MB moeten organiseren. Hoewel ze ervan overtuigd zijn dat reflectie en MB een belangrijk onderdeel vormen van professionalisering, zijn uitkomsten niet hard te maken. Dergelijke procesmatige uitkomsten zijn voor managers moeilijk te managen, aangezien ze geen bemoeienis willen met de inhoud – hooguit met de output. Maar omdat die output verweven is met het proces van interactie tijdens het MB zelf (dus in de ervaring), is invloed hierop niet of nauwelijks mogelijk.

Een ander punt in de uitkomsten van deze studie betreft de vraag of de manager al dan niet deel moet nemen aan het MB. Een deel van de managers zegt resoluut ‘nee’: zij vrezen dat hun aanwezigheid een remmende werking heeft op de gespreksvrijheid én de verantwoordelijkheid over de uitkomsten - een voorwaarde voor dialoog. Met deze houding, die beperkt blijft tot een faciliterende rol, positioneert de manager zich echter buiten het team. Daarin zit een paradox ten opzichte van de doelstellingen die de managers hanteren voor MB: hoewel het team door MB beter zou moeten gaan samenwerken, is het team incompleet door afwezigheid van de manager. Op die manier dringen geleerde lessen niet door tot de top van het team.

Anderen zeggen net zo resoluut ‘ja’ op de vraag of men al dan niet aanwezig is bij het MB. Hun aanwezigheid benadrukt hun betrokkenheid bij teamprocessen en bij de inhoud van de casuïstiek. De deelname van managers aan MB brengt echter ook dilemma’s met zich mee die rechtstreeks samenhangen met de karakteristieken van het MB: vertrouwelijkheid, openheid, en kwetsbaarheid. Zo vragen managers zich af wat ze mogen doen met de vertrouwelijke informatie die ze horen tijdens een MB.

MB roept vragen op die te maken hebben met de positionering en (daarmee) de identiteit van de manager ten opzichte van zijn team. Dit betreffen vragen rondom openheid, kwetsbaarheid en integriteit. De bevindingen op basis van de focusgroep werpen een licht op managementstrategieën die passend zijn in een transformatief en participatief leiderschapskader, waarin de verbinding tussen organisatorische en persoonlijke waarden wordt gezocht. Vanuit deze geïntegreerde houding ontstaat een wederkerig proces die zich uit in gedeeld eigenaarschap, gedeelde inspiratie, motivatie en verantwoordelijkheid. Voor het MB is dit een interessant perspectief op or-
organiseren. We concluderen dan ook op basis van onze bevindingen dat de organisatie van MB kan dienen als voorbeeld voor transformatief of participatief management, waarin de manager zonder vooraf opgelegde doelstellingen kijkt wat een instrument (hier: MB) kan opleveren in procesmatige termen. Indien de manager deelneemt aan MB, opent zich een gelegenheid om direct tot gelijkwaardige dialoog te komen, waarin de betekenis van het werk in de instelling tot uitdrukking komt in een situatie waarin men gezamenlijk leert.

**Hoofdstuk 4**

**Aandachtsfunctionarissen moreel beraad**

Het hoofdstuk over de aandachtsfunctionarissen geeft goed zicht op bottom-up processen die van belang zijn bij de implementatie van MB. Aandachtsfunctionarissen MB zijn leden uit het team (doorgaans verpleegkundigen) waarin MB plaatsvindt die verantwoordelijk zijn voor de dagelijkse organisatie van het MB. Het aandachtsfunctionarisschap MB is een relatief kleine taak die volgens de bevindingen uit het onderzoek evenwel van grote waarde is voor de continuïteit en de interne betrokkenheid bij het MB vanuit het team. Uit de bevindingen van deze studie blijkt dat de aandachtsfunctionaris geen ideologische binding heeft met het MB (‘MB móet omdat ethiek zo belangrijk is!’). Hij vindt het moeilijk om het MB uit te leggen en legt nadruk op het belang van de ervaring met MB: je moet het ondergaan om te begrijpen wat er gebeurt. Hoewel MB samen gaat met begrippen die nogal eens als zwaar of gewichtig worden ervaren (moreel, ethiek, waarden, normen, beraad) beschouwt hij de MB’s als een verfrissende manier van in gesprek gaan met diverse disciplines.

De aandachtsfunctionarissen laten zien dat MB in haar wijze van organisatie een pragmatische aanpak vereist. Helderheid over wat er van wie verwacht wordt, wanneer het MB is en toezien op een variatie aan disciplines of perspectieven zijn hierin belangrijke aspecten. Teamleden zijn, mede uit loyaliteit naar hun collega, gemotiveerd om deel te nemen aan het MB. Op deze manier zorgt de pragmatische aanpak van de aandachtsfunctionaris ervoor dat het MB aan continuïteit wint.

De studie naar de aandachtsfunctionarissen is leerzaam om meerdere redenen. In de eerste plaats laat zij het belang zien van bottom-up betrokkenheid bij de organisatie van MB. Hun inspanningen dragen bij aan de voortgang van het MB. Op die manier eigenen zij zich het MB toe, wat als katalysator werkt op hun betrokkenheid en pro-actieve bemoeienis. De pragmatische houding van de aandachtsfunctionarissen laat ethici zien dat MB praktische activiteiten vereist die belangrijk zijn voor het MB. Aandachtsfunctionarissen geven met hun praktische houding weer hoe ethiek in bedrijf gezet wordt. Tegelijk zijn dergelijke activiteiten (ruimte, koffie, thee) vaak
ongezien of ondergewaardeerd door hun vanzelfsprekendheid. In de studie noemen we dit ‘invisible work’. Door hun ervaring en specifieke expertise uit te lichten, wordt de waarde van het werk van de aandachtsfunctionaris in de organisatie van MB gecijferd. Het ‘bottom-up eigenaarschap’ van de aandachtsfunctionarissen voor MB zorgt er mede voor dat de teamleden het MB gaan ervaren als iets van het team, in plaats van een verplichting top-down. Top-down en bottom-up gaan hier dus hand in hand, blijkt uit de studie.

De studie laat ook zien dat de implementatie van MB (of ethiekondersteunende activiteiten in bredere zin) niet kan varen of groeien vanuit ideologische betrokkenheid alleen. De overtuiging dat ethiek móet omwille van de ethiek, versmalt de voedingsbodem waarop het MB zich kan ontwikkelen. De studie onder aandachtsfunctionarissen leest als een pleidooi voor een verbreding van eigenaarschap van MB top-down en bottom-up, waarbij een pragmatische houding voorwaardenscheppend is om het MB in duurzame(re) zin van de grond te tillen. Bovendien laat de studie zien dat de betekenis van het MB niet bepaald wordt door vooraf gestelde ideologische overwegingen, maar dat die zich open en ontwikkelt in de directe ervaring van alle betrokkenen bij de organisatie en realisatie van MB. Omdat MB interfererent met de lokale context waarin het MB plaatsvindt, is betrokkenheid van andere belanghebbenden dan de ethiekfunctionaris cruciaal. In die betrokkenheid wordt waarde en nut van het MB helder, en wordt eigenaarschap gedeeld. Dat is niet alleen belangrijk uit praktische overwegingen, maar ook vanuit morele overwegingen: het is uiteindelijk hun context die in beweging wordt gebracht via MB, en daarmee is een democratische manier van organiseren en implementeren een gerechtvaardigde keuze.

Hoofdstuk 5
Doelen en oogst van moreel beraad

In de praktijk van ethiekfunctionarissen leven veel vragen met betrekking tot de uitkomsten of resultaten van moreel beraad. Instellingsdocumenten over MB suggereren vaak dat MB zou bijdragen tot verbetering van de kwaliteit van zorg en de toename van werktevredenheid. In hoofdstuk 5 van dit proefschrift komen doelstellingen die managers formuleren voor MB aan de orde, alsook de ervaren uitkomsten van MB uit monde van de deelnemers. In deze studie spreken we van ‘oogst’ in plaats van uitkomsten of resultaten.

De bevindingen op basis van naturalistische dataverzameling laten zien dat managers MB primair zien als een training gericht op samenwerking en communicatie. Daarnaast verwachten ze dat MB bijdraagt aan een kritische verhouding ten opzichte van het werk (tegenover het werken vanuit onnadenkendheid en routines). Maar
managers zien MB ook als een plek voor verpleegkundigen om op te laden, op verhaal te komen, om te delen. MB kan bovendien leiden tot inzicht in het unieke van het verpleegkundigenvak en daarmee trots en onderscheid voeden. Managers vinden dat verpleegkundigen geneigd zijn vanuit begrip en empathie met elkaar in contact te staan, wat afbreuk doet aan hun kritische blik. MB leert verpleegkundigen te oefenen met openlijke, constructieve feedback geven en ontvangen. Voorts zien managers MB als een manier om de zorg te verbeteren. Die verbetering betreft de verpleegkundige als spreekbuis en advocaat voor de cliënt tijdens multidisciplinair overleg, bijvoorbeeld.

Voorbeelden van oogst van de deelnemers aan MB betroffen toename van vaardigheden op het terrein van samenwerking, en dan in het bijzonder als het gaat om het vinden van onderlinge steun. Verpleegkundigen realiseren zich in het MB ook de complexiteit van hun vak en koppelden daar de noodzaak tot kritische reflectie aan. Vervolgens noteerden de deelnemers als oogst dat zij zich gesterkt voelen door MB in termen van empowerment: ze voelen zich na een MB krachtiger en assertiever om zich uit te drukken. Ook draagt MB bij aan directheid in spreken. Kwaliteit van zorg was eveneens een item onder de deelnemers, met name gericht op een afname van de paternalistische houding tegenover cliënten. Naast deze oogst noteerden sommige deelnemers ‘niets’ als antwoord op de vraag wat ze hadden geleerd. Omdat alle evaluaties anoniem werden afgenomen, konden we helaas niet achterhalen wat dit exact betekende.

De categorieën van de managers en deelnemers verschillen, maar zijn soms ook verrassend overeenkomstig. Zo zeggen beide belanghebbendengroepen dat het proces van MB met name belangrijk is, sterker dan de inhoud van morele kwesties dan wel concrete, harde uitkomsten. Wij als onderzoekers vonden het bovendien verrassend dat er relatief weinig managers/deelnemers waren die ‘kwaliteit van zorg’ als doel of uitkomst zagen. Traditioneel wordt dit als motivatie voor MB opgevoerd, maar uit onze data blijkt dit niet het meest prominente doel te zijn.

Tot slot noteren we als belangrijk punt in onze analyse dat de overeenkomstigheid tussen doelen en oogst, alsook de impact van MB op de dagelijkse werkprocessen van de deelnemers, aanleiding kan geven om de organisatie en implementatie van MB op te pakken als een kans om dialoogisch management te introduceren. Gedurende de studie kwamen we erachter dat doelstellingen noch oogst tussen management en deelnemers wordt gedeeld. Hierdoor wist het team doorgaans niet waarom men aan MB ging doen, en de manager kende de lessen niet die uit een MB sessie werden getrokken.

De studie concludeert dan ook dat, als doelen en oogst naast elkaar worden gelegd, het sleutelwoord ‘gezamenlijkheid’ is. Gelet op de concrete, op ervaringen gestoelde oogst van de deelnemers werd ook duidelijk dat deelnemers vanuit het MB tot inno-
vatieve, praktische ideeën komen om de dagelijkse praktijk te verbeteren. Dat was nu juist de intentie van de manager, maar helaas worden deze zaken niet uitgewisseld. Om die reden denken wij op basis van onze studie dat het raadzaam is wel tot deze uitwisseling te komen. Wanneer doelen en oogst op regelmatische basis onderwerp van gesprek zijn, zou dit in potentie kunnen leiden tot een gedeeld eigenaarschap over praktische veranderingen in de dagelijkse gang van zaken die direct bijdragen aan de verbetering van samenwerkingsprocessen en een positieve sfeer op de langere termijn.

Hoofdstuk 6

Cliëntparticipatie in moreel beraad

In tegenstelling tot de andere hoofdstukken gaat hoofdstuk 6 niet in overstijgende zin over het MB, maar over MB zelf: de praktijk van de totstandkoming van een dialoog. Specifieker wordt er in deze studie gekeken naar de dynamieken binnen transdisciplinaire groepen: MB’s waaraan behalve zorgprofessionals ook cliënten en/of familieleden deelnemen. Om te kunnen begrijpen wat het MB aan implementatietiviteiten nodig heeft, was het noodzakelijk te weten welke dynamieken aan de orde zijn binnen de praktijk van het MB.

MB in transdisciplinaire samenstelling kan opgevat worden als een dialogisch streven optima forma: perspectieven die nogal eens buiten beschouwing blijven, en groepen die niet als vanzelfsprekend een stem hebben, krijgen een gelijkwaardige plek in deze beraden. MB met cliënt- of familieparticipanten betekent recht doen aan inclusie, gelijkwaardigheid. Binnen de institutionele MB-groep van GGNet werd het initiatief tot deze beraden dan ook toegejuicht, maar men gaf een positief noch negatief advies en zegde toe het proces te willen begeleiden. De reden van deze (normatieve) terughoudendheid was het eigenaarschap van het MB optimaal aan de praktijk te laten. Een geïnstitutionaliseerde probleemeigenaar aanwijzen, bijvoorbeeld de MBgroep, zou daar haaks op staan. Dergelijke overwegingen komen voort uit de hermeneutisch-dialectische fundamente van (de implementatie van) MB, waarbij de daadwerkelijke ervaring leidend is in de betekenisgeving van praktijken, voor die praktijken.

Simultaan aan de aanvraag en het lopend proces van cliëntparticipatie in MB, werd onderzoek gestart naar deze initiatieven om te kijken wat er geleerd kon worden over de implementatie van MB aan de hand van de ervaringen in transdisciplinaire groepen. Binnen dit onderzoek werden alle betrokkenen (cliëntparticipanten, deelnemers MB, gespreksleiders, aandachtsfunctionarissen, management, MB-groep) doorlopend gehoord en actief geïncludeerd in het verloop van te nemen stappen en de interpretatie van de bevindingen.
De studie laat zien dat de totstandkoming van een dialoog niet vanzelfsprekend is wanneer een groep mensen om de tafel zit, en ook niet wanneer een methode strikt en stapsgewijs wordt gevolgd. Uit de voorbeelden blijkt dat MB, door haar beroep op onderlinge openheid en dus kwetsbaarheid, haar beroep op vooronderstellingen opschorten, gelijkwaardigheid en vertrouwelijkheid, kan leiden tot relationele spanningen tussen de diverse deelnemers. Ondanks de inzet op een gelijkwaardige ontmoeting, kwam deze niet tot stand zonder de nadrukkelijke (bij)sturing van de gespreksleider om deze dynamieken te ontzenuwen. Hoewel tijd en ervaring ertoe leidden dat men de cliëntparticipant als geïntegreerd deelnemer ging zien, bleken vooronderstellingen over en weer te bestaan in termen van ‘de’ cliënt en ‘de’ hulpverlener (stereotiepen). Incidenten leidden ertoe dat oorspronkelijke gevoelens van wantrouwen, vooringenomenheid en angst opnieuw herleefden met het risico van pseudo-participatie tot gevolg.

Het onderzoek heeft doen inzien dat het streven naar dialoog solide werk vereist ten gunste van de na te streven normen die aan de dialoog worden toegekend. Inclusie, gelijkwaardigheid, vrijmoedig spreken en vooronderstellingen opsporen en onderzoeken vergt moed van de deelnemers en doortastendheid van de gespreksleider, die in staat moet zijn om momenten van spanning en relationeel ongemak of spanningsvolle machtsverhoudingen te signaleren en te benoemen. Dat betekent een openlijk onderzoeken van gevoelens van angst, terughoudendheid, geslotenheid, groepsvorming, vooringenomenheden waarbij alle betrokkenen (professionals én cliënt- of familieparticipanten) betrokken zijn langs de karakteristieken van het MB.

Met deze groepsdynamische spanning daagt transdisciplinair MB de karakteristieken van het MB uit. MB wordt dan een praktijkoefening om gelijkwaardigheid, onderlinge openheid en inclusie te oefenen en te expliciteren. MB kan langs de lijn van deze oefenplek een domein worden waarbinnen dit streven wordt onderzocht in termen van haalbaarheid, successen en belemmeringen, die veelal relationeel van aard zijn. Daarmee is een transdisciplinair MB een gelegenheid om te onderzoeken wat randvoorwaarden zijn om cliëntparticipatie in bredere zin in de praktijk te realiseren.

**Hoofdstuk 7**

**Algemene discussie en conclusies**

In het afsluitend hoofdstuk worden de voorgaande hoofdstukken met elkaar verbonden door de centrale onderzoeksvragen uit hoofdstuk 1 te hernemen. Wat is er nu geleerd met betrekking tot de implementatie van MB en de rol van de dialoog in dat proces?

Labour staat dan voor die zaken die we allicht als vanzelfsprekend beschouwen en die niet zelden onzichtbaar blijven (‘invisible work’). Work wordt met name zichtbaar in de rol van de manager (het initiëren van MB, zorgen voor opkomstafspraken en beschikbaar stellen van tijd en formatie voor MB) en de rol van de gespreksleider. Hiervoor worden in de studie 5 domeinen tentatief aangewezen waarop de gespreksleider zou moeten functioneren om recht te doen aan de normatieve uitgangspunten van het MB. Action omvat de daadwerkelijke dialoog binnen het MB zelf: de onverwachte richtingen die dat uit kan gaan en de relationele dynamieken die daarbinnen een rol spelen. Maar Action verwijst ook naar de houding van de manager, die slechts ten dele het proces en de uitkomsten kan bepalen (Work) maar voorts vooral geëigend is het proces los te laten en niet te sturen op doelstellingen die op voorhand zijn opgesteld. Met andere woorden: de drie niveaus van Labour, Work en Action zijn doorlopend met elkaar verweven en gelijktijdig aanwezig. Er bestaat geen hiërarchie tussen deze niveaus maar een geïntegreerde, dynamische relatie waarbinnen de drie lijnen elkaar voeden, stimuleren en aanzetten.

De rol van de dialoog is noodzakelijk in de totstandkoming van de implementatie van MB op de diverse lagen van het proces van geïntegreerd ethiekbeleid. Omdat het MB rechtstreeks ingrijpt op cultuuraspecten van het teamfunctioneren, moet er dialogisch gekeken worden naar uitkomsten en doelstellingen, idealiter in de vorm van een dialogisch overleg waarbij ieder betrokken is. Dialogisch onderzoek bleek in dit proces behulpzaam omdat het ertoe leidde dat er volop ruimte werd gecreëerd om eigenaar schap over het MB te delen en te ervaren. Tegelijk kan dialogisch vormgeven van een implementatieproces niet zonder heldere contouren (Work). Dit bepaalt de veiligheid binnen het MB (middels een stappenplan of een heldere methode waaraan strikt wordt gehouden) en in organisatietermen bepaalt het de realisatie van de dialógische praktijk middels randvoorwaarden, afspraken en roldefiniëring. Als deze processen gelijktijdig en in verweven zin samen één praktijk vormen, ontstaat er een betrokkenheid die zowel top-down als bottom-up ervaren wordt. Deze betrokkenheid doet recht aan de normatieve doelstellingen van het MB als praktijk: Dialogue At Work.
Summary

Dialogue at Work
Summary

Over the past years, methods of clinical ethics support (CES) have developed and changed in terms of their organization and characteristics. This change was particularly influenced by the upcoming care-ethical theories of the 1990s. Changing views on ethics supported the idea that moral issues should not only be processed through ethics experts (such as ethics committees), but acknowledge the actual experience of morality in daily healthcare and the moral expertise of the work floor. The changes in thinking about morality in daily healthcare resulted in methods of ethics support that included the voice of those directly involved in the moral issues. It resulted in an increase of deliberative methods of CES, such as moral case deliberation (MCD). In Dutch healthcare MCD has become more and more common over the years.

This thesis follows, evaluates and describes the process of implementing MCD in a large mental healthcare institution in the eastern part of the Netherlands, called GGNet. The study pictures aspects of the implementation of MCD in a dialogical way. Throughout its evaluation, there is a consistent decision to understand MCD’s implementation from the perspectives of those who are directly involved in the practice and organization of MCD. Their experiences relate to participation in actual MCD sessions, supportive practices of MCD, facilitating MCD and organizing MCD.
Chapter 1

Introducing Dialogue at Work

The first chapter introduces MCD, its origins and theoretical background and describes the practice of an MCD session. It also describes the development of CES, in which since the 1990s increased attention has been paid to ‘everyday ethics’: moral experiences of employees directly on the work floor. In this thesis, MCD is bound to a hermeneutic, dialectical vision of ethics in which dialogue is the means and outcome of an MCD session. This implies that the concrete experience of the moral issue, the joint exploration of diversity in perspectives, and a joint learning process are central aims in the practice of MCD. Together, these processes are methodically brought together in the concept of ‘dialogue’.

An MCD session is a group conversation between healthcare employees (who may or may not work in direct patient care) in which one authentic case and one single moral question are central. Applying a methodical, disciplined conversation structure supports the realization of a dialogue. The facilitator of the session is specifically trained and has no connection with the content of the session. A dialogue is distinctive from a debate, conflict or discussion: all steps are directed towards a thorough mutual understanding via asking questions rather than convincing others of a particular standpoint. Presuppositions are systematically questioned to check their validity in relation to the facts of the case. MCD is characterized by trustworthiness, confidentiality, mutual openness, (moral) equality.

Considering the dialogical qualifications and characteristics of MCD, the starting point of this thesis was that the implementation of MCD should also contain a dialogical structure. This meant we would remain loyal to the characteristics of the practice of MCD, so that the implementation process of MCD would be in congruence with the dialogical aims of MCD itself, thereby striving for a shared ownership over MCD among its users. This is in line with current insights on leadership, striving for an active role of professionals in implementation processes.

The above considerations resulted in the decision to merge the characteristics of our research design with the aim for dialogue. Responsive evaluation is closely connected to the characteristics of the practice of MCD. After this decision, a threefold application of the concept of dialogue became visible in this thesis: in the practice of MCD, in its implementation process, and in the research on implementing MCD. Based on these initial considerations, three central research questions were formulated:

1. What is the role of dialogue in MCD?
2. What is the role of dialogue in the process of implementing MCD?
3. To what extent does responsive evaluation as dialogue contribute to the implementation of MCD?
Chapter 2

Implicit and explicit clinical ethics support

Chapter 2 provides an overview of the several methods of CES in Dutch healthcare institutions. These may either be explicit (structured, institutionalized attention to moral issues including professional facilitation) or implicit (‘organic’ attention to moral issues that arise during peer supervision, team meetings, patient discussions, on the fly or during coffee breaks, etcetera). In the study diverse healthcare contexts were included: hospitals, residential homes for the elderly, care institutions for (mentally) disabled people and mental healthcare.

Findings show that ethics committees are common in the Netherlands – in particular in hospitals. Roughly half of the Dutch care institutions have MCD, apart from mental healthcare institutions: almost two-thirds of those institutions have MCD. Ethics consultants are not very common in Dutch healthcare.

The study findings show that explicit attention to moral issues is considered important, yet acknowledgement of implicit ways of dealing with moral issues is necessary. Explicit CES are generally combined with implicit ways of CES. MCD, with a clear structure and at the same time possessing specific characteristics that leave room for authenticity and searching, may form a bridge between explicit and implicit ways of dealing with moral issues.

Chapter 3

Managers and moral case deliberation

Chapter 3 describes the relation and experiences of managers who initiate MCD in their teams. Mostly these are managers of nursing teams, although within GGNet other teams also have MCD: Human Resource Management, services, secretary, board of directors or gardeners of the institution. The paper describes why managers initiate MCD, how they relate to MCD, what their expectations are regarding MCD and how they relate to the outcomes of MCD in daily practice. By means of a managers’ focus group these issues were investigated.

The findings showed that managers perceive MCD as training that teaches employees to communicate and cooperate in alternative ways. MCD supports critical thinking and paves the way for a critical-constructive approach by colleagues. MCD is the place at which employees are not primarily empathic but straightforward. In the perception of the managers, MCD as training contributes to the way in which team members relate to each other, thereby influencing the ward climate in daily practice. Considering the explorative space and methodical structure that is offered in MCD, managers perceive MCD as an informal, non-committal orientation on moral issues
from practice, and at the same time as formal, focused communication and cooperative training.

The informal and formal status of MCD results in a search by managers on how to organize MCD. Their concern regarding the organization of MCD also refers to the process-related outcomes of MCD. Although they are convinced that moral reflection is a necessary competence of employees, the outcomes of a session are not considered measurable. Managers struggle with these process-related outcomes, because they do not want to influence the content of the sessions; at most they wish to be able to manage the outcomes. But because this output depends fully on the process of the experiences during the MCD session, it is practically impossible to influence the outcomes of MCD.

Another important finding of the study is the question whether or not – and to what extent – managers should participate in MCD. Some of the managers firmly stated they would never participate: they consider MCD as nurses’ domain and fear that their presence may obstruct the openness between the other participants. Some managers also think that their presence would prevent the team members assuming responsibilities themselves and they would refer them to their manager. With this decision, the manager nevertheless her/himself outside the team. Regarding the cooperative aims that managers formulate for MCD, this may be considered a paradox: although the team should improve its cooperation and communication, the team remains incomplete in the absence of the manager. Lessons learnt will therefore not reach the top of the team.

Other managers eagerly do join the MCD sessions. Their presence shows the team members that moral issues also matter to them and that they are intrinsically part of the process of dealing with those moral issues. Yet participating in MCD brings dilemmas for the manager that coincide with MCD’s characteristics: confidentiality, openness, vulnerability. Managers wonder for example if they may use information heard during MCD outside the sessions.

The findings show that managers search for how to relate to MCD, not only in terms of their organizational, facilitative tasks but also in terms of their identity. They have issues regarding confidentiality, vulnerability, openness and integrity. The findings of this study highlight management strategies that fit in the framework of a transformative and participative leadership, which focuses on a connection between organizational and personal values. An cooperative attitude results in a two-way process that results in shared ownership, shared inspiration, motivation and responsibility. As regards the organization of MCD, this may be an interesting perspective on leadership.

From our findings we conclude that the organization of MCD can therefore mean explorative space for transformative or participative management, as the manager
learns how to deal with the introduction of a new instrument without knowing what this instrument may result into. If the manager decides to join the sessions, there may be occasion for immediate equal deliberation, in which the meaning of working in an institution is shared in a context of joint learning processes.

Chapter 4
Local moral case deliberation coordinators

In Chapter 4, bottom-up involvement in organizing MCD is addressed by means of the introduction of local MCD coordinators. Local MCD coordinators are members of a team in which MCD takes place. Usually they are nurses. The tasks of local coordinators concern a relatively small part of their normal job, but given the findings of our study, their work is of great relevance for the implementation of MCD. The findings of the study show that local MCD coordinators have no ideological bonding with MCD. They generally find it difficult to explain to colleagues exactly what MCD is and highlight the importance of the experience of MCD: one must undergo the session to understand what MCD is about. Although MCD often comes with heavy terms such as ‘ethics’, ‘deliberation’, ‘morality’, ‘values’, ‘norms’, the local coordinator perceives MCD primarily as a refreshing way of meeting others, particularly other disciplines.

Local coordinators show that MCD needs a pragmatic organizational approach. There needs to be clarity about expectations and scheduling, and presence of multiple disciplines is required to optimize harvest. Team members are, from the perspective of loyalty, more likely to join sessions. This way, and by their eagerness to succeed in their efforts on bringing people together for an MCD session, local coordinators are dedicated to applying their pragmatic organizational tasks.

The study on local coordinators and bottom-up involvement in organizing MCD is informative in many ways. First, it shows the importance of bottom-up involvement in the organization of MCD. Such efforts contribute to the continuation of MCD in the team. As experience proceeds, they start co-owning MCD together with management and team. This contributes to their proactive interference. The pragmatic attitude of local coordinators teaches ethicists that MCD requires practical activities which are important for MCD’s implementation. They show, by means of practical orientation, how to make ethics operational.

Yet the tasks of the local coordinators are typically the kind of activities that are easily overlooked or under-appreciated because of their self-evidence. In this study, we mark this type of activity as ‘invisible work’. Highlighting the experiences and specific organizational expertise of local coordinators explicates the value of their contribution to MCD. In turn, this results in increasing proactivity by the local coordinators:
a catalyst that works both ways.

Second, it was learnt that this ‘bottom-up ownership’ of local coordinators helps other members of the team to experience MCD as something that is theirs, rather than some initiative of the manager. In this process the local coordinator nevertheless needs to take care that MCD is enduringly perceived as a team instrument. If s/he is not able to achieve this, MCD might then be perceived as something owned by the local coordinator. From experiences like these, it was learnt that MCD cannot do without top-down interference.

Finally, it was learnt that MCD (or CES in a broader context) cannot come from ideological involvement alone. The conviction that ethics is necessary for its own sake narrows the opportunity for MCD to develop. The study among local coordinators can be understood as a plea for a broadening from top-down, to top-down and bottom-up. A pragmatic approach on organizing MCD is preconditional for a durable continuation of sessions with motivated people from the work floor. Hence, the study shows that meaning does not come from predefined ideological considerations but that the meaning of MCD arises from the experiences of those involved in (the organization of) MCD.

Because MCD interferes with the local context in which the sessions take place, it is important to include others in the organization of MCD as well as the ethics functionary. In this context, the value and usefulness of MCD are clarified and co-ownership is felt. This is not only important for practical reasons but also for moral reasons: in the end, it is their context that is brought into motion via MCD. For that reason, a democratic modus of organizing and implementing MCD is a justified choice.

Chapter 5
Aims and harvest of moral case deliberation

In ethics practice, many questions are asked about the outcomes of MCD. Written institutional documents on MCD often suggest that MCD will contribute to better care and improvement of job satisfaction. Chapter 5 of this thesis presents the aims that managers formulate for MCD on the one hand and the experienced outcomes (‘harvest’ we call it) regarding the participants on the other. This study, for which a natural data collection strategy was applied, showed that managers primarily perceive MCD as training on cooperation and communication. They expect that MCD will contribute to the development of a critical attitude towards daily practice instead of staff slipping into old routines without thinking. But managers also note MCD as a way to regenerate nurses and take care of them. In MCD nurses are able to express experiences that had great impact on them personally or on the team. Moreover, MCD provides the
opportunity to regain sight onto the uniqueness of the nursing job and profession. Managers also believe that nurses tend to talk to each other from empathy, which diminishes their critical view on practice. MCD contributes to open, clear and critical feedback. Managers further consider MCD an instrument to improve care.

Examples coming from the ‘harvest’ of participants particularly refer to an increase at the level of cooperation, direct and clear communication and finding mutual support. They become aware of the burden of their job, and therefore the need for collective reflection. Further, participants noted an element of empowerment, particularly towards other disciplines. Quality of care was another aspect that participants considered as harvest of MCD. Some nurses also wrote that they learnt ‘nothing’ in MCD. Because of the autonomous processing of the evaluation questionnaires, it is not possible to fully understand what they meant by this, but we do think that for reasons of completeness it is important to mention this category also.

The categories of managers and participants do differ, but there are also some striking similarities. Both aims and harvest generally notified the process of MCD as most beneficial, rather than concrete outcomes or expectations or a focus on moral development related to the content of the session. Another important finding was that there were few aims and little outcome in terms of the quality of care. Our final finding concerns the opportunity to understand the organization of MCD as a chance for dialogical management practice. Through the research process we came to understand that generally information on neither aims nor harvest is exchanged between manager and team. As a result, the team possibly did not understand why MCD was being introduced, whereas the manager did not know what lessons came out of a session.

The study concludes that a key word in both aims and harvest is ‘togetherness’. It expresses the eagerness and the necessity for team bonding and intensified cooperation. The concrete, experience-based outcome of the nurses has shown that nurses have innovative and practical ideas on how to improve daily practice – just like the manager intended with MCD. If therefore information on aims and harvest is exchanged on a regular basis between manager and team, this may result in an increasing co-ownership of practice changes that directly contribute to the improvement of ward issues and a cooperative climate.

Chapter 6
Client participation in moral case deliberation
In contrast with the former chapters of the thesis, this sixth chapter probes the practice of MCD: the practice of realizing a dialogue. Specifically this study focuses on
dynamics in transdisciplinary groups, in which not only professionals participate but also clients. To understand what is needed to implement MCD, it was necessary to see which dynamics are at stake during MCD itself. MCD in a transdisciplinary group can, according to our vision of MCD, be perceived as a dialogical aspiration optima forma. Perspectives that are often neglected, and groups that do not have a self-evident voice in moral decision-making processes, claimed an equal part in these MCD’s. MCD’s with clients or family participants implied doing justice to inclusion and equality. Within the institutional MCD steering group of GGNet this initiative was therefore acclaimed. The steering group nevertheless decided not to give a ‘go’ or ‘no-go’ signal but agreed to support and monitor the process. The reason for this (normative) reticence was to optimize the ownership of MCD in practice. Appointing an institutional owner of this project, for example the MCD steering group, would be in conflict with the startingpoint that refers to the hermeneutic-dialectical foundations of MCD in which the actual experience decides the assignment of meaning over that practice.

So, simultaneously with the request for client participation in MCD, a study was started to see what could be learnt about (implementing) MCD while following the experiences in transdisciplinary groups. All stakeholders (client participants, participants with a professional background, facilitators, local coordinators, management, MCD steering group) were included in the study. They were heard and actively involved in the study to see which steps could (not) be taken next and to check the credibility of our findings.

The study showed that dialogue is not a given once people are brought together and follow a method. From the included examples in our study it was learnt that the characteristics of MCD (confidentiality, mutual openness, vulnerability, equality, postponing judgements, etcetera) may even provoke relational tensions between participants. Despite the focus on equality, the conversation facilitator had to work hard to try to realize this and to take the edge of the dynamics that emerged. Although time and experience helped the client participant to become a full member of the MCD sessions, presuppositions based on stereotypes persisted: THE client, THE caregiver. Incidents resulted in a revival of the initial reticence and fear, thereby opening up the risk of pseudo-participation.

The study taught us that the aspiration of dialogue is not enough once MCD is initiated. MCD implies continuous solid working towards values and norms concerning inclusion, equality, frank speaking and tracking down presuppositions. This conversational attitude requires great courage from the MCD participants, as well as thoroughness in the facilitation of the session. It implies an open search for moments of
tension, relational inconvenience or delicate power issues that are mostly implicit. It also implies an open search for feelings of reticence, fear, discomfiture and latent presuppositions regarding others. In this process, the conversation facilitator needs to employ the characteristics of the MCD practice.

Given these delicate group dynamics, transdisciplinary MCD’s challenge the characteristics of MCD itself. If applied strictly, MCD may become an exercise in practising and explicating equality, mutual openness, inclusion. Provided that the MCD sessions are thoroughly facilitated, the practice of MCD can then function as a domain in which participants discover to what extent equality, inclusion and mutual openness are obtainable. Transdisciplinary MCD’s can therefore help to construct preconditions for client participation in healthcare in a broader sense.

Chapter 7
General discussion and conclusions
The final chapter of this thesis merges the findings of the former chapters by answering the research questions that were formulated in Chapter 1. What can be learnt from the evaluated process of implementing MCD and what is the role of dialogue in that respect? Combining the findings from the separate chapters constitutes a continuous movement between processes that are based on experiences of all stakeholders in (implementing and researching) MCD, of firm institutionalization and the creation of solid preconditions for (implementing) MCD. The ongoing movement of these three areas calls upon associations with concepts from the political-philosophical work of Hannah Arendt. In her book The Human Condition (1958) she introduces three distinctive stages of the human condition: Labour, Work and Action. We apply the concepts of Arendt as an excurse to shine an extra light on our findings, and to deepen our reflections on the processes that occur in implementing MCD.

In our study, examples of Labour come particularly from the local coordinators, who appear to form the backbone of the continuation, motivation, agreements and preconditions of MCD within their teams. Work in the implementation process of MCD refers particularly to the role of the manager (initiating MCD, taking care of agreements on who is participating and facilitating time et cetera), and the role of the MCD facilitator (summarized in five tentatively formulated competences of an MCD facilitator that optimize the realization of the normative startingpoints of MCD). Action refers to the dialogue as the means and outcome of an MCD session: opening up to unexpectedness in terms of the content of the session and the relational dynamics that come with the process of deliberation. Action also refers to the role of the manager, who can settle agreements on organizing MCD (Work) yet cannot manage the outcomes of a series of
MCD’s. S/he needs to let go as the process evolves and cannot direct predefined aims. MCD can result in concrete working agreements (Work) that originate from the deliberative process of MCD and the experiences within it (Action). Those agreements need to be processed in regular team meetings (Work), after which they can be inserted in regular working processes. For their realization, solid preconditional work is necessary (Labour). In other words, the three levels of Labour, Work and Action are continuously interwoven and are present simultaneously in the process of (implementing) MCD. There is no hierarchy between those three concepts: there is an integrated, dynamic relation in which Labour, Work and Action nourish and stimulate each other.

The findings of our study note that dialogue is necessary for implementing MCD in diverse stages of realizing an integrative ethics policy in the organization. Because MCD interferes with local team processes and cultural dynamics (because of its particular characteristics and its relational impact), dialogical exchange of aims and harvest is needed. Not only does this do justice to the sometimes high impact of MCD sessions but it is also in line with our theoretical startingpoints of including experience and work floor expertise in processes that are meaningful. The meaning of MCD can, from a hermeneutical-dialectical perspective, only be understood in direct relation to experiences and the (personal) values that resonate within those experiences. This theoretical perspective on the implementation and practice of MCD coincides with current insights on change management (participative, democratic or transformative management) that aim to actively include employees in processes of change. Ideally, this process is shaped by means of dialogical processes so that all stakeholders can be involved.

A research design that also focused on the realization of a dialogue, inclusion and joint learning appeared helpful in this process. Responsive evaluation created space to share ownership of MCD’s practice and implementation and include experiences for a nuanced view on MCD. But at the same time a dialogical implementation process (or its evaluation) cannot do without clear frameworks (Work). Those frameworks, that were visible at all levels of the practice of MCD, the implementation of MCD and the research on MCD’s, serve safety and zest in the respective processes: for example, via clear agreements, methodical structures, role definition or solid preconditions. If these processes merge and remain interwoven (meaning that agreements come from deliberative processes, and deliberative processes come from changes that are based on agreements, etcetera), they come together in one dialogical practice. Ideally, this process will lead to both top-down and bottom-up involvement, shared ownership and continuous joint learning. This would do justice to the normative starting-points and aims of MCD in practice: Dialogue at Work.
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Lieve mare

Fijn dat jie boek af is, ooit zulck het lezen

Kes mare
Curriculum Vitae

Froukje Cornelia Weidema was born in 1973 in Amersfoort, the Netherlands, as the third out of five children. In 1996, she completed her study as an arts therapist and worked successively in a mental healthcare institution in Cambridge UK and in a nursing home in Nijmegen (elderly care).

In 2000, she commenced her study at the University of Humanistics (Utrecht), where she was trained as a spiritual counsellor. She specialized in medical ethics, care ethics and palliative care. Simultaneously she completed an additional course, obtaining a grade-one teaching qualification on ethics and religion. In 2007, she successfully finished her study with a master thesis titled ‘My hands at this bedside; work, self-image, heroism and motivation of care takers in nursing homes’. This thesis was awarded with the annual Benelux Leo Polak Scriptieprijs in 2008.

During her study she and her fellow student Marielle Schuurman founded ‘Zusters in Ethiek’ (‘Sisters in Ethics’), a company developing and offering creative and low-threshold ways of dealing with ethical issues. As such, they contributed to a range of conferences, and offered workshops in many settings, especially healthcare institutions.

From 2007, Froukje worked as an ethics consultant in an institution for people with an intellectual disability in Hilversum. The question that became most prominent in that job, namely ‘how to implement moral case deliberation in a healthcare institution’, inspired her to apply for the vacancy on a PhD research on the implementation of moral case deliberation and, as a result, writing this thesis.

Currently Froukje is working as an MCD programme director at GGNet (mental healthcare). In addition, she works at VUmc Amsterdam, department of Medical Humanities, as project manager of the National Network of Clinical Ethics Support in the Netherlands. She also supports institutions towards developing and implementing MCD, teaches ethics and frequently works as an MCD conversation facilitator. Finally, Froukje is co-organizer of the Dutch Annual Working Conference on Moral Case Deliberation.

Froukje is fortunate to be married to Lucia Donkers, and proud mother of a daughter (Mare Lucia) and a son (Imme Ferdynand). Beyond her family, loved ones and work, dancing, camping, hot-tub sessions under a winter’s starry night, gardening and endlessly listening to the Canto Ostinato make her extremely happy.