Moral Case Deliberation is a form of Clinical Ethics Support which focuses on stimulating reflection and joint learning processes of health care professionals on moral issues stemming from practical experiences. ‘Learning by doing’ played a crucial role in the development of the theory and practice of Moral Case Deliberation and making it work in health care. This experience-based approach uses practical experiences as a source for generating knowledge. It provides insights into the three domains of fostering moral learning, organizing clinical ethics, and training health care professionals as facilitators of Moral Case Deliberation.
LEARNING BY DOING
DEVELOPING MORAL CASE DELIBERATION IN HEALTH CARE
Colophon

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Learning by doing

Developing Moral Case Deliberation in health care

ACADEMISCH PROEFSCHRIFT

ter verkrijging van de graad Doctor aan
de Vrije Universiteit Amsterdam,
op gezag van de rector magnificus
prof.dr. V. Subramaniam,
in het openbaar te verdedigen
ten overstaan van de promotiecommissie
van de Faculteit der Geneeskunde
op vrijdag 4 maart om 11.45 uur
in de aula van de universiteit,
De Boelelaan 1105

door

MARIA MARGARETHA STOLPER

geboren te Hardenberg
promotor: prof.dr. G.A.M. Widdershoven
copromotor: dr. A.C. Molewijk
“Phrases like ‘learning by doing’ suggest not only that we think about doing but that we can think about doing something while doing it. (...) When good jazz musicians improvise together, they also manifest a ‘feel for’ their material and they make on-the-spot adjustments to the sounds they hear. Listening to one another and to themselves, they feel where the music is going and adjust their playing accordingly. (...) They are reflecting-in-action on the music they are collectively making and on their individual contributions to it, thinking what they are doing, in the process, evolving their way of doing it. (...) They reflect through a ‘feel for the music’.”

Donald A. Schön, In: The Reflective Practitioner. How Professionals Think in Action, p.54-56
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1 General Introduction

The aim of this thesis is to develop and study the learning processes within practice in fostering moral learning by means of MCD, organising clinical ethics support and training health care professionals to become MCD facilitators who foster moral learning. By studying these learning processes, this thesis intends to provide insight in the role of experience in (moral) learning processes. Furthermore, it aims to provide insight in the process of developing moral learning by means of MCD in practice from the perspective of facilitating and organising ethics. In the third place, it aims to provide insight in the process of transferring the expertise and the methods and tools for teaching health care professionals to become facilitators of MCD. Next to the insight into practical learning processes, the thesis aims to contribute to the development and refining of theories and knowledge about moral learning and clinical ethics support, and to contribute to the development and improvement of tools and methods that can be used in training programs for facilitators of Moral Case Deliberation.

In this introductory chapter, the research questions will be presented, situated in the context of developments in medical ethics, especially clinical ethics and clinical ethics support (CES). Furthermore, the theoretical back-
ground of the study and the methodologies used will be described. Finally, an outline of the thesis will be sketched.

From theoretical and expert ethics to interactive and embedded ethics

From the beginning in the second half of the last century, bioethics aimed to critically reflect on developments in medical practice. Moral theory and knowledge were regarded as important tools to understand, interpret and provide answers to moral questions in medicine and health care. The ethicist was regarded as an expert who could provide answers to difficult moral issues. In health care institutions, ethics committees were developed that served as advisory or consulting boards for practitioners (Kloot Meijburg et al 2001). Teaching ethics was regarded as fostering knowledge of ethical theories and principles. The task of bioethics was mainly characterized as normative and prescriptive.

The approach which was most influential and initially developed as a theoretical approach, was the four principles of Beauchamp & Childress. It aimed to ‘bring some order and coherence by means of a systematic analysis of the moral principles’ in the mixture of discussions that were going on in the nascent field of bioethics due to the lack of useful methods (Beauchamp & Childress 2013; Rauprich & Vollmann 2011). Later on this approach evolved by others into a more applied ethics (Demarco & Fox 1986; Hoffmaster 1991; Jonsen & Toulmin 1988).

More recently, especially in Europe, other conceptual frameworks were proposed leading to a more interactive and embedded ethics (Vanleare & Gastmans 2007; Walker 2009; Chambers 2009; Abma et al 2010). This approach aims to develop the professionalism of health care practitioners taking into account the characteristics of practice (Verkerk et al 2007). Ethics is no longer considered as a matter of applying theoretical knowledge, or interpreting practice from a theoretical point of view, owned by ethicists or experts in ethics, but as a tool for reflection among stakeholders within practice (Widdershoven 2009, 2010). Interactive and embedded ethics emphasizes the importance of personal moral experiences as a starting point.
to examining the meaning of relevant theories, principles and premises. It starts with experiences and practical knowledge already in place, aiming to bridge the gap between academic ethics and day-to-day dilemmas in health care practices (Abma et al 2010).

In the area of ethics research, empirical ethics became more prominent, acknowledging the importance of moral knowledge of professionals as a source for ethics, and attributing a different role to theoretical concepts and moral theories. Parallel to the changes in ethics research, a similar movement appeared in the field of clinical ethics. Whereas until then moral expertise was mainly reserved for ethicists using concepts and theories in order to understand moral issues in practice, now the importance of the moral expertise of those working within practice was recognized. This transition in clinical ethics, towards a more embedded and interactive approach, led to more interdependent practices of responsibility focusing on practical learning processes through reflection on experiences in practice.

Clinical ethics support as fostering ethics expertise in practice

Interactive and embedded ethics aims to support health care professionals by providing tools and methods which enable them to deal with moral issues and (or) to make decisions by themselves, or to develop (normative) views on practice. This implies that health care providers are the primary moral agents, who can reflect on ethical issues without being dependent on (external) experts like an ethicist or an ethics committee. This leads to the question: how to support health care practitioners (or institutions) to practice this new form of clinical ethics and how to help them to develop their own ethical expertise?

Interactive and embedded ethics uses (moral) experiences to foster learning processes that generate moral knowledge and expertise and aims an enhancement of the moral expertise of health care professionals. It requires an approach that is, in contrary of the more traditional approach, focussed on facilitation and support. This is in line with more general international developments in clinical ethics support. The American Society for
Bioethics and Humanities (ASBH) that focus on the profession of ethicists, describes in the Task Force of Standards for bioethics an ‘ethics facilitation approach’ that contains two core tasks namely identifying and analysing the nature of the value uncertainty and facilitate principled ethical resolution (Tarzian 2013). Furthermore it provides in the first and later more extended in the second edition of the Task Force on Standards for Bioethics a range of precisely defined core competencies meant for an ‘ethics facilitation approach’ in clinical ethics (Aulisio 2000; Fox 2007; Tarzian 2013). It distinguishes skills (like ethical assessment, process, interpersonal, basic and advanced etcetera), knowledge (for example theoretical concepts and moral reasoning, clinical context) and character traits (such as tolerance, patience, compassion etcetera). Although the ASBH core tasks and standards are aimed at professional ethicists, they involve skills and knowledge that are overall similar to what the experienced based ethics aims to foster amongst health care professionals. One of the forms of ethics support that closely connect to the ‘ethics facilitation approach’ and aims to establish an attitude in which ethical knowledge and skills of the health care professionals themselves are used, is Moral Case Deliberation (Molewijk et al 2008; Abma et al 2009; Verkerk et al 2007).

**Fostering moral learning in health care**

Moral Case Deliberation (MCD) is a dialogue among diverse stakeholders (preferable interdisciplinary) who are reflecting on a moral question in a personally experienced, concrete case from practice. The dialogue is fostered by a trained facilitator who uses a structured and methodical approach. In the last decade MCD has become more known, applied, and implemented in health care institutions in various countries in Europe (Steinkamp & Gordijn 2003; Molewijk et al 2008 b,c; Pederson et al 2009; van der Dam et al 2011; Weidema 2014; Bartholdson et al 2015; Svantesson et al 2014).

MCD is a tool for health care professionals that intends to stimulate reflection and joint learning processes, centred around a genuine question that is based on practical experience and that involves a moral doubt
or uncertainty about doing good. MCD emphasizes the uniqueness of each case in professional practice and acknowledge the associated uncertainty, instability and complexity of this setting. In participating actively in MCD participants learn to understand and make explicit their own and others’ normative ideas (that might justify actions in the past or future), and if necessary to take decisions or formulate agreements (Steinkamp & Gordijn 2003; Molewijk et al 2008a, 2008b; Abma et al 2009; Molewijk & Ahlzen 2011). MCD aims to exchange perspectives by means of a dialogue (Widdershoven 2005; Abma et al 2009; Weidema et al 2014; Metselaar et al 2015). By doing so MCD utilizes practical moral experiences of professional pluralism on the shop floor and strengthens moral and interprofessional learning processes. Furthermore MCD aims to improve professionalism through reflection on personal actions and values (‘why am I acting the way I do? What do I consider as good care in this situation?’), help practitioners to (re)discover the motivation and passion for their professional work, and to contribute to team building and development of vision and policy (Molewijk 2008a, 2008b; Metselaar et al 2015). In these processes, various factors are important, such as the way MCD or ethics in general is organised in a health care institution, the profile, contribution and role of the facilitator of MCD, and the methods and instruments used in facilitating moral learning.

Organising clinical ethics support in healthcare

In the area of clinical ethics, various forms of clinical ethics support (CES) in health care institutions can be distinguished, such as MCD, ethics consultants and ethics committees (Dartel van 1998; Slowther et al 2001, 2012; Meulenbergs et al 2005; Fox et al 2007; Pedersen et al 2009; Forde et al 2011; Dauwerse et al 2011, 2014). Traditionally, knowledge about ethical issues in health care was mainly attributed to ethics committees; they were considered as the experts that provided ethical (medical) advice to for example the board of directors or the medical staff that consults them when they encountered complex cases (Kloot Meijburg van der et al 2001; Steinkamp et al 2007; Agich 2013; Dam van der et al 2014). The develop-
ments in clinical ethics, described above, lead to the idea that reflection on how to deal with ethics and ethical issues in practice should also, or even mainly, be organised on the shop floor and practiced by the health care professionals themselves. As a consequence the role of an ethics committee changed from an expert-committee into a body that aims to support health care professionals in developing moral expertise (Dartel van 1998; Abma et al 2010).

Interactive and embedded CES not only aims to make health care professionals moral agents themselves and make them responsible for their own (moral) actions, but also to equip them with tools for moral learning and developing moral competencies that make them a better professional, resulting in an improvement of quality of care. Health care professionals are regarded as moral experts who intuitively make moral judgements (Lande-weer et al 2011). Their moral knowledge is directly related to their practical experiences; it is the task of clinical ethics support to provide them with tools to make the moral issues explicit and to examine their presupposition regarding the moral issues they encounter. This process of fostering moral learning by means of CES requires a way of organising that ensures that what health care practitioners learn will be integrated in the actions of everyday practice (Molewijk et al 2008a en b; Weidema et al 2010).

Passing the expertise: Developing methods and instruments to facilitate moral learning in health care practice

In line with the developments in clinical ethics support sketched above, the interest in MCD grew rapidly in the last decade. Consequently, the demand for people who can facilitate MCD increased. In order to meet the need for facilitators, a training program has been developed for practitioners who want become facilitator of MCD. However, this initiative was not only a response to a practical need; it was also motivated by more fundamental normative reasons. In the first place, in line with the focus of interactive and embedded ethics on the development of responsibility and professionalism
of health care professionals, health care institutions should be encouraged
to develop their own expertise and knowledge regarding the process of
fostering moral learning in their institution. In the second place, teaching
health care practitioners appeals to the responsibility of health care institu-
tions to develop a policy and structure which secures the process of dealing
with moral questions in the institution. In the third place, teaching health
care practitioners to become facilitators of MCD fits in with the concept of
professionalism that emphasizes that a professional should be competent to
reflect on their own values, norms and virtues, as part of the professional
profile (Verkerk et al 2007).

In view of these practical and fundamental reasons, in 2006 a course
was developed and organised in the Netherlands to teach health care pro-
fessionals to become facilitators of MCD. The development of the training
program and the practice of teaching health care professionals to become
facilitators, gave rise to questions regarding our view on transferring ethical
expertise and the profile of a facilitator of MCD. The concept of MCD
presupposes that a facilitator has tacit knowledge requiring an extensive
set of skills and a specific attitude. How to foster and teach this knowledge
and the related skills and attitude of a facilitator to health care professionals
who should become facilitators of moral learning? What kind of knowledge
and skills should be trained in the first place?

**Research questions**

The changing view on clinical ethics and the new developments in clinical
ethics support evoke questions about how to organise a process of foster-
ing moral learning in practice, using existing but implicit expertise. Re-
garding the view on clinical ethics as ‘ethics of and within practice’, health
care professionals and institutions seem more in need of learning how to
make explicit and reflect upon their own morality, than of applying ex-
ternal normative frameworks from ethics deductively. To support them in
this process an approach is needed that fits in the philosophy of the new
view on clinical ethics support. An approach that takes also into account
a clear view on the didactics of fostering moral learning and transferring moral expertise in practice. This thesis describes the learning processes in practicing this new way of fostering moral learning within health care practice. In the first place, it describes the process of experiences in developing and fostering moral learning of health care professionals that participate in MCD. It furthermore examines experiences and learning processes in organising moral learning within health care institutions. Finally, it elaborates on the development and use of didactic methods and instruments to train health care professionals as facilitators of moral learning in MCD. The main research question is:

How to foster and secure moral learning and reflection on moral questions of professionals in health care practice?

The following sub-questions will be investigated:

(a) What are the practical learning processes in fostering moral learning by means of Moral Case Deliberation?
(b) What are the practical learning processes in organising clinical ethics, especially Moral Case Deliberation?
(c) What are the practical learning processes in training health care professionals as facilitators of Moral Case Deliberation?

Theoretical framework: Pragmatic hermeneutics, dialogical ethics, Socratic epistemology

and to deal with them not primarily by reading books, but by experiencing and reflecting on ethical issues in practice.

Pragmatic hermeneutics claims that practical and concrete experiences are essential and needed for learning and acquiring knowledge (Widdershoven 2001; Widdershoven et al 2009; Abma et al 2009; Widdershoven & Molewijk 2010; Molewijk & Ahlzen 2013). Theoretical ideas or cognitive knowledge are only useful when they are embedded in experience and in the practice of daily life (Kinsella 2009). This approach goes back to Aristotle who claimed that (moral) wisdom and knowledge emerge in reflection in and on concrete situations. This means that acting morally correct is always contextual and temporarily. Thus it requires a continuous inquiry of the experiences in and closely connected with practice (phronesis) (Abma et al 2010). Pragmatic Hermeneutics furthermore emphasizes the necessity of exchanging perspectives, in order to enrich the (mutual) understanding of the meaning of doing-good (Widdershoven & Molewijk 2010; Widdershoven & Metselaar 2012; Ohnsorge et al 2012). Moral knowledge is situational, dynamic and affected by others. By focusing on exchanging perspectives, pragmatic hermeneutics is akin to dialogical ethics.

Dialogical ethics refers to a framework that emphasizes the exchange of views between participating parties. It focuses on the attempt of each participant to understand the arguments and needs of the other(s) in order to make a decision (of disagreement) or reaching a kind of consensus by improving the arguments (Rudnick 2002). Dialogue requires ‘mutual learning, involvement of all parties by an equal say, and openness and frank speaking’ (Abma et al 2009). A dialogue can be seen as a vehicle for developing mutual understanding, implying a critical attitude to self and to others (Widdershoven et al 2009; Rudnick 2002). The latter is an important notion in the process of fostering moral learning. It refers to the Socratic epistemology that questions what knowledge is and how it can be acquired.

Socratic Epistemology refers to the practice of Socrates who, in public areas, discussed conceptual and fundamental issues with ordinary people by questioning them about their knowledge – related to the topic – and the way they acquired that knowledge. It emphasizes the importance of
directed questions (Nelson 1994). It is used in the theory and practice of MCD in which participants learn to explore and reflect upon their moral presuppositions concerning the moral issue(s) in the presented case. Socratic Epistemology emphasizes the art of questioning as a tool to search experiential knowledge. It can be seen as a tool that fosters a critical attitude of questioning in the process of reflection. Knowledge is seen as closely connected to context and experiences, it cannot be generalized but is always contextual and temporarily.

Research approach: participatory, interactive and dialogical

In the research approach several considerations concerning the theoretical framework, the role of the researcher, and the characteristics of the research method were taken into account. Regarding the theoretical framework, a research approach was needed that would fit to the theoretical framework of Moral Case Deliberation, and to ‘learning by doing’ instead of only applying deductively our theoretical views. The core of the research approach should be to engender a learning process in and within practice, aiming at reflection on ideas, presuppositions, and findings concerning the practice of MCD and the way we teach facilitators of MCD.

Regarding the role of the researcher, an approach was required that would allow for learning processes in and within practice, with an active role for the researcher in the interactive learning and research process, as facilitator MCD and trainer.

Concerning the research method, an approach was indicated that would provide tools to study interactive learning processes in and within practice. The methodology should: a) acknowledge the complexity and specific (unique) meaning of practice, b) focus on (reflections on) action, learning and reflection on learning including that of myself and of colleagues that are closely involved in the research, and c) enable collaboration between researchers on the one hand and health care professionals and institutions on the other hand. The method should support active involvement of and interaction between all parties in the process of fostering moral learning,
organising clinical ethics support, and developing tools for moral learning to improve the practice of clinical ethics.

To meet these needs a participatory, interactive and dialogical research approach was chosen. In this approach the involved parties (including the researchers) actively participate, share and reflect upon their experiences, and jointly search together for ‘good practices’ with respect to the research questions at stake, in order to gain a better understanding of themselves, the other and the given practice.

Research methodology: case study, Action Research, Responsive Evaluation

This study combines the methodology of case study (details of the situation, and focus on the particularities and meanings of a case), Action Research (learning in practice while aiming at newly emerging goals) and Responsive Evaluation (shared ownership, interactive learning) (see table 1.1). In this section, all three methodologies will be addressed.

Case-study
A case-study is an empirical inquiry that explores or describes a contemporary phenomenon in real life and is particularly suitable for research questions that are focussed on what, why and how a phenomenon is like it is (Yin 2009; Verschuren 2010; Donelly et al 2012). It is an in-depth study that uses a variety of data sources that highlights the particularity, complexity and uniqueness of a single case; the boundaries between the phenomenon and context are not clearly evident (Baxter & Jack 2008). In a case-study approach there are more variables of interest than data points as one results; it relies on multiple sources of evidence. A case-study builds upon the premise of a social construction of reality. It admits a close collaboration between the researcher and participant(s), which means that participant(s) are able to describe their views of reality, and enables the researcher to understand better the practice of the participants (Baxter & Jack
Table 1.1: Overview of the research focus, design and methodology, instruments for data collection

<table>
<thead>
<tr>
<th>Chapter Focus</th>
<th>Design/Methodology</th>
<th>Data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Clinical ethics in The Netherlands: MCD in health care organisations</td>
<td>Case study and Responsive Evaluation</td>
<td>Participatory observations, analysis of written meeting reports and notes of oral evaluations, notes of semi structured interviews, in-depth interviews (directly after the course and later)</td>
</tr>
<tr>
<td>3 The theory and practice of moral case deliberation in the clinic</td>
<td>Case study and Responsive Evaluation</td>
<td>In depth interviews, evaluations survey, observations during clinical side visits, observations reported systematically in logbook</td>
</tr>
<tr>
<td>4 Moral Case Deliberation in a Dutch Hospice about a dilemma concerning a patients' wish to die</td>
<td>Case study</td>
<td>Observations and analysis of written reports of the MCD meetings (n=2)</td>
</tr>
<tr>
<td>5 Tensions between theory and practice of Moral Case Deliberation in the context of an academic hospital in the Netherlands</td>
<td>Case study and Action Research</td>
<td>Observations, analysis of reports of: MCD meetings • Project (n=15) and steering group (n=8) meetings • Informal and formal meetings with stakeholders of each ward • Yearly report of project (n=3)</td>
</tr>
<tr>
<td>6 Prevalence and characteristics of moral case deliberation in the Dutch Health Care</td>
<td>Mixed methods</td>
<td>Survey questionnaires (n=2), focus groups (n=2), individual interviews (n=17)</td>
</tr>
<tr>
<td>7 Training health care professionals to become facilitator of Moral Case Deliberation</td>
<td>Case Study</td>
<td>Formal and informal written evaluations, evaluation questionnaire (n=53), observations of participants and trainers, (self) reflections of and with participants</td>
</tr>
<tr>
<td>8 A conversation method for facilitating moral learning by means of Moral Case Deliberation</td>
<td>Case Study</td>
<td>Observation and analysis of a MCD meeting and the written report of the MCD meeting (n=1)</td>
</tr>
</tbody>
</table>
These characteristics show resemblance with pragmatic hermeneutics, which carries out the importance of a contextual investigation in (real life) experiences. It resonates with the focus of MCD on pluralism and multi-perspective reflection on concrete practices.

In a case-study the researcher explores individuals or organisations through complex interventions, relationships, communities or programs and supports the deconstruction and subsequent reconstruction of various phenomena (Yin 2003). This approach is particularly valuable for developing theory and interventions and evaluating programs because of its flexibility and rigor. Hence it fits in with the research design of this thesis that on the one hand aims to evaluate experiences and practical learning processes and on the other hand to develop and improve the theory and practice of moral learning including new interventions like methods and instruments.

In six studies the case-study approach was used (see table 1.1). Two of the six case-studies analysed the practical learning processes of organising clinical ethics in a healthcare institution by conducting an evaluation study (chapter 3 and 5). Five of the six case-studies focussed on the experiences and learning processes of various stakeholders (participants in MCD (chapter 3, 4 and 8), facilitators of MCD (chapter 8), and trainees and trainers in a course for becoming a facilitator of MCD (chapter 2 and 7)).

**Action Research**

In a part of the study, the methodology of Action Research was used (Cohen & Manion 1989; Reason & Bradbury 2001; Reason 2006; Webb & Scoular 2011). This research approach is in line with a view on clinical ethics which focuses on interactive learning processes with and within practice. It is also in line with and complementary to the theory and methodology of the case study approach; it clearly acknowledges the nature of clinical practice (as being complex and uncontrollable), emphasizes creative ways to achieve development and improvement, and allocates the role of stakeholders as being important perspectives that are indispensable for the research process and therefore have to be included from the beginning.

Action Research is a well-applied research method in health care organisations as the theory is grounded in maintaining – like the case study approach – the focus on the ‘real world’. It acknowledges the daily struggles
of social actors, tries to deal with the complex organisational processes and focuses on close connections with people in practice (Kelly, 2001). Action Research is a *value-oriented approach* and has therefore the normative presupposition to achieve a change and/or improvement in practice. Action Research emerges, evolves and establishes in collaboration with practice during the process. It justifies the fact that people are part of a social and ecological context in which they are closely connected with others. The way it takes place is *situation-dependant*; in the many choices that might be taken there is a close attention for the context and the particular circumstances of the inquiry (Reason 2006). Characteristic of Action Research is that participants as well the researchers participate in the analysis, design and decision-making (in all choices that have to be made). Regarding the studies the following parties were involved in the research process of the practical learning processes: participants in MCD, facilitators of MCD (in training and graduated), stakeholders involved in organising ethics, the trainers and researchers themselves.

*Learning with and in practice and reflection on personal experiences* are essential elements in the Action Research methodological framework and is conducted by a four step cyclic process (planning, action, observing and reflecting), that represents a process of choices gradually made, closely related to the context of the case and the specific (research) conditions. In the first phase, the focus is on the awareness of the need to improve aspects of a specific situation, whereas in the second phase, the focus is on constructive criticism when the work progresses (Kelly & Simpson 2001). The last two phases focus on the findings that emerge by means of an evaluation through qualitative and quantitative data. During the whole research process the role of the stakeholders (the people involved) is important; their opinions are considered along the way, and all participants have equal authority. As work progresses, all findings and assumptions are constantly exchanged with stakeholders, aiming to create interplay amongst expertise, theory and practice in order to develop a joint supported content regarding the organisation of ethics and MCD, and good practices in fostering moral learning.

*Experiences* and what has been learned played a crucial role in the studies we made about the organising ethics and moral learning. Action Research emphasizes the importance of gathering experience and learning from it (Winter 1989). The insights gained from action research can result
in a deeper understanding of situations and happenings. This underpins the view that when we learn from our experiences, we use skills and methods which can be described and improved (Kelly & Simpson 2001).

This view characterizes the way of doing research in an experiential field of organising and developing the practice of clinical ethics (support) and investigating the moral learning processes by means of MCD during the years. It stresses the use of self-reflection that aims to enable people to conceptualize their (moral) discomfort and identifying the actions and/or changes that might be taken to change the situation (Kelly & Simpson 2001). This was applied in the separate studies to the role of the researcher that used the on-going reflection (of self and others, by means of dialogue) to pinpoint the results and meaning (or significance) of these results in order to anticipate and adjust the research process as it proceeds.

**Mutual collaboration and the role of stakeholders**

As in other research designs, Action Research aims for evidence to improve practice. In contrary of more regular research designs, Action Research goes beyond the distinction between producing and using evidence. It emphasizes creative ways to achieve the improvement, which includes enabling open dialogue and collaboration between academics and other disciplines like health care providers (Gregory et al 2011). With the precondition of a minimal understanding of the research itself and their role, a strong collaboration with relevant parties involved (stakeholders) is desirable, considering them as being the experts regarding the objects of a research project. In general two approaches of collaboration are distinguished: technical and mutual. Whereas technical collaboration involves a more one-way action in which the researcher implementing a theory in a specific situation, a mutual collaboration aims for a more equal involvement between all participating parties and tries to develop a more situational theory. The second approach produces a more durable change and might result in developing a new theory (Kelly & Simpson 2001). In the study there was a mutual collaboration included the following stakeholders: persons that were concerned with: a) being a participant in MCD, and/or b) being a facilitator of MCD (trainee or graduated), and/or c) being a trainer of trainees that will become facilitators of MCD.
Responsive Evaluation

In several studies, the methodology of Responsive Evaluation was used. Responsive Evaluation is a form of Action Research influenced by hermeneutic philosophy, in which interpretation and understanding take place during the process (Freeman 2011). It intends inquiry that results in qualitative-evidence; it is a process-oriented research design that aims to foster quality improvement of practices though reflection and ongoing dialogue (Abma 2005, Abma et al 2009). This kind of evaluation research was introduced by Robert Stake in the seventies as a pendant of the more conventional scientific evaluation inquiries in education that assumes an existence of an objective reality that operates independently of observers and participants of the inquiry, and emphasis the behavioural outcomes rather than the actual process of how one arrives at that point.

To evaluate processes in the dynamic context of health care practices, a research approach is required that acknowledges the value of intersubjective relationships and intuitions of health care practitioners. Responsive Evaluations aims at the inclusion of the concerns and issues of the stakeholders from the very beginning (Abma 2005, 2006; Bauer et al 2010). Additional to Action Research approach, the stakeholders are actively involved in the dialogical process of reflection on the value of their practice. This links with the view on ethics that endorses the value of the contribution of all participating perspectives and of their practice that serves as a fruitful base for fostering a dialogue. The inclusion of the stakeholders is not only for analysing the stories to generate data but to a greater extent, to use the stakeholders as narrators in a dialogical process in order to foster mutual learning (Abma 2003). That means that the researcher (also named ‘the evaluator’ (Abma 2006)) does not only take an interest in the opinions of the stakeholders like in the Action Research approach, but also in their experiences, including feelings and emotions, and in what people have learned in practice (Abma 2006; Widdershoven 2001). He or she starts a partnership in the evaluation process with the groups of people whose interests are at stake by giving them a voice in the dialogue. This relationship and dialogue are intrinsically important because it aims to facilitate a development of good practice (Abma 2006). It reflects the plurality of practice and refers to a practice in which people are concerned about others and feel supported by others. Here the methodology of Responsive Evalu-
Data collection meets the same underlying idea as those which have been carried out through pragmatic hermeneutics and dialogical ethics: that people are caring and social beings and that they are focused and depending on one another. Together they carry out the same following values: interaction, equal say – in the sense of all perspectives are part of the process rather than in the decision making itself –, dialogue and participation of all parties involved (Abma 2009; Weidema et al 2011; Metselaar et al 2014).

Methodologically the research design emerges during the process, in conversations with and in dialogue among the stakeholders. The researcher conducts and facilitates a dialogical process and examines the study and findings as it proceeds; there is a temporarily “work-document” and the researcher asks the stakeholders for commentary on the way the evaluation is unfolding (Abma 2006). This organic way of doing research fits the dynamic nature of practice and leaves room for necessarily adjustments in the research design as a response on unpredictable happenings that might appear during the study.

Data collection

Four of the six studies (chapter 2-4 and 7) made use of both quantitative and qualitative data in the data collection. With the exception of chapter 4 in which a mixed method design was used, in all studies qualitative data were the core component, and quantitative data were added.

The data collection in the separate studies consisted of research participants’ self-evaluations (oral and/or written; conducted by colleagues, institutional stakeholders, trainees, trainers), observations (of facilitators MCD, institutional stakeholders concerning the implementation of MCD, trainers), peer debriefing and validation (by meetings on a regular basis during the year), and learner validation (McNiff 1991). The latter contains studying the learning process of MCD participants and trainees (assessment) that was included in observation reports of facilitator(s) of MCD and trainer(s), reports about the content of the meetings and of self-evaluations (oral and/or written). In studying the role of the facilitator, peer-meetings (2-3 per year) with trained facilitators were organised to discuss outcome
and questions related to facilitating MCD. For studying the experiences and learning process of trainers, oral and written evaluations of training programs were used (questionnaires filled in by trainees and trainers) and peer-meetings with trainers were organised.

The role of the researcher

In contrast to research designs characterized by the researcher being an objective or detached ‘outsider’, in this study the researcher was participant in the practice under consideration, and, in the tradition of Action Research, ‘insider’ (Kelly & Simpson 2001). This insider role implies a close cooperation between the researcher and the stakeholders involved in the practice. For example, in one of the studies, the researcher initiated and facilitated MCD and a course to become a facilitator of MCD, while at the same time she organised an ongoing process of interaction with the participants, trainees and trainers aiming to evaluate and adapt the theory and practice of projects and training programs of MCD. This multifaceted role can be challenging, as the researcher for example has to find a balance between being a participant and being a researcher. This requires a transparent and trustworthy research process that aims at correspondence between the interpretation of the researcher(s) and the perspectives of the stakeholder(s), and also at a generalisation of the findings.

However, the multifaceted role of the researcher also creates possibilities, and for example provides access to unspoken narratives (Postholm & Skrøvset 2013). The researcher’s role requires specific attitudes and skills such as openness (being able to listen), receptiveness (to impressions and expression) and being reflective (aware of own beliefs and presuppositions). Next he or she should be constructive in creating an exploratory partnership with the stakeholders. That means being open to critics, accepting surprises, and being creative and responsive (Postholm & Skrøvset 2013). A responsive evaluator and action researcher is not searching for the answer on a particular problem. Instead he or she is searching for findings as they emerge in the context, before drawing conclusions and offering solutions. This means allowing the research being process driven and being
Outline of the thesis

This thesis consists of three parts. The first part presents three studies that describe the process of *moral learning in health care practice by means of participating in MCD*. Chapter 2 presents the development of the theory and practice of MCD in the Netherlands. Chapter 3 describes the results of a long-term project of applying MCD in a healthcare institution. Chapter 4 presents a case study that describes in more detail the way MCD can be applied.

The second part of this thesis is about *organising ethics in health care*. Chapter 5 shows the tensions between the theory and practice of MCD in the process of implementing and embedding MCD in an academic hospital. Chapter 6 presents the state of art of clinical ethics support in the Netherlands and shows some difficulties in organising ethics in health care.

The third part consists of two chapters that describe the process of *developing methods and instruments for facilitating moral learning in health care practice by means of training health care professionals as facilitators of MCD*. Chapter 7 presents the process and content of developing a course to teach facilitators of MCD. It describes the development of the training and the lessons learned through the years. Next it describes the relation between the theoretical background of MCD and the way facilitators are trained, and the methodology and didactical interventions used in the training. Chapter 8 presents a conversation method that can be used by a facilitator of MCD as a tool to structure the conversation and deepen the moral inquiry. It describes the methodological steps of the Dilemma method, and addresses

prepared for unexpected events. This role is well fitted to case studies and action research, that are sensitive to complexity, emphasize the particularity and uniqueness of the context, and provide room for unexpected conditions emerging during the research process (Verschuren 2010). This parallels the theoretical framework and the view on clinical ethics described above, which presuppose that the notion of good care or a good facilitator are not given beforehand but emerge from a joint moral inquiry in the context of the specific situation.
the aim and the theoretical background of each step. It shows how facilitators can use the tool to foster moral learning in health care practices.

Although the three parts each have a specific focus, several chapters combine various learning processes, and deal with both fostering moral learning, and organising clinical ethics (support) or training facilitators of moral learning. All practical learning processes addressed in each chapter will be included and integrated in the discussion chapter of this thesis.

The final discussion chapter aims to integrate the findings of the studies and to answer the research questions. Furthermore, it relates the outcomes of the studies to the work of Donald A. Schön. It also reflects on the quality, strengths and limitation of the separate studies. Finally, it describes some challenges and recommendations for future practice and research regarding the topics addressed in the thesis.

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PART I

Fostering moral learning in health care practice
Clinical ethics in the Netherlands. Moral Case Deliberation in health care organisations

Introduction

“The management of health care institutions should not only focus on ethical questions in the primary caring process. It should also pay attention to ethical questions regarding the organization of care and regarding the position the institutions want to take within societal developments in health care. Such instruments as health ethics committees and the formulation of codes of conduct and protocols which are now well-known are important instruments, yet they are not sufficient. Therefore, in the nearby future, I will stimulate the management of health care institutions to take ethics into account within every quality management policy. A possible way to promote this role of ethics is the organization of a structural dialogue among patients, care givers and management in order to discuss ethical questions.”

(Translated: Letter of the Minister of the Department of Public Health, Welfare and Sports (VWS) to the House of Representatives of the Netherlands, 2000).

In the Netherlands, interest in clinical ethics has increased considerably in the last few years. Health care institutions are increasingly forced to account for their activities. This has led to an adaptation of institutional policies towards a stronger focus on efficiency and transparency. The development of a national certification system for health care institutions (i.e. a benchmark) leads to more competition among the health care institutions. Next to this, there is also an increased attention to enhancing the (moral) competencies of health care professionals in order to deal better with moral dilemmas. As a consequence, there is an increased demand for training and educational programmes that promote professionals’ moral competencies (Verkerk et al. 2007). In 2005, a national report by the Centre of Ethics in Health Care (CEG) appeared, focusing on the quality and quantity of

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1. The Department of Public Health, Welfare and Sports of the Netherlands is commonly abbreviated as VWS (Volksgezondheid, Welzijn en Sport).
2. Centre of Ethics and Health (Centrum voor Ethiek en Gezondheid). CEG was instituted in 2001 by the Minister of VWS as a cooperative of the national Health Council and the Council of Public Health. The function of CEG is to involve society by finding and formulating answers in order to construct an effective policy in the field of medicine and biology. The aim of this task is to satisfy the statutory duty of care.
clinical ethics in health care institutions. Based on a national survey (CEG 2005), the report describes a shift in focus from big moral issues towards small everyday ethics. The report concludes that many health care professionals lack basic ethical knowledge and skills that may help them to deal with moral issues. Moreover, the report observes a lack of awareness of the fact that ethics is linked to everyday forms of care. In line with the above citation, the CEG advised the Dutch government to pay more attention to structural moral deliberation among health care professionals. The CEG also recommended an ongoing connection between moral case deliberation and institutional policy (CEG 2005). Almost at the same time, the Dutch Minister of Health Care, Welfare and Sports (VWS) placed more attention on ethics in health care in general and asked for more structural attention to moral deliberation within health care institutions (Department of Public Health (VWS) 2005). This was the beginning of an ongoing process in which many clinical ethics committees (or health ethics committees) transformed their role from that of distant expert with a focus on policy and guidelines, into the so-called “steering group”. In general, a steering group aims to develop the moral competencies of health care professionals and to guarantee an ethics climate throughout the whole institution.

The focus on the moral competency of health care professionals fits well within the theoretical frameworks of dialogical ethics and pragmatic hermeneutics. Both frameworks emphasize that the domain of ethics and ethics expertise should not be restricted to academic ethics and ethicists in health ethics committees. Health care professionals already frequently participate in ethical deliberations and discussions since they actually have to deal with moral questions. Moral case deliberation (MCD) gives health care professionals the possibility to exchange their views and the difficulties they encounter on moral questions in order to enhance their moral competencies. Based upon the theoretical assumption that every human being possesses moral experiences and the wisdom of expertise, health care professionals who participate in MCD are regarded as moral experts. The role of the facilitator of MCD is to help professionals to make their moral knowledge explicit and to foster a dialogue. It is presupposed that the facilitator has practical moral expertise himself or herself. Yet it is not clear what knowledge and competencies the facilitator needs to support the group process. What kind of attitude and ethics knowledge is needed? And finally, what is the role of ethics theory in MCD?
This chapter focuses on these questions by describing the practice and theory of moral case deliberation. First we give an outline of the meaning of the concept of MCD and several reasons why organizations introduce MCD. Next we give a description of the theoretical background of MCD and the way we monitor and facilitate MCD projects through research. By describing a pilot training programme in which health care professionals are trained as facilitators of MCD, we will highlight the specific approach of the Moral Deliberation Group at Free University Medical Centre. Finally, the evaluation of this pilot will serve as a basis for discussing some main characteristics of our approach and for drawing some conclusions.

Moral Case Deliberation

What is a Moral Case Deliberation?
A MCD is an interactive session in which health care professionals systematically reflect on one of the moral question(s) that has emerged in concrete personal experience (i.e. a case). Usually it involves a heterogeneous group, such as a multi-disciplinary team or a group of health care professionals from different settings with different professional backgrounds. In general, there are three levels of distinctive goals of MCDs: (1) The case level: to reflect on the case and improve the quality of care within the case, (2) The professional level: to reflect on what it means to be a good professional and to enhance the professional’s moral competencies, and (3) The institutional or organizational level: reflection on policy issues and on prerequisites for improvement of the quality of care at that level.

An MCD session takes in general 60–90 minutes and is structured and facilitated by a facilitator. The facilitator structures the meeting by means of a conversation method (depending on the specific goal of the MCD). Some methods focus on the moral case itself and aim towards a well-considered decision, while other methods use the moral case to focus on the attitude of a professional in order to enhance moral competencies (Steinkamp & Gordijn 2003, 2004). The conversation methods aim to foster an open and ongoing dialogue. This implies a respectful and critical attitude of the par-
participants in which they question each other in order to understand each others’ perspectives; an attitude that is focused on an inquiry of each others’ judgements and presuppositions, not on debate and rhetoric.

The expertise of the facilitator of an MCD consists of fostering an open and safe atmosphere to promote a sincere and constructive dialogue (Abma et al 2009). The aim of the dialogue is to reflect on the quality of the work of the participants, the ideas behind their professional behaviour and their presuppositions about good care. The facilitator does not give advice, nor does he or she morally justify a specific decision. The facilitator acts as a Socratic guide by supporting a critical inquiry of moral convictions and moral questions. Besides using general conversation skills, the facilitator of an MCD keeps an eye on the moral dimension of the case, applies one or more conversation methods, supports the joint reasoning process, and helps the group in planning concrete actions in order to improve the quality of care.

Why Moral Case Deliberation?
Moral case deliberation can be performed on an ad hoc basis. It can also be implemented in a more structural way. In order to reach the latter goal, long-term projects between the university and the health care organizations are being set up with a duration of two to six years. These projects consist of several implementation phases in which various ethics activities (such as MCD) are planned (see section 2, ‘Facilitating Moral Case Deliberation’). The overall aim of the moral deliberation projects is to use the structural embedding of MCD as a means for other goals, such as enhancing professional quality and fostering quality of care. There are various reasons why Dutch health care organizations might embrace a MCD project. Reasons often mentioned include; to enhance professional quality (i.e. increasing the acting repertoire of the health care givers) or to improve cooperation and mutual understanding after a recent merger or reorganization. MCD can also be regarded as a structural part of an institutional educational policy with the aim of an ongoing reflection on the justification and improvement of the quality of care. Another possibility is to use MCD as part of a quality assurance policy.
MCD differs from clinical ethics consultation (Molewijk et al 2008b, 2008c; Ranson et al 2006). Clinical Ethics Consultation (CEC) is the support of a decision-making process by an ethical expert. The report of the ASBH Taskforce on the Core Competencies for Health Care Ethics Consultation stresses the procedural and expert approach of the ethics consultant in discussing ‘the ethics facilitation approach’. A central goal of the ethics consultant is to answer the question, “Who is the appropriate decision-maker?” in a morally and legally appropriate way (ASBH Task Force 1998; Aulisio et al 2003). The ethics consultant focuses more on the answer to the question, “What is morally right?”, whereas the facilitator within the moral deliberation focuses more on the process by which the group members reach this answer on their own (Molewijk et al 2008b).

The differences between CEC and MCD are not only practical, they also have a theoretical background. Whereas CEC is based upon a view of ethics as individual problem solving, MCD focuses on moral learning through dialogue. In the next paragraph we will clarify the underlying theoretical background of MCD.

Theoretical Background of Moral Case Deliberation
The design of the MCD projects at Free University medical centre and the methods of MCD are inspired by a combination of pragmatic hermeneutics and dialogical ethics (Gadamer 1960; Molewijk et al 2008a; Rudnick 2007). A fundamental claim of pragmatic hermeneutics is that ethics and morality starts with actual experience. This means that theories and concepts are subordinate: they may be useful, but ultimately they should be based upon and made applicable to concrete practices. This approach to ethics goes back to Aristotle, who claimed that moral wisdom and moral knowledge originate from reflections on and within concrete situations. Moral knowledge is dependent on experience (Widdershoven 2005; Widdershoven & Abma 2007). This means that the construction and meaning of morality

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3 In rare MCD cases, it happens that the health care professionals only become aware of the perspective of the patient because it is an explicit step within the conversation method of a MCD.
is inherently contextual and temporal. The meaning of good care, for example, is not given beforehand, but arises out of a dialogue among open-minded people in practice. Knowledge from ethical theories may play a role in a dialogue but it cannot claim epistemological authority. Following this, MCD always starts with concrete personal experiences; hypothetical thought experiments or definitions of ethical concepts are not the starting point of MCD.

**Monitoring and Facilitating MCD Projects through Research**

All MCD projects are monitored and facilitated by means of quantitative and qualitative research methods within the framework of a Responsive Evaluation research design. This is an interactive process-oriented methodology, based on the same theoretical inspirations as MCD (Abma et al 2009). This approach reframes the traditional way of evaluation (i.e. determining the effectiveness of programmes on the basis of given policy goals) into a process of interpreting the results of a programme by engaging stakeholders and their issues of concern (Abma et al 2001; Abma 2006, Abma and Widdershoven 2006). This approach aims to enhance the mutual understanding of a situation by fostering ongoing dialogues about relevant issues among various stakeholders. The stakeholders, groups of people whose interests are at stake, participate actively in the evaluation process and they are involved in monitoring the project. They become equal partners in the evaluation process by being involved in the formulation of research questions, the selection of participants and the interpretation of findings. Through dialogue the participants share their issues and concerns, but also respond to those of others, to reach an understanding of important issues of other stakeholders (Abma et al. 2009). The underlying notion is to acknowledge the plurality of the interests, values and perspectives of all the stakeholder groups. This research design includes collecting data by both qualitative and quantitative research methods (such as semi-structured interviews, focus groups, participative observation, questionnaires).
Facilitating Moral Case Deliberation: Training for health care professionals

Now that we have presented the practical and theoretical features of MCD (including the role of Responsive Evaluation), we will focus on the training of health care professionals as MCD facilitators, which is a part of the final implementation phase. By elaborating on the training and its evaluation, we will demonstrate the actual meaning and consequences of our approach.

Following the idea that MCD should support the existing moral expertise of practitioners, our claim is that the facilitation of MCD can and in the end should also be performed by practitioners. This however requires a specific training programme. How should one train health care professionals to become facilitators of MCD? What kind of skills and ethics knowledge do they need? How should we train these skills? In order to answer these questions we will share our experiences concerning a pilot training programme for health care professionals in two psychiatric hospitals in the south of the Netherlands (Molewijk et al. 2008a).

Pilot training facilitating Moral Case Deliberation

A pilot training programme facilitating MCD was offered to employees in two different psychiatric hospitals (an intramural health care institution and an extramural one) in the south of the Netherlands. The training was part of a long-term project in which MCD was implemented in several phases:

1. Moral sensitization by means of various pilot activities,
2. Transmission of moral expertise and competencies to health care professionals,
3. Training health care professionals to become facilitators of MCD, and
4. Forming an organizational structure and institutional policy to embed the moral deliberation activities (Molewijk et al. 2008a).

These phases overlap with each other.
Both institutions participated in a joint training programme in which health care professionals were trained to become facilitators of MCD. This was special because normally these institutions do not often cooperate (among other things, due to competitive market mechanisms). The training was facilitated by the Moral Deliberation Group and offered three times for groups of 10 participants from various professions (nurses, psychologists, managers etc.). In the first training programme, members of the board of directors also participated.

Organization
The training programme consisted of six meetings of four hours spread over half a year. The participants were trained in three different conversation methods. The participants prepared for every meeting by studying some basic literature about ethics or a specific topic, for example, a conversation method. Usually this consisted of one or two articles or a chapter of a book. During the meetings the participants were expected to practise their role as a facilitator of MCD. Between the meetings, participants were expected to practise these methods. The exercises were arranged by themselves in their own multidisciplinary team or in other teams. The participants were encouraged to practice in pairs. Experiences of these exercises were extensively discussed during the following meeting.

The purpose of the training was to teach the participants to act as facilitators in MCD. This means generally that the facilitators should be able to foster a sincere and constructive dialogue on a moral question. The meetings were organized around the following general aims: to learn to coach a group, to feel familiar with the conversation methods in order to foster a dialogue, to learn to distinguish moral issues from other issues (such as psychological or technical problems) by themselves and with the participants, to learn to moderate a collaborative endeavour, and finally, to learn some basic knowledge about ethical theories, concepts, arguments and reasoning. Every meeting started with an opening and some announcements followed by a collective reflection on the experiences with practicing MCD. Next, the homework including the literature was discussed. Then the participants exercised with one of the conversation methods. In total, three different methods were used. One participant would act as a facilitator.
during 20 minutes. The other participants would act as members of the MCD. Each exercise was jointly evaluated by discussing the experiences of the facilitator trainee, the other participants, and the trainer. During the exercises every participant could ask for help or advice from the trainer; the trainer intervened when necessary by asking the facilitator for clarity or by asking the facilitator and the group, “What are you doing and why are you doing that? What are the alternatives?”

Method of Evaluation
The training was evaluated by using the methodology of Responsive Evaluation. A PhD student conducted participatory observations, analysed the written meeting reports, the notes of the oral evaluation after each meeting, and the notes of the semi-structured interviews. The data were analysed by the PhD student; interpretations and conclusions were shared and checked by a senior ethicist (who also acted as the trainer in the training programme) and a senior academic in health care ethics.

Furthermore, in-depth interviews were held with each participant two months after the end of the training programme. The participants were asked about their experiences with the training programme, their opinion about the content and organization, and their expectations and experiences regarding the practical application of the training. Two years later some participants were approached again with a questionnaire containing questions about their experiences as facilitator of MCD (success factors and failures) and the frequency of facilitating the MCD in a time frame of a year.

Results
In general the participants were satisfied with the training. The analysis of the interviews shows that they became more sensitive to moral issues in daily practice and had an increased awareness of the variety of perspectives. At the same time the training contributed to a less ad hoc behaviour. The content of the meetings were evaluated as highly satisfactory and the practical exercises as a useful way to become more familiar with the conversation methods. However, some of the participants criticized the number
of conversation methods (three) related to the number of meetings (six). Some participants also criticized the preparatory literature on the grounds that it was too academic and lacked feasibility.

The interviews clarified the reasons why some participants were not very active during and after the training. Lack of motivation was the main reason. They had not participated voluntarily, but were sent by their boss. Finally, the interviews revealed criticism regarding the composition of the group. The mix of different professionals from various levels in the organization resulted in an unequal balance of power, with the effect that some participants were afraid of negative consequences. As a result they experienced less openness and transparency, which is alarming because both are core features of MCD.

The participatory observations showed among other things that those who had little previous experience with MCD needed more time and attention to become acquainted with the conversation methods, the recognition of moral issues in general, and gaining a clear picture of MCD, and therefore were less able to focus on developing the specific role of facilitator of MCD.

One of the main results from the written questionnaire after two years was the lack of clarity among the trained facilitators about how many hours and in which team/department they were allowed to facilitate MCD. It remains necessary to practise as a facilitator of MCD, both during and after the training.

Discussion

In general, projects of clinical ethics following the approach of the Moral Deliberation Group of Free University are well received and successful (Molewijk et al. 2008a, 2008b, 2008c). However, with respect to the experiences of the pilot training programme, there were some critical notes concerning two main topics: (1) The attitude of a facilitator of MCD and the way knowledge and skills are trained, and (2) The pitfalls in the organization of a MCD.

The evaluation of the training showed that participants with little ex-
perience with MCD needed relatively more time and attention to have an idea of MCD, to feel familiar with the conversation methods and to learn to identify the moral issues. This comes at the expense of learning to develop their role as facilitator of MCD. In response to this criticism, we decided to formulate a pre-condition for participation in training, that every participant should have experienced a MCD at least six times. By setting this precondition, we can be sure that the facilitator trainee already knows what it means to participate in a MCD, and therefore can more easily focus on the specific requirements of becoming a facilitator of MCD in the training. With experience and knowledge about MCD, participants will be able to pay more attention to the specific role of the facilitator of MCD.

Furthermore, the evaluation shows lack of motivation of some participants as a hindering factor for active participation in the training. Therefore we decided to develop a recruitment policy. This recruitment and selection procedure can also support the implementation and embedding of the training. We concluded that it should be the concern of the health care organization to develop an implementation policy, and, for instance, to create opportunities for the participants to practise their MCD facilitator’s role, during and after the training.

Both in interviews and in the written evaluation, some organizational elements of training were criticized, like the number of conversation methods and the preparatory literature. This shows the need for a balance between theory and practice. In response to these criticisms we adapted the training by reducing the number of conversation methods (two instead of three conversation methods) and lengthening the training with one extra meeting. Furthermore, we diminished the literature and emphasized the practical exercises in and between the meetings by using reflection reports written by the participants. This point is connected with the view on the role, knowledge and skills of the facilitator of MCD. As we mentioned earlier the main goal of MCD is to foster an open and sincere dialogue with the aim of promoting the moral competencies of health care professionals. A supporting Socratic attitude of the facilitator is more important than theoretical ethical knowledge. This does not mean that theory has no role to play. One might consider using theoretical elements in a follow up of a MCD session or in the training programme. In line with our hermeneutic philosophy, however, theory should always be closely related to practice,
and applied to practice. The appropriate place of theory (and the sort of theory) is a further question to be addressed in our MCD projects. Such questions can, we think, only be answered by doing experiments in practice.

An issue for discussion in our MCD sessions and projects is the absence of the patient. Although the patient perspective is always brought in, the patient is usually not physically present. This is questionable since MCD assumes that all participants are morally equal. Some implicit and explicit considerations may justify the absence of the patient. For example, a main pillar and also a significant condition of MCD is an open atmosphere to promote a sincere and constructive dialogue. This could be compromised if the patient were present. For example, when a nurse has problems with the behaviour of a patient, they might feel barriers to speaking openly and freely about their ideas and feelings when the patient is physically part of the conversation. Furthermore, there are certain preconditions for the patient to participate in the conversation. The patient should be capable of understanding the conversation before they can take part in it. Especially with psychiatric patients this is not always the case. Recently several health care organizations have experimented with different forms of MCD (or clinical ethics consultation) in which the patient or a patient representative is involved (Fournier 2005; Richter 2007). At GGNet, a large institution for mental health care in the east of the Netherlands, both patients and patient representatives are currently participating in MCD sessions together with health care professionals and family representatives. Pitfalls and successes of these developments should and will be made public in order to learn from these initiatives, since a true dialogue on good care also implies a dialogue with patients (and not only about patients).

Conclusion

According to the approach of the Moral Deliberation Group, the main goal of MCD is to educate health care professionals and to improve their moral competence. The focus of this approach is a joint inquiry about what is good within the context of a concrete case. This chapter has described the
theoretical and practical implications of an MCD project focusing on a pilot training programme for facilitators of MCD. The findings show that the organization and embedding of an MCD project are easily underestimated. Implementing MCD is not only a matter of planning an MCD project and training health care professionals to become MCD facilitators. It is a complex and difficult process with several dimensions. To ensure the quality of the expertise of the facilitators and the MCD sessions, one needs the assistance of external experts in ethics and implementation strategies. This means a permanent supply of (extra) training and supervision for the trained facilitators of MCD, especially after the training. This is also needed in order to keep an eye of the quality of MCD. MCD can only support and develop the moral expertise of health care professionals if it is structured by experienced facilitators, who themselves need to be properly trained.

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Teaching ethics in the clinic.
The theory and practice of Moral Case Deliberation

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Abstract

A traditional approach to teaching medical ethics aims to provide knowledge about ethics. This is in line with an epistemological view on ethics in which moral expertise is assumed to be located in theoretical knowledge and not in the moral experience of healthcare professionals. The aim of this paper is to present an alternative, contextual approach to teaching ethics, which is grounded in a pragmatic-hermeneutical and dialogical ethics. This approach is called moral case deliberation. Within moral case deliberation, healthcare professionals bring in their actual moral questions during a structured dialogue. The ethicist facilitates the learning process by using various conversation methods in order to find answers to the case and to develop moral competencies. The case deliberations are not unique events, but are a structural part of the professional training on the work floor within healthcare institutions. This article presents the underlying theory on (teaching) ethics and illustrates this approach with an example of a moral case deliberation project in a Dutch psychiatric hospital. The project was evaluated using the method of Responsive Evaluation. This method provided us with rich information about the implementation process and its effects, and the research process itself also lent support to the process of implementation.
Introduction

Teaching medical ethics gets increasing attention because of the upcoming framework of core competencies within current educational programmes for healthcare professionals. Yet, traditional ways of teaching medical ethics have some limitations. The abstract knowledge of textbook ethics makes professionals feel alienated from their own moral experiences, expertise, and insights. Professionals may learn ethical concepts and principles, but are not adequately trained and motivated to apply this abstracted knowledge in their own clinical practice. Even teaching programmes that focus less on knowledge transmission of ethical theories (e.g. casuistry), seem to pay little attention to the training of moral competencies, virtues and to dialogue and deliberation amongst practitioners. In these approaches the analysis of the case itself and required analytical skills are central. In order to focus more on collective situational and competency learning, an alternative way of teaching medical ethics has been developed, namely moral case deliberation. Moral case deliberation consists of a collaborative, systematic reflection on a real clinical case (see Appendix A for an example). The reflection takes 45 minutes to 1 day and is structured by means of one of the conversation methods (Manschot & van Dartel 2003; Steinkamp & Gordijn 2003). Methods are chosen depending on the purpose of the moral case deliberation and can focus on the process (e.g. individual self-reflection, teambuilding, training attitude or skills) or the product (e.g. solutions, compromises, answers, actions). The ethicist functions as a non-directive facilitator as opposed to an expert and concentrates on the quality of the deliberation process and the meaningfulness of the moral issues. By means of moral case deliberation, professionals develop moral skills and an appropriate reflective attitude.

Moral case deliberations are ideally not unique events, but a regular and structural part of the professional training on the work floor within healthcare institutions. This fits well with trends in education and organisational learning. Within these disciplines the transmisssional view on information processing and learning as a cognitive act has been criticised (Brown & Duguid 1996; Dixon 1994; Lave & Wenger 1991; Stake 1975). Alternative ideas emphasise the context-bound nature of learning in relationships between people (Nicolini et al 2003). In The Netherlands several healthcare
institutions have started moral case deliberation projects on the work floor in collaboration with ethicists (Dartel van 1998). This has resulted in a practical guidebook for moral case deliberation (Manschot & van Dartel 2003). At a national level the Dutch Minister of Health has advised healthcare institutions to implement moral case deliberation in the clinic (CEG Report 2005). In 2004, the University of Maastricht and Hans van Dartel (Leiden University) established an expert platform on Moral Case Deliberation with the Ethics Department of the Ministry of Health. Since 2005, these parties started to organise annual working conferences on the methods and implementation of moral case deliberation. In order to illustrate moral case deliberation we present a practical example. It concerns a three-year project within a chronic care division in a psychiatric hospital in The Netherlands. The division management requested moral case deliberation to enhance the competence of professionals, to stimulate reflection on the quality of care and to develop a culture of openness and transparency (Molewijk et al 2005; Annual Report of Division of Chronic Mental Health Care, Mental Health Care Institution, Den Bosch). In response a project plan was developed between the university and division members. A project-group and a steering committee composed of staff members to middle and top-managers were installed. Teaching activities included clinical site visits, monthly moral case deliberation sessions with two permanent multi-disciplinary groups with members from different teams, reading and discussing papers, interactive presentations and joint writing. The project was monitored and evaluated through the method of Responsive Evaluation in order to adjust and improve the teaching activities undertaken.

This paper focuses on what professionals actually learned as part of the moral case deliberation project. Its central aim is to present a contextual approach to teaching ethics. We start with a description of the theoretical background of our approach. Next, the method of evaluation will be elucidated. After the presentation of the results, we will reflect on the strengths and weaknesses of moral case deliberation.
Theoretical background: pragmatic hermeneutics and dialogical ethics

The background of our approach to teaching ethics is a combination of pragmatic hermeneutics and dialogical ethics. Both approaches stress the importance of practical processes of meaning-making, always related to concrete problems. They require openness towards the views of others. Important vehicles for meaning-making are stories, by which people interpret and understand their situation and try to find out which actions are suitable. In stories, our experiences are at first vague and ambiguous, and then get a more prominent form (MacIntyre 1981). Stories make explicit the implicit meaning of lived experience. In stories, the pre-narrative structure of life is transformed into a narrative structure (Ricoeur 1983; Widdershoven 2001, 2005). Pragmatic hermeneutics and dialogical ethics are in line with narrative ethics in their interest in stories. They differ in that they emphasise the need for deliberation and dialogue as a way of making sense of stories and coming to joint interpretations (Ashcroft et al 2005). Pragmatic hermeneutics is critical of all attempts to frame the problem in terms of strictly defined principles and to solve it through abstract procedures. Ethical problems in healthcare are always complex and concrete (Leder 1994). One should investigate what the situation means for those who are practically involved in it. How do they define the issue? What solutions do they envisage? What problems do they encounter? Pragmatic hermeneutics is sceptical about interpretations which are general and ahistorical. In trying to make sense of a situation, one should be aware of its intricacy and of its historical and contextual background. Pragmatic hermeneutics urges participants in a practice to be open to the contextuality and contingency of the situation. It invites people to interpret their situation not within a fixed and rigid set of principles but to be flexible and open to new possibilities.

Dialogical ethics focuses on processes of joint learning. Learning means extending one's perspective, or broadening one's horizon (Gadamer 1960). This typically takes place in a dialogue. In a conversation, we can be confronted with unexpected statements or utterances. In such a case, dialogical understanding means that one tries to see the point the other makes. It means being open to what the other has to say, being prepared to accept it as
relevant and valid for oneself. To quote Gadamer: “Openness to the other, then, involves recognising that I myself must accept something against me, even though no one else would bring this up.” (Gadamer 1960 p.343).

Method: Responsive Evaluation

Working from this theoretical background, we developed a moral case deliberation project at a chronic care division in a psychiatric hospital. The project was evaluated by a team of two evaluators. One conducted the research activities. The other also coordinated the project and moderated the regular meetings with two moral case deliberation groups. The evaluators followed a Responsive Evaluation approach (Stake 1975; Abma & Widdershoven 2005; Guba & Lincoln 1989; Koch 2000). The term negotiation characterises the essence of Responsive Evaluation. Evaluation criteria are derived from the issues of various stakeholders and gradually emerge in conversation with and among stakeholders. Besides the identification of issues, conditions are created for the interaction between stakeholders. In this instance, the evaluators identified the following stakeholders: hospital and division management, healthcare professionals and staff members. Research activities included six in-depth interviews with key figures about their expectations of moral deliberation within the institution at the start of the project. The participants also responded to a regular evaluation survey (n=57) after every moral deliberation session and a final evaluation survey (n=11). Furthermore, both evaluators visited a clinical site (e.g. one of the units of the division) in order to participate within regular work activities and to raise several moral issues that came out of the observations during the visit. Since the evaluators also acted as moderators of the moral case deliberation sessions they gathered a lot of inside information about the group dynamics and actual learning processes of the participants. This participant observation information was systematically recorded in a logbook. In addition two focus groups were organised with the participants in the moral case deliberation sessions. In these focus groups, participants shared their experiences with the project as a whole and with the deliberation sessions in particular, and discussed whether or not the sessions had helped
them in their clinical practice. The participants also responded to controversial statements derived from the interviews with key-figures as part of the dialogue between stakeholder groups. The dialogical process between various stakeholder groups mainly took place within the meetings of the moral case deliberation groups, the project-group and the steering committee. The participants in these groups responded to the stakeholder issues and data gathered by the interviews, participant observation, focus groups and surveys at several moments in time during the project. This helped the evaluators to gain a broad spectrum of perspectives on the project within the institution, but it also fostered the implementation of findings. It is known that stakeholder participation and communication are key factors for implementation of evaluation findings (Greene 1988; Shulha & Cousins 1986).

**Teaching Moral Case Deliberation in a psychiatric hospital**

Soon after the project had been started, research activities made it apparent that healthcare professionals experienced several problems. They did not feel secure enough to openly share professional doubts and feared these were seen as signals of professional weakness. Stressful and complex cases (e.g. violence, coercion, patients with double diagnoses, uncertainty about justification of mild paternalism) led to feelings of emotional burn out. Professionals also reported they lacked words, competencies and structured meetings to constructively reflect on these cases. As one of the healthcare professionals said:

“There are many moments in which I feel morally uncomfortable with the situation, without being able to express for which reasons the dilemma came into existence in the first place. It would be wonderful if we could recognise the elements of our dilemmas, share them with our colleagues, and get to learn how we could transform powerless feelings into concrete and constructive ways of dealing with those dilemmas.”
These issues, including the requests of the division management, were formulated as learning goals within the project plan. During the interim and annual project reports, and the meetings of the project group and the steering committee, these learning goals were evaluated and if necessary adjusted. Concrete examples of what participants learned during the moral case deliberation project are described below.

What moral questions?

Twenty moral case deliberation sessions in one year with an average of seven participants led to a division-related database of approximately 100 moral cases of which about 20 were extensively discussed, recorded and analysed. The moral questions of the cases were categorised into: client-centred, professional-centred, and organisational-centred moral questions (Stolper et al 2006).

Some examples of client-centred questions:

- A long-term patient has real difficulties with cleaning his room and becomes anxious. Should I help him and clean his room for him or should I demand that he cleans his own room?
- A Korsakov patient has been on the waiting list for admission to the hospital for a long time but the treatment facilities are not yet well-developed. Should I still refer him, or should I persist and ask the therapists to develop the treatment facilities first?

Professional-centred issues include, for example:

- A nurse-trainee does not seem to be functioning well. How much time and how many opportunities should I give him before we decide that he is not able to continue his nursing education?

Organisation-centred moral questions consist of the following:
• Smoking is by law prohibited in all hospitals. Patients at the long-term care division live within the hospital. Should we respect the law or allow the patients to smoke in “their” home?
• A long-term patient has been away for a long time because of his psychiatric treatment elsewhere, which is still not finished. How long should we keep his place open at the long-term facility?

Which moral competencies?

The ethicists in the project divided the moral competencies the professionals learned into knowledge, attitude and skills. Instead of teaching moral theories, professionals were taught how to deal with clinical ethical issues in real life situations. With respect to knowledge, the ethicists showed how to recognise moral issues and how to formulate moral questions or moral dilemmas. The ethicists discussed questions such as: What are values and norms and how are they related? What are differences between a dialogue and a debate? In which different ways can one determine what is morally good? The ethicists only brought in ethical concepts when they were actually relevant for the topic of the case deliberation. So, within the teaching activities, knowledge played a minimal role and the knowledge taught was instrumental for the teaching of attitudes and skills. Knowledge itself was not the main goal of teaching. With respect to the attitude of professionals, they learned how to actually have or create a moral dialogue with their colleagues. They were enabled to postpone their initial judgments, their desire to convince the other, to run for the practical answer without a well thought-out analysis of the question itself, and to focus on “the” only right answer or action. They learned to critically reflect on the actual underlying moral questions, to listen actively by means of questioning, to respect other or even opposite viewpoints on the case, and to distance themself from moral dilemmas that initially paralysed them. During the Responsive Evaluation research process, the participants formulated their changing attitude as follows:
I learned to see our common professional behaviour as more special and complex
• I am aware of the normative dimension of my professional attitude
• Team decisions are made less on an ad-hoc basis and are better considered
• I learned to give words to uneasiness which increased my constructive attitude
• I realised that others are also uncertain about what is morally good, that there is not just one simple moral answer that is right; I felt less insecure about sharing my questions
• I learned to learn from people who do not agree with me
• I felt less emotionally distressed since I could more easily distance myself from, and reflect upon my moral dilemmas: dilemmas no longer control or capture me

With respect to participants’ skills, healthcare professionals learned communication skills (e.g. non-judgemental listening, asking fundamental questions), reasoning skills (e.g. logic, connection between moral values and norms, inductive versus deductive reasoning) and moral skills or virtues (e.g. postponing moral judgments, creating dialogue instead of convincing the other). Given our pragmatic hermeneutic and dialogical approach to ethics, communication skills and moral virtues are particularly important. Reasoning skills are relevant, but need to be alongside communication and moral virtues, especially within clinical contexts (Hope et al 1996). Based of the evaluation questionnaires, participants reported they learned the following:

• I am able to recognise moral dilemmas as such, which makes many cases less emotionally overwhelming
• I can postpone initial judgments
• I learned to ask questions
• I learned that there is a limit to my professional responsibility
• I am more clear about my professional limits and better able to ground them
• It has become easier for me to refine the questions of the patients
How did the participants value the learning process?

Ongoing research gave the ethicists the opportunity to monitor the way healthcare professionals evaluated the moral case deliberation project. The learning activities were evaluated on a scale of 1—10 and averaged at eight or higher. The professionals felt the moral case deliberations were a necessary activity since they do not normally have the time to reflect on what they are doing. They also felt that instead of teaching knowledge, their own cases and their own expertise were appealed to. The participants from the structural moral case deliberation groups felt more secure and were able to increase their competencies regarding dealing with moral questions and dilemmas. At the end of the project, the participants concluded that the moral deliberation should take place even closer to the place where they actually work with their own team. As one participant put it:

“Learning to deal with moral issues is tough, but trying to implement moral case deliberation within our own units is even tougher. We feel like we need more support, both from the ethicist, from the university and from our own managers.”

Overall, during the moral case deliberation project, a dynamic and interactive cooperation emerged between the ethicists and the stakeholders within the psychiatric hospital. Healthcare professionals were involved as co-owners which helped to facilitate the implementation of moral case deliberation. A large amount of context-based data has been collected: with respect to the learning of moral competencies; with respect to professionals’ concrete moral cases; and with respect to the implementation process of moral case deliberation in the clinic. In retrospect we conclude that the moral deliberation approach has been beneficial in the setting described. Yet, knowledge, attitudes and skills are not the only, and maybe not even the most important, outcome indicators and success factors. The project described has been successful, because practitioners got engaged in the process and invited us to their wards. This important lesson is, however, hard to demonstrate, because it requires closer monitoring of the whole process and illuminative description of the learning history at the site.
Discussion

Moral case deliberation, as applied in our project, is based on a pragmatic-hermeneutical dialogical approach to ethics and gets constructed with, and within, the actual clinical work environment. Moral case deliberation fits well within new experiential learning paradigms in which the in-company training of competencies plays a central role. The method of Responsive Evaluation has been useful to study and facilitate the learning and implementation process. Healthcare professionals continuously experience complex moral cases in which “the moral questions” or “the relevant facts” are not as clear-cut as in many medical ethics textbooks. Moral case deliberation can serve as a way to deal with concrete problems and to train moral competencies at the same time. As a consequence, methods for moral case deliberation are now also introduced in various educational and teaching programmes in The Netherlands, for instance in medical education and in education for nurses and psychologists. The relatively simple structure of the moral case deliberation methods helps to structure the often confusing and complex moral cases. The structure of moral case deliberation is also helpful for regulating the complex dynamics of the groups. Furthermore, due to the contextual approach, the implementation process becomes smoother as stakeholders become co-owners. Of course, the process of implementation is never easy. A problem we encountered was that the moral deliberation group tended to become somewhat detached from the wards. Introducing ward-visits solved this. From this we learned that we have to do better at taking the relation to the wards into account in future projects. Several issues for discussion, research and improvement remain. One may question whether there is a link between moral case deliberation, the learning of moral competencies and the quality of care. In the case under consideration the professionals became more sensitive for moral dilemmas and they were better able to structure and analyse moral problems. Yet, more attention should be paid to conceptual clarification and empirical measurement of the learning of moral competencies (e.g. the improvement of various kinds of moral skills) (Rest & Narvaez 1994).

Furthermore, it is plausible that the development of professionals’ moral competencies affects the quality of care, but it is as yet unknown which part of the quality of care actually improves and what the effect will be.
in the longer run. One way to improve the quality of care is by including patients and their moral cases within the moral case deliberation (Abma & Widdershoven 2005; Abma 1998; Abma & Widdershoven 2006). Another way is to arrange a structural connection between the moral case deliberations and the hospital’s quality of care policy. Qualitative and quantitative research is needed in order to support, approve and further develop the relationship between moral case deliberation and the quality of care (Molewijk et al 2008). Another issue concerns the role of the ethicist in moral case deliberation. Should ethicists persist in a procedural moderator role or should there be room for ethicists to bring in their moral judgements when situations are considered morally wrong? Within a pluralistic liberal society, the question emerges of how to define what is morally wrong. Should ethicists justify or criticise substantial decisions of the healthcare professionals? Should they ultimately leave the hospital and let the healthcare professionals do their own moral case deliberations? Ethicists and healthcare professionals who are involved within moral case deliberation projects need to find balanced and reasoned answers to those role questions. The theoretical background of pragmatic-hermeneutics and dialogical ethics provides a framework for dealing with those questions in a non-dogmatic way.

References


Appendix. Example of a moral case deliberation method

As mentioned, there are various divergent methods for a moral case deliberation (Manschot & van Dartel 2003; Steinkamp & Gordijn 2003). The methods are inspired by different moral theories and reflect divergent understandings of moral problems and ways of dealing with them. For example, the hermeneutic method is especially process oriented and focuses on multiple interpretations of text and form. Its main goals are meaning-pluralism, comprehension and understanding. The Socratic dialogue can be both process and product oriented, and consists of philosophical research on conceptual and argumentative presuppositions in real cases. Its goals are conceptual clarification, finding conceptual consensus, and critical reflection on the logic of someone’s thinking process. The Dilemma method is mainly product oriented (stepwise problem solving) and tries to ground the decision making process by means of inventory the various values and norms of the involved stakeholders. Below you will find a brief description of the Dilemma method (inspired by Bavdvin and by Graste (2003)).

Description of steps within the Dilemma method

Goal: list and structure perspectives, values, norms in dilemma (analytical goal) in order to prepare the decision-making process (no guarantee for problem solving or consensus!). Experiencing a dilemma is feeling that you are being forced to do either A or B. It is not logically possible to do both (A and B). Not doing A or B causes a moral burden or a moral damage.

1. Moral case is presented
2. Formulation of a general moral question
3. Short formulation of a dilemma (of the case presenter):
   - Should I do A or B?
   - Concrete as possible
   - Prevent abstract concepts
   - Prevent implicit normative formulations
4. Possibilities for clarification & questions
Table 3.1: Scheme with perspectives, values and norms of an example case

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Values</th>
<th>Norms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Dilemma</td>
<td>Respect autonomy (A)</td>
<td>Professional has to respect patient’s wish</td>
</tr>
<tr>
<td></td>
<td>Well being (B)</td>
<td>Professional has to aim at patient’s well being (etc.)</td>
</tr>
<tr>
<td>Patient etc.</td>
<td>Autonomy (negative freedom) etc.</td>
<td>Patient’s right to refuse treatment etc.</td>
</tr>
</tbody>
</table>

5. Scheme with ‘perspectives’, ‘values’, ‘norms’ (see table 3.1)
   - Position dilemma in scheme
   - Connect values/norms to original dilemma (A or B)

6. List all possible alternatives (without discussing feasibility)

7. Make individual round (write down first)
   a. I think the right thing to do is ...
   b. Because of...
   c. Therefore I’m not able to do ...
   d. How can I cope with or decrease moral burden/damage?
   e. Which virtues are necessary to do the right thing?

8. Discuss possible group consensus or decision (‘weigh’ values & norms)

9. Make practical appointments and plan date to evaluate those appointments
Dealing with dilemmas around patients’ wishes to die: Moral Case Deliberation in a Dutch hospice

Abstract

Dealing with a patient’s wish to die is morally difficult for professionals involved in end-of-life care. In the Netherlands, the law allows physicians to assist patients in dying on their request, if specific criteria are met. The Dutch law on euthanasia presupposes a physician’s conflict of duties when a patient asks for his or her life to be ended. A request for euthanasia implies a dilemma for the physician; he or she on the one hand has the moral duty not to end life, but on the other hand will experience the obligation to relieve the patient’s suffering. Not only physicians are involved in end-of-life care. Nurses and other healthcare professionals play a role too, especially in palliative care settings. In hospices, physicians and nurses are sometimes confronted with a wish to die, involving moral dilemmas. Clinical ethics support can help professionals in dealing with these dilemmas. A case example of a Moral Case Deliberation in a Dutch hospice illustrates a joint moral inquiry around a dilemma of a physician concerning a request for euthanasia. The clinical ethics support example shows the importance of involving the experiences, views, and emotions of various stakeholders in end of life care. The inclusion of all care professionals in the deliberation results in empowering them as moral subjects, widening the dialogue and fostering a more responsible practice.

Keywords

Euthanasia, Palliative Care, Moral Case Deliberation, Hospice, Moral Dilemma, Clinical Ethics Support.
Introduction

In the Netherlands, end-of-life decisions have been an issue of debate for several decades. Euthanasia has been an important topic in the debate. Physicians have played a central role in putting euthanasia on the agenda and developing criteria for good care, the so-called due care criteria (Kennedy 2002). These criteria have received a legal status, first in jurisprudence, and since 2002 in the euthanasia law. The euthanasia law is based on the legal notion of a conflict of duties. When a patient expresses a wish to die in a situation of unbearable suffering, the physician experiences a conflict between the duty to refrain from administering lethal medication on the one hand, and the duty to help the patient and stop the suffering on the other hand. This conflict takes the form of a moral dilemma. In a moral dilemma, a person has to choose between two options, knowing that each of the options involves doing harm. If the physician decides to perform euthanasia, the moral duty not to end a patient’s life is harmed. If the physician decides not to follow the wish of the patient, the moral harm is that suffering will continue. The euthanasia law does not solve this dilemma, but provides a legal context in which the physician can, and is expected to, make a decision based on moral concerns. Physicians play a central role in Dutch euthanasia practice. They are the only professionals who can be legally exempt from punishment in case of assisted dying. Thus, the decision to respond to a patient’s wish to die can only be made and put into practice by a physician. Yet often other professionals will also be involved. Euthanasia is the result of a long process of care of a patient in a serious condition. In this process, complex care arrangements will often be required, involving physicians, nurses, and other care professionals. This is especially the case in palliative care at the end of life, for example in hospices.

In the last two decades, palliative care has become more prominent in the Netherlands. This is in part a result of the legalization of euthanasia. One of the due care criteria entails that the physician and the patient should have come to the conclusion that no other reasonable solution remains. This conclusion can only be drawn if palliative care options have been explored. Complementary to the legal regulation of euthanasia, the Dutch government has set up a program to stimulate palliative care. Palliative
Dealing with dilemmas around patients’ wishes to die

Care is well-developed in the Netherlands nowadays, both in consultation teams and hospices. Consultation teams for palliative care are multidisciplinary, including nursing expertise. In hospices, nurses are crucial for day-to-day care of the patients. Whereas euthanasia and palliative care used to be clearly distinct, both in theory and in practice, the two are becoming more related in the Dutch debate and in Dutch healthcare. The growing importance of the perspective of palliative care in relation to euthanasia is for example reflected in the attention for palliative sedation as a possible alternative to euthanasia. Palliative care settings, which used to exclude euthanasia as an option because of ideological motives, nowadays are more open to euthanasia, but refrain from making this widely known. In hospices, patients expressing a wish to die and requesting for euthanasia may give rise to dilemmas for the medical as well as the nursing staff.

In this article we will first elaborate on the legal situation around end-of-life decisions in the Netherlands, focusing on euthanasia and physician assisted suicide (PAS), and their relation to palliative care. Next, we will discuss the basic principles of Moral Case Deliberation as a way of offering clinical ethics support to health care professionals. Then we present an example of an actual Moral Case Deliberation meeting about euthanasia in the context of a palliative care setting. We will show that Moral Case Deliberation helps to make normative orientations of various professionals explicit, and enables the participants to exchange views and learn from one another in a dialogical process. We will conclude that Moral Case Deliberation helps to clarify the views of all professionals and to give them a role in deliberations about end-of-life care, even if the final decision about whether or not to go along with the patient’s wish to die remains the discretion of the physician. This final decision, crucial as it may be from a legal perspective, can only be taken in the context of a process of good care, taking into account the perspectives and responsibilities of all involved.
Medical decisions in response to a wish to die in the Netherlands

Various kinds of medical decisions at the end of life

When a patient expresses a wish to die, various medical decisions can be relevant. In the following, we will describe these types of decisions, and provide information on their occurrence in end-of-life situations in the Netherlands in 2010 (Onwuteaka-Philipsen et al 2012).

In the first place, the physician may decide to end or not to start treatment, which may result in a hastening of death. In 2010, 18% of all deaths involved a medical decision to end or not to start treatment. In the second place, the physician may start palliative care. Palliative care aims to make the process of dying comfortable for the patient. In general, it will not lead to shortening the patient’s life, but the latter may be an (unintended) side-effect. In 2010, palliative care interventions were present in 36% of deaths. An example of palliative care is palliative sedation or continuous deep sedation, in which heavy sedatives are administered to make the patient unconscious, so that he or she no longer feels any pain. In the Netherlands, palliative sedation is only indicated for patients with a life expectancy of less than two weeks, so that death is not the result of stopping of artificial fluids and nutrition after sedation. (Janssens et al 2012). In 2010, palliative sedation was administered in 12% of all deaths.

The former medical decisions are to be regarded as part of normal medical practice. If the patient’s wish to die is formulated as an explicit request for active ending of life, the physician may perform euthanasia or physician-assisted suicide (PAS). In the Netherlands, these two medical interventions are not regarded as normal medical practice, and regulated by a special law, which exempts physicians from prosecution under the criminal law prohibiting assisted suicide, if specific criteria are met. In 2010, euthanasia was performed in 2.8%, and PAS in 0.2% of deaths.

The Netherlands was the first country in which euthanasia (i.e. the active termination of life by a physician on the request of the patient) and physician-assisted suicide (PAS) were legally permitted under specific circumstances (Griffiths et al 1998). Yet, controversies remain over the moral legitimacy of assistance in dying, if this involves actively and deliberately
shortening the life of the patient on the patient’s request (Keown 1995; van Delden 1999; Battin 1994; Hendin 2002; Cohen-Almagor 2004; Gill 2002). This is particularly the case if patients do not (or not only) suffer from somatic illnesses, but (also) from mental disturbances such as in case of chronic mental illness or Alzheimer’s disease (Berghmans 2010).

Legal context of euthanasia and PAS
In Dutch law, euthanasia and PAS are defined as ending of the patient’s life by a physician on the explicit request of the patient. This means that the physician’s action originates in the patient’s wish. According to Dutch law, euthanasia and PAS can be acceptable if a number of conditions—the so-called due care criteria—are met. For euthanasia or PAS to be acceptable, physicians must:

(a) Be convinced that the patient’s request is voluntary and well-considered;
(b) Be convinced that the patient’s suffering is unbearable and without prospect of improvement;
(c) Have informed the patient about his/her situation and prognosis;
(d) Have come to the conclusion together with the patient that there is no reasonable alternative in the patient’s situation;
(e) Have consulted at least one other, independent physician, who must see the patient and give a written opinion on whether the due care criteria set out in (a) to (d) have been fulfilled;
(f) Have exercised due medical care and attention in terminating the patient’s life or assisting in his/her suicide.

A case of euthanasia and PAS should be reported to one of the five existing regional euthanasia review committees in the Netherlands. After a retrospective assessment of the case—on the basis of the due care criteria—the committee judges whether the case was acceptable or not. If the case is judged acceptable, no further legal action is taken. If not, the case is sent to the health inspectorate and the public prosecutor who may decide that the case will be brought before the criminal court. Between 1998, the year of
the installation of the Committees, and 2009, 23,268 reported cases were reviewed, of which a mere 50 were judged as “not careful” (van Dijk & van Wijlick 2010).

Importance of palliative care
As was shown above, the practice of palliative sedation (or continuous deep sedation) is much more frequently applied than euthanasia and PAS together. This illustrates the important role of palliative care at the end of life, as palliative sedation is one of the practices which take place in the context of palliative care. Palliative care and euthanasia are related, as palliative care may be an alternative option before euthanasia can become acceptable. In this sense, good palliative care may prevent the need for euthanasia because it can decrease or take away the suffering. This does not mean that all requests for and cases of euthanasia and PAS can be prevented; it can neither be claimed that such requests and cases are a symptom of a lack (or low quality) of palliative care.

Hospice care and euthanasia
Basically, and traditionally, a tension exists between palliative care and hospice practices on the one hand, and euthanasia on the other. The philosophy behind and goals of palliative care are 1. The recognition that dying is an intrinsic part of life, 2. That neither the acceleration nor the postponement of death is an aim of palliative care, 3. That palliative care aims at lessening pain and other burdensome symptoms, 4. That palliative care is designed to help patients become as active and autonomous as possible, and 5. That palliative care supports the family in coping with the disease and death of their loved one (Olde-Rikkert & Rigaud 2010). Some of these elements are in conflict with the goal and practice of euthanasia (particularly 2), while others are clearly reconcilable with euthanasia (in particular 1 and 4). In the Netherlands, the majority of physicians providing palliative care accept euthanasia as a means of last resort. In other countries there is no consensus that euthanasia should be excluded from palliative care (ten Have 2010). Data from the Dutch right to die society NVVE (Nederlandse Vereniging voor een Vrijwillig Levens einde) show that 80% of the Dutch hospices allow
What is Moral Case Deliberation?

A Moral Case Deliberation is a meeting of a group of health care professionals who systematically reflect on a moral issue emerging in a clinical case from their practice (Molewijk et al 2008; Steinkamp & Gordijn 2003; Steinkamp & Gordijn 2004). Usually the group consists of health care professionals with different professional backgrounds, like doctors, nurses, social workers, either in a team or from various wards or settings (van der Dam et al 2011). The focus of the deliberation is a moral question. This question can be: “What should we consider as the morally right thing to do in this specific situation and how should we do it in a morally right way?” Besides focusing on arguments (e.g. for behaving in a certain way), a moral case deliberation also may focus on emotions and on what it means to be a morally good person.

A Moral Case Deliberation meeting, which takes usually between one and two hours, is facilitated by an ethicist or someone who is trained in conversation methods for moral case deliberation. The facilitator structures the meeting by means of a conversation method (Steinkamp & Gordijn 2003; Verkerk et al 2004). The expertise of the facilitator consists of keeping an eye on the moral dimension of the case, supporting the joint deliberation process, and helping the group in planning actions in order to improve the quality of care.

The primary goal of a Moral Case Deliberation is to foster a constructive dialogue among the participating health care professionals in order to create a critical and respectful moral inquiry into both the moral issues in a clinical ethics case and the way participants feel and reason. The aim of the dialogue is to reflect on the professional quality of the work of the participants, the ideas about professional behaviour, and their presuppositions about good care on the case level and the organisational or institutional
level (Abma et al 2009). The facilitator does not give substantial advice and does not morally justify or legitimize a specific decision (Widdershoven & Molewijk 2010).

Moral Case Deliberation is based on the assumption that good care is not given beforehand, but gets defined and redefined in concrete situations. Confronted with difficult situations, caregivers cannot just sit back and think about their practice. There is an urgency to act and to find answers to the particulars of the situation (Abma et al 2009). In Moral Case Deliberation, views on what is good care are explored and scrutinized in a deliberative process. By highlighting the different perspectives of the relevant persons involved in the case, and exploring their values and norms, health care professionals become aware of conflicting values and ideas in the case. Health care professionals explore their own ideas about good care in the specific context, compare their ideas with those of others, and jointly develop a new and more encompassing view. The outcome of a Moral Case Deliberation depends on what the group defined as a goal of the meeting. Health care professionals may aim to better understand each others’ ideas and emotions. In an urgent situation, they may need to come to a decision about the morally right action. In a Moral Case Deliberation ideally there is equality among the health care professionals. That means that views and ideas are explored irrespective of professional hierarchy, expertise or status. Each voice is important and counts. Still, there are different responsibilities in a team that have to be acknowledged, and consensus is not always possible in the decision-making process.

A Moral Case Deliberation concerning a patient with a wish to die in a hospice

In this section we will present an example of a Moral case Deliberation in a hospice in the west of the Netherlands. Up to now, the hospice has a non-euthanasia policy. A physician, who herself had been involved in a case of euthanasia before she came to work in the hospice, has put the non-euthanasia policy on the agenda by arranging a Moral Case Deliberation. She expects that in the near future some patients in the hospice might want
to explore the option or even ask for euthanasia. She has organised a Moral Case Deliberation with an external facilitator. The meeting takes place after working hours, and the complete staff is invited. They all attend, and the group consists of 15 participants: 2 physicians, 11 nurses and 2 former volunteers who are employed as cleaners. The physician who organised the meeting brings in a case that happened in another hospice where she worked a year before.

“A terminal patient, a woman of 56 years old, suffers unbearably and asks for euthanasia. The hospice where she stays is on an island, where the patient has lived all her life and has played an active role in the community. The hospice has a non-euthanasia policy. At entrance, patients are informed about this policy; the woman has also been informed. A couple of days ago, she was in great pain and she screamed loudly for a long time. With medication we could reduce the pain for a while. Afterwards, the patient said that she did not want to experience such a pain anymore. The question arose: will we change our policy, or do we tell the patient that for euthanasia she will have to be transferred by helicopter to a hospital on the main land?”

As a first step in the Moral Case Deliberation, the person who brings in the case is asked to describe the situation in the form of a dilemma, with the help of the other participants. The physician formulates the following dilemma:

“Are we willing to perform euthanasia or are we going to transfer the patient?”

To clarify what is at stake in the dilemma, the facilitator asks the group to elaborate the negative consequences of each of the options. What will happen if the first option is chosen (and consequently the second option cannot be realized), and the other way around?

When we perform euthanasia it may lead to individual conscientious objections, loss of volunteers and emotional problems of health care professionals.
When we transfer the patient this may cause mental instability and physical burdening because of the transfer, we disappoint a patient who already stays here for a couple of weeks and take her out of her personal environment.

The next step is to analyse the norms and values in the situation. First a list is made of perspectives relevant in the case. These include the people who are involved in the case (stakeholders), but also wider perspectives (for instance the institution or society at large). For each perspective, the group investigates the values behind the views and actions, and the norms which make these values concrete. A value may for instance be ‘sanctity of life’, and the corresponding norm: ‘the physician should not end life actively’. Sometimes the same value is chosen by two different participants, but translated into two different norms. Values and norms are not derived from ethical theory, rules or guidelines, but are explicit expressions of implicit orientations and rules of each of the stakeholders involved. This requires an interpretation of the views and concerns of the stakeholders, both those who are present at the meeting, and those who are absent. The parties which are present, for instance the physician or the nurses, can directly confirm interpretations by the group. The values and norms relevant for the stakeholders who are not present, for instance the patient and the family, can also be explored by the group: those who know them well can inform the others by giving information and telling stories about them, highlighting orientations and actions.

For the physician, two fundamental values are identified: care for the patient and concern for other people involved. These are made concrete in two norms: ‘I have to end the patient’s suffering’ and: ‘I have to be aware of emotions and values of nurses and other patients’. For the nurses, an important value is respect for autonomy, with the corresponding norm: ‘we have to respond to the wishes of the patient’. A second value mentioned by the nurses is ‘solidarity with the physician’, which leads to the norm: ‘we should support the physician in a difficult situation and back her up’. A third value is ‘concern for the image of the hospice’, which is translated into the norm: ‘we should be careful not to get the image of an institution that does not hold on to
the ideas of palliative care’. The nurses express specific worries related to the last value: ‘if people will notice that we perform euthanasia, probably more terminal patients will come with the same wish, knowing that it is possible here’. The cleaners, who used to be volunteers, said that the hospice is a place where euthanasia does not belong. This is expressed in the value ‘peace’ and the corresponding norm: ‘a radical intervention such as euthanasia should not be performed in our hospice’. For the patient, two values relevant to the situation are identified: ‘dying peacefully’ and ‘being part of the community’; the corresponding norms are: ‘I should be helped not to die in agony’ and ‘I should be allowed to die where I have always lived and feel at home’. The patient’s family is motivated by concern for the patient’s wellbeing. This implies that their values and norms are in line with those of the patient.

After the exploration of all the perspectives and corresponding values and norms, each participant of the Moral Case Deliberation meeting is asked to make an individual choice of what he or she considers as the morally right action in this case. They can choose one of the two sides of the dilemma (performing euthanasia or transferring the patient), or an alternative. They are asked to answer the question: ‘what would you do and based on which value and norm would you act?’ A further question is: ‘what value which you deem important would not be realized and how would you repair this moral damage?’

Both of the physicians say that they choose for euthanasia, because they want to end the patient’s suffering, and are most concerned about invoking emotions in the nursing staff and among the volunteers. They want to try and repair this by talking extensively with these groups. The nurses are divided. Some choose for euthanasia, referring to the values of care and alleviating suffering, although they are worried about the turmoil which might result and the stress for other nurses and volunteers. They would try to respond to these negative consequences by clearly stipulating the policy of giving everyone the option not to be involved in any way. Others choose against euthanasia because of their concern for other patients and volunteers in the hospice. They would
try to explain this to the patient and reassure her that she would receive optimal pain medication. Both cleaners choose against euthanasia, because they regard it as incompatible with palliative care values. They would explain to the patient that euthanasia is not a good death.

The last step is comparing individual choices and investigating the differences, in order to understand each other better and to see whether new ways of dealing with the situation can be found which do justice to crucial values and take into account all perspectives as far as possible.

While comparing individual choices and underlying values and norms, the group recognizes that not allowing euthanasia at all will lead to moral problems, because the physician will not be able to make his or her own judgment, and some patients will have to go elsewhere at a moment of great distress. Yet, allowing for euthanasia in the hospice will inevitably have a large impact. Euthanasia in the hospice setting is not only a matter for the physician. Nurses will be involved in the process much more than in cases of euthanasia at home; they will have to take care of the patient constantly, while knowing that the patient’s life will be ended by the physician within a few days or even hours. They will have to be informed beforehand and allowed not to take part in the care for the patient any longer. Nurses and other staff will always know about the upcoming euthanasia, and have to be sure that the physician will act responsibly, even if they are not involved in the process in any way. Thus, the physician will have to explain and share his or her views with the nurses and other staff, not about the individual case, but more generally. This need for explanation takes a concrete form during the deliberation, when one of the cleaners expresses her sincere worries about the impact of performing euthanasia on the physician herself. She directly addresses the physician who presented the case, saying: ‘how can you ever sleep again after doing such a thing?’ The group is impressed by her concern for the physician, and the physician shows gratitude for her sympathy. The physician explains that euthanasia for her is always difficult, but that she feels relieved afterwards, if all has gone well and the patient has died peacefully. The value of peace, which the cleaner deems so important, is also crucial for her, albeit in
another way. The cleaner still has difficulty to understand the physician’s view, but she is happy that the physician sincerely explained how euthanasia works out for her, and feels no longer distressed by the idea that the physician would not be able to sleep again after performing euthanasia.

At the end of the Moral Case Deliberation, which lasted for over two and a half hours, the group formulated the following conclusions: performing euthanasia should not be totally prohibited in the hospice; it should always be an exception, only to be considered after seriously examining the patient’s wish to die and possible alternative ways of relieving the patient’s suffering; the procedure should be explained carefully to the staff; nurses or other staff should not be obliged to participate in the care of the patient; other patients and volunteers should not be informed or involved in any way; a debriefing should be organised for the health care professionals involved.

Discussion

The case example shows that a Moral Case Deliberation enables the participants to investigate normative aspects of a situation in which a patient expresses a wish to die, and find ways of dealing with them. By making explicit values and norms related to various perspectives and courses of action, and exchanging views and concerns, the participants gain understanding of the moral dimensions of the case and the moral orientations and convictions of all those concerned. In the process of investigating and exchanging values and norms, participants get the opportunity to ask questions, to examine presuppositions and to give explanations, as, for example, the physician explained her experiences around performing euthanasia to the cleaner who showed concern for her well-being. During the deliberation the participants show a growing understanding of and concern for each other, and for the persons not present, such as the patient and the volunteers. This process of understanding each other’s perspective and showing concern for each other’s values and emotions is especially important in settings like a
hospice, in which people have to cooperate closely in the care for patients in difficult circumstances.

During the Moral Case Deliberation, the patient’s wish to die was examined by the participants, and found to be related to the realistic expectation that the pain might recur, even with optimal medication. The participants agreed that the patient’s wish should be critically investigated. This is in line with the Dutch euthanasia law, which states that the physician has to discuss the wish to die with the patient, and, together with the patient, come to the conclusion that there are no other reasonable options to relieve the patient’s suffering. In a hospice setting, other professionals, such as nurses, will also be included in this process. They will often be the first to hear the wish to die in the daily process of care, and to discuss this with the patient. They will also discuss this with the physician, and give their view on the background and meaning of the patient’s wish. Thus, the interpretation of the patient’s wish to die requires an in-depth communication between various professionals, and an exchange of views on the nature of the patient’s wish.

A Moral Case Deliberation gives voice to all parties involved and enables them to be open about what they care for and what they experience as difficult. In Moral Case Deliberations in a hospice, not only physicians, but also nurses, other professionals and volunteers play a role. Their experiences in the care process and their values get a prominent place. In this case, the views of the nurses and the cleaners contained important issues and concerns. The nurses were divided. This was regarded by the other participants as an expression of the problematic nature of the situation. The nurses were not forced to take a side, but were enabled to express their different views. The group concluded that differences should be acknowledged and respected. The cleaners were very concerned about the idea of euthanasia being performed in the hospice. Their concerns were taken seriously. Their arguments were not scrutinized from an abstract, theoretical point of view, but they were invited to explain their worries and concerns. This enabled the physician to understand them, and to elaborate on the emotions that euthanasia invoked in herself. In the process of exchanging experiences and responding to emotions, the participants in the group all had an equal position and were empowered as moral subjects.

Facilitating a Moral Case Deliberation presupposes awareness of power
differences, and requires specific interventions to deal with them, such as inviting participants to ask each other questions for explanation instead of making judgments about what the other says, and securing that all participants have the same opportunity to express their views and experiences. This does not mean that all stakeholders have the same legal position or the same role in end-of-life decisions. The legal decision whether the patient’s request for euthanasia is granted is up to the physician. Yet, within a Moral Case Deliberation, every participant will have to take into account the consequences of any decision for all stakeholders and take into consideration everybody’s values and emotions.

The outcome of this Moral Case Deliberation was not only a growth in understanding of each other’s views and concerns, but also a move towards a new institutional policy. Euthanasia was no longer regarded as totally wrong in the context of hospice care. In exceptional cases, it might be the only alternative left for the patient. This conclusion is actually in line with Dutch euthanasia law. Euthanasia can only be considered if all reasonable alternatives have been explored. In a hospice setting, more medical and spiritual alternatives are available than at home. Thus, euthanasia will be very exceptional. Euthanasia in a hospice requires specific safeguards, for instance in relation to other patients and volunteers. The need for careful practice, which is fundamental in all euthanasia cases, is especially prominent in a hospice setting. By becoming more open towards the possibility of euthanasia, the professionals working in the hospice are not forced to give up palliative care values. Rather, fundamental values such as ‘mutual trust’, ‘acceptance of dying’, and ‘providing support in difficult situations’ become even more important if euthanasia is considered. The new institutional policy concerning euthanasia implied a change for the hospice, in that some views became less self-evident, especially the idea that active ending of life is against the very notion of palliative care and therefore always wrong. Yet, this also implied a new view on euthanasia, emphasizing not the patient’s right to die but the need for help if all other options have failed, and on the requirements of careful practice, which in an interdisciplinary setting requires attention for the needs and emotions of all stakeholders.
Conclusion

Euthanasia and palliative care have a different history, and embody different values and norms. They come from different traditions, are organised differently in healthcare practice, and have a different legal position. Yet, traditions, practices and legal systems are not isolated. They touch upon each other and coexist in contemporary society in general and healthcare in particular. This may cause frictions, for instance when euthanasia is put on the agenda in a hospice. Such frictions clearly have a normative dimension.

Decisions around the end of life require attention for the experiences, values and emotions of physicians, nurses and other professional and non-professional caregivers. Moral Case Deliberation gives all participants a voice and invites them to take part in a joint process of moral investigation. By including nurses and other professionals in the deliberation, they are empowered and their values and concerns are put on the agenda, resulting in a widening of the dialogue. Moral Case Deliberation may help participants to explore moral views and concerns and to help finding responsible ways of dealing with dilemmas in healthcare practice.

In a Moral Case Deliberation, the perspectives of all parties involved in a dilemma are investigated. What values are at stake for the patient who expresses a wish to die? What values are important for the physician and other professionals involved? How can these values be taken into account in the final decision whether or not to assist the patient in dying? The aim is to better understand the views and experiences of all stakeholders, and examine possible ways of dealing with them. This implies that a patient’s wish to die is neither discarded nor accepted as given. It is regarded as a moral appeal, requiring interpretation and deliberation. What exactly does the patient ask from the physician and the other professionals involved? How can they respond in a meaningful and responsible way, doing justice to their own normative views and experiences? A joint investigation of the values and normative considerations of all parties involved may provide a basis for a dialogical exploration of experiences and dilemmas around a patient’s wish to die, which may result in new ways of dealing with individual patients and new institutional arrangements.
References


PART II

Organising ethics in health care
Moral Case Deliberation in an Academic Hospital in the Netherlands. Tensions Between Theory and Practice

Abstract

In this article we describe the process of developing an ethics support service in a Dutch academic hospital by means of implementing moral case deliberation (MCD). In MCD, health care professionals discuss their moral issues pertaining to a real case in order to come to mutual understanding and/or a shared idea of what is best to do and in which way. MCD is inspired by the philosophy of dialogical and hermeneutic ethics. Equal dialogue and critical constructive reflection are both important aims and means of MCD. This requires equality of perspectives, time to deliberate about values and considerations, and active involvement of all participants (ownership). However, within the context of an academic hospital, these conditions are not evident, given the prevalence of power and hierarchy, the need for efficiency and time management, and the emphasis on experts’ advice instead of joint responsibility. This paper introduces the core features of the philosophical background of MCD and describes ways of dealing with some tensions between MCD’s philosophical inspirations and the practical context of an academic hospital while implementing MCD. The paper shows that these philosophical inspirations can be helpful in the cooperation with an academic hospital when implementing MCD together. This joint process of making MCD meaningful and useful for the practice while dealing with different tensions is as important as offering high quality MCD sessions.

Keywords

Clinical Ethics Support, Moral Case Deliberation, Academic Hospital, Time, Power, Ownership, Dialogue.
Introduction

The complexity of care and the rapid development of medical technologies increasingly confront health care professionals with complex situations and difficult decisions, making the question ‘what is good care’ all the more relevant. Traditionally, support for dealing with ethical issues in health care institutions in the Netherlands, as in other Western countries, have been dealt with by ethical committees (Dauwerse 2011). Over the past ten years, however, Moral Case Deliberation (MCD) has become more widely used (Molewijk et al 2008a, 2008b; Stolper et al 2010). This form of ethical reflection seeks to support health care professionals in dealing with moral issues that they encounter in their daily work. In contrast to ethical committees, which discuss cases with experts who are usually not involved in the case themselves and which provide health care professionals with an expert judgment on the best way to act, MCD aims to reflect on cases with the health care professionals who are actually involved in the case. So, in MCD, primarily the health care professionals themselves reflect. The MCD facilitator does not behave as a substantial expert and does not give advice with respect to the matter that is discussed. Finally, the context also differs: MCD does not take place in a committee meeting, but on the ward.

In this article, we will describe our experiences with practicing and organising MCD in an academic hospital. We will start with introducing MCD and discuss both reasons for and aims of MCD. Then we briefly describe the specific health care context. Next, core features of a hermeneutic and dialogical ethics approach to MCD are presented as well as some tensions between the ideology of this approach and the characteristics of a setting of an academic hospital. Tensions that we will be addressed are: 1) Equality among participants of MCD as against power relations, hierarchy and the emphasis on expertise and efficiency in a hospital setting, 2) time management, and 3) shared ownership. Finally, we will go into the way in which we have dealt with these tensions challenges in practice while implementing MCD in an academic hospital setting.
Moral Case Deliberation, reasons and aims

Moral Case Deliberation

Moral Case Deliberation is a group process of (self)reflection on a concrete moral case by means of a dialogue, aimed at a joint moral inquiry. It is a structured conversation between members of a multi-disciplinary group of health care professionals (nurse, physician, physiotherapist, etc.) about a moral issue in their own practice. The case is put forward by one of the health care professionals; it can be either retro- or prospective. The health care professional should have experienced the case him- or herself and should sincerely doubt what ‘good care’ means in the specific situation and which actions would follow from that conception of good care. By a joint exploration of the values and norms of the people who play a role in the case – patient, family, doctor, nurse, manager, etc. – the participants investigate how the dilemma is experienced by all the parties involved and what they deem important in the situation. Finally, they present their personal views on how to decide on the dilemma and on what should be done, and examine the differences and similarities.

A trained facilitator, an ethicist or a health care professional seriously trained in MCD facilitates the deliberation (Plantinga et al 2012). The training, developed by the Department of Medical Humanities, usually takes 6 months and consists of 8 training sessions of 4 hours. Both during and in between the training sessions the focus is on experiential learning by means of exercising the facilitating process of the various phases within a MCD in the training group and in the own work environment of the students. The training can be understood as a joint inquiry through dialogue on what it means to be a good facilitator (Plantinga et al 2012).

The trained MCD facilitator structures the conversation using a specific conversation method e.g. the dilemma method or the Socratic dialogue (Kessels & Boers 2009; Molewijk & Alhzen 2011). Rather than putting forward his or her own normative opinion or offering consultation, the facilitator fosters a dialogue among the participants and enables them to take an attitude of listening to each other, postponing judgements and asking questions in order to understand each other and to help each other to explore experiences and beliefs.

The facilitator guides the conversation and ensures that the group stays
focussed on the actual moral issue. He or she encourages and improves the participants’ sensitivity for moral issues, their awareness of the moral side(s) of the discussed case and their moral reasoning. Furthermore, the facilitator creates a safe and free space for participants to express their views and ideas about the moral aspect(s) in the case. He or she encourages – primarily by means of a methodical, step-by-step approach – the participants to slow down and explore their own and each other’s beliefs with regard to the moral issue(s) at stake, without being restricted by rules, laws, theories or hierarchy.

In this ‘free space’, the participants have an equal say and the input of each participant is considered valuable. In a hospital setting this means that the considerations of the physician, nurse or a facility employee (e.g. a cleaning professional) are equally important and valuable. However, MCD is not automatically a democratic decision making process which replaces the usual way of decision making in that specific context. In MCD, participants reflect on possible solutions to a moral dilemma, a reflection in which everyone participates equally. The final decision after the deliberation depends on formal tasks and responsibilities in the given situation.

Reasons for doing Moral Case Deliberation
Why should one practice MCD in a hospital? First, we will address some reasons for specifically using MCD as one of more types of ethics support services (and not for example an ethics committee). There are different ways in which one can offer and organise ethics support in a hospital and sometimes different ways are combined. For example, one can found an ethics committee, one can hire an (external) ethics consultant, or one can arrange ethics courses or lectures as continuing education. The strength of MCD, as compared to other types of ethics support, is that is closely attached to the daily practice of health care (Molewijk 2008a, 2008b). The health care professionals who participate, the moral issue that is at stake in a MCD and the way MCD is organised on the specific ward are all directly connected to the concrete work environment in which one aims to deliver ‘good’ care. This makes MCD relatively successful in its justification, the support it gets from the whole team, the implementation and its contribution to the quality of the work and the work environment. Furthermore,
due to its focus on dialogue and experiential learning, MCD also has a strong educational and team building impact (see next section on aims for MCD). But why should a hospital pay attention to ethics (support) at all? This is not always evident. Therefore, it is important to be explicit, again and again, about the core justifications for organising ethics support in general and MCD in particular. We will present some reasons for taking care for ethics by means of MCD. Most of these reasons are connected to basic fundamental (meta-)ethical theories such as dialogical and hermeneutical ethics (Abma et al 2009).

First, good care cannot be defined without the concrete context nor the people that are involved in a case. Good care is not universal and timeless; what is good care today will be different tomorrow. For example, a team of doctors and nurses decide today that it is morally right to continue the treatment of a severely ill premature baby, might make a different decision one month later, not only because of different circumstances but also because they have changed over time themselves. This means that continuous reflection on moral issues is needed in order to define what good care means to every individual patient or with regard to each individual situation in which a moral dilemma is experienced.

Second, a care setting like a hospital has a moral dimension. To provide good care is not just a matter of technical or professional knowledge or insights. Rather, every nurse or doctor has his or her moral opinion or presuppositions with regard to ‘good care’, reflected upon or not. A health care organisation that truly propagates quality of care should pay attention to this moral aspect of being a professional and of organising health care. MCD is a way to deal with the intrinsic moral dimension of a health care setting.

Third, human beings are moral beings: they intuitively use normative frameworks such as ‘right’ or ‘wrong’. Especially in a health care setting like a hospital, where it is a professional duty to help others, implicitly reflecting on ‘good care’ is always inherently present in health care professionals’ behaviour. MCD helps to make this implicit reflection explicit and systematic: ‘Why do professionals experience something to be either right or wrong? What are their ideas and beliefs? How does this relate to the actual situations in which they operate?’

Fourth, MCD offers a platform for an on-going learning process to im-
prove professional quality, both of individual doctors or nurses and of the health care organisation. Professional quality is characterized by a genuine and open attitude for critical self-reflection and improvement.

Finally, MCD contributes to taking care for health care professionals themselves, and can result in decreasing their moral distress at work and absence through illness. MCD gives nurses and doctors the chance to reflect on their motivation for doing their work and creates space for expressing and exploring the source of emotions involved in frustration or distress.

Aims of Moral Case Deliberation
The aims of MCD can be distinguished on three levels: case level, professional level and organisational level. In the following, we will elaborate on each of these levels.

At case level, MCD provides insight into the complexity of the situation and into what matters in the case. For example, a case concerns a premature boy born with 29 weeks and 3 days, suffering from various disorders due to his premature birth and who has abnormalities suggestive of an inherited severe disease. The parents wanted to continue the treatment while the neonatologists saw no further prospects. When the case was discussed at the ward in a multi-disciplinary team, it turned out that the parents were religious (Muslim) and that they had two earlier children who died of the same inherited disease in the past five years (half year and 3 years old). Assembling the knowledge of all aspects of the case and the personal views from diverse professional backgrounds, including that of the imam, provided a broadened perspective on what mattered in this case for those involved, as well as new insights on how to deal with the dilemma. At the end of the discussion, the staff had more understanding for the parents view, and was able to give them genuine support in the difficult situation.

On a professional level, MCD contributes to a better understanding of the drive and underlying motives of the different health care professionals in the team. A MCD with a multi-disciplinary team at the Paediatric Intensive Care Unit about the wish of a couple to stop the treatment of their two-year old daughter with a severe infection of the chicken-pox, which would result in severe mental and physical disabilities, clarified various dilemmas of the practitioners from the different disciplines involved.
Whereas the doctors doubted whether they had to accept the wish of the parents (also because of legal regulations), the nurses struggled with the question whether they should influence the decision of the parents by convincing them of choosing differently. This example illustrates how MCD makes the team members aware of and sensitive to the many and different moral issues their colleagues encounter in their daily work. It improves the mutual understanding and enhances the moral competence of health care professionals.

On an organisational level, MCD can support a hospital (or a ward) developing its identity by exploring and defining core values. Moreover, it contributes to translating these core values into policy and concrete actions (and vice versa). For instance, what does ‘patient safety’ mean in the daily practices of a doctor or nurse? Or: what policy has to be developed when a team repeatedly encounters dilemmas with patients of different cultural backgrounds?

Context of Moral Case Deliberation in an academic hospital

In 2009, the Department of Medical Humanities at the Free University Medical Centre (VUmc), started with a two years pilot project which aimed at experiencing moral case deliberation at three wards of an academic hospital in the Netherlands: the Neonatology ward, the Paediatric Intensive Care Unit and the Haematology ward. All wards started with monthly MCD meetings. The objectives were: 1) Starting a dialogue on the ward, 2) Improving moral competences of the staff at the wards (skills, attitude and knowledge), and 3) Developing a vision and policy regarding the ‘multicultural’ identity of the hospital. Before the actual MCD meetings started, 10 to 13 interviews were held with several practitioners from different disciplines. The interviews helped the researchers and MCD facilitators from the Department of Medical Humanities to become acquainted with the ward, to gain some insight into the moral questions they encountered in their daily work and to assess their expectations of the MCD project.

The monthly MCD meetings were organised and facilitated by the de-
department of Medical Humanities in cooperation with the staff of the wards. On two wards, an ethicist from the Department of Medical Humanities facilitated the MCD meetings. One ward had its own trained facilitator (a medical doctor), who shared the facilitation process of the MCD's with an ethicist. Within this project, one specific conversation method of MCD was chosen: the Dilemma Method (Molewijk & Ahlzen 2011). The MCD meetings consisted of health care professionals who were on duty that day (nurses, doctors, specialists, social workers, etc.). Sometimes professionals from disciplines that were involved in the case where specially invited (e.g. a psychiatrist, an imam). The aim was to include all relevant disciplines, in order to broaden perspectives and improve the quality of the deliberation.

Originally, the idea was to compose a fixed group of multi-disciplinary health care professionals on each participating ward. A fixed group usually easier develops a safe atmosphere (Dam van der et al 2011). This is important in order to create an open genuine dialogue and foster a joint learning process over a longer period of time. However, because of the varying work schedules of doctors and nurses, this appeared not to be feasible. So the actual groups varied in number and composition of participants. Yet, some participants were able to participate regularly, providing continuity to the MCD groups and enabling the new participants to learn how to reflect more quickly in later group meetings.

The cases discussed in the MCD meetings generally were introduced by a nurse or a doctor and contained either an urgent actual case or a troublesome situation from the near past. The output of the deliberations was formulated in terms of concrete actions (e.g. ‘What to do and by whom?’ or ‘How to avoid this situation next time and what to improve/change?’). The MCD project was connected to an overall theme (intercultural aspects of healthcare). Therefore, cases with a clear connection to this theme prevailed. However, at some wards, more specific themes were chosen for in depth examination. For example, at the Neonatology ward, several meetings were held on dilemmas related to the local policy that preborns after only 24 weeks of gestation should be treated.

The MCD’s started with formulating a dilemma, experienced by the person who presented the case. An example of such a dilemma came from the Neonatology ward: ‘Should we operate (for the 5th time) this severely ill premature baby of 26 weeks because of the wish of the parents, while
we know for certain that the chances of survival are poor for this baby, or should we abstain from invasive treatment?’. At another ward, a doctor presented a case of a patient, a young man and a Muslim, who refused care from a young female doctor on duty that evening. The doctor formulated his dilemma as follows: ‘Should I accept the wish of the patient or should I convince him of the need of care?’. Another dilemma was introduced by a nurse with a part time job who wondered whether she could refuse to care for a difficult (in terms of emotionally touching) patient that had been allocated to her by her manager, and for whom she had already cared the last three days.

Philosophical principles and tensions with practice

Moral Case Deliberation is based on philosophical and ethical theories such as dialogical and hermeneutical ethics (Molewijk & Widdershoven 2010). In particular, Gadamer’s philosophical hermeneutics is foundational to our approach of MCD (Widderhoven & Metselaar 2012). In the following, we will briefly present three central notions of Gadamer’s hermeneutics and relate them to MCD. Next, we will introduce why it is a challenge to put these notions into practice in current healthcare settings: a hermeneutic dialogue such as MCD requires certain conditions that are not easily met in an academic hospital.

First of all, Gadamer’s notion of dialogue is central to MCD. A dialogue consists of an joint process of opening up to the other, postponing one’s judgments and conclusions, and putting one’s prejudices into play in order to come to a better understanding (Gadamer 1975). In MCD, health care professionals are encouraged to put their moral intuitions into words, to listen actively, to share and investigate personal viewpoints, values and answers to moral questions, and to postpone their initial judgments and conclusions. In line with this, another important methodological element of MCD is the Socratic or maieutic art of asking the right questions – an art wholeheartedly embraced by Gadamer – accompanied by the strategic attitude of agnosia (‘not-knowing’) (Gadamer 1982). Such a dialogue, however, requires a process of slowing down one’s train of thought and
decision-making. Its pivotal question is not so much ‘What should we do?’ but rather questions like: ‘Why do we think it is important to act in a certain way?’ ‘What are the negative consequences of our actions?’ ‘What values are behind our inclinations and intuitions?’ ‘What values may be relevant to other stakeholders’ and ‘how can we take them into consideration?’ Nevertheless, this approach of slowing down and reflecting on the grounds for our actions is at odds with the pressure in the academic hospital to solve problems in a fast and efficient way (Gadamer 1987).

Second, MCD encourages moral learning of health care professionals. If health care professionals would merely follow the expert judgment of the ethicist, and thus delegate their moral responsibility, it is unlikely that this would result in further development of their own moral knowledge and their own ability to deal with a complex situation and its ambivalences. In a MCD, however, in which the ethicist is first and foremost a facilitator of the ethical reflection, practitioners can morally ‘cultivate’ themselves. This cultivation Gadamer calls ‘Bildung’, which he describes ‘trained receptivity towards otherness’ and which requires a transformation (Gadamer 1982). Therefore, he argues that a successful dialogue establishes the transformation of the interlocutors involved, as ‘to reach an understanding with one’s partner in a dialogue is not merely a matter of total self-expression and the successful assertion of one’s own point of view, but a transformation into a communion, in which we do not remain what we were’ (Gadamer 1982). Presupposed to the establishment of this communion is that all participants in a dialogue should have an equal say and position. This, however, is clearly at odds with the power positions in the hospital in everyday practice: physicians decide on the treatment plan, whereas the role of the nurses is to act in line with these decisions. In MCD, on the contrary, everyone’s view is as important as long as it is formulated sincerely and refers to concrete experiences.

In the third place, hermeneutical ethics regards the personal experience of health care professionals to be the principal source of moral knowledge, rather than the expert knowledge of an ethical consultant. As health care professionals are involved in a situation that they themselves experience to be morally troublesome, and as they are the ones responsible for making decisions and taking action, their ‘practical wisdom’ is both the point of departure and the decisive point of reference. This relates to Gadamer’s adaptation of the Aristotelian concept of ‘practical wisdom’: Aristotle
already observed that moral or practical wisdom (phronêsis) is different from objective, theoretical wisdom, in which the knower is standing over against a situation that he merely observes. Rather, in the case of phronêsis, the subject is directly affected by what he sees and morality is something he has to do. Moreover, phronêsis is always judgment informed by experience. Accordingly, only through experience, one can become ethically virtuous and practically wise. From this perspective, health care professionals are seen as the experts of their own professional world and they are supposed to develop the answers to their moral questions in interaction with one another. The role of the ethicist, consequently, is not to provide expert opinions, but to help health care professionals to investigate their experiences and to find new ways of dealing with a morally problematic situation. This view on practical knowledge is however at odds with the way in which problems tend to be solved in academic hospitals, that is by consulting external experts and referring to external sources of wisdom such as Evidence-Based Medicine.

Another difficulty with concern to the primacy of personal experience in MCD is that in the hospital, abstract knowledge and principles tend to be dominant. In MCD meetings, physicians regularly use general ethical concepts, like autonomy or beneficence, or medical-technical terminology, without applying them directly to (their experience of) a concrete situation, thus cutting short the process of deliberation. Hence, both the principles of equality and concrete experience that regulate MCD may easily be overruled because of power differences and abstract discourses that are prevalent in a hospital setting.

Thus, putting into practice the philosophical grounds behind MCD requires that certain discursive, social and practical conditions are met, which is not always easy to accomplish in a current academic hospital setting.

Dealing with challenges

How can one deal with such tensions between the philosophical principles of MCD and facilitating and implementing MCD in the context of an academic hospital? In line with hermeneutic philosophy, we want to
emphasize that this is not a matter of theoretical expertise, but of practical experience and joint learning (both for the ethicists and facilitators from the Department of Medical Humanities and the health care professionals). Also we want to stress that implementing MCD is not merely offering high quality MCD sessions: even important is the process of sharing the ownership of MCD and adjusting the meaning and aims of MCD to the health care professionals that are involved. This requires an ongoing (pro-)active attitude from those who offer MCD. In this section, we will present how we developed ways of dealing with the tensions mentioned above, by experimenting with styles of facilitating individual MCD session and looking for new ways of implementing MCD in the hospital in a more general sense.

We first address the issue of inequality. In MCD sessions, the facilitator can use various interventions to deal with this. The facilitator can explain the ideas behind MCD, thus making clear that equality is important. The facilitator can elucidate that, in a moral case deliberation, no one is more entitled to a moral truth than any other, certainly not on the basis of medical expertise or status. Next to explaining basic principles, the facilitator can stimulate and foster an attitude of listening, by encouraging participants to ask questions to each other and reflect on the answers that are given. These actions of the facilitator can help playing down the influence of power relations. When doctors are stimulated to really listen to moral concerns of others, such as nurses or social workers, the usual hierarchy present in a hospital setting is momentarily – more or less – neutralized. This often leads to decisions that are more sensitive to various aspects of the situation and that are more widely supported. As a consequence, the participants may experience the interventions of the facilitator as helpful to their own practice. Such experience is more powerful than the mere explanation of the importance of the principle of being open towards each other.

Paying attention to the role of the physicians, however, is not only important during individual MCD meetings; it is also relevant for the implementation process as a whole. In organising MCD meetings on the wards, one should make sure that physicians actually participate in the meetings. This requires good preparation of the meetings. The participation of physicians is fostered if some individual physicians become interested, and spread the word. These physicians may be actively involved in the im-
plementation process, giving advice on how to make the sessions more in line with their colleagues’ expectations and needs. The same holds for the role of nurses in the implementation process. Active nurses can take part in considering when and how to organise the session, and how to involve nurses. By discussing such matters with interested physicians and nurses, and giving them both a role in the implementation process, equality is again fostered.

The second issue concerns time-pressure and the focus on efficiency that is common in a clinical setting. As mentioned above, MCD aims to slow down the decision making process, to postpone normative ideas and solutions, to ask questions rather than give judgments, and to examine oneself instead of the patient's case. Moreover, it encourages a multi-disciplinary approach to responsibility for making a well-balanced decision. This is why, in particular when practitioners experience moral case deliberation for the first time(s), it may feel like ‘lingering’ ineffectively on urgent cases, or even as a redundant activity taking up precious time. How can a facilitator deal with this challenge? First of all, the facilitator should make clear that MCD does not take away individual responsibilities. This is again a thing which can be explained, but which also can be experienced in practice. As practitioners become acquainted with MCD, they may come to see that reflecting on values and sharing views and considerations may be complementary to the way in which they usually handle situations. They may become aware that moral case deliberation is particularly appropriate for specific occasions, for instance in a case in which moral complexity is such that ‘regular’ decision making is experienced as less effective. Also, MCD can give the possibility to reflect on past decisions which are still experienced as difficult, or on a specific recurrent dilemma the ward has to deal with. In such cases, having an MCD session may actually result in gaining time. In the process of implementation, time is something that needs to be addressed constantly. What is the best moment to organise MCD session? When do physicians and nurses have time in their busy schedules? How long should the meeting last? Whereas in long-term care institutions, MCD meetings are often planned for two hours, in an academic hospital a one-hour slot is more realistic. This requires specific abilities on the side of the facilitator. Often, not all steps can get equal attention. The facilitator needs
to be flexible, and respond to the rhythm of the group quickly. By regularly taking (a short) time for evaluation of the meeting, the group may become more involved in and responsible for decisions about time-keeping in MCD meetings.

A third challenge pertains to the ownership of MCD. Ideally, MCD meetings in the hospital are not dependent on the expertise of the ethicist, but supported by the professionals at the ward and thus become a structural part of the activities at the ward. If health care practitioners transfer the responsibility for identifying moral issues or organising an MCD session primarily to the facilitator, the project is prone to fail. Although a facilitator does have a major responsibility in taking initiatives, the process of implementation can only succeed if the participants are seriously involved, motivated and take on responsibility as well.

One way in which we deal with this challenge is by discussing the need of shared responsibility and by creating a close cooperation with one or two persons at the ward who become in charge and responsible for planning the deliberation meetings, who make sure cases are prepared in advance and that people are motivated to join. An impetus from the management or team manager of the ward is also crucial. Finally, training of practitioners at the ward to become facilitators themselves has proven to be a good way to make the ward ‘own’ moral case deliberations.

Conclusions

Implementing MCD in an academic hospital setting is a complex process. On the wards, moral issues are abundant. Professionals recognise dilemmas and tend to be interested in having ‘ethics meetings’. This provides a good basis for starting MCD sessions and developing an MCD project. The way of dealing with moral issues in MCD meetings provides a broadening of perspectives and fosters processes of moral learning, which are appreciated by the participants. Yet, the philosophical principles behind MCD are often at odds with the prevailing ways of working and communicating in an academic hospital. Equality, slowing down decision-making, and shared
ownership may be experienced as unnatural and demanding. Fostering implementation of MCD requires acknowledging these tensions, and looking for practical ways to deal with them. The philosophical principles of dialogical and hermeneutical ethics can be helpful in dealing with these tensions.

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Prevalence and characteristics of Moral Case Deliberation in Dutch health care

Abstract

The attention for Moral Case Deliberation (MCD) has increased over the past years. Previous research on MCD is often written from the perspective of MCD experts or MCD participants and we lack a more distant view to the role of MCD in Dutch healthcare institutions in general. The purpose of this paper is to provide an overview of the state of the art concerning MCD in the Netherlands. As part of a larger national study on Clinical Ethics Support (CES) in the Netherlands, we will focus on the prevalence and characteristics of MCD in Dutch health care. A mixed methods design was used in which we combined two survey questionnaires (sent to all health care institutions), two focus groups and 17 individual interviews with top managers or ethics support staff. The findings demonstrate that MCD is prominent in mental health care, care for people with an intellectual disability, and hospital care. Institutions with MCD differ from institutions without MCD concerning size, kind of problems and importance of ideological background. Characteristic of MCD is that it often exists for 3 years or more, has a high participation of health professionals and middle managers and is both organized scheduled as unscheduled. 'Integration in existing policy' and 'key persons' emerge as important issues in relation to the positioning of MCD. We conclude that MCD is a common part of an integrated ethics policy in Dutch health care and serves as a (bottom up) catalyst for such an integrated ethics policy.

Key words

Moral Case Deliberation, Clinical Ethics Support, National Survey, Mixed Methods, Implementation, Dutch Health Care
Introduction

Moral case deliberation (MCD) is a specific kind of clinical ethics support, in which a trained facilitator uses a specific method to support a group of health care professionals in their reflection on and analysis of a concrete case (Molewijk et al. 2008a). There are several ways of organizing MCD meetings (e.g., retrospective or prospective case-analysis, thematic MCD meetings on a specific topic, with or without patient and family representatives). In the Netherlands, the attention for and the actual use of MCD as a type of clinical ethics support has increased over the past years. In 2006, the national Centre for Ethics in Health Care (CEG) concluded, on the bases of a research report, that the knowledge and skills of health care professionals and health care institutions are limited when it comes down to recognizing and dealing professionally with moral issues. The CEG advised the Dutch government to stimulate both health care institutions and health care education programs to build up expertise of dealing with moral issues (among others with MCD). Since 2005, once or twice a year, a national MCD platform meeting is organized at the Dutch ministry of Health during which MCD experts meet and share experiences. Also since 2005, almost every year, a national working conference on MCD is organized with specific topics and various participants. Recently, as a consequence of a growing number of trained MCD facilitators, a national network for MCD facilitators has been set up. Various Dutch health care institutions have started MCD implementation or MCD training projects, often together with trainers and researchers from universities. More and more health care institutions, in various health care domains, develop MCD expertise and organize MCD meetings.

As a consequence, Dutch and English articles about experiences with MCD have been published. General descriptions of MCD and its theoretical roots in pragmatic hermeneutics and dialogical ethics are described by Abma et al. (2009) and Widdershoven & Molewijk (2010). Evaluation studies of both MCD sessions and MCD implementation projects in two different mental health care institutions reported that participants were positive about MCD (Molewijk et al. 2008b/c). However, implementation of MCD causes ongoing challenges. Various implementation reports pay attention to the roles of local coordinators of MCD, participants of MCD,
and managers in organizing MCD (Weidema et al. 2011, 2012, 2013). Experiences with MCD in an academic hospital and in elderly care have been reported (respectively Stolper et al. 2012, Van der Dam et al. 2011, 2012). Training programs for facilitators have been evaluated, showing that participants were positive about the training and had trust in their competence (Plantinga et al. 2012). Other studies have been published about MCD methods (Steinkamp & Gordijn 2003; Molewijk & Ahlzen 2011a) or the role of emotions in MCD (Molewijk et al. 2011b/c).

Most of these publications focus on local or institutional initiatives. Although a local focus is useful for a detailed insight of how MCD works in a specific context, it does not provide insight into the prevalence of MCD in the various domains of Dutch health care (i.e. hospital care, mental health care, elderly care, care for people with an intellectual disability). There have been two nation-wide studies in the Netherlands regarding clinical ethics support (Van Willigenburg et al. 1991; Van Dartel et al. 2002) but both did not report on (the prevalence of) MCD. Given the increased attention for MCD in the past 10 years, new and more detailed prevalence information is needed. How many health care institutions organize MCD? What are their characteristics, and in which domains of health care are they situated? For how long have they used MCD as clinical ethics support? How often are MCD sessions organized and in which way? Who participate in these MCD sessions? How is MCD positioned within the health care institutions? This paper will address these questions.

Prior publications on MCD are often written from the perspective of MCD experts or MCD participants. In some publications (Weidema et al. 2012), health care professionals and managers are involved in evaluating MCD as clinical ethics support. Yet, most of the studies that are reported come from institutions that were motivated to start with MCD and to study it. This may result a positive bias towards MCD practices. We lack a more distant view to the role of MCD in Dutch health care institutions in general. Furthermore, we do not know how managing directors of the health care institutions think about MCD in their institutions, and whether this differs from the views of staff responsible for organizing ethics support services.

In this paper we give an overview of the state of the art concerning MCD in the Netherlands. As part of a larger national study on CES in the Netherlands, we will focus on the prevalence and characteristics of MCD in Dutch
Moral case deliberation as clinical ethics support

A moral case deliberation consists of a meeting with health caregivers who systematically reflect on one of their moral questions within a concrete clinical case from their practice (Molewijk et al 2008a). It focuses on concrete moral issues: ‘What should we consider as the morally right thing to do in this specific situation and how should we do it rightly?’ However, also more philosophical questions, for example conceptual and virtue-based questions, are at stake (e.g. ‘What does understanding mean?’ and ‘When am I a good professional?’) (Abma et al 2009). Four central, often co-existing, goals of moral case deliberation are: (1) to reflect on the case and to improve the quality of care within that case; (2) to reflect on what it means to be a good professional and to enhance professional moral competencies; (3) to reflect upon what good multidisciplinary cooperation means in light of the quality of care; and (4) to reflect on institutional or organizational issues and improve the moral quality of care at that level (i.e. use insights from MCD for policy, guidelines, cultural change, etcetera).

The reflection, which takes 45 min to 2 hours, is facilitated by a trained facilitator and structured by means of a selected conversation method (for examples of conversation methods see: Steinkamp & Gordijn 2004; Kessels et al 2008, 2009; Molewijk et al 2008a; Molewijk & Ahlzen 2011). The facilitator, an ethicist or someone who is trained in clinical ethics and conversation methods, does not give substantial advice and does not morally
justify or legitimize a specific decision (Stolper et al., 2012). The expertise of the facilitator consists of, among other things, fostering a sincere and constructive dialogue among the participants, keeping an eye on the moral dimension of the case, supporting the joint reasoning process, and helping the group in planning actions in order to improve the quality of care. Methods are chosen because of the specific goal of a moral case deliberation.

Moral case deliberation differs significantly from clinical ethics consultation (Abma et al. 2009). With respect to ethics consultation, the ASBH taskforce on the Core Competencies for Health Care Ethics Consultation describes a more procedural and expert approach of the ethics consultant when discussing ‘the ethics facilitation approach’. A central goal of the ethics consultant is to answer the question “Who is the appropriate decision maker?” Specific attention is being paid to the knowledge from existing policy, guidelines and law (ASBH 1998; Aulisio et al. 2003). Even though both approaches facilitate moral reasoning, it seems as if the ethics consultant focuses more on the answer of the question ‘What is morally right according to existing knowledge from policy, guidelines and law?’ while the MCD facilitator focuses more on how the MCD participants contribute concepts of and arguments for morally good care through dialogical processes.

Methods

By post, we asked managing directors of all (i.e. 2147) Dutch health care institutions (hospitals, mental health care institutions, elderly care institutions, and institutions for people with an intellectual disability) to participate in a national survey questionnaire (SQ 1). 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, web-based, questionnaire (SQ 2). Ethics support staff are employees who organize ethics support, for example ethics committee chairs. Further qualitative data were assembled through interviews and focus groups, with professionals involved in CES (including managing directors, staff employees, and bioethicists) from various health care domains.
Survey 1
The first survey (SQ 1) was organized between December 2007 and December 2009. A postal questionnaire was developed in close connection with experts in the field of CES (n = 7). The questionnaire was tested with 9 participants. Considerable refinements were made to the survey tool (particularly to the length) and the introductory explanation. After the first round, two reminders were sent. The questionnaire addressed various kinds of ethics support, with specific attention for moral case deliberation.

Interviews and focus groups
Following the first survey (Sept 2008), five interviews were conducted with managing directors and ethics support staff members to complement and get further insight in the data of the findings of the questionnaire. In addition, two focus groups with 22 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 advantages and disadvantages of moral case deliberation were discussed.

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

The second questionnaire included a question about the prevalence of MCD, several questions for institutions in which MCD was absent or deemed not important, and 23 questions about the characteristics of MCD for institutions in which MCD was considered important. The second questionnaire was addressed 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, twelve individual interviews were conducted with ethics support staff members and managing directors from institutions with (a combination of): 1) an ethics committee, 2) moral case deliberation, 3) ethics consultation, and 4) implicit kind of CES (peer-supervision). These interviews aimed to help interpret and reflect on the survey findings. The interviews focused on the experiences and views of interviewees concerning the specific CES which was present in their institution.

Analysis
Both questionnaires consisted of closed and open questions; the results were analyzed using quantitative and qualitative methods. SPSS 15 and Excel were used to analyze the 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 within the research team. Throughout this process, emerging patterns and hypotheses were developed and checked, resulting in a refinement of the analyses. To confirm the analyses, individual member checks with interviewees and focus groups participants were performed.

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 use of the 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 the data collection it turned out that the initial 2137 individual health care institutions were members of 864 legal bodies (umbrella organizations with a legal status). As a consequence, there are two response rates for this first questionnaire, namely 30% (638 / 2137) 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) second questionnaire was sent by email 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
The results are ordered in four sections. First, we present the prevalence of MCD in healthcare institutions, related to other forms of CES, and the perceived importance of MCD in healthcare institutions with MCD. Second, we compare characteristics of Dutch healthcare institutions with MCD with those of institutions without MCD. Third, we describe characteristics of MCD in Dutch health care institutions in which MCD is deemed important. Fourth, we describe how MCD is positioned within the organization. For the prevalence, we use data from the second questionnaire, directed at ethics support staff. Ethics support staff reports higher prevalence of CES than managing directors. We consider the data of ethics support staff more reliable, because they know more about CES in daily practice in the institution. For the perceived value, we use data from interviews and focus groups with managing directors as well as ethics support staff.
Prevalence of MCD in Dutch health care
In this section we will present: A) prevalence of MCD in general, B) prevalence and importance of MCD in different health care domains and C) prevalence of MCD, combined with other kinds of CES, in different health care domains.

A. Prevalence of MCD in Dutch health care in general
According to ethics support staff, MCD is present in 44% of Dutch health care institutions (see table 6.1). This is more than ethical consultation (15%). It is less than ethics committees (51%) and implicit forms of CES (91%).

B. Prevalence and importance of MCD in different health care domains
MCD is prominent in mental health care, care for people with an intellectual disability, and hospital care. In these domains it is mentioned as present in the organization by respectively 62%, 58 %, and 54% of the respondents (see table 6.2). In elderly care, 36% of the ethics support staff members mentioned MCD as present in the organization.

We also asked ethics staff members whether MCD is important in the organization. In almost half of the health care organizations in which it is present, MCD was regarded as important by the respondents. If we look at the health care domains, we see that MCD is considered important in more than 60% of the mental health care institutions in which it is provided. In care for people with an intellectual disability, MCD is important in almost half of the institutions in which it is present. In elderly care and hospital care, in less than 40% of the institutions with MCD, it is regarded as important.

Table 6.1: CES in Dutch health care institutions in general (N = 247)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCD</td>
<td>109</td>
<td>44%</td>
</tr>
<tr>
<td>Ethics committee</td>
<td>125</td>
<td>51%</td>
</tr>
<tr>
<td>Ethics consultant</td>
<td>36</td>
<td>15%</td>
</tr>
<tr>
<td>Implicit CES</td>
<td>224</td>
<td>91%</td>
</tr>
</tbody>
</table>
Table 6.2: Prevalence MCD in various health care domains (N = 247)

<table>
<thead>
<tr>
<th>Sector/CES</th>
<th>MCD present</th>
<th>Besides MCD, also present</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total 109</td>
<td>Ethics committee</td>
</tr>
<tr>
<td></td>
<td>N %</td>
<td>N %</td>
</tr>
<tr>
<td>Elderly care (N = 131)</td>
<td>49 37%</td>
<td>35 71%</td>
</tr>
<tr>
<td>Hospital (N = 46)</td>
<td>25 54%</td>
<td>20 80%</td>
</tr>
<tr>
<td>Mental health care (N = 29)</td>
<td>18 62%</td>
<td>8 44%</td>
</tr>
<tr>
<td>Care intellectual disability (N = 36)</td>
<td>21 58%</td>
<td>14 67%</td>
</tr>
</tbody>
</table>

Table 6.3: Importance of MCD in the organization

<table>
<thead>
<tr>
<th>Sector/CES</th>
<th>MCD is important in the organization (N = 52 of 109)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N %</td>
</tr>
<tr>
<td>Elderly care (N = 131)</td>
<td>21 16%</td>
</tr>
<tr>
<td>Hospital (N = 46)</td>
<td>9 20%</td>
</tr>
<tr>
<td>Mental health care (N = 29)</td>
<td>11 38%</td>
</tr>
<tr>
<td>Care intellectual disability (N = 36)</td>
<td>10 28%</td>
</tr>
</tbody>
</table>

C. Prevalence of MCD, combined with other kinds of CES, in different health care domains

MCD can be combined with other kinds of explicit CES (see table 6.2). It is mostly combined with ethics committees especially in hospital care and elderly care. Our qualitative findings confirm that various kinds of explicit CES are combined:

“The preferred institutional policy is to stimulate ethical reflection through moral case deliberation. The ethics committee is asked for ethical advice.” (MCD facilitator and ethics committee member, Elderly care).

Also the combination of MCD with implicit CES is highly prevalent (see table 6.2).
“We combine moral case deliberation with regular policy meetings at the ward. In the latter, we do not use the method of MCD, but focus on policy issues, involving ethical aspects.” (MCD facilitator, hospital).

Characteristics of Dutch health care institutions with MCD
In this section, institutions with MCD and without MCD are compared, using data provided by ethics support staff (SQ2). We will focus on size, type and identity of the institutions (table 6.4). MCD is less frequent in small institutions than in large institutions. MCD is present in 31% of institutions with under 500 employees, and in 54% of institutions with 2000 or more employees. MCD is more often to be found in institutions with 500–1000 employees (54%) than in institutions with 1000–2000 employees (45%). Regarding kind of problems, MCD is present in 85% of the institutions which indicate they mainly have acute problems. Related to ideological (religious or worldview / philosophical) background, MCD is less present in institutions in which the ideological background is unimportant (37%) than in institutions in which it is important (63%).

Characteristics of MCD in Dutch health care institution
Respondents who reported that MCD was not only present, but also important in their organization (N=52, see page 112 and table 6.3 above), were asked further questions about A) period of existence, B) number and background of participants in MCD, and C) frequency of (scheduled and unscheduled) MCD meetings. In this section we present the data from these questions.

A. Number of years of MCD existence
In the majority (56%) of health care institutions in which MCD is important, it exists for more than three years. Our qualitative data show that it takes time to put MCD on the agenda of the organization and get people interested:
Table 6.4: Comparison of health care institutions with and without MCD

<table>
<thead>
<tr>
<th>Number of employees</th>
<th>Hc institutions with MCD (N = 109)</th>
<th>%</th>
<th>N</th>
<th>Hc institutions without MCD (N = 138)</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000 or more (N = 59)</td>
<td>54% 32</td>
<td>46% 27</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1000-2000 (N = 55)</td>
<td>45% 25</td>
<td>55% 30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>500-1000 (N = 37)</td>
<td>54% 20</td>
<td>46% 17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-500 (N = 85)</td>
<td>31% 26</td>
<td>69% 59</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Kind of problems</th>
<th>Hc institutions with MCD (N = 109)</th>
<th>%</th>
<th>N</th>
<th>Hc institutions without MCD (N = 138)</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mainly chronic disease (N = 166)</td>
<td>39% 64</td>
<td>61% 102</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equal division of acute and chronic disease (N = 62)</td>
<td>50% 31</td>
<td>50% 31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mainly acute (N = 13)</td>
<td>85% 11</td>
<td>15% 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Ideological background important?</th>
<th>Hc institutions with MCD (N = 109)</th>
<th>%</th>
<th>N</th>
<th>Hc institutions without MCD (N = 138)</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes (N = 111)</td>
<td>53% 59</td>
<td>47% 52</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No (N = 104)</td>
<td>37% 38</td>
<td>63% 66</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not know (N = 19)</td>
<td>32% 8</td>
<td>58% 11</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

“MCD started during the period in which there was interest in reducing the use of coercion and restraint, that movement was very strong here. After three years there was a regression. We took a new initiative two, three years ago, and it appears to enter a next phase now.” (Managing director, mental health care).

It also takes a long time before MCD is part of organizational policy:

“It took nine years before a policy decision was made, stating that our institution prefers MCD as an instrument” (MCD conversation leader, ethics committee member, care for people with an intellectual disability).
B. Number and background of MCD participants

Most MCD meetings (29%) have 7-9 participants (see table 6.5). There are also smaller meetings, with 4-6 participants (23%), and larger ones with 10 or more participants (21%). In all institutions, MCD meetings are multidisciplinary. The participation of professional caregivers (nurses, physicians and nursing aids) is relatively high (respectively 56%, 48% and 48%) (table 6.6). The participation of professionals who have training in ethics, for example spiritual caregivers, ethicists, and legal experts, is considerably less than that of health care professionals (respectively 38%, 19%, and 4%). The participation of patients and their family within MCD is relatively low (respectively 10% and 17% of MCD meetings). The participation of middle managers (54%) is relatively high, compared to the rather low participation of (location) managers (19%), board members (15%) and directors (10%).

In the interviews, some respondents complain about the low participation of physicians in MCD:

“For most physicians the outpatient ward and the operation room always have priority”; “The participation of physicians is limited, much too limited.”

The quantitative data do not seem to support these complaints, since physicians are relatively often mentioned as participants. The difference between quantitative and qualitative data may be not that large, since it might be the case that only a small number of physicians participate in MCD (or always the same physician who is involved and acknowledges the relevance of the perspective of a physician in MCD).

The relatively low presence of spiritual caregivers and ethicists in MCD might be related to their traditional role of providing normative guidance, rather than focusing on moral experiences of health care professionals. During an interview, a respondent says:

“I have the idea that when a spiritual caregiver grabs hold of ethics too fast, people immediately see it is to claim a position and responsibility. That will not lead to success” (spiritual caregiver, mental health care).

Respondents in the interviews confirm that the participation of patients in
Table 6.5: Characteristics of MCD in institutions that have MCD and in which MCD is deemed important (N = 52)

<table>
<thead>
<tr>
<th>1. Period of existence</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 or more years</td>
<td>56%</td>
<td>29</td>
</tr>
<tr>
<td>0–2 years</td>
<td>19%</td>
<td>10</td>
</tr>
<tr>
<td>Stopped</td>
<td>2%</td>
<td>1</td>
</tr>
<tr>
<td>No answer</td>
<td>25%</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Average number of participants in MCD sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4–6</td>
</tr>
<tr>
<td>7–9</td>
</tr>
<tr>
<td>10 or more</td>
</tr>
<tr>
<td>No answer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Average number of scheduled MCD sessions per MCD group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–4 times a year</td>
</tr>
<tr>
<td>5–8 times a year</td>
</tr>
<tr>
<td>8 or more times a year</td>
</tr>
<tr>
<td>Different numbers of scheduled meetings for different groups</td>
</tr>
<tr>
<td>No scheduled meetings (only ad hoc)</td>
</tr>
<tr>
<td>No answer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Number of unscheduled (ad hoc) meetings for an MCD group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–4 times a year</td>
</tr>
<tr>
<td>5–8 times a year</td>
</tr>
<tr>
<td>8 or more times a year</td>
</tr>
<tr>
<td>No unscheduled meetings</td>
</tr>
<tr>
<td>No answer</td>
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</tbody>
</table>

MCD is low. Some say this is a conscious choice, as MCD is seen as a means for reflection and dialogue between professional care givers only:

“No, they [patient and family] are not present. We say that a good conversation or good communication with patients and family should meet other quality criteria than MCD within the team. MCD should be an instrument for the team, to deliberate on what they think is moral desirable or see as a moral acceptable action. The team should have some room for this, to talk, to say what they think, without hav-
Table 6.6: Background participants (N = 52)

<table>
<thead>
<tr>
<th>Professional care givers</th>
<th>Background of MCD participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Yes</td>
</tr>
<tr>
<td>Nurse</td>
<td>56%</td>
</tr>
<tr>
<td>Physician</td>
<td>48%</td>
</tr>
<tr>
<td>Nursing assistant</td>
<td>48%</td>
</tr>
<tr>
<td>Management</td>
<td></td>
</tr>
<tr>
<td>Middle manager</td>
<td>54%</td>
</tr>
<tr>
<td>(Location) manager</td>
<td>19%</td>
</tr>
<tr>
<td>Board member</td>
<td>15%</td>
</tr>
<tr>
<td>Director</td>
<td>10%</td>
</tr>
<tr>
<td>Staff</td>
<td></td>
</tr>
<tr>
<td>Spiritual care giver</td>
<td>38%</td>
</tr>
<tr>
<td>Ethicist</td>
<td>19%</td>
</tr>
<tr>
<td>Staff employee</td>
<td>19%</td>
</tr>
<tr>
<td>Law specialist</td>
<td>4%</td>
</tr>
<tr>
<td>Patient/family</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>17%</td>
</tr>
<tr>
<td>Patient</td>
<td>10%</td>
</tr>
</tbody>
</table>

Other respondents think it is desirable that patients participate in MCD:

“It would be desirable to involve family in it [= MCD]. We, for example, organized thematic meetings about autonomy and sexuality. For some of them we also invited patients; both patients and employees. And that [patient participation] was very good and clarifying. […]” (Board secretary, mental health care).
C. Prevalence of scheduled and unscheduled meetings

MCD meetings can both be scheduled (organized in a regular basis within a team), or ad hoc (organized when a specific case requires deliberation). In half of the institutions which report scheduled meetings, MCD groups are planned 1-4 times a year; in the other half, groups meet more than 4 times a year. In interviews, respondents mention as advantage of scheduled meetings that they stimulate continuous learning cycles and contribute to moral competence:

“Ultimately, ethics is about ‘how should we relate to each other and to the world around us?’, and to reflect on that. So education is on-going and permanent for that matter. It is important that there is willingness to reflect on one’s attitude. Scheduled meetings can stimulate this process, but are no ‘sine qua non’” (Ethics support staff, institution for people with an intellectual disability).

For ad hoc meetings, the numbers are similar to those of scheduled meetings. In almost half of the institutions which report these meetings, ad hoc meetings take place in a team 1-4 times a year, in the other half, more than 4 meetings a year are requested by a team. Respondents see as an advantage of ad hoc meetings, that they allow professionals to bring up burning issues to be discussed in an MCD session immediately:

“As soon as a dilemma or problem in the care around a patient arises, the MCD facilitator is contacted.” (MCD facilitator and ethics committee member, care for people with an intellectual disability).

In circa 80% of the institutions which report scheduled and/or unscheduled meetings, both are present. This means that a series of meetings is planned, but that ad hoc meetings of the MCD group are organized when a specific case comes up which cannot wait until the next scheduled meeting. Respondents in the interviews say this combination is useful, because it stimulates regular reflection, but also enables a quick response to sudden difficult cases.
Positioning MCD in the institution
Both in the questionnaires and the interviews and focus groups, the topic of positioning MCD in the organization was addressed. In this section we present data on positioning of MCD in relation to institutional policy and structures, and the role of key persons in giving MCD a recognizable position in the institution.

A. MCD and organizational policy
About one third of the respondents who gave an answer to the question whether MCD is related to institutional policy (leaving the ‘no answer’ group out), mentioned that MCD is part of a long-term policy project within the organization, and is not seen as a temporary activity (table 6.7). In the responses to the questionnaire for ethics support staff (SQ2), examples are mentioned:

‘Ethics policy connected to projects like experience oriented care and small scale living’ (MCD conversation leader, ethics consultant, spiritual caregiver, elderly care)

Integrating MCD in a long-term policy increases the impact of ethics in the organization as a whole. In an interview, a director explains the success of
MCD in his mental health care institution by referring to the connection of MCD to organizational themes like the reduction of coercion and restraint. When MCD is not a part of a long-term policy, there is always a threat that MCD is being overruled by other priorities. Ethics support staff says they continuously struggle to keep MCD on the agenda. Connecting MCD to other long term policies or structures (like quality policy of the quality management staff) helps them to anchor MCD within the institution:

“Make sure that MCD is anchored in quality policy.” (Ethics expert supporting MCD in organisations).

A managing director explains that giving employees a MCD training contributes to the internal quality procedure:

“Currently we have trained about 25 people as facilitator of MCD. Then it spreads through the organization, people learn to, or at least try, to have a dialogue. Within the frame of internal quality development that has value. It belongs to quality policy. Because quality is essentially an ethical issue. You want to do something good, to make it better than it was.” (Managing director, mental health care).

An ethics committee member in elderly care explains that connecting MCD to a larger project around professionalization, contributed to its visibility:

“As part of the professionalization project, a sort of market was organized, in which we offered two MCD workshops. The attendance was high, we were evaluated good and the participants were very diverse, including middle managers and care workers.” (Ethics committee member, elderly care)

**B. MCD and organizational structures**

In SQ 2, we asked whether MCD is connected to organizational structures. The respondents who answered this question (again leaving the ‘no answer’ group out), more than 80% mentioned that such a connection exists (see table 6.7). In the answers to the open ended questions in SQ2, the ethics
committee is often mentioned as a relevant structure. This is in line with the results presented in section 1 above, showing that MCD is often combined with other forms of CES, especially with an ethics committee. Whereas the results of section 1 showed that both MCD and the ethics committee exist together, the answers here indicate that both are actually related to one another (and thus do not operate independently). Respondents in interviews and focus groups underline the importance of integrating various ways of CES. An expert in organizing ethics explains in an interview that MCD and an ethics committee are complementary, and can and should reinforce one another:

“MCD is another kind of ethics than an ethics committee which, for example, makes normative pronouncements. And I think both kinds of ethics are desirable. And a combination between them.” (Expert in organizing MCD in various contexts)

The aims of both forms of CES differ according to this respondent. MCD focuses on supporting professional care givers, whereas an ethics committee provides institutional guidelines:

“MCD really is supporting professionals, it is not normative, which implies that the ethicist does not guide the content and does not say ‘this is how it should be.’ But an ethics committee can and probably should do that in a hospital, and conclude for instance: ‘This is not proper informed consent, this was poor.’ ” (Expert in organizing MCD in various contexts)

By connecting MCD to the ethics committee, outcomes of deliberations on concrete cases can be translated into institutional policy in general. Respondents state that this is important in order to generate moral learning in the institution:

“It is important to translate the outcomes of MCD to vision and policy” (Spiritual caregiver, elderly care)
“What is learned during MCD, is too little translated to learning at organizational or policy level. It tends to be confined to nice conversations in a team, without learning in a broader way. Sometimes not even within the team, and certainly not within the division or institution.” (Expert in organizing ethics, various contexts)

Next to the connection of MCD to the ethics committee, other structures are mentioned, which provide implicit CES, such as: team meetings, structured peer supervision, multidisciplinary team meeting, introduction meetings for medical specialists, contact persons, department meetings, and education of physicians, psychologists and nurses. Respondent in interviews underline the importance of connecting MCD to structures in which ethical issues are addressed more informally and implicitly. Connecting MCD to peer-review and (multidisciplinarity) is regarded as especially useful for giving it a firm position in the organization. A respondent says:

“When ethics is integrated in daily processes, peer-supervision, regular work meetings, it has the greatest chance for success.” (Board secretary, mental health care).

Integrating MCD in such meetings prevents a separate, ‘yet another’ meeting:

“So, you don’t have to organize a separate meeting from 3 to 5, on Friday afternoon, with a conversation leader. It is integrated in the usual meetings, and makes participants be aware, together, of the ethical dimension of emerging problems.” (Board secretary, mental health care).

C. Role of key persons in positioning MCD
Key persons involved in organizing MCD play an important role in positioning MCD in the organization. A hospital medical ethicist, responsible for MCD, explains that he can help to position MCD in his institution because he is a member of the medical staff:
"Through my appointment as medical ethicist and my position within the organization, the board showed it [= ethics] is important for them. [...] I was made a member of the medical staff, and participated in the oncological center. Currently after two years, I participate in strategic deliberations." (Medical ethicist, spiritual caregiver and nurse, hospital).

Professionals who are responsible for MCD, as facilitator or organizer, can play an exemplary role, especially if they have a strong link with the work floor. The hospital medical ethicist quoted above, explains that he continues working as a nurse for one day a week, which makes he is seen as ‘one of the nurses’:

“I know many people and because I am also a nurse, I speak the language. They also know me from the work floor.” (Medical ethicist, spiritual caregiver and nurse, hospital).

Interviewees explain that the role of MCD facilitators is essential and is not always recognized as such:

“I say to him [= MCD facilitator]: don’t underestimate your role. Because he doesn’t see that anymore. Often you have to do the work with incompetent people. People who do MCD ‘in name only’. That’s one of the pitfalls of ethics policy and especially of MCD. [...] People who think: ‘well, being a facilitator, everyone can do that.’ Well, people tend to take it for granted but this requires many skills.” (Managing director, mental health care)

Strengths and weaknesses of this study

A strength of this study is that data are not limited to views of MCD experts, or MCD participants, but are provided by managing directors and ethics support staff, in the context of a larger national study on clinical ethics
Another strength is that it combined quantitative and qualitative data. Qualitative data enabled us to deepen and further explain the outcome of the surveys. A further strength is that all health care institutions in various health care domains were addressed for the survey studies.

A weakness is that the results of the survey studies cannot be fully extrapolated, since institutions which did not respond might have less CES in general, and MCD in particular, than responding institutions. A further weakness is that the ethics support staff (SQ 2) was designated by managing directors responding to SQ 1, which means that SQ 2 was not open to all health care institutions. A weakness is also that the prevalence of MCD (and other forms of CES) mentioned by ethics support staff (SQ 2) was higher than that mentioned by managing directors (SQ 1), which shows that various stakeholder groups have different views on the presence of CES in the organization. This means that the data we used from SQ 2 are not corroborated by the data from SQ 1. We decided to use SQ 2, because we assume that ethics support staff is more knowledgeable about the presence of CES than managing directors are. Interestingly, the number of institutions in which MCD is present according to managing directors is more or less in line with the number of institutions in which it is present and deemed important by ethics support staff (see table 6.3). This may indicate that managing directors are more likely to report the presence of MCD if it is important in the organization in the eyes of ethics support staff. This may explain the differences in the data on prevalence between SQ 1 and SQ 2, and may also support our decision to use the data from SQ 2.

**Conclusion and discussion**

This paper presents results of the first national study on prevalence and characteristics of MCD in Dutch health care institutions, as part of a larger study on different kinds of clinical ethics support (CES) in the Netherlands. Two nation-wide surveys among respectively managing directors and ethics support staff members, and 17 interviews and 2 focus group interviews, provided insight in the current state of the art concerning MCD in
the Netherlands. In this section we will discuss central findings and present recommendations for practice and research of MCD.

According to ethics support staff, MCD is present in 44% of Dutch health care institutions. For different health care domains, ethics staff members mention a different prevalence of MCD: 62% in mental health care, 58% in care for people with a intellectual disability, 54% in hospitals, and 36% in elderly care. MCD is regarded as important in 38% of mental health care institutions, in 28% of the institutions for care for people with an intellectual disability, in 20% of hospitals, and in 16% of elderly care institutions. In most of the institutions with MCD, also other kinds of explicit CES are present. For example, the prevalence of ethics committees is high, particular in elderly care and hospitals. This indicates that MCD is not an alternative for ethics committees, but provides an add-on service. Ethics support staff also mentions a high percentage of implicit CES next to MCD. This indicates that MCD does not replace informal interactions on moral questions, but rather acts as a complement to these, enabling structured reflection on moral experiences.

Concerning the characteristics of the institutions: MCD is less present in small institutions (with a maximum of 500 employees) than in larger ones. Furthermore, MCD is more often present in institutions for acute care than in institutions for chronic care. This is not reflected in the current literature, as many articles on MCD focus on MCD in elderly care and (chronic wards in) mental health care (Van der Dam et al 2011, 2012, 2013; Molewijk et al 2008b). MCD is more present in institutions in which the ideological background is deemed important. This may indicate that MCD is seen as a means to reflect on and promote institutional values.

MCD is often organized in institutions for a longer period (more than 3 years). This indicates that institutions, once they start with MCD, are dedicated to continue. This is in line with the literature, stressing both that experiences with MCD are evaluated positively, and at the same time that implementing MCD is not a short term activity: it requires a long and creative process (Weidema et al 2012, 2013).

The way MCD meetings are organized may vary. Most MCD meetings are interdisciplinary, with participants from various professional groups and from middle management. Nurses often take part in MCD meetings. It is unclear to what degree physicians participate. The quantitative data
indicates that they are present in almost half of the meetings. In interviews, respondents say that physicians have comparatively little interest in and time for MCD. Physicians’ interest might be higher when they can bring in an acute decisional problem in an ad-hoc MCD session. This subject requires further investigation. Patients and family are relatively absent in MCD meetings; most MCD sessions are for health care professionals only. For theoretical and normative reasons, patient and family perspectives are relevant in the dialogue on what is or constitutes morally good care (Weidema et al 2011). The relative absence of patients and family in MCD might be related to concerns of safety and privacy among health care professionals. This is something to explore in further research.

In most institutions in which MCD is found important, both scheduled and unscheduled MCD meetings take place. Both kinds of meetings can complement one another, because scheduled meetings serve as a vehicle for structural reflection on and learning from moral experience in teams, while ad hoc meetings enable deliberation on cases which need instant attention and decision-making. Combining scheduled and unscheduled MCD meetings may be a useful tool for implementing MCD in the organization.

Implementation of MCD can further be improved by combining it with institutional policy issues and integrating it with institutional structures. Relevant structures include quality management and ethics committees (which explicitly aim at ethical reflection and policy making), team meetings and peer supervision. Combining various kinds of explicit and implicit ethics support calls for a clearer vision of an integrated policy for various ethics support activities on several levels within the institution (Reither Theil et al 2011; Fox et al 2010). Furthermore, key persons may foster the visibility of MCD in the organization. As ambassadors of ethics, they can help to further develop an institutional ethics policy, which aims to integrate MCD with relevant structures in the organization and to translate outcomes of MCD into more general normative guidelines. Given the risk that MCD meetings only function as isolated meetings on singular cases, with a limited amount of participants, and with no follow-up at other levels within the institutions, the institutional integration of MCD meetings is crucial. Future MCD research should focus on how to use insights from MCD meetings for professionals who did not participate and for formulating policies or guidelines. How to develop a guideline out of a series
of MCD meetings? How to transfer local insights from MCD participants to more abstract policy rules at the institutional level? How to use such policy or guidelines, once developed, in other specific contexts? Qualitative participatory research such as Responsive Evaluation and Action Research might be useful to address these research questions in concrete contexts.

References


PART III

Developing methods and instruments for facilitating moral learning in health care practice
Learning by doing. Training health care professionals to become facilitator of Moral Case Deliberation

*HEC Forum, 27:47–59*
Abstract

Moral Case Deliberation (MCD) is a dialogue among health care professionals about moral issues in practice. A trained facilitator moderates the dialogue, using a conversation method. Often the facilitator is an ethicist. However, because of the growing interest in MCD and the need to connect MCD to practice, healthcare professionals should also become facilitators themselves. In order to transfer the facilitating expertise to health care professionals, a training program has been developed. This program enables professionals in health care institutions to acquire expertise in dealing with moral questions independent of the expertise of an (external) ethicist. Over the past 10 years, we developed a training program with a specific mix of theory and practice, aiming to foster the right attitude, skills and knowledge of the trainee. The content and the didactics of the training is developed in line with the philosophy of MCD: pragmatic hermeneutics, dialogical ethics and Socratic epistemology. Central principles are: ‘learning by doing’, ‘reflection instead of readymade knowledge’, and ‘dialogue on dialogue’. This paper describes the theoretical background and the didactic content of the current training. Furthermore, we present didactic tools which we developed for stimulating active learning. We also go into lessons we learned in developing the training. Next, we provide some preliminary data from evaluation research of the training program by participants. The discussion highlights crucial aspects of educating professionals to become facilitators of MCD. The paper ends with concluding remarks and a plea for more evaluative evidence of the effectiveness and meaning of this training program for doing MCD in health care institutions.

Keywords

Training Program, Moral Case Deliberation, Experiential Learning, Clinical Ethics.
Introduction

During the past 10 years, Moral Case Deliberation (MCD) has become widely practiced in health care institutions in the Netherlands. Although the concept is still developing and expanding, the practice has increased rapidly and is nowadays implemented in many institutions in Dutch health care (Dam van der et al 2011; Dauwerse 2011; Molewijk et al 2008a, 2008b, 2008c; Weidema et al 2012).

During a MCD meeting, health care professionals (8-12 persons) reflect on a specific moral question that they experience(d) in a concrete case. This might be a moral question about dilemmas in the interaction with patients, for instance: ‘do we accept the wishes of a terminal ill patient who wants to go home, while we know that there are not enough care facilities available?’, or a moral question related to the interaction in the team, for example: ‘should I address a colleague about not doing his work properly?’. It might also be a moral question on management level, for instance: ‘is it right that we transfer money from a profitable division to a division which makes losses?’ The case is presented by one of the participants and concerns a situation in which he or she is (or more of the participants are) involved, in order to prevent hypothetical reasoning. The participating health care professionals ideally come from different professional backgrounds, enabling an exchange of different views and perspectives. The dialogue focuses on one central moral question raised by the person who experienced the case. By having a dialogue and exchanging views, the participating health care professionals examine what they perceive as morally good and how to act morally right in the case.

1 Moral case deliberation is also practiced with patients, family members, managers, house holding staff (in and outside the domain of health care).

2 A hypothetical case is not connected with personal experiences including personally felt values and moral concerns. Moreover a hypothetical case misses a connection with relevant facts, which entails the risk that participants make their moral opinions based on assumptions about facts.

3 In this paper we distinguish between ‘dialogue’ and ‘debate’. A dialogue aims at mutual understanding through asking sincere questions and postponing one’s own initial judgments. It requires an attitude of listening and questioning, arising from honest inquisitiveness to the underlying motives of the other person. A debate starts with a judgment or normative position and aims at convincing the other.
The meeting is moderated by a facilitator using a specific conversation method to structure moral inquiry and support the participants in the process of reflection (Molewijk et al. 2008a; Steinkamp & Gordijn 2003; Kessels et al. 2006, 2009; Molewijk & Ahlzen 2011). The facilitator aims to foster a dialogue among the health care professionals in order to support the collaborative reflective inquiry of the central moral question. The facilitator does not bring in his or her normative opinion about the case. Rather (s)he stimulates and improves the participants’ awareness of the moral aspects of a case, their reasoning process and their sensitivity for moral issues in general. The facilitator aims to create a safe and free space for the participants of MCD to explore their ideas and beliefs about the moral issue(s) in the case.

As a result of the increasing demand for MCD in health care institutions, the number of MCD projects grew rapidly (Molewijk et al. 2008a, 2008b, 2008c; Weidema et al. 2012). This has led to a growing need to develop a program for training health care professionals to become facilitators of MCD. From a practical point of view, the growing number of MCD’s cannot be facilitated by external ethicists only. From a fundamental point of view training healthcare professionals to become facilitators of MCD enhances the capacity of practitioners in health care institutions to deal with moral questions without being dependent on external experts. Therefore, 9 years ago, we started developing a training program. This program is continuously monitored and adapted (Abma et al. 2009). As a consequence, the current training program is the result of long-term experience.

In an earlier paper we presented our view on teaching ethics (Molewijk et al. 2008a). In this paper we focus on the development and didactic content of our training program (based on the experiences of the trainees and trainers). Firstly we explain the theoretical foundation of the training. Secondly we describe the design of the current training program followed by a description of the didactical tools used in the training for active learning. Next we describe some lessons we have learned during the development process. Furthermore, we provide some first results of evaluations by the trainees who followed the current training program. In the discussion we highlight some challenges which we encountered during the process of developing and improving the training.
Theoretical foundations of the training

Like MCD, the training program is inspired by pragmatic hermeneutics, dialogical ethics and Socratic epistemology (Gadamer 1960; Dewey 1960; Abma et al 2009; Widdershoven et al 2010; Kessels et al 2006, 2009; Vlastos 1991; Nelson 1994; Heckmann 1981). Pragmatic hermeneutics emphasizes that moral knowledge is related to practical experience, that participants in a practice, because of their experience, have practical wisdom and that practice thus can be seen as a source of knowledge. Dialogical ethics assumes that moral perspectives can be enriched in dialogue as a joint process of opening up to the other and developing a shared view on the situation. Socratic epistemology stresses an attitude of not-knowing and asking sincere questions as the core of dialogue. MCD presupposes that good care is not determined beforehand by theoretical notions or theories, but emerges from the dialogue in which the participants examine and exchange their views (based on earlier experiences) (Abma et al 2009). Likewise, the training is not based on transferring theories about facilitation, but on ‘learning by doing’, and exchanging practical experiences. The training is in line with the theoretical assumptions of MCD. In MCD, participants are not taught ready-made ethical knowledge and moral answers, but they are challenged to reflect on their views and ideas about good care in the given situation (the case). In the training, the trainers do not prescribe beforehand what the ideal facilitator of MCD is. The trainees continuously reflect on their views on and experiences in facilitating MCD. This approach to learning and gaining knowledge is embodied in the design of the training program.

Design of the training program

The training program consists of 8 sessions of 4 hours (or 4 full days) within a period of half a year. The program of the sessions reflects the various aims of the training (see Text box 1): basic knowledge about ethics, profound knowledge about two conversation methods, attitude & skills for facilitating a dialogue and analytical reasoning.
Text box 1. Objectives of the training program

General objectives

- Basic knowledge of moral deliberation and two conversation methods
- Sufficient experience for independently facilitating a structured Moral Case Deliberation, using a conversation method (Dilemma Method or Socratic Dialogue)
- Learning to reflect on and develop one's style of facilitating

Knowledge objectives

- What is Moral Case Deliberation (background, goals, methods) and what not?
- What is the theoretical basis of Moral Case Deliberation?
- How do we recognize a moral issue or question in a concrete case?
- What are reasons for not organizing a Moral Case Deliberation?
- What is the difference between a dialogue and a debate?
- What are the steps of the Dilemma Method and the Socratic Dialogue?

Skills and attitudes

- Ability to apply the steps in the conversation method
- Ability to develop a facilitator attitude (including an attitude of asking, listening, patience, responsibility, involving others, activating the group)
- Ability to foster a dialogue within the group
- Ability to postpone one's own and others' judgments, and turn them into questions for inquiry
- Ability to avoid referrals to authority or hypothetical reasoning
- Ability to make the group responsible for the deliberation
- Ability to use the flip-over so that it contributes to the structure and process of the conversation and the moral inquiry
Design of the training program

- Ability to appreciate silence and confusion in the process of inquiry
- Ability to distinguish between discussion, debate and dialogue
- Ability to distinguish and apply various strategies in facilitating the deliberation
- Ability to be transparent about your facilitating activities and style
- Ability to recognize ‘good’ cases and questions
- Ability to help others to talk openly and honestly
- Ability to assist others in formulating their thoughts and questions
- Ability to stay focused on the case and the question
- Ability to avoid thinking for others
- Ability to be aware of group processes and the need for a safe and respectful environment for mutual learning

During each session various different didactic elements are offered: literature, lecture, discussion and exercises (see Text box 2).

**Text box 2. Examples of topics embedded in the training program**

- How to organize and start a Moral Case Deliberation?
- Criteria of a good case and moral question (as different from practical, psychological or technical questions)
- The difference between Moral Case Deliberation and peer-support
- The difference between discussion and dialogue
- The use of a flip-over
- The different roles of a facilitator of Moral Case Deliberation
- The role of emotions
- How to deepen the joint process of moral inquiry?
- Implementing Moral Case Deliberation in healthcare practice
Each session contains recurring elements like practicing facilitation of MCD stepwise, lectures on specific topics of MCD, and discussing literature and specific questions raised by the trainees based on their experience with practicing MCD in their own organization (see Text box 3).

Text box 3. The program of a meeting contains the following items:

- Start (welcome, announcements)
- Lecture and exercise about a specific topic, e.g. ‘what is a good case and a good moral question?’
- Discussing questions and experiences of the trainees in practicing Moral Case Deliberation on the ward
- Discussing literature
- (Re)formulation of the personal learning goals of the trainees
- Practicing Moral Case Deliberation: Each trainee practices a step in the method. The other trainees participate as participants of the Moral Case Deliberation. After each step feedback is provided about the content of the moral inquiry and the trainee’s performance. First the trainee reflects on the exercise, followed by the feedback of the other trainees and the trainer.
- Preview to homework and the program of the next training session.

During the discussions or lectures, concrete examples of the issue at stake are addressed. In line with our theoretical framework, theoretical issues are only discussed in relation with practical exercises with MCD during the training session.

In the training, two different conversation methods are practiced: the Dilemma method and the Socratic Dialogue (Molewijk & Ahlzen 2011; Kessels et al 2006, 2009; Birnbacher 1999). Both conversation methods structure the MCD stepwise and support the moral inquiry. Whereas the Dilemma method entails a stepwise reflection on a concrete dilemma – a choice between two actions, each entailing a clear loss – the Socratic Dialogue is focused on a stepwise clarification of a moral concept. During the training, the emphasis is on learning how to apply the conversation meth-
ods and to understand and practice the underlying notions of each (step in the) method. We on purpose practice two different methods; trainees learn that there are different ways to reflect on moral questions and that choosing the right way depends on various criteria such as the aims of the MCD and the nature of the moral question. This is not only relevant for the choice of a specific conversation method but also for the way a specific conversation method is used. So, the focus is not on applying a conversation method always in exactly the same way but on increasing trainees’ awareness of and abilities in dealing with the different steps in a moral deliberation. Being aware of various possibilities and being able to justify a chosen action are essential for being a skilled and flexible facilitator. In the end, the use of the conversation methods is not an aim in itself, but a means to structure the conversation and to stimulate an open and genuine dialogue and moral inquiry.

Practicing MCD (during and after the training sessions) is a central part of the training. However, knowledge of theories and concepts is important too. Therefore, facilitators of MCD are expected to have certain knowledge of ethics in general and of the theoretical background of MCD (see Text box 4). The literature is actively processed through interactive questions and discussions, always connected to concrete MCD exercises and experiences.

**Text box 4. Literature and topics**

- Dilemma method and Socratic Dialogue
- Ethical theories like deontology, consequentialism, etc.
- Morality, values and beliefs
- An example of a good case
- Why and how to apply Moral Case Deliberation
Didactic tools for active learning

In this paragraph we will elaborate on the didactics of the training in applying ‘learning goals’ and fostering a reflective process on group- and individual level.

In the first session the trainees are invited to deliberate about the question ‘What is a good facilitator?’ During the deliberation questions become more specific, for example: ‘To what extent does a facilitator need to control and guide the conversation?’; ‘What is the responsibility of the facilitator regarding the outcome (and follow-up) of the MCD?’ These questions are related to the ultimate aim of the training: teaching the trainees to become capable facilitators who, in line with the theoretical background, are able to foster a dialogue in an open and constructive atmosphere. The trainees are also challenged to develop their own style and attitude as a facilitator. In line with the presupposition of MCD that good care is not given beforehand, no blueprint of ‘a good facilitator’ is offered in the training. Based on our view on ethics and MCD, the trainee shapes the role as facilitator by experience and practice facilitating MCD. As mentioned before, the conversation methods are taught as a tool. Therefore the two different conversation methods are practiced alternatively during the training.

During the training sessions, the trainee’s learning process is reflected upon and discussed. Each trainee has to formulate personal learning goals at the beginning of the training, to stimulate the learning process. In every exercise of MCD these personal learning goals help to structure and focus the self-reflection by the trainee and the feedback from both the trainers and the other trainees. Based on the concrete experience and the feedback, the trainee can reformulate his personal goals and uses them when exercising the role of facilitator the next time. This dynamic process of (re)formulating learning goals on the bases of concrete experiences activates the trainee’s learning process and offers insights for the trainer in the assessment of the trainee.

The trainee is expected to exercise MCD in between the training sessions by organizing and facilitating MCD in his own team or organization (see Text box 5).
Text box 5. An example of homework

1. Read the literature and formulate minimal 1 question or comment, whether or not related to your experience in performing Moral Case Deliberation.

2. Organize and perform the role of facilitator Moral Case Deliberation in your own team (or organization) and ask one of the other trainees to observe you. Formulate your personal goals and explain them to the observer. Prepare the Moral Case Deliberation meeting together, write a reflection report afterwards and send this together with the report of the observer to the trainer(s) and the other trainees before (dd-dd-dd).

3. Write down a personal case and send this to the trainer and other trainees before (dd-dd-dd).

The underlying assumption is that one learns and gains knowledge by experiencing in practice (see foundations of the training, and Text box 1). These practical exercises are organized in pairs of trainees. The trainees cooperate as buddies and alternate the role of facilitator and observer of the trainee. During the MCD, the observer reflects upon the personal learning goals as formulated by the trainee in order to focus the observation. After the MCD, both the trainee and the observer write a separate report using specific format for self-reflection and observation which is developed by the trainers. These reports are used for several purposes: firstly, items from the reports are discussed with the other trainees and the trainer in the training sessions. Secondly, they contribute to the learning process of the facilitator during the training. The trainee has tools to reflect on his attitude and performance in order to generate new personal learning goals for the next exercise. Thirdly, the reports give insight into the trainee’s progress, which can be used by the trainers to assess the trainee.
Developing the training: lessons from experience

Above, we have described the training program as it is today. However, since the start of the program 10 years ago, we have adapted it in several ways. The changes were based on both the experiences of trainees and trainers (including informal evaluations) and continuous process of relating practical experiences to our theoretical framework (see section 2). In line with this framework, we ourselves also learned regarding the design of the training by doing. So what did we learn? We distinguish three topics that we consider as experiential lessons of major importance.

Content of the training: less teaching of knowledge, more practical exercises
In the past years, our motto changed from ‘doing by learning’ into ‘learning by doing’. During the first version of the training program, trainees had to digest a lot of theory by lecturing and providing papers and books. Moreover, the trainers taught the trainees knowledge about MCD and tried to summarize their experience rather than stimulate them to find out for themselves through their experience. Nowadays, we are more aware that the learning effect of the trainees is larger when making them practice MCD and offering them exercises, instead of lecturing on how to facilitate MCD. Through practical experiences we focus on creating a joint inquiry about ‘What is a good facilitator?’ By integrating and discussing specific (theoretical) topics in the context of the experience itself, and connecting them to concrete moments that trainees experienced, the (theoretical) knowledge becomes meaningful and practical at the same time.

This change also affected the role of the trainer. In the beginning, the trainer mainly acted as an expert in facilitating MCD; nowadays the emphasis is on facilitating and fostering a (joint and individual) process of reflection on what good facilitating means. The trainer stimulates the reflection of the trainee (and the other trainees) by means of questions. For example: ‘Which intervention was helpful for the process of moral inquiry, and which was not?’ In this way, the trainer aims to stimulate the development of the trainees’ (underlying) ideas regarding the role and attitude of a facilitator.
Selection of trainees: First experiencing MCD, then learning to facilitate
In the beginning, candidates for the training were selected on specific
communication or presentation skills. Even without any MCD experience,
candidates could participate in the training. Over the years, we learned
that having experienced MCD as a participant and being motivated are
more important than having specific knowledge about MCD or commu-
nication and presentation skills. Of course, it is useful if a trainee has spe-
cific knowledge of (clinical) ethics or if (s)he has a talent for working with
groups. However, we noticed that knowledge or skills are not decisive for
the progress of a trainees’ individual learning process. The evaluations of
the first training programs showed that trainees who had not experienced
MCD before, needed more time to visualize what MCD actually is and
how to facilitate it in practice. This also had consequences for the learning
process of the group; when individual learning processes in a group are
dispersed, the efficiency of joint learning is not optimal. Nowadays, the
rule is that candidates for the training should have participated in at least 4
MCD sessions.

Follow-up after the training: Creating an ongoing learning
environment
In order to become a good facilitator, following the training program is
not enough. Trainees need to keep on facilitating MCD and developing
their skills and qualities through reflection upon their experiences after the
training. Like learning to drive a car, the most important lessons start after
having passed the exam. Therefore, during the training, a learning network
is developed within or between trainees’ institutions. Peer review, collegial
feedback, supervision and continuous education are proposed as means
of furthering skills and expertise. Trainees can help each other with this.
Furthermore, trainees are encouraged to exercise on a regular base (e.g.
monthly) after the training. Learning is an ongoing process of practical
experience.
Over the years, the interest in the training program has grown (see Figure 7.1). At the moment, 437 healthcare professionals have finished the program and a large number of them act as facilitator MCD in their institutions. Besides our positive experiences with the training program so far, systematic evaluative research is needed in order to scrutinize the effectiveness of the program. Therefore we started an evaluation study (Plantinga et al. 2012) in which the training program was evaluated by a questionnaire, filled in by the trainees. The preliminary results of the questionnaire (N = 53) show that trainees are very positive about the training program. In the questionnaire we included an open question, asking which element of the training program contributed most to the participants’ learning process. Exercising MCD (in and in between the training sessions) and receiving feedback from the trainers are particularly appreciated by the trainees.
These elements are mentioned in almost all questionnaires as crucial items of the training program:

“Exercising the role of facilitator was very important for me, especially in combination with the interventions of the trainer.”

Some trainees mentioned they would like to have had more exercises:

“The more I practice the role of facilitator, the better the results are, and the more confident I become. (…) I still need to practice a lot to develop my own style as facilitator.”

The role and attitude of the trainers is regarded as very important:

“Both of the trainers were exceptionally stimulating. They encouraged me to practise and to reflect. I also started reading more about ethical reflection.”

A trainee sums up the crucial elements as follows:

“The most important elements of the training were a) practicing MCD during the training sessions, b) participating in MCD as a participant before the start of the course, and c) the reflection on the concrete situation.”

These results confirm the learning experiences reported in section 5. In another paper we will go into the results of our evaluation study more in-depth.

Discussion

Over the years, the training program has become robust and varied, working out well for trainees and trainers. This training program has been used in different health care contexts, with different health care professionals
as participants and even within different European countries. As has been
described, the development of the training is an ongoing process in which
we encounter new challenges for further development and improvement.
In this paragraph we will highlight and discuss some of these challenges.

In the first place, the combination of becoming a facilitator of MCD and
having a specific professional position in the organization may complicate
the trainees’ learning process. Being a team leader or having a management
role may interfere with acting as a facilitator. The facilitator should not in-
fluence the content of the dialogue. He should create a safe and open space
for moral exploration in which hierarchy and professional status of the
participants play no role. This may be hard to accomplish for a trainee with
a double role of facilitator and team leader or manager. Even if the trainee is
able to separate the roles, the participants of the MCD (his employees) may
not be able to make this distinction. Consequently, the participants may
hesitate to speak openly. Or the facilitator may end up in the uncomfortable
position of being involved in the case discussed, while at the same time
not being able to participate in the deliberation due to his facilitating role.
It is important to reflect on whether persons with powerful or influential
positions in organizations should facilitate MCD with their own employees
or team members, and if so how. During the process of embedding MCD in
the institution and selecting trainees for the training this requires attention.

In the second place, assessing the quality of a trainee-facilitator is not
easy. Initially, we used a brief evaluation form for assessing the quality of
the MCD sessions and the performance of facilitators. By investigating the
appreciation by participants of MCD and their views on the extent to which
MCD is meaningful or helpful for themselves or related to their daily work,
this form provides insight into the quality of the MCD’s and the facilitators.
However, this is not sufficient to gain a clear picture of the quality of the
trainee’s performance. Therefore we developed an assessment form. This
form aims to assess all elements of facilitating an MCD. It gives an overview
of the strong and weak points of the facilitator’s performance. The form is
used by trainees and their buddies, to establish the quality of the facilitation
during the exercises. It is also used by the trainer to assess the quality of the
performance during training sessions. The scores on the assessment forms
together give insight into the development of individual trainees during the
In conclusion, the training program aims to make healthcare professionals capable and flexible moderators of moral inquiry. A central characteristic of the training is ‘learning by doing’. During as well as in between the sessions, trainees exercise as a facilitator of MCD. This is in line with the theoretical background of the training, which emphasizes learning by experience. The design of the training and the program are directly linked to the theoretical framework and views behind MCD. Whereas a participant of MCD examines what good care means in a specific case, a trainee examines the role and attitude of a good facilitator during the training. The trainee is challenged and encouraged to find his own style as a facilitator of MCD, without losing the main essence of MCD out of sight. The trainee is taught in using various conversation methods and several skills regarding the process of moral inquiry and group dynamics. In each session, a mix of theory, lecture, discussion and exercises is offered. Much attention is paid to the experiences that trainees report in exercising the role of facilitator of MCD in their own team or organization.

The present training program is the result of several years of ‘learning by doing’ and many experiences in facilitating and evaluating the training program, together with the trainees and their healthcare organizations. It is the outcome of a continuous process of adjustment and improvement based on a joint inquiry of both trainees and trainers. Thus, the development of training, and enables trainers to judge whether a trainee is competent to act as a facilitator in practice. The assessment form is currently being piloted.

In the third place, more evaluation research is needed. After years of developing and improving the training, making use of various informal evaluations and a first more formal evaluation study (see section 6), we experience the need for more thoroughly evaluation studies. More empirical research about the experiences of the trainees, the trainers, and the implementation of the MCD’s in healthcare organisations after having followed such a training program, is a necessity to further validate the training program.
the training program is as much an example of experiential and dialogical learning as the learning process in MCD sessions and within the training itself.

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Bioethics education in a clinical setting: theory and practice of the dilemma method in Moral Case Deliberation

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Abstract

Moral Case Deliberation (MCD) is a specific form of bioethics education fostering professionals’ moral competence. MCD aims to support healthcare professionals in learning to deal with their ethical questions. MCD stimulates methodological reflection and reasoning through a systematic dialogue on real cases, facilitated by an ethicist or a trained healthcare professional. One of the methods used in teaching bioethics through MCD is the dilemma method. It focuses on moral experiences of participants concerning a concrete dilemma in practice. The specific didactics of MCD and the dilemma method makes it suitable for teaching in the clinical setting. In this paper we will elaborate on the theoretical background of the dilemma method in MCD, and explain how it works in practice, using a case example. In the discussion we will go into the specific characteristics of the learning process which the participants experience, and the role of the facilitator as a teacher.

Keywords

Education, Clinical Setting, Moral Case Deliberation, Dilemma Method, Moral Competence
Introduction

Bioethics education is mostly developed and performed in the academic context, for example in bachelor and master programs in medical education or nursing education (Favia et al 2013; Park et al 2012; VanLaere & Gastmans 2007). Usually concepts and theoretical frameworks from ethics are presented via didactical measures such as reading and lecturing (Beauchamp & Childress 2001; Molewijk et al 2008a; Abma et al 2010). Sometimes hypothetical cases are discussed, using one of the theoretical frameworks from the ethics literature. This approach aims to teach knowledge about theoretical concepts, theories and methods of moral reasoning to students. Teaching knowledge about concepts and frameworks and using hypothetical cases to be analysed deductively with theoretical concepts and principles is important. At the same time it has several limitations when it comes down to bioethics teaching in healthcare practice. One of the limitations is that the focus on cognitive knowledge transfer tends to result in neglecting the importance of skills, attitude and character development. Another limitation is that the moral questions and the framework or principles are often determined beforehand, without waiting for which moral question and principles emerge from the case and the involved professionals. A third limitation is the fact that ethical expertise and insights from outside the context are being applied to the unique situation, without taking into account sufficiently the experiences and insights of the health care professionals themselves.

In health care practice, actual cases with concrete moral questions are often used for reflection and discussion. Yet, such discussions tend to lack structure, theoretical depth and focus on the moral reasoning as the focus is on solving the case at hand practically. Moral Case Deliberation (MCD) aims to combine reflection on concrete cases with methodical procedures to foster moral learning (Molewijk et al 2008b, 2008c). In MCD, health care professionals (physicians, nurses, social workers, etc.), but also managers, family and patients discuss a moral question in a real case within clinical setting. A central aim of MCD is to support health care professionals in reflecting on their actual ethical questions and their actual reasoning in a structured manner. Furthermore, within MCD dialogue is used as a form of moral inquiry in which insight and conclusions are created during the
process, as opposed to knowledge transfer via ethics experts) (Abma et al 2009; Kinsella 2009; Korthagen & Kessels 1999).

In the Netherlands, MCD has developed rapidly over the last decade (Dauwerse et al 2011). Currently, it is one of the major kinds of clinical ethics support in the health care sector (Dauwerse et al 2013). Scientific evaluation research indicates that practicing MCD results in various skills e.g. increased sensitivity for moral issues (recognizing moral topics in daily work), an improvement of communication skill (listening and asking questions rather than convincing the other), and a more open attitude to other viewpoints (postpone judgements) (Weidema et al 2013; Molewijk 2008b, 2008c; van der Dam et al 2013). The aim of this article is to describe the theory and practice of the dilemma method as a conversation method used in MCD. We will describe how this method works in practice, illustrated with a case example. We will discuss the usefulness of the dilemma method for teaching bioethics to professionals in a practical setting, focusing on both the process of learning as experienced by the participants and the role of the facilitator as teacher.

Theoretical background of MCD

The dilemma method, which is elaborated in this article, is based on a specific view on ethics and moral learning: hermeneutic ethics (Widdershoven & Molewijk 2010). It emphasizes the importance of dialogue as a way of learning through exchange of perspectives and fusion of horizons, practical rationality (phronësis), and Socratic epistemology (Gadamer 1960; Aristotle 1941; Kessels et al 2006; Kessels et al 2009; Nelson 2004). A common element in these approaches to ethics is the role of the actual experiences in daily practice: the validity and reliability of knowledge (claims) and moral judgments are constructed and examined in and with the practice itself (Widdershoven & Molewijk 2010). The dilemma method focuses on experiences of professionals in practice (Molewijk & Alhzen 2011). Ethical issues are not defined beforehand, but are derived from practice. In MCD, the moral problem under consideration is always a concrete moral issue, experienced by one of the participants. This issue is presented as a case
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(for example concerning a treatment decision with an individual patient). The case is analysed, not by deductively applying general moral concepts or principles, but by investigating values and norms of the stakeholders in the case. The dilemma method aims to stimulate reflection on personal moral experiences and considerations, and on the discrepancy among the views and experiences of other participants in the MCD.

Some key principles of MCD that arise from the theories mentioned above are: 1) experience as a starting point for moral reflection; 2) take in account variations related to interpretations and appreciations of facts by the participants of MCD plus the conclusions allied by them; 3) reciprocation of the moral question by linking the values and norms of the participant to concrete facts in the case; and 4) dialogue as a process and product in which knowledge and practical wisdom emergence and flesh out by learning by doing (Widdershoven & Molewijk 2010). Applying these principles in MCD means that participants inquire, with the help of the facilitator, answers on moral questions in the concrete experience within the case. Only when the participant experiences a moral issue, question or dilemma, it will be accepted as a starting point in MCD. A theoretical situation cannot be used as a starting point. Next, MCD emphasizes the variation in thoughts and experiences of health care professionals. The correct answer to a moral question does not exist. In a MCD different viewpoints are examined and scrutinized. The initial aim is not to decide which perspective or answer is right, but to ask open and critical questions in order to elaborate assumptions behind the perspective, and to find out how it is applicable to the case at hand. When one of the participants brings in an ethical notion, for instance the concept of autonomy, the focus will be on examining what autonomy means for this person in this case, and why it is regarded as important. This may result in a deliberation on various interpretations of autonomy, and their relevance for the argumentation with respect to the dilemma in the case. The result of that joint inquiry process is a temporary and context-dependent answer. The insights emerging from an MCD may be valuable in similar new situations, but can never be automatically transposed.
The dilemma method in practice

In this section we will describe the dilemma method, and show how it works in practice, using a concrete moral case deliberation as an example. We will elaborate the steps, by first presenting the example, and then discussing the aim and procedure of the step under consideration.

The setting

A group of 12 people sits together in the living room in a house for sheltered living for people with an intellectual disability. The meeting is organised to discuss a problem in the support of one of the clients, Harry. All employees involved in the care for Harry have been invited. Three family members are also present. Two members of the ethical committee of the health care institution participate, one of them as MCD facilitator. Marian will present the case. The participants sit in a circle. There is a flipchart available for the facilitator to write down the findings during the various steps within the MCD.

Step 1. Introduction

The facilitator welcomes the participants, especially the family. She explains the issue that will be addressed at the meeting: a problem in the care for Harry. She explains shortly the theoretical background and procedure of the MCD and emphasizes the confidentiality of the meeting. Together with the participants the facilitator formulates the aim of the meeting: elucidating the problem and finding a way of dealing with it.

During the first step, the aim and procedure of MCD is explained by the facilitator. The facilitator addresses issues such as: what is MCD, what is the aim of this meeting for the participants, what are the mutual expectations
(e.g. open and honest communication), and the explanation of the steps in the method. Also the occasion and the context of the MCD are introduced.

The aim of the specific MCD meeting is not determined beforehand, but determined by the group. The aim should be kept in mind by the facilitator during the process of deliberation. In case the aim is a decision by one of the participants at the end of the MCD (taking into account the views from others) the facilitator has to take care of the time in order to create space for making a reasoned decision. If the aim is to gain mutual understanding, time for decision-making is not needed. Instead, the focus of the last phase of the meeting will be on elaborating similarities and differences regarding the moral considerations of the participants.

Step 2. Presentation of the case

Marian briefly sketches the case: Harry (56 year old) was transferred one year ago from another residence in a village nearby because the sheltered home in which he lived needed to be renovated. He was told that he would return to his former home after the renovation. Harry is doing very well in his new environment. He can work in the garden. He is liked because he often helps other people. In his old residence, he had little to do, and he often was made fun of in the village. Over the past weeks, Harry repeatedly asked when the renovation would be finished, so that he can return. When he brings up the subject, Marian explains to him how well he is doing right now. But Harry keeps insisting that he wants to move back to his old home because that was promised to him. Marian indicates that she does not know what to do, how to respond to Harry’s wish. The facilitator asks Marian at which moment she experienced the problem most strongly. Marian says this was during the last conversation with Harry on this subject three days ago. The facilitator invites Marian to describe this conversation for the other attendees and to explain her feelings. She pictures the situation: she met Harry in the garden, he immediately started talking about the renovation, indicating that he wanted to know when he could return. She felt uncertain about what to answer, since the renovation
was nearly finished, but she wanted to make Harry understand that a
return to his former home would mean that he would no longer have
the current opportunities for doing work and helping other people.

This step focuses on the experience of the case presenter. The presenter is
asked to describe a concrete personal situation in which he or she expe-
rienced the moral issue at stake. This can be in the past or in the (recent)
present. The presenter is invited to focus on a specific moment, in which
the experience of the moral concern was most prominent. This moment
is called ‘the moment of heat’ of the case. The case presenter is asked to
exactly describe the situation at that moment. What happened? What did
the case presenter feel?

Step 3. Formulating the moral question and the dilemma

The facilitator invites Marian to formulate the moral question, and
suggests to the other participants to help Marian in this. The following
moral question is formulated: ‘Do we have to do what is promised to
Harry?’ Next, the facilitator asks Marion to describe the two alterna-
tive actions from which she has to choose. She formulates her dilemma
as follows:

- A: I follow the wish of Harry and let him move back to his old
  place.
- B: I make Harry stay where he lives now.

The facilitator asks the case owner to make a list of the negative con-
sequences of both choices. She notes down on the flip chart:

- A: When I follow the wish of Harry and he will go back to his
  old home, he will have less opportunity to help people and he will
  risk to be made fun of again.
- B: When I make Harry stay where he lives now, I will not respond
  to his wish and he will continue to repeat his wish.
In this step, the moral question is made explicit. By explicitly stating the moral question, the participants understand what (morally) matters for the case-presenter. The moral question can be expressed in the form of a theme e.g. 'honesty' or a question like 'may I withhold information?'.

To make the moral question concrete, the case presenter is asked to formulate the situation in terms of a dilemma. What are actions are possible? In a dilemma, there are two options which mutually exclude one another. Each of the actions has negative consequences. Formulating explicitly the negative consequences of each of the two options makes clear what is at stake for the case presenter.

Step 4. Clarification in order to place oneself in the situation of the case presenter

The facilitator invites all participants to ask questions for clarification concerning the situation. The following questions were asked:

- What was the attitude of Harry when he mentioned his wish?
- How firm did he express his wish?
- Will the old housemates of Harry return to the former home?
- What kind of people make fun of him?

The fourth step aims to foster understanding of the situation, so that the participants can put themselves in the shoes of the case presenter. The aim of clarification is to (re)construct as clearly as possible the situation presented by the case owner. All participants put themselves as well as possible in the position of the case-presenter at the moment of heat. This is important because all the participants later will be invited to answer the dilemma question for themselves: what would I do in this situation and how do I justify this?
Step 5. Analysing the case in terms of perspectives, values and norms

The facilitator asks the participants to make explicit the values of the various stakeholders in the case, related to the dilemma. For each value, the group is also invited to formulate a normative rule of action (a norm) that follows from the value. She notes down the results systematically on the flip chart.

<table>
<thead>
<tr>
<th>Perspectives</th>
<th>Values</th>
<th>Norm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marian (personal supervisor)</td>
<td>Happiness</td>
<td>I have to foster Harry’s happiness</td>
</tr>
<tr>
<td></td>
<td>Being consequent</td>
<td>A promise should be kept</td>
</tr>
<tr>
<td></td>
<td>Honesty</td>
<td>I should tell Harry when the renovation of the house is finished</td>
</tr>
<tr>
<td>Frederic (team member)</td>
<td>Autonomy</td>
<td>I/we (as a team) have to respect Harry’s wish</td>
</tr>
<tr>
<td></td>
<td>Well being</td>
<td>We must take care for Harry’s development</td>
</tr>
<tr>
<td>Lizz (team leader)</td>
<td>Autonomy</td>
<td>We should follow Harry’s wish</td>
</tr>
<tr>
<td></td>
<td>Participation</td>
<td>We should foster Harry’s contribution to social life</td>
</tr>
<tr>
<td>Harry</td>
<td>Independency</td>
<td>I must take part in decisions about my place of living</td>
</tr>
<tr>
<td></td>
<td>Helpfulness</td>
<td>I want to help others</td>
</tr>
<tr>
<td>Family</td>
<td>Involvement</td>
<td>We need to keep an eye on Harry</td>
</tr>
<tr>
<td></td>
<td>Protection</td>
<td>We must ensure that Harry does not get into trouble</td>
</tr>
<tr>
<td></td>
<td>Self esteem</td>
<td>Harry ought to be not harassed</td>
</tr>
<tr>
<td>The health care institution</td>
<td>Self-determination</td>
<td>Our clients should decide about their lives</td>
</tr>
<tr>
<td></td>
<td>Support</td>
<td>We should support the clients in realizing their personal goals</td>
</tr>
<tr>
<td></td>
<td>Involving social network</td>
<td>We should actively involve the family in the care for Harry</td>
</tr>
</tbody>
</table>

To gain insight in the complexity of the case, the participants investigate the values and norms of the stakeholders involved, and jointly construct a perspectives, values, and norms diagram.

The analysis of the perspective of the case presenter will entail values and norms which either support choice A or choice B. Not all stakeholders need to have values and norms which go in both directions. Some will have a clear preference for one of the options, and experience no dilemma themselves. The values and norms are not formulated in general; they are always related to a perspective, and expressed in the way they are concretely experienced by the stakeholder under consideration. Thus, the values are not derived from moral theory, but from lived experience.
Step 6. Looking for alternatives

The facilitator asks the participants to formulate alternative actions. What other options can be thought of besides making Harry return to his former home or having him stay where he lives now?

Various options are suggested:

- Make Harry live with his family
- Try a return for one month, and evaluate
- Do not address the issue anymore

The aim of this step is to have a brainstorm in order to get a view on possible courses or actions which lie beyond the dilemma. The focus is on stimulating creative out-of-the-box thinking (not on the desirability or feasibility of the alternatives). Some of the alternatives mentioned might be useful later when participants answer the moral dilemma question for themselves and reflect on their underlying considerations.

Step 7. Making an individual choice and making explicit one’s considerations

The facilitator asks the participants take pen and paper and individually answer the following questions:

(a) It is morally justified that I choose option A, B or an alternative.
(b) Because of…. (which value or norm?)
(c) Despite of…. (which value or norm?)
(d) How can you limit the damage of your choice mentioned under c?
(e) What do you need to act according your answer under ‘a’?

The facilitator asks who has chosen option A. Carleen says her choice is option A and reads out what she wrote down:
(a) I think it is morally justified to act in line with option A (moving back).
(b) Because of Harry’s self-determination.
(c) Despite of Harry’s happiness.
(d) I would intensify support and try to foster social participation in the village (I would visit meetings together with him et cetera).
(e) I need support and agreement of the family. I also need financial means to deploy more staff.

Next the facilitator asks who chose for option B. John answers first and reads out:

(a) To me it is morally justified to act in line with option B (not moving back).
(b) Because of Harry’s happiness and my responsibility; I am employed here and it is my duty to make the clients happy instead of unhappy.
(c) Despite of hurting Harry’s trust in us (breaking a promise).
(d) I would admit not being able to keep the promise and meet Harry’s wish in another way, for example by going with him to the garden fair.
(e) I need the support of all team members; we should all choose the same option.

The facilitator asks the other participants what choice they made and what considerations can be add to those of Carleen and John. The facilitator notes down all the answers on the flip chart.

The aim of this step is to have the participants formulate their personal views, values and norms in relation to the case. The aim is not to give advice to the case-presenter, but to examine one’s own thinking concerning the moral issue in the case. The participants chose between option A and B, or an alternative (either mentioned in step 5, or not) including the main value or norm that motivates their choice. Furthermore, each of them reflects on the value and norm which cannot be realized, but is still important, and in need of repair. Each participant also makes explicit what he or she needs to
repair the so-called ‘moral damage’ which is often an inherent feature of a moral dilemma.

Step 8. Dialogical inquiry

Most of the participants have chosen option B, not making Harry return. The values mentioned are compared. Some, like John, consider ‘happiness of Harry’ the main value. Others have mentioned ‘participation in society’. The family members all have chosen option B. For them it is important that Harry is protected against been bullied.

The facilitator asks what value is under pressure for those who have chosen option B. For most participants this is ‘self-determination’. This value motivate Carleen to choose option A. The facilitator asks Carleen to elucidate her understanding of self-determination in this specific situation. Carleen says that to her self-determination means people should be able to make choices, even if these might seem wrong. She highly values Harry’s wish to return to his former home, given his firmness and tenacity. John remarks that Harry’s tenacity seems to be related to his conviction that promises should be kept. According to John, Harry’s notion of respect does not primarily mean that he wants to choose by himself where to live but that promises which have been made to him are kept. Others recognize this. The participants conclude that showing respect to Harry does not necessarily mean following his wish, but taking into account the importance he attaches to promises.

The facilitator summarizes the dialogue and concludes that the main values in the dilemma have been changed. The value that is opposed to happiness and participation is not self-determination but trustworthiness.

In this step similarities and differences between the individual considerations are examined. Sometimes, two participants make a different choice in the dilemma based on the same value. On the other hand, participants may choose the same option in the dilemma based on different values or norms. Identifying similarities and differences may lead to a better understanding of one another and a better insight in what is important in the specific
case. Thus, the participants reflect on their own values and learn to see the relevance of other positions. In dialogue, they may reach a new and richer view of the situation. A dialogue is distinguished from a discussion. In a discussion, the participants try to persuade each other that their own position is superior. In a dialogue the participants focus on understanding and examining each other’s viewpoint. A dialogue requires a critical yet constructive attitude of listening and asking questions.

Step 9. Conclusion

The participants go into the consequences of the outcome of the previous deliberation, which resulted in the insight that Harry’s wish to return is not induced by his attachment to his old home but by his conviction that promises should be respected. They conclude that this is not a good basis for organising a move. Thus, the decision is to make Harry stay where he lives now. It is also decided that it is necessary to do justice to the importance which Harry attaches to promises. The team leader proposes to ask the personal caregiver of Harry in his former home, who made the promise, to discuss this with Harry. She expects Harry will accept an explanation by the former caregiver that the promise was premature. If this will not work out in a satisfactory way, a new MCD meeting will be arranged.

In this step, the participants are invited to sum up conclusions and make a plan for action. The facilitator returns to the moral question which was formulated at the start of the MCD, and asks the group to make explicit the insights which have been reached. These insights can relate to the issue at stake, to the joint reflection process, or to some basic key principles that can be a starting point for a similar case in the future or a corner stone for developing policy or guidelines concerning the more abstract more issue that lies behind this specific case. In case of limited time, this step can be shortened to a brief inventory of the conclusions of the participants or a summary by the facilitator.
Step 10. Evaluation

The facilitator evaluates the MCD with the participants. What are the results of the case discussion and the MCD? How was the process experienced? The attendees indicate they acquired a better insight in the dilemma and a better understanding how to take Harry seriously without acting immediately in order to meet his wish of returning to his old home. The family feels satisfied because their worries have been taken seriously. All participants mention they experienced the conversation as open and constructive.

Evaluation is important in order to learn from positive and negative learning experiences regarding the process and the result of the moral deliberation. This may also lead to changes concerning the skills, attitudes and procedure next time, taking into account limitations experienced.

Discussion

The dilemma method is a specific conversation method for MCD which fosters reflection of and dialogue between professionals on a concrete case in their own practice. The teaching of bioethics through MCD in general, and the dilemma method in particular, takes seriously the actual moral concerns of professionals in practice, as their own cases and experiences are the point of departure. It makes professionals aware of their presuppositions and their reasoning skills and attitude. It also broadens their thinking by focusing on a variety of perspectives and exchange of views. In the following we will discuss the specific characteristics of the learning process which the participants experience, and go into the role of the facilitator as a teacher.

The moral learning process of the participants
MCD in general, and the dilemma method in particular, does not focus on raising knowledge of ethical concepts, theories and argumentations, but on
fostering practical rationality and moral competence. This way of teaching ethics fits in with competency-based learning, which is currently emphasized in medical teaching. It is in line with the CanMEDS approach, which focuses on competences of the physician (Frank & Danoff 2007). One of the competences distinguished in the CanMEDS approach is professionalism. MCD may enhance professionalism; participants point out that MCD not only makes them think and act differently, but also makes them better professionals (Molewijk et al 2008c). MCD contributes to the development of reflective professionals, who possess the deliberate and moral skills needed to have a constructive dialogue and to justify their actions (Verkerk et al 2007). In MCD, participants develop specific moral competences. These include: growing awareness of their behaviour and thinking, listening critically and sincerely, postponing moral judgements and an awareness of perspectives of others. Participants indicate that the method helps them to gain a better insight in the moral issues in a case (Molewijk et al 2008b, 2008c; Molewijk & Alhzen 2011). The method results in actions that are rooted in a) their own convictions and reasoning (i.e. conclusions do not come from theory or experts), and b) the concrete context in which the moral question emerged. The close connection between the moral problem and the process of reasoning and finding a solution within one and the same context makes MCD an effective learning method. A crucial element of teaching bioethics in MCD is fostering an exchange of perspectives through dialogue. MCD makes professionals aware of their own presuppositions and thinking process, and broadens their views. Evaluation research shows that participants experience this as a central feature of moral learning (Plantinga et al 2012).

By defining ethical issues in terms of two mutually excluding options, the dilemma method makes the moral dimension of a case concrete. The participants are made aware that ethical issues are not theoretical but practical: a moral decision makes a difference in practice. The formulation of a dilemma also makes clear that moral decisions entail costs. If one decides for option A, one cannot realize the values that underlie option B. Through MCD, participants learn that dealing with moral issues comes at a cost. Moral life is inherently tragic (Nussbaum 2001). Although the dilemma method focuses on moral competence, it does foster insight in moral concepts. In the first place, the method creates awareness of the both the existence and status of values in moral life. Moreover, it promotes reflection and
deliberation on the concrete meaning and implications of specific values. In the case example, the value of respect for autonomy was investigated by the group. Whereas, at first, respect for autonomy was interpreted by most of the participants in terms of following the wish of Harry and enabling him to return to his former residence, later it became clear that, for Harry, respect for autonomy meant that a promise made to him should be taken seriously. Respect thus would entail showing that Harry could trust that former agreements would not be ended one-sidedly. This resulted in the conclusion that respect for Harry might take the form of discussing the limitations of the promise with him. Thus, the group themselves developed the insight that respecting autonomy does not simply mean following the other’s wishes, but creating a relationship of trust, in which the other experiences being treated and respected as a person.

The facilitator as teacher

Facilitating MCD, applying the dilemma method, is different from giving a lecture on ethics or explaining a moral concept or argumentation. The role of the facilitator in MCD is not to elucidate theories from textbooks, but to help participants to reflect on their own moral experiences and reasoning, make explicit the values involved and become open for other values and perspectives. Asking questions is a central feature in MCD. The facilitator should be a Socratic teacher who possesses the art of ‘maieutics’ (Kessels et al 2006; Abma et al 2009). He or she should be a role-model in the Socratic attitude and encourages the participants to question rather than to argue. Through questioning, MCD participants develop a more active learning style. In order to acquire skills, knowledge, attitude and a specific view on ethics, a facilitator needs a solid training (Plantinga et al 2012; Stolper et al 2015). The facilitator should primarily foster the process of reflection and dialogue in the group. This, however, requires insight in ethical issues and concepts. The facilitator should be able to explain to the group what distinguishes an ethical question from a practical one, and to elucidate the nature of a moral dilemma. He or she should be able to explain what values and norms are, how they are related, and should help the group to formulate the values and norms of various stakeholders in the case. The facilitator should be able to stimulate and support the group in investigating spe-
specific values. Knowledge of ethical theories and concepts may be helpful in this respect. Yet, the facilitator should be careful not to apply theoretical knowledge too quickly, and must be open to possible new interpretations of concepts which differ from those in the literature. Thus, the facilitator should not simply write down a concept mentioned by a participant, for example ‘respect for autonomy’, but should help him or her in investigating its meaning in the concrete situation. This may then result in a new and richer view of the concept, as we saw in the dialogue on Harry’s views on the relationship between respect for autonomy and taking seriously former promises. The facilitator should also have knowledge of the theoretical background of the method and the various steps involved, but most of all he or she should be able to apply the method in a context-sensitive way. The facilitator should foster a joint inquiry and dialogue rather than following mechanically the method step by step. The steps within the method should support the process and the moral inquiry. That means the MCD facilitator should focus on the content of the deliberation. The facilitator, like the participants, should listen to what is being said – and sometimes not being said. Eventually the method should support the process of getting insight into the issue at stake. Method is not important in itself, but only as a means to get insight into what Gadamer calls truth: the method should lead to a joint learning process and a broadening of horizon, resulting in an increased insight into what really matters in the case and what is right to do (Gadamer 1960; Widdershoven & Molewijk 2010).

Conclusion

Bioethics education in academic programs for medical students or nurses often aims at knowledge transfer and at deductively applying ethical principles or theoretical frameworks to textbook cases. MCD is a specific form of bioethics education in the context of clinical practice which focuses on real cases and moral issues that are actually experienced by health care professionals. The approach to MCD presented in this paper is based on hermeneutic ethics, practical rationality and a Socratic epistemology. MCD follows an inductive learning approach through a dialogical moral inquiry
in which participants develop not only knowledge but also skills, attitude and character. The dilemma method – a specific conversation method used for MCD – and its underlying view on teaching ethics are useful for supporting health care professionals and teaching them how to reflect on their own moral issues in practice. MCD participants report that they learn to recognize the moral dimension of daily practice and that they feel more able to distinguish various perspectives and reason in a systematic manner. The facilitator as teacher focuses not on explaining moral theories and concepts, but helps the participants to reflect on their experiences, presuppositions and reasoning through a dialogical moral inquiry with others.

References


General discussion

Introduction

This thesis investigates various learning processes in *fostering and securing reflection on moral questions of professionals in health care practice*. It presents experiences in the field of practicing and organising clinical ethics including training health care professionals as facilitators of moral case deliberation (MCD). Learning through experiences in practice is an important element of a recent trend in the field of bioethics in which ethics evolved from an external critique of practices to a more ‘interactive’ and ‘embedded learning’ approach that aims at improving practices with the stakeholders involved (Abma et al 2010). The concepts of ‘interactive’ and ‘embedded learning’ are both important concepts in pragmatic hermeneutics which is the theoretical background of MCD. This philosophical approach is based on the assumption that practical experiences are the main source of moral knowledge and that learning processes are generated through interactive processes of reflection. This means that knowledge emerges through dialogical processes of reflection in which the exchange of perspectives leads to a broadening of view and new ways of thinking and dealing with practical (moral) issues (Widdershoven et al 2012). This
view on learning processes will also be the focus of this final Discussion chapter. The chapter presents and discusses the main findings of the various chapters in this thesis, and reflects upon the learning processes of the stakeholders involved, by interpreting the experiences in the processes of fostering moral learning, organising ethics and teaching facilitators, and the actions in which these learning processes have resulted.

In the General Introduction of this thesis (chapter 1), three research questions were presented:

a. What are the practical learning processes in fostering moral learning by means of Moral Case Deliberation?
b. What are the practical learning processes in organising clinical ethics, especially Moral Case Deliberation?
c. What are the practical learning processes in training healthcare professionals as facilitators of Moral Case Deliberation?

In this chapter, these research questions will be answered and reflected upon using the work of Donald Alan Schön on learning. First, his theory will be introduced. Next, the main findings of the various chapters will be presented, focusing on the practical learning processes of fostering moral learning, organising clinical ethics support (CES) and MCD, and teaching facilitators of moral learning. These findings will be related to the work of Schön, in order to get a deeper understanding of the main findings, but also to see what the findings might add to Schön’s theory. Next, the strengths and limitations of the studies will be addressed. Then, recommendations for practice and future research regarding moral learning will be provided. Finally some conclusions will be drawn.

The theory of Schön on learning and experience

This thesis investigates the notions of ‘learning’ and ‘experience’ in relation to MCD. These notions also play an important role in the work of Donald Alan Schön, elaborated in his books ‘The Reflective Practitioner’ (1983) and ‘Educating the Reflective Practitioner’ (1987), and other publications.
In contrast with the traditional way of teaching, which presupposes that students and practitioners acquire professional knowledge by learning technical knowledge and studying theories and concepts, Donald Schön introduces an experience-based approach which has a different view on professional knowledge and learning processes. This approach emphasises the role of practical experiences. Schön argues that educating students and practitioners in technical rationality ignores the important questions of practice; it neglects the actual experience of practitioners. This kind of education also ignores the context of practice, which is always unique, uncertain, uncontrolled, and often shows value conflicts. The experiences and context of practice do not correspond with categories of (scientific) theories and techniques (Schön 1995-1996; Kinsella 2010). A practitioner has to deal with a unique problematic situation. That means that the practitioner cannot treat the problem instrumentally by applying rules deriving from his or her professional knowledge, but he or she must reconcile and integrate (sometimes conflicting) appreciations of the situation (1987 p.5-6).

Schön emphasises that experiences in practice produce a specific kind of knowledge. He elaborates the ideas of Dewey about the concept of ‘professional artistry’ (1987 p.22). This concept refers to the kinds of competence that professionals show when dealing with difficult situations in practice and plays a central role in the description of professionals’ competence (Schön 1987 p.35). Schön argues that doing-good is not per se cognitively knowing-good. It is practically knowing-good. Whereas others interpret this as instinct or intuition, Schön proposes ‘a kind of knowing in the action itself’ (Schön 1995-1996). Reflection on practice can help to clarify and make this type of knowledge explicit, with the aim to improve practical wisdom and enhance professional artistry.

Schön’s view on learning and experience can be useful to deepen the reflections on the findings of the experiences and practical learning processes described in this thesis, including our own learning processes. It can be useful in reaching a better understanding of the various processes in fostering moral learning, in organising ethics and in teaching facilitators of moral learning.
Main findings and reflection

This section addresses the main findings of the various studies. In line with the research questions the findings are divided in three domains: the practical learning processes in A) fostering moral learning by means of MCD, B) organising ethics and MCD, and C) training facilitators of moral learning. For each domain, a summary of the main findings derived from the various chapters will be presented, followed by a reflection from the perspective of Schön, and comments on Schön’s views and concepts in the light of the main findings.

A. Practical learning processes in fostering moral learning by means of Moral Case Deliberation
Several practical processes of fostering moral learning have been described in the previous chapters. Chapter 2, 3 and 5 described processes of fostering moral learning by means of MCD in the context of a health care institution. Chapter 4 addressed the reflective process by means of a case-discussion from a MCD-session and reflected upon the process of moral learning in a group of health care practitioners. Chapter 8 elaborated on a specific conversation method for MCD, the dilemma method, which can be used to contribute to the process of fostering moral learning.

The findings in the studies about fostering moral learning provided insight into the experiences and learning processes of the participants in MCD and the facilitators of MCD. The following main findings stand out: 1) The importance of practical experiences, 2) The need to connect reflection to daily practice, 3) The importance of an equal say and of empowering all professionals in the reflective process.

1. The importance of practical experiences
The experiences with MCD showed the importance of practical and personal experiences in the reflection process. Each step in the structured reflection process assumes practical experience and personal involvement. For example, a participant in MCD starts with explaining to others what matters to him or her: what is the moral issue that he or she experience(d) in the situation? He or she should explain what is at stake within his or
her experience of that specific situation: what are *his or her* conflicting values and norms? The moral learning process continues with discovering and examining the differences in the participants’ *personal views* upon the moral issue (exchanging perspectives). Next, the participants, including the case-owner, consider their *personal choice* of doing good in this concrete situation including their personal considerations. Finally, the moral learning process ends with the formulation of concrete and practical actions in line with what the participants consider, based on *their personal view and experiences*, as good care in the *context of the case*.

Practical experiences are essential in the reflection process. They stimulate the participants in MCD to reflect upon and examine their personal ideas and presuppositions in relation to the concrete (facts of the) situation of the case. Without practical experiences the reflective process might digress into hypothetical reasoning about ‘what might or could be morally right to do’, without a connection to the actual situation. Consequently, the need to connect the reflection to the concrete situation of daily practice disappears.

2. **The need to connect reflection to daily practice**

Chapter 2 and 3 described the practice of fostering moral learning by means of MCD in *cross-organisational groups*. These groups, organised in monthly meetings, consist of diverse health care professionals working at different wards in the health care institution. Chapter 4 and 5, and indirectly in the example of the case discussion presented in chapter 8, described a process of fostering moral learning, organised in monthly and ad hoc meetings, with multi-disciplinary teams *on the ward*. Fostering moral reflection in cross-organisational groups and on the ward are different and complementary approaches. The idea of organising MCD meetings on the ward was triggered by the need of the MCD participants in the cross-organisational groups to connect their moral reflection with their daily practice, which included a reflection that is closely connected with their workplace and colleagues who are involved in the moral issues that are discussed in the MCD meetings. Due to the fact that the reflective processes of the participants in the multi-disciplinary groups on the ward were directly connected with their *daily practice* and their actual *experiences*, the processes of moral learning became strongly embedded. It also strongly encouraged the de-
development of professionals’ own moral knowledge and their own ability to deal with the complex situations and its ambivalences in their own practice. By facilitating moral learning processes on the ward (e.g. through MCD), a local reflective practice is created. This means that the moral issues at stake in MCD, the people who are directly or indirectly involved in those issues, and the location where the MCD is organised, are all directly connected to the concrete work environment in which one actually aims to deliver ‘good’ care. Furthermore, this strong connection contributed to the ownership of reflective practices: the health care professionals experienced the MCD meetings as their practice. Moreover, due to the connection and embedding in daily practice, MCD had a positive impact on team building processes at the specific wards.

3. The importance of an equal say and of empowering all professionals in the reflective process

Chapter 4 and 8 showed the importance of not only including the professions that are involved in the moral issue or case itself, but also the considerations of including other professions in the reflective process, whether or not they are explicitly involved in the moral issue or case. Specifically the chapter about ‘patients’ wishes to die’ (chapter 3) showed that each participant had his own valuable contribution in the moral learning process of the group, that led to new insight and knowledge about how to deal with the euthanasia policy in the institution. In the dialogical process in which moral learning was fostered, all the participants within the MCD had an equal say, in addition to the professionals that were not directly involved in patient care. In the process of exchanging and reflecting upon the experiences and views new perspectives were opened and the participants in MCD were compelled to respond to each other’s ideas and emotions. This multi-disciplinary character of reflective practice led to empowerment of all participants in MCD as moral agents. Furthermore it contributed to the moral learning processes of the whole group and enhanced a reflective practice in general.

Reflection on the findings in the light of the theory of Schön.

In line with our practice of fostering moral learning by means of MCD, Schön emphasises the importance of a reflective practice and the need for
concrete and real experiences. In the process of enhancing professional knowledge and competence, Schön stresses the necessity of the aspects of ‘reflection’ and ‘in practice’. He describes a reflective practice as ‘a critical assessment of one’s own behaviour as a means towards developing abilities in the workplace’ and ‘as a didactical process in which thought and action are integrally linked’ (Schön 1987, p.31). This description emphasises that in reflective practices a critical assessment can never be detached from the workplace, the practice or the practitioner himself. Moreover, it shows the need for an integration of thoughts and action in a reflective practice, which is similar to what happens in fostering moral learning by means of MCD; within MCD the facts in the case are constantly connected with and related to the participants’ thoughts and normative opinions.

According to Schön, fostering a reflecting process is necessary to raise the awareness of implicit normative frames that a practitioner inherently has and which he applies to daily issues. When practitioners are unaware of their normative frames, they do not experience the need to reflect on them and choose among them. With the absence of this awareness, one may consider reality as simply given or one may suffer from ‘overlearning’ (i.e. learning something which one already knows) that can lead to narrowness and rigidity (Schön 1983, p. 61). Schön acknowledges that a lot of knowledge already exists (‘tacit knowledge’) and is acquired by experience. However this knowledge cannot always be phrased in words (Schön 1995-1996). By reflecting on and examining actions in practice, practitioners critically investigate this tacit knowledge, make it explicit and become aware of their ‘normative templates’ (Schön 1983, p.61; Kinsella 2010). By making the implicit normative frames explicit, the practitioner becomes aware of the values and norms (to which he or she has given priority) and alternative ways of framing reality (Kinsella 2010).

Chapter 4 and more explicitly chapter 8 show that this is exactly what happen in processes of fostering moral learning by means of MCD. Through the exchange of views and the methodical structured approach, participants become aware of their own and others’ (normative) frames, values and norms, and of alternative ways to frame the moral problem. The awareness of their own and others’ values and norms can result in new insights with respect to the moral issues present in their daily practice. Sometimes, the new insights also lead to alternative ways of dealing with the
problems. The awareness of how others frame reality can also lead to mutual understanding of how others perceive the situation at hand (Weidema et al. 2013).

In the learning processes of a reflective practice Schön distinguishes two ways of reflection: reflection-on-action and reflection-in-action. The first one refers to a reflection process in which one thinks back on what one has done in order to discover how one’s knowing-in-action has contributed to a certain outcome (Schön 1987, p.26). It can be done afterwards or in the midst of the action. In either case there is no direct connection to present action. The second one, reflection-in-action, refers to the know-how people reveal in their intelligent action (Schön 1987, p.25). It is a period of time in which a practitioner, in response to surprise, reflects and reshapes what he or she is doing while he or she is actually doing it. Schön calls this the artistry of competent practitioners who are able to conduct on-the-spot experiments (Schön 1987, p.26, 28).

In the process of fostering moral learning of health professionals by means of MCD we conducted reflection-on-action by discussing retrospective or actual cases (see chapter 3 and 8). Health care professionals who participate regularly in MCD sessions develop skills (e.g. recognising, distinguishing and verbalising moral issues in daily practice; postponing initial judgements; refining of the patients) and an attitude of questioning themselves and others, which were useful in daily practice (see chapter 3). Thus, to reach the level of reflection-in-action, which enables health care professionals to connect their reflections to daily practice, it is essential to rehearse the exercise of MCD again and again. This leads to an artistry that enables health care professionals to reflect on their own actions while they are doing it, and at the same time to link the results of their reflection to further actions.

In the process of learning Schön distinguishes different abilities: the ability of reflection ‘in’ and ‘on’ action and the ability of verbalising actions and what one is thinking. A practitioner might be able to reflect ‘in’ and ‘on’ the action, but verbalising it and reflecting on the results are two other abilities. The studies about moral learning in MCD sessions shows how the two other abilities emerge in MCD: the participants learned, also via other participants in MCD, to reflect upon and formulate their actions and their
thinking (see chapter 2 and chapter 8, step 2-6 in the dilemma method). At the same time, during MCD, participants learn an attitude that enables them to reflect on the site, on what has been said (by themself or others) and on the results of the reflection process (see chapter 3 and chapter 8, step 7-10 in the dilemma method).

**Reflection on the theory of Schön in light of the findings**
Both the approach and theoretical framework of MCD and the theory of Schön emphasise the crucial contribution of ‘experience’ in the process of moral learning. What is not explicitly mentioned or described in Schön’s theory about reflection ‘in’ and ‘on’ action is the role and contribution of including other perspectives; perspectives which are not directly related or involved in the actual experience or situation. Furthermore, the importance of the exchange of views based on an equal say in the reflection process is not explicitly described within Schön’s theory. Whereas Schön mainly describes reflection processes in which a practitioner learns (by means of his or her own experiences, to criticise his or her own (tacit) knowledge and to explicate his or her normative ideas and frameworks), our third finding emphasises the relevance of an equal say and the role that other perspectives can play in the learning process of a reflective practice such as MCD.

**B. Practical learning processes in organising clinical ethics, especially MCD**
Chapter 2, 3 and 5 are case-studies of experiences and learning processes in organising clinical ethics (support) in health care institutions. Based on these studies, the following main findings stand out: 1) There are various ways of Clinical Ethics Support (CES) that can support and improve structural moral reflection, 2) Implementing moral reflection by means of MCD calls for creating (co-)ownership, and 3) Implementing moral reflection by means of MCD requires an ongoing learning environment at an organisational level.
1. There are various ways of CES that can support and improve structural moral reflection

Chapter 2 and 4 described the process of organising ethics in the context of a psychiatric and an academic hospital, focusing on MCD, as an instrument that fosters moral learning in multidisciplinary groups. However, the results in chapter 6 showed that there is a need for various forms of CES. This means that reflecting on moral issues in practice is not restricted to MCD; depending on the specific needs and goals of those involved, reflection can be organised and facilitated in many ways. This also means that MCD should not be considered as an alternative for ethics committees. Neither should it be seen as an alternative for informal interactions and more implicit reflections on moral questions in daily practice. MCD rather provides an add-on service; it functions as a complement to other clinical ethics support services, enabling structured reflection on moral experiences.

2. Implementing moral reflection by means of MCD calls for creating (co-)ownership

An insight stemming from the practical learning processes in organising ethics is the importance of creating (co-)ownership. This issue was addressed specifically in chapter 5, which described our experiences in organising ethics in an academic context. As the study showed, we experienced not only the need for a firm back-up from management but also the need for dedicated local health care professionals from the ward who are willing to adopt the tasks and responsibilities of implementing and embedding MCD on their ward. Creating structural reflection within a health care organisation implies several responsibilities and organisational tasks that have to be adopted on diverse levels in an organisation (Weidema et al 2011a). To create (co-)ownership on the ward level, we experienced the benefit of appointing two local professionals on each ward, preferably a medical doctor and a nurse or team leader, who gradually took up the tasks and responsibilities of organising content, time and place for MCD on their ward. Furthermore, we experienced the need for specific support and supervision for the so called ‘local MCD coordinators’ (Weidema et al 2011a). Next, we experienced the additional value of the presence of health care professionals who were trained as MCD facilitators. On the wards with trained facilitators of MCD within their team, we noticed enhanced
(co-)ownership, as these facilitators made health care professionals and the local MCD coordinators aware of the need and the actual contribution of MCD to their work. Moreover, by appointing and discussing new moral issues at the moment they emerged, the trained facilitators stimulated the moral reflection with and amongst their colleagues. By doing so, they made the moral learning processes even more contextual and therefore more meaningful; it contributed to the learning processes of reflection-in-action. Having trained facilitators of MCD on the ward improved the reflective climate and increased the change of a more embedded moral reflection in daily practice (see van der Dam et al 2012).

3. Implementing moral reflection by means of MCD requires an ongoing learning environment at the organisational level

Related to the previous finding is the importance of and need for an ongoing learning environment at an organisational level. Chapter 2, 3 and 5 described the experiences of several projects of implementing and embedding MCD. Particularly the studies of implementing MCD in a psychiatric hospital (chapter 3) and in an academic context (chapter 5) showed that when a health care organisation aims to foster moral learning and considers it as part of professional competencies of health care practitioners, possibilities – in terms of time, money and support – should be created for practitioners to develop and enhance their moral competencies. We have learned that it should be the concern of a health care organisation to develop an implementation policy for a reflective practice in which moral learning can flourish and participants can develop or enhance their moral competencies (see also Weidema et al 2011 and Weidema et al 2014). Introducing an active project group and steering group contributes to the coaching and support of the health care organisations in organising and implementing their clinical ethics policies and MCD (chapter 2, 3 and 5). Both groups have their own tasks and responsibilities regarding the organisational aspects of either practical or management issues of implementing MCD. Both groups can bring forward their views and ideas about the way ethics support should be organised in their institution. With the active involvement of these groups the awareness for the need of a reflective practice on all levels within the organisation increases, which supports all stakeholders (e.g. local MCD coordinators, facilitators of MCD). It also improves the learning processes of
the implementers and researchers (i.e. ourselves). Next, the project group and steering group contribute strongly to the process of embedding the organisation and implementation of MCD within the culture, identity and ideas of the healthcare institution in general and more specific of the wards and teams. Thus, the inclusion of all stakeholders is necessary for creating reflective practices and the actual reflections on the moral issues within MCD (see General Introduction and section A). The inclusion of all stakeholders is also indispensable in the practice of organising ethics support; it contributes to an open atmosphere and interaction amongst the healthcare professionals, implementers and the researchers, monitoring the process of implementation and creating possibilities for necessary changes or corrections in the creation of an ongoing learning process throughout the whole healthcare institution.

**Reflection on the findings in the light of the theory of Schön**

The teaching processes that Schön describes, emphasise the contribution and role of the dialogue between coach and student (Schön 1987, p.100-118). Although the context of teaching is not comparable with processes of implementing and organising clinical ethics (support), his view on coaching can be used for reflection on the interaction between the implementers (including the researcher) and the healthcare institution or the ward. Schön refers to a dialogical way of coaching in which, in the situation of organising clinical ethics and MCD, the implementers and the healthcare institution or ward both bring their own specific experience and expertise for building 'a capacity for a particular kind of dialogue, that they see at first in such divergent ways' (Schön 1987, p.101). He distinguishes three essential features of the dialogue: a) it takes place in the context in which one attempts an action, b) it makes use of actions and words; and c) 'it depends on reciprocal reflection-in-action' (p.101). In the process of reflection he refers to reflection upon the process and upon the product, so that both provide material for reciprocal reflection-in-action (Schön 1987, p. 118).

This dialogical way of coaching corresponds with our approach of implementing moral reflection that aims to foster a dialogue in order to foster ethics support. It emphasises, like Schön’s concept of reciprocal reflection-in-action, the pragmatic process of learning by doing in organising and implementing ethics support. The parallel also applies to practicing research
in the tradition of Action Research and Responsive Evaluation, both of which are forms of reflection that aim to build on and generate experiential knowledge within practice through a process of reflection. This implies a cyclic process of presenting and reflecting upon temporary results based on experiences and research. Through this process in and within practice, the stakeholders and researchers monitor and adjust the scope of research and adapt or translate these results into concrete actions. This form of pragmatic reflection research, in which stakeholders are closely involved in the process of research, stimulates, creates and increases not only ownership of the research process, but also the actual moral learning processes.

Schön describes various elements of the dialogue between the coach and a student: 'telling and listening' and 'demonstrating and imitating.' ‘Telling and listening’ refers to a way of coaching in the context of the action (of the student). Schön considers this form of reflection as ‘a heightened potential for efficacy’ (Schön 1987, p.103). ‘Demonstration and imitation’ refers to a way of coaching in which the student can either choose to reproduce a process or copy the product. However, Schön recommends a combination of both ways of coaching in which the ‘verbal description can provide clues to the essential features of a demonstration, and demonstration can make clear the kind of performance denoted by a description that at first seems vague or obscure’ (Schön 1987, p. 112).

Both ways of coaching described by Schön provide insights in the practical learning processes of organising ethics. Our contextual approach of organising ethics support, presented in the chapters 2, 3 and 5, which aims to connect with and trying to embed the practice of ethical reflection in the identity, culture and specific structure of a health care organisation or ward, can be regarded as an instance of the coaching form of ‘telling and listening.’ ‘Demonstrating and imitating’ applies to the way we use and present the results of (learning) experiences in organising ethics support, inside and outside the health care institution. In our studies we mainly used these results to monitor the organisation and implementation process of CES in a particular health care institution. However, the results of the learning experiences within our studies show a diversity of practicing CES in various health care organisations, teams and wards. Other health care institutions or wards may benefit by adapting or imitating one of these ways of organising CES, which can again be monitored and facilitated in
a reciprocal process of reflection-in-action, resulting in an ongoing cyclic process of learning.

According to Schön, an optimal effective learning process in interaction between teacher and student requires a ‘learning circle’ which is characterized by mutual dependency (Schön 1987, p. 118). The learning circle entails an interaction in which the coach ‘must learn ways of showing and telling’, which, in the situation of organising clinical ethics and MCD, match *the peculiar situation and qualities* of a ward or a health care organisation that organises the CES. He or she has to learn ‘how to read the particular difficulties and potentials from the efforts at performance’ of a ward or health care institution regarding the experiences with CES and ‘discover and test’ what a ward or health care institution makes of the interventions (Schön 1987, p. 118). Schön continues with specifying the meaning of the role of the coach in the context of a dialogue and stresses ‘every attempt to produce an instruction is an experiment that tests both the coaches’ reflection on his own knowing-in-action and his understanding of the difficulties’ of the other(s)’ (p. 104). On the other hand, a ward or health care institution is expected to learn operative listening, reflective imitation, and reflection on his own knowing-in-action.

The interactive and dialogical approach of coaching which Schön describes, shows the need for a careful consideration in the search for a form of CES that fits in the context of the particular health care organisation or ward. Secondly, it emphasises the role of a continuous process of reflection-in-action, particularly in the process of coaching in organising CES. In general, it refers also to the process of creating a learning environment that starts with learning together in the search for the meaning of ‘a good organisation of CES’ and continues in creating a climate of an ongoing learning environment throughout the whole organisation.

*Reflection on the theory of Schön in the light of the findings*

Schön’s concept of a dialogical way of teaching and coaching assumes a situation of a party who has to learn (the student) and a party who already knows (the teacher). In the studies of organising clinical ethics presented in this thesis, the concept of dialogue has a different meaning: it entails the expertise of all parties involved. Likewise, in the research design in this thesis, dialogue implies an exchange of views (‘telling and listening’) between all
parties involved. Each party has a different know-how and there is no hierarchy in expertise, and no interaction in which one is educating the other. Although we as researchers had our experiences and expertise in organising CES and fostering moral learning, and could therefore claim our role as teacher, we at the same time had to listen carefully to other stakeholders and their expertise, to link up with the structures and specific culture of the particular health care organisation in order to make the processes of organising ethics and moral learning work out in the setting. This approach to dialogue, which is embedded in the tradition of pragmatic hermeneutics (see General Introduction) implies respecting and using the expertise of all stakeholders. Organising CES is like investigating a moral issue in MCD: it is a joint learning process in which all stakeholders participate in the inquiry of ‘the best way to implement CES’ and each has expertise which equally contributes to this joint search. This requires a particular approach in organising CES in each specific health care institution and ward.

The second issue which needs to be addressed regards Schön’s description of the attitudes of the coach and the student. According to Schön, the coach tries to respond to the learning process of the student with advice, criticism, explanations, descriptions and performances of his own. Schön describes the students’ attitude as ‘being willing to try something (……) while still retaining a sense of responsibility for self-education’ (Schön 1987 p120, 163). As mentioned before, the teaching context in which Schön frames the attitude of a coach and student is not comparable with the context of organising and implementing CES, since the latter is not characterized by a relationship of dependency. Moreover, as addressed in the previous issue, the interactive and dialogical approach of MCD projects assumes an equal say and expertise of all parties involved. Thus, the attitudes of the participants in implementing MCD are less complementary than Schön envisages.

Although the results in this thesis show the importance of equality in the process of implementing CES, sometimes the type of coaching that Schön describes can be needed. Organising ethics for and with a health care institution or ward means a ‘willingness to try’ new ways of improving the professionalism of their health care practitioners and ‘retaining a sense of responsibility’ to make this CES function as a form of self-education. Implementers of CES sometimes have to ‘invent on the spot many strate-
gies of instructing, questioning, and describing – all aimed at responding to the difficulties and potentials’ of the particularity of the setting (Schön 1987, p.105). In some cases, similar to a teacher and student interaction, (a part of) a health care organisation is not (sufficiently) willing, or contextual features in organising ethics support obstruct the learning process (Schön 1987, p. 119-156). This requires extra effort and investment of both parties to find the right stance or level for a dialogue with the aim to create a constructive learning process in which both can benefit and improve.

C. Practical learning processes in training health care professionals as facilitators of moral learning

During the years of developing, (re)designing and facilitating the training program for facilitators of MCD, processes of learning took place, inspired by feedback and input of trainees, trainers and people that were involved in the development and facilitation process (such as education experts). These learning processes resulted in new views on teaching facilitators of moral learning, on the organisational side and on the content and didactics of the teaching program. Based on these learning processes, the following main findings concerning training facilitators of moral learning can be formulated: 1) From doing by learning to learning by doing, 2) A shift in the role of trainer: from expert-teacher to a Socratic-coach, 3) A change in organisational aspects of the training facilitators of MCD, and 4) A search for appropriate didactical tools for stimulating the reflection process on the role of facilitator of moral learning.

1. From doing by learning to learning by doing

Chapter 2 and chapter 7 described the changes over the years regarding the view on fostering moral learning and teaching facilitators of moral learning. In the beginning, a traditional way of teaching was used, offering literature and lectures and showing examples of experts. Gradually, the training program was changed into a practice-oriented approach that emphasises the concept of experiential learning and ‘learning by doing’. The academic literature was replaced by short articles and hand-outs addressing specific topics of facilitating MCD based on concrete experiences with trainees. This resulted in extra time for exercising the actual process
of MCD (or specific skills of the MCD facilitator) and subsequent reflection on the experiences by the participants. Furthermore, a buddy-system was introduced, aiming to stimulate reflection and discussion among the trainees about the meaning of a ‘good facilitator’. This change in view on transferring expertise was based on practical teaching experiences and a process of reflection on these experiences in the light of the theoretical assumptions underlying MCD and facilitating MCD. Experiential learning imposes the active use of existing knowledge and skills. It elaborates on what one has learned through the process of experience and it stimulates reflection on the experiences. This is in line with the theoretical framework of MCD (pragmatic hermeneutics) that starts with the assumptions that (moral) knowledge is related to and grounded in experience and that practical wisdom is the source of (moral) knowledge. The current training program offers many practical exercises in facilitating MCD (experiential learning) that are practiced both within the training session supervised by a trainer (learning in action) and in their own team or institution with the help of colleague-trainees (reflection on action).

2. A shift in the role of trainer: from an expert-teacher to a Socratic coach
In line with the previous finding, the role of trainer shifted from an expert-teacher to a Socratic coach. Instead of putting the emphasis on (theoretical) knowledge by lecturing about theories and showing examples of the concept and practice of MCD, a coaching style was developed in which the art of Socratic questioning became the core activity aiming to accentuate the contribution of experienced based learning and the reflection upon those learning processes. This enabled a shift in the focus of the training from teaching ‘the profile of a good facilitator’ to an inquiry amongst participants of what it means to be a good facilitator of MCD, based on their own experiences and reflections (and on that of others such as trainees, trainers and participants in the MCD session). Instead of telling the trainee what he or she should do (or not do), the trainer starts a reflection process and dialogue with the facilitator of MCD and the other trainees.
3. A change in organisational aspects of the training: new entry-conditions, a follow-up training program and fostering awareness of the double role of the facilitator

Based on the studies, new insights were gained concerning the organisational aspects of the training.

The first insight refers to the ‘entry-conditions’ of the facilitator training. As both chapter 2 and 7 show, the procedures about the preconditions for those who want to participate in the training program were adapted. Whereas, initially, ethical knowledge was considered as one of the features that would support a trainee in his learning process to become a good facilitator of moral learning, this turned out to be less relevant over the years. Of more importance was the trainees’ ability to incorporate the concept of MCD into his attitude and skills in the role of facilitator. A decline in the learning curve of a trainee (in the role of a facilitator) was mostly not related to a lack of knowledge about theories and ethical concepts. Instead, prior experience with participating in MCD affected the learning process of the trainee much more. This insight led to a change in the entry conditions, stipulating that those who applied for the training should have experienced MCD as a participant at least three times before the start of the training.

The second insight is the acknowledgement of the importance of a follow-up plan once trainees have finished their training. In the case of a car-driver, who has received his driving license, nobody assumes that being certified guarantees being a ‘good’ driver. Indeed, one easily acknowledges that a driver needs driving experience in order to keep up his skills and become a good driver. This is also the case with trained facilitators of MCD; once a health care institution considers implementing MCD through training facilitators, we strongly advise the inclusion of a follow-up plan for the facilitators in which they can continue to practice and reflect upon their role of facilitator of MCD. An ongoing learning environment for moral learning throughout the whole organisation also includes ongoing attention for the learning process of the trained facilitators.

The third insight concerns the necessity to critically examine whether managers or team leaders can be the facilitator of MCD sessions within their own teams. To foster a dialogue and a moral inquiry requires a safe climate and atmosphere that encourage participants to speak open and freely (see also: Abma et al 2009, Weidema et al 2014). This aspect of training
health care professionals might be at risk or can be obstructed in case a trainee is a powerful or influential person within the institution. Although facilitators with a double role can certainly be able to foster a sincere dialogue, this topic deserves attention, and needs to be put this on the agenda before starting a training program in a health care institution.

4. A search for appropriate didactical tools
As chapter 7 (and indirectly chapter 8) describes, various didactical tools were developed over the years, based on the principle of experiencing and practicing the role of facilitator. The search for appropriate tools emanated from the development and experiences described in finding 1 and 2 above. The methods and tools should be in line with the view on learning in and within practice by means of reflection; didactic tools that stimulate experiential learning and the reflections on the role of facilitator, enlarge the practical knowledge of fostering a dialogue and moral inquiry, and integrate theory of MCD with the trainees’ experiences and practical wisdom. This resulted in the following didactical tools: a refined conversation method for moral learning (the dilemma method as described in chapter 8), 16 handouts (short notes about a specific topic of facilitating MCD in which existing theories are incorporated), video-recording of MCD exercises including reflection instructions, assessment formats of the facilitator consisting of a self-reflection questionnaire for the trainee, and an observation questionnaire (for a buddy trainee or supervisor) and exercises which focus on specific facilitator skills (i.e. asking factual questions; finding and formulating the key moral question).

Reflection on the findings in the light of the theory of Schön
In this section, the theory of Schön will serve as a basis for reflection upon three issues: 1) learning by doing, 2) the trainer as Socratic coach, and 3) the role of didactical tools.

1. Learning by doing
The concept ‘learning by doing,’ is described by Schön as a ‘felt-path’ in which a student or trainee learns to discern what he or she knows-in-action (Schön 1995-1996). It refers to the ‘sorts of know-how one reveals in his or her intelligent action,’ which is ‘publicly observable’ and shows ‘physi-
cal performances’ (Schön 1987, p. 25). Schön compares this with riding a bicycle; the majority of people reveal practical knowledge by spontaneous skilful execution of performance, yet most of us are unable to make this verbally explicit. In the training program we use the notion of ‘learning by doing’ to support the trainee in gaining and revealing his know-how about the role of facilitator of MCD.

Schön (1995-1996) suggests some steps to create a felt-path in which the intertwined process of thinking and doing derives. There are clear similarities between these steps and the learning process of a trainee becoming a facilitator MCD. Schön distinguishes four steps. First, a student should do the thing before knowing what it actually is. In our training program this was manifested in the entry-conditions we imposed of experiencing what moral learning is by participating in MCD. Second, a student starts to perform in the presence of a competent senior practitioner who tries to help the trainee to learn and acquire the skills and attitude. In our training sessions, the trainee starts to exercise MCD and the role of facilitator of moral learning together with the other trainees in the presence of a trainer who can support and coach the trainee in his or her learning process of facilitating moral learning by means of MCD. Exercising together with the other trainees in the training sessions complies with the third step: the student is performing with other students who are also trying to learn to do it. The fourth and final step, according to Schön, is ‘doing it in a virtual world that represents the practice’ (Schön 1995-1996). This process of facilitating in ‘a virtual world that represents the practice’ happens in the exercises of MCD in the training sessions. In our training program we added an extra step in the felt-path which is exercising the role of facilitator in ‘a real world’, in their own team or organisation.

2. The trainer as Socratic coach
Schön describes a specific attitude of the trainer or coach to encourage the process of reflection in action: ‘The coaches will emphasise indeterminate zones of practice and reflective conversations with the materials of a situation’ (Schön 1987 p40). The current role of the trainer in our training program is similar to Schön’s idea of the role of teacher. It is based on the hermeneutic assumption that the meaning of being a ‘good facilitator’ is not given beforehand. It is contextual and should be discovered and found
out through practical experiences and reflections on those experiences. Socratic questioning aims to increase practical wisdom about the process of facilitating MCD. It has several goals. First, Socratic questioning aims to develop the trainee’s ability to reflect on the role of facilitator and the attitude and skills of a ‘good facilitator’. Second, Socratic questioning aims to make the tacit knowledge of a trainee explicit and to connect it with the actual experience. It enables the trainee to use the tacit knowledge and to start a learning process about the concept of a good facilitator by using the experience and the context of the current situation. Third, Socratic questioning aims to encourage the trainee to reflect upon and develop his or her own style as facilitator in line with conceptual ideas of being a ‘good facilitator’. To do so means, according to Schön, that a trainer ‘is capable of inventing on the spot many strategies of instructing, questioning and describing’ – all aimed at responding to the difficulties and potentials of a particular student (Schön 1987, p.105).

3. The role of didactical tools
In the description of a reflective practice, Schön emphasises the integration of thinking and doing through dialogue. A reflective practice is a ‘dialogue of thinking and doing through which one becomes more skilful’ (Schön 1987, p. 31; Kinsella 2010). As described in section B, Schön distinguishes various components of a dialogical approach to coaching (i.e. telling, listening, demonstrating and imitating). These components are visible in the tools we developed to stimulate the trainees’ search for the meaning of a ‘good’ facilitator, their critical self-assessment, and the improvement of the skills of the trainees in their role as facilitator of MCD. For example: ‘telling’ is presented in hand-outs and presentations of the trainers during the training session; ‘listening’ is presented in observations of the exercises of MCD in the training sessions; ‘imitating’ is presented in the video-recording.

Reflection on the theory of Schön in the light of the findings
In reflecting on the theory of Schön in light of the findings, the following topics will be addressed: 1) the role of theory, 2) the normativity of a trainer and facilitator of MCD, and 3) the quality and assessment of trainees.
1. The role of theory

As shown above, practical exercises and the dialogical approach of the trainers are the main sources in developing practical wisdom concerning the role of a facilitator of moral learning. This experience-based approach is similar to Schön’s theory of ‘learning by doing’. However, in the concept of Schön, the connection between experiences and theory has been lost somehow. This involves the risk that practical wisdom might be equated to tricks and recipes that work in practice without a solid theoretical backing. In the development of the training program, we avoided this risk by relating tools to hermeneutic theory, both for ourselves and for the trainees.

As described above, the content and program of the training, over the years became less focused on theory, and more on ‘learning by doing’. Yet, theory was not eliminated completely. Literature was selected with a clear relevance for the practical exercises. Although theory can be static and detached from the particular and specific situation, as Schön warns, it can also help the logical structuring and understanding of phenomena in experiences (Lunenberg & Korthagen, 2009). Lunenberg & Korthagen (2009) present a triangular relationship between practical wisdom, theory and experience (see figure 9.1). Ideally the three elements should be embodied in the trainer (or teacher) and the training program. The interaction between them depends on how the trainer combines them in the practice of teaching and coaching the trainees.
Although Lunenberg & Korthagen (2009) criticise experience-based approaches, they acknowledge that there are fruitful approaches which start from experience. They distinguish three approaches in which theory and practical wisdom are incorporated: 1) Studying cases, observations, watching videos, 2) Detailed reflections on students’ own practices, and 3) Self-study research in which teachers or trainers analyse their own professional development setting an example (role-modelling). The underlying view is that trainee's professional learning will be more effective when he or she reflects in detail on his or her experiences (Korthagen 2001, p. 71). Lunenberg and Korthagen emphasise the need for an analysis of a small part of the exercise and claim that the more specific the analysis, the more a trainee is supported in developing practical wisdom and thus sensitivity to the particulars of situations of facilitating moral learning processes (Lunenberg & Korthagen 2009).

The current design of the training program facilitator MCD aims to connect ethical theories and concepts with practical experience during the training sessions and the exercises that trainees practice in between the training sessions. The didactical tools described above are in line with the approach which Lunenberg & Korthagen suggest. Evaluations of training programs and sessions shows that trainees appreciate the didactical tools. The hand-outs reduced the amount of literature, but provided important theoretical subjects in ethics or (facilitating) MCD. The video-recording supported them in reflecting (in a detailed way) on specific parts of the facilitation process and the assessment questionnaires were helpful to reflect on their skills and attitude in detail.

2. The normativity of a trainer and facilitator MCD
A second issue that follows from the main findings is the tension between the need for an open dialogue on what counts as a good facilitator, and the normativity concerning the concept of a good facilitator which underlies the training program. The approach of learning by doing implies an open and safe environment in which the trainee can learn and discover his or her own style of facilitating MCD. To encourage the learning process, the trainer practices the role of a Socratic coach, observing and questioning the trainees, instead of using Schön’s concept of ‘telling and demonstrating’ by using knowledge and expertise. However, at the same time, normative ideas
about the profile of ‘a good facilitator of MCD’ underlie the training. For example, in the training, the importance of a Socratic attitude as a facilitator of MCD is emphasized. The same applies to the role of facilitator: he or she is supposed to ask questions to stimulate reflection on the moral issue and dialogue among the participants of MCD. The trainer is also normative when performing a role-model during the training program. Implicitly or explicitly, the trainer will show the specific attitude of a facilitator MCD or the specific way of fostering a dialogue. Often, trainees also ask for normativity of the trainer, for example, in the assessment process of their quality as trainee-facilitator. In a Socratic and dialogical approach, the normativity of the trainer is not a definite judgment, but an invitation to the participants to reflect on their experiences, to become aware of their own normative frames and values, and to stimulate exchange of perspectives. Yet, normativity of the trainer is always at work.

The tension mentioned above can also be recognized in Schön’s work, for instance in the combination of listening and telling, and in the notion of giving an example to the student. Schön, however, does not address the tension explicitly. Our results show the importance of being aware of one’s own normativity and reflecting on the way in which to combine this with a dialogical stance. This need for awareness and reflection is not explicitly addressed in Schön’s view on ‘learning by doing’.

3. Quality and Assessment of the trainees
Schön does not mention the issue of assessing the student. However, this issue is important, both for the trainers and for the trainees. A trainee might demonstrate a high level of knowledge about MCD, but this does not automatically guarantee being a ‘good’ facilitator of moral learning. Theoretical knowledge is not a criterion for having skills, but having done practical exercises may also be insufficient. Schön’s model of the four steps felt-path (see above) seems to assume that once a student or trainee has gone through the last step, he or she is skilled and has reached the level of ‘professional artistry’ that is characteristic of a competent practitioner who is able to reflect-in-action (Schön 1987, p. 22). Yet, in order to assess whether a trainee has reached the level of ‘professional artistry’, a concrete tool can be useful that describes the features of a ‘good’ facilitator (see chapter 7). We developed a (reflection and observation) questionnaire
that served both as a tool for the trainers in the assessment of the trainees and for the trainees to reflect on their actions in the exercises during the training program. This tool has also been useful for certified facilitators to keep up their own quality and skills as a facilitator by using the questionnaires as a reflection tool. Yet, the question remains how to use the tool in order to judge the facilitator-trainee, or to audit the quality, skills and knowledge of facilitators of MCD once they are certified. This question has not been answered in this thesis. It still is a central issue in the current debates in the USA on certification of ethics consultants (see for example the ASBH code of ethics for professional clinical ethics consultants, Tarzian et al 2013).

Quality, strengths and limitations of the studies

Reflection on the methodology that has been used in this thesis is important in order to assess the quality of the studies. Characteristic for the methodologies case-study, Action Research and Responsive Evaluation is starting with every day experiences and examining situational knowledge. In the studies presented, this way of conducting research, focusing on knowing-in-action, emerged over time in an evolutionary and developmental process, in which the process of inquiry is as important as the specific outcomes (Reason 2006). That implies that the research cannot be programmed in pre-defined steps, thus it is difficult to define quality and justify the choices made. Therefore, Reason (2006) suggests to put the researchers’ choices under multi-perspective scrutiny. He emphasises that quality rests on stimulating an open discussion and therefore emphasises the importance of transparency. These suggestions fit in with our hermeneutic view on research and practice. There are many realities or perspectives alongside each other, which can merge in a dialogical approach to drawing conclusions. In this section, first the quality criteria of credibility and transferability will be addressed, in order to foster accountability for the methodology of the studies. Next, the strengths and limitations of the studies will be discussed.
Credibility

Credibility refers to the trustworthiness of the research and the degree of correspondence between the researchers’ interpretation and the participants’ perspectives. In the studies several actions were taken to enhance credibility. Member checks were organised, in which the interpretations of data from interviews and questionnaires were shared with the stakeholders (participants in MCD, initiators of implementing MCD, trainees and trainers). The process of creating inter-subjective knowledge provided the opportunity for a continuous process of interaction with the stakeholders including checking the findings. This member check happened both on an individual level (in the case of interviews), by sending a summary of the interview to the interviewee, and in organised meetings with the stakeholders, such as focus groups (for example with certified facilitators of MCD) and project and steering group meetings (with the initiators of implementing MCD). Member checks also took place in natural settings such as evaluations in training sessions or in the feedback of observations of facilitators of MCD.

Moreover, the credibility of the studies was enhanced by sharing results in peer meetings with colleagues (e.g. other trainers or researchers), and during international conferences and seminars. These debriefings aimed to encourage the awareness and reflection on prejudices and theoretical assumptions and to stimulate an interdisciplinary dialogue about the theoretical framework and practical experiences and findings of moral learning.

Also, multiple data collection methods were used in the separate studies (such as: interviews, questionnaires, observations) together with a naturalistic approach to the data collection. Several research methods were used to study phenomena in its natural settings, such as the process of moral learning (Patton 2002, p.39). Next, the separate studies reflect a development process over years and an iterative process in which data sets and findings were used as input for data collection activities in latter stages of the research to refine the findings and outcomes. For example, in chapter 7, data collected in the study of chapter 2 were used.
Transferability
Transferability refers to ‘the empirical process of checking the degree of similarity between sending and receiving contexts’ (Guba & Lincoln, 1989 p.241). In the research designs of case study and Action Research including Responsive Evaluation, a unique situation is being studied. The focus in the study is on the uniqueness, the local and particular issues of that context (Kelly & Simpson 2001; Stake 2013). To reach transferability one needs to provide a thick and detailed description of the context, stakeholders and meaning in order to reach generalization. This thick-detailed description makes the reader able to note comparable items in other contexts. However, because a unique situation is studied, generalizability is not interpreted as comparability in a standard way (Kelly & Simpson 2001). The aim is to engender understanding of a local situation which may have meaning for others and can be transferred to other situations (Abma & Stake 2001). The studies in this thesis aimed to foster the transferability by providing the reader with detailed descriptions about, for example, the practice of organising and fostering moral learning in health care institutions (chapter 2, 3, 4 and chapter 5). Chapter 7 and 8 provided detailed descriptions about the design, content and didactical tools of the training program and about the way the conversation method has been used and trained. By doing so, conditions were created for the reader to have ‘vicarious experiences’ (Stake 1995, p. 86). The detailed descriptions may have learning potential for those who are struggling with fostering moral learning, or organising ethics, or teaching facilitators of moral learning.

Strengths and limitations
The studies in this thesis have several strengths and limitations. A first strength is the use of three research methodologies namely case study, Action Research and Responsive Evaluation. The choice of these three research methodologies was motivated by the intention to study and evaluate phenomena in their natural (context-specific) setting. These three methods are distinctive and complementary to each other; each research design has its own focus, which provides the opportunity for in-depth separate studies on one hand, and a broad scope including various types of studies (of moral learning processes, the organisation and implementation of ethics and teaching moral learning) on the other hand.
Responsive Evaluation, as a structured form of Action Research, has been particularly useful to study the experiences and learning processes in facilitating and implementing moral learning and MCD in health care institutions (chapter 2 and 3). In the method of Responsive Evaluation, stakeholders are actively involved in the dialogical process, aiming to foster mutual learning and shared ownership of the implementation of MCD.

The latter relates to a second strength, which is the involvement of all stakeholders including participants in MCD, initiators of implementing MCD, trainees, trainers, and researchers. Their perspectives gave a rich understanding of the experiences in fostering learning processes. However, the absence of the experiences of patients or clients might be considered as a weakness in some of the studies, especially because it is a characteristic in the methodology of Responsive Evaluation to include patients and clients (Abma et al 2009; Nierse et al 2012). Participation of clients in MCD can be found in some health care institutions (Weidema et al 2011b). Including the perspective of patients or clients in the studies about learning processes of fostering moral learning might have provided additional and different insights in the character of joint moral learning processes among patients and health care professionals.

As mentioned in the General Introduction, the researcher has a particular role in the tradition of Action Research and Responsive Evaluation. He or she has an insider role that typifies a close cooperation with the other stakeholders. This insider-role offers both pros and cons in the process of studying fostering moral learning, organising ethics and training facilitators of moral learning. As an insider, the researcher is part of the social world being studied and thus influences the research process and interpretation of the data. Postholma & Skrøvset (2013) refer to this as ‘creating an intersubjective knowledge’ between the stakeholders under study and the researcher him- or herself. A close involvement and being part of the research process and interpretation of the data might become an obstacle for the researcher. At the same time, those processes can provide insightful data that might never have been provided if a researcher had an outsider role. In the types of studies presented in this thesis, which aimed to gain insight and knowledge with and within practice, creating intersubjective knowledge is crucial and a necessity. For example, the lessons learned during the years of developing and adapting the training program
Recommendations for research and practice

In this section, future challenges and recommendations for practice and research are presented, in line with the three research questions: moral learning processes in practice, organising clinical ethics support, and training facilitators of moral learning. Since in this thesis practice and research are interwoven, the recommendations relate to both, focusing sometimes more explicitly on practice, and sometimes on research.

Moral learning processes in practice
In the search for ways to improve the practice of fostering moral learning and in line with Schön’s concept of reflection-in-action, it is important to a) examine what participants learn within the moral learning processes, differentiated in terms of knowledge, skills and attitude, and b) how they carry out and embed the lessons learned in their actions in daily practice. Related to this challenge, it would be interesting to examine in and within practice which other instruments of CES (next to MCD) support moral
learning and enhance the professionals’ reflection-in-action and in what way they contribute to the process of moral learning.

Related to the practice of fostering moral learning, further research is desirable on how patients and health care professionals learn together when both participating in CES and in MCD in particular. Research has shown the contribution and added value of the participation of patients (Weidema et al. 2011b). However, it is not clear how moral learning processes take place when both are participating in MCD and in which way the learning processes of both groups differ from each other, and what the specific requirements or conditions are for fostering joint learning processes between patients and health care professionals.

Organising clinical ethics support
In comparison to the attention for doing CES, attention for organising CES is often scarce. Following the findings about organising CES and the reflection upon them using the theory of Schön, in particular his concept of learning by ‘demonstrating and imitation,’ it would be fruitful to make use of the existing expertise and experiences of many health care organisations in which CES is organised. The creation of a professional network, in which health care institutions and CES staff can demonstrate and exchange their CES practices and also their knowledge about organising them, will be helpful in learning from each other (Molewijk et al. 2015). It might also be beneficial to distinguish and describe in more detail ‘best practices’ in organising CES.

A challenge for research regarding the organisation of CES is to examine and reflect upon barriers and resistance, and how to deal with them. Chapter 5, for example, highlighted some challenges in implementing MCD in an academic context and mentioned the hierarchical culture and the difficulties of addressing ethical issues within MCD sessions in that particular setting.

Training facilitators of moral learning
To improve the practice of training health care practitioners as facilitators of moral learning it is recommended to develop and use concrete didac-
tic tools that enhance the reflection-on-action and reflection-in-action of trainees and trained facilitators. An example is the use of a portfolio, which has been introduced in teaching programs for academic teachers (Tigelaar et al. 2006). Such a tool, in which the trainee's learning development is documented, can contribute to the reflection and learning process of the trainee. It can also be helpful for the trainers in the assessment of the trainee; it fosters transparency and improves the quality of the assessment process.

Another way to improve the training could be the didactical strategy of ‘demonstration and imitation’ performed by moral learning experts (either life or via video recording). Whereas in the current training program the trainers mainly use Socratic questioning to encourage and stimulate the reflection process of the trainee, an integration of other didactics would be helpful to vary and strengthen this reflection process.

A third recommendation relates to the reflection upon the findings concerning the role of theory in the practices of fostering moral learning (both within the MCD sessions and within the training program for facilitators of MCD). It is important to investigate further, both in research and clinical ethics practice, how and to what extent theories contribute and relate to the process of generating practical wisdom in the context of moral learning processes in MCD and the training of facilitators of MCD. As described above, Lunenberg and Korthagen (2009) provide a framework in which theory is related to experience and practical wisdom. It would be interesting to examine the role and meaning of theory in the process of moral learning and ‘learning by doing’, by determining how theory is currently used, implicitly and explicitly, by certified facilitators of MCD and by trainers and trainees in the training program.

A challenge for future research regarding the training of facilitators of moral learning is to examine and develop, with and within practice, tools that stimulate the reflection-on and in-action of trained facilitators of moral learning. For example, a guideline that reflects the various behavioural aspects of a ‘good facilitator’ that can be used by trained facilitators to reflect on their skills, knowledge and attitude. It could function both as a reflection and assessment tool that improves the quality of the (reflection process of the) facilitator and indirectly also the quality of the CES sessions in which the moral learning processes take place (such as in MCD). The challenge lies in the way the guideline will be used in practice,
as a risk is that it may function to criticise or even exclude facilitators of MCD who do not meet the requirements, or have another view on what it means to be a good facilitator.

Conclusions

This thesis provided insights in three domains: a) fostering moral learning by means of moral case deliberation (MCD), b) organising clinical ethics support (CES), especially MCD, and c) training facilitators of moral learning. The insights and findings were derived from learning processes of various stakeholders involved in practicing MCD, in projects organising and implementing CES and in training programs for facilitators of MCD. Through being active in these three domains, my colleagues and I experienced learning processes in the roles of facilitator of MCD, organiser and implementer of CES, trainer of facilitators of MCD, and researcher.

The studies in the domain of fostering moral learning by means of MCD showed the importance of a reflective practice, the need to connect reflection to the daily practice of health care professionals and the importance of an equal say of all professions in the reflection processes. The studies in the domain of organising CES showed that there are various ways in which CES contributes to and improves structural moral reflective practices. Furthermore, they showed that implementation of reflective practices such as MCD calls for (co-)ownership and requires an ongoing learning environment at an organisational level. The studies regarding the learning processes in training facilitators of moral learning showed a transition in the way of transferring the expertise: from doing by learning into learning by doing. In this transition, the role of the trainer shifted from an expert-teacher to a Socratic coach. Furthermore they showed the need for a change in organisational aspects of the training and for appropriate didactical tools to stimulate reflection on the role of facilitator of moral learning. The work of Donald Alan Schön, describing the crucial role of experiences in learning processes, helped to deepen the understanding of and reflection upon the findings. This reflection led to recommendations for practice and research in the three domains.
Based on the insights and findings it can be concluded that a crucial element of all learning processes has been the role of others who were directly or indirectly involved. We all, independently of whom we are and what role we have, are to a certain degree unaware of our normative frames and therefore there is a need to reflect on them by means of the help and support of others. In the domain of moral learning processes, interactions and exchanges of views with other participants are needed in order to foster a reflective practice in which (joint) moral knowledge can be developed and enriched. In the domain of learning processes in organising clinical ethics, the practical support and input of stakeholders involved in the implementation of MCD proved indispensable in creating an interactive and joint learning process in making CES meaningful and contextual in each health care institution. In the domain of learning processes in developing a training program for facilitators of moral learning, the input, experiences and views of the trainees and trainers were necessary to reflect upon and (re)discover how to transfer the expertise and meaning of a 'good facilitator of MCD'. Finally, in the (fourth) domain of conducting research in the field and practice of moral learning and CES, dialogical interaction with all stakeholders and with colleague researchers is required in order to reflect critically upon one's roles and experiences during the research process.

In all these learning processes, the concept of 'learning by doing' is crucial. The experience-based approach, in which practical experiences and reflection upon these experiences are used as a source for the generation of practical (moral) knowledge, provided knowledge of and insights into each of the three domains. It resulted in a continuous process of learning in and on action; a cyclical and intertwined process in which we as practitioners and researchers are still learning. The process of learning and reflection in and on action is never-ending. The field and practice of moral learning and organising various types of CES (such as MCD) will keep on evolving, so that new challenges and experiences will emerge and require attention. This is a promising future in which all participants, including professionals, facilitators, organisers, trainers and researchers, will continue to learn and develop new ways of fostering moral learning, organising CES and training facilitators of moral learning.
References


Summary

This thesis is about experiences and learning processes in developing the theory and practice of moral case deliberation in health care. Chapter 1 provides a general introduction. It describes the transition in the field of bioethics, from a normative and descriptive task towards a more interactive and embedded approach. This approach aims to support health care professionals by providing tools and methods of clinical ethics support, which enable them to deal with moral issues and to make decisions by themselves, and to develop normative views on their own practice. This approach presupposes that health care providers are the primary moral agents in health care and emphasises the importance of personal moral experiences to foster learning processes that generate moral knowledge and expertise.

Moral Case Deliberation (MCD) is a form of Clinical Ethics Support (CES) which fits in the approach of interactive and embedded ethics and aims to establish an attitude in which both ethical knowledge and skills of the health care professionals are fostered. MCD is a structured dialogue among stakeholders, stimulating reflection and joint learning processes on a moral question stemming from practical experience. The goals of MCD are to improve professionalism through reflection on personal actions and values,
to help practitioners to (re)discover the motivation and passion for their professional work, and to contribute to team building and development of policy.

Interactive and embedded CES, such as MCD, aims to equip health care professionals with tools for moral learning and developing moral competencies, resulting in an improvement of quality of care. This process of fostering moral learning requires that what health care practitioners learn ought to be integrated in the actions of everyday practice. Furthermore, it requires a structure within the health care organisation that ensures a learning environment and provides health care professionals with time, tools and expertise to start up moral learning processes. Teaching health care practitioners to become facilitators of MCD fits in with a concept of professionalism which emphasizes that a professional should be competent to reflect on their own values, norms and virtues, as part of their professional profile. In line with these practical and fundamental reasons, a training program for facilitators of MCD has been developed since 2006.

The development of MCD as a specific approach in CES, of organising ethics support in health care institution, and of teaching health care professionals to become facilitators of MCD, gave rise to several questions regarding how to foster moral learning, on how to organise CES and on how to transfer ethical expertise to health care professionals.

The main research question is: How to foster and secure moral learning and reflection on moral questions of professionals in health care practice?

The following sub-questions are investigated:

(a) What are the practical learning processes in fostering moral learning by means of Moral Case Deliberation?
(b) What are the practical learning processes in organising clinical ethics, especially Moral Case Deliberation?
(c) What are the practical learning processes in training health care professionals as facilitators of Moral Case Deliberation?
The thesis consists of three parts. The first part presents three studies that describe the process of fostering moral learning in health care practice by means of participating in MCD. The second part focuses on the tensions between the theory and practice in the process of organising, implementing and embedding MCD in various contexts. The third part describes the process of developing methods and instruments for training health care professionals as facilitators of MCD.

Although the three parts each have a specific focus, most chapters combine various learning processes, and deal with both fostering moral learning, and organising clinical ethics support or training facilitators of MCD.

Part I Fostering moral learning in healthcare practice

The first part focuses on the developments of the theory and practice of fostering moral learning by means of MCD. The study in chapter 2 describes the process of organising clinical ethics in health care organisations in the Netherlands by means of MCD, in a case-study on two projects in two different psychiatric hospitals, including a pilot training programme for facilitators of MCD. The project and the training were evaluated by quantitative and qualitative research methods within the framework of a responsive evaluation research design. The findings of this study show that the organisation and embedding of a MCD project are easily underestimated. Implementing MCD is not only a matter of planning a project and training health care professionals to become MCD facilitators. It is a complex and difficult process with several dimensions. It requires permanent support and supervision of the trained facilitators of MCD, and continuous monitoring of the quality of MCD.

A common approach to teaching clinical ethics is to provide knowledge about ethics. Chapter 3 describes MCD as an alternative contextual approach to teaching ethics, grounded in pragmatic hermeneutics and dialogical ethics. These theories stress the importance of practical processes of meaning-making, related to concrete morally problematic situations,
and focuses on processes of joint learning. The chapter describes a case-study on the practice and theory of teaching ethics in the clinic in a Dutch psychiatric hospital. It focuses on what professionals actually learned in cross-organisational groups in which ethics is taught by means of MCD. The findings describe several moral competencies and changes in attitude that participants of MCD experienced. It also shows that the contextual approach of MCD has been beneficial in the setting of the case-study. However, the structure of teaching ethics in cross-organisational groups involves the risk of getting detached from moral questions that come up on the ward. The project was successful because practitioners got engaged and created a connection between MCD and their ward by inviting the researchers to their ward. A structural connection between the moral case deliberation and the hospital’s quality of care policy also contributed to the success of the project.

Chapter 4 presents a case example of a MCD session in a Dutch hospice that illustrates a joint moral inquiry of a dilemma of a physician concerning a request for euthanasia. The Dutch law on euthanasia presupposes a physician’s conflict of duties when a patient asks for his or her life to be ended. A request for euthanasia implies a dilemma for the physician; he or she on the one hand has the moral duty not to end life, but on the other hand will experience the obligation to relieve the patient’s suffering. Clinical ethics support by means of MCD can help professionals in dealing with such dilemmas. The MCD example shows the importance of involving the experiences, views, and emotions of various stakeholders in end of life care. The inclusion of all care professionals in the deliberation results in empowering them as moral subjects, widening the dialogue and fostering a more responsible practice.

Part II Organising ethics in health care

The second part of the thesis focuses on the organisation of clinical ethics support in health care. Chapter 5 describes a process of developing and implementing MCD as an ethics support service. This chapter presents the structure and organisation of an implementation project and shows the
tensions between theory and practice of MCD, in the specific context of an academic hospital in the Netherlands. It introduces the core features of the philosophical background of MCD and describes ways of dealing with some challenges between the philosophical inspirations of MCD and the practical context of an academic hospital while implementing MCD. ‘Equality’, ‘slowing down the process of decision-making’ and ‘shared ownership’ may be experienced as unnatural and demanding in an academic context. Yet, the findings show that the philosophical inspirations of MCD can be helpful in dealing with the challenges and in the cooperation with an academic hospital. Fostering implementation of MCD requires acknowledging these tensions, and looking for practical ways to deal with them.

Chapter 6 presents results of a national study on CES in the Netherlands. In 2006 the Dutch government stimulated both health care institutions and health care education programs to build up expertise of dealing with moral issues. As a consequence, the use of MCD increased during the following years. This chapter describes the prevalence and characteristics of MCD in Dutch health care. The findings demonstrate that MCD is part of an integrated ethics policy in Dutch health care and serves as a (bottom up) catalyst for such an integrated ethics policy. It shows that MCD is prominent in mental health care, care for people with an intellectual disability, and hospital care. Institutions with MCD differ from institutions without MCD in size, kind of problems and importance of ideological background. MCD often exists for 3 years or more, has a high participation of health professionals and middle managers and is both organised scheduled as unscheduled. ‘Integration in existing policy’ and ‘key persons’ emerge as important issues in relation to the positioning of MCD in the institution.

Part III Developing methods and instruments for facilitating moral learning in health care practice.

The third part of the thesis describes the development of methods and instruments that support the process of fostering moral learning by means of MCD in health care.
Chapter 7 presents a case-study on a training program for facilitators of MCD that was developed over the past 10 years. Because of the growing interest in MCD and the need to connect MCD to practice, the need to train health care professionals to become facilitators themselves increased. The training program described in this chapter enables professionals in health care institutions to acquire expertise in dealing with moral questions independent of the expertise of an external ethicist. The chapter presents a program with a specific mix of theory and practice, aiming to foster the right attitude, skills and knowledge of the trainee. It presents the result of several years of ‘learning by doing’ and many experiences in facilitating and evaluating the training program, together with the trainees and their health care organisations.

Chapter 8 presents the dilemma method, a conversation method which is often used in MCD. This conversation method focuses on moral experiences of participants concerning a concrete dilemma in practice. The chapter describes the theoretical background of the dilemma method and explains how it works in practice, using a case example. It shows the specific didactics of the dilemma method which makes it suitable for teaching in the clinical setting. The results of the case study in this chapter show that MCD participants learn to recognize the moral dimension of daily practice and feel more able to distinguish various perspectives and to reason in a systematic way. The chapter also describes the role of facilitator; he or she focuses not on explaining moral theories and concepts, but helps the participants to reflect on their experiences, presuppositions and reasoning through a dialogical moral inquiry with others.

In the last chapter (Chapter 9) the research questions of this thesis are addressed by presenting the main findings. The chapter reflects on the experiences in the processes of fostering moral learning, organising ethics and teaching facilitators, and the actions in which these learning processes have resulted. In this reflection, the work of Donald Alan Schön is used, and it is shown that his theory can help to get a deeper understanding of the main findings, but also that the findings add to his theory.

The findings of the studies in the domain of practical learning processes in fostering moral learning by means of MCD emphasize the importance of
a reflective practice, the need to connect reflection to the daily practice of health care professionals and the importance of an equal say of all professions that are participating in the reflection process.

The findings of the studies in the domain of practical learning processes in organising clinical ethics show that there are various ways in which CES contributes to and improves structural moral reflective practices. MCD provides an add-on service; it functions as a complement to other clinical ethics support services, enabling structured reflection on moral experiences. Furthermore, the findings show that implementation of reflective practices such as MCD calls for (co)ownership and requires an ongoing learning environment at an organisational level.

The findings of the studies regarding the practical learning processes in training health care professionals as facilitators of moral learning underline the importance of a transition in the way of transferring the expertise: from doing by learning into learning by doing. In this transition, the role of the trainer shifts from an expert-teacher to a Socratic coach. The findings also show the need for new entry-conditions, a follow-up training program and the awareness of the double role of the facilitator. Furthermore, they show the need for appropriate didactical tools to stimulate reflection on the role of facilitator of MCD.

In conclusion, in all the learning processes, the concept of ‘learning by doing’ played a crucial role. This experience-based approach, in which practical experiences and the reflection upon these experiences are used as a source for the generation of practical (moral) knowledge, provided insights into each of the three domains. This resulted in a continuous process of learning in and on action; a cyclical and intertwined process in which we as practitioners and researchers are still learning. An important element of the learning processes has been the role of others who were directly or indirectly involved. To become aware of the normative frames there is a need to reflect on them by means of the help and support of others.

The chapter also reflects on methodological issues, and presents future challenges and recommendations for practice and research. The recommendation for moral learning processes in practice entails research on how instruments of CES support moral learning and in what way they contribute to the process of learning. Related to the practice of fostering moral
learning, further research is desirable on how patients can participate in CES in general, and in MCD in particular.

The recommendation for the practice of *organising clinical ethics* recommend a professional network of learning, in which health care institutions and CES staff can demonstrate and exchange CES practices and also knowledge about organising them. A challenge for research regarding the organisation of CES is to examine barriers and reflect on how to deal with them.

A recommendation for the practice of *training health care practitioners as facilitators of MCD* concerns the development and use of concrete didactic tools that enhance the reflection-on-action and reflection-in-action of trainees and trained facilitators. An example is the use of a portfolio. Another way to improve the training could be the didactical strategy of ‘demonstration and imitation’ performed by moral learning experts, for example the trainers. The final recommendation entails research on the role of theory in the process of moral learning and ‘learning by doing’.
Samenvatting

Dit proefschrift gaat over ervaringen en leerprocessen in de ontwikkeling van de theorie en praktijk van Moreel Beraad als methode van ethiekondersteuning in de gezondheidszorg. Hoofdstuk 1 introduceert het onderwerp en de vraagstelling van het onderzoek. Het start met de beschrijving van een transitie in het veld van de bio-ethiek, dat lange tijd gedomineerd werd door theoretische principes en analytische vormen van argumentatie en waarin ethici als experts werden gezien. Eind vorige eeuw ontstond een nieuwe visie op ethiek, gericht op interactie in en met de praktijk. Deze visie gaat er vanuit dat zorgverleners zelf morele experts zijn en benadrukt de rol van persoonlijke ervaringen als bron voor het leren en ontwikkelen van nieuwe (morele) kennis en expertise. Een van de vormen van klinische ethiekondersteuning die aansluit bij deze nieuwe visie is moreel beraad. Moreel beraad is een dialoog tussen zorgprofessionals, waarin ze gezamenlijk reflecteren op een morele vraag uit de eigen praktijk. Doelen van moreel beraad zijn het bevorderen van reflectie op het persoonlijk handelen en de onderliggende waarden, het stimuleren van de onderlinge samenwerking, het (verder) ontwikkelen van morele expertise van professionals in de zorg, en het bijdragen aan de ontwikkeling van visie op en beleid rond morele vraagstukken in de praktijk. Moreel beraad beoogt door middel van een
methodische aanpak hulpverleners te ondersteunen in morele leerprocessen. Dit vraagt om een contextuele aanpak waarin hulpverleners het geleerde direct in hun eigen praktijk kunnen toepassen en integreren. Dit vereist binnen zorginstellingen een leeromgeving waarin zorgverleners mogelijkheden, handvatten en tijd hebben om hun reflectievaardigheden te ontwikkelen. Om moreel beraad verder te verspreiden in zorginstellingen is het van belang dat zorgverleners zelf de rol van gespreksleider leren hanteren. Dit heeft er toe geleid dat er in 2006 een begin is gemaakt voor het ontwikkelen van een training voor gespreksleiders moreel beraad. Dit proefschrift doet verslag van de ervaringen en leerprocessen rond de ontwikkeling van moreel beraad als een specifieke vorm van klinische ethiekondersteuning, het organiseren van moreel beraad in zorgorganisaties en het ontwikkelen van een trainingsprogramma voor het opleiden van zorgverleners tot gespreksleider moreel beraad.

De centrale onderzoeksvraag van dit proefschrift is: hoe kan reflectie op morele vragen van zorgverleners in de gezondheidzorg worden gestimuleerd en gewaarborgd?

Deze vraagstelling is nader toegespitst op de volgende sub-vragen:

(a) Welke ervaringen en praktische leerprocessen doen zich voor wanneer zorgverleners deelnemen aan moreel beraad?
(b) Welke ervaringen en praktische leerprocessen doen zich voor in het organiseren van klinische ethiekondersteuning, in het bijzonder moreel beraad?
(c) Welke ervaringen en praktische leerprocessen doen zich voor tijdens de ontwikkeling van een training voor zorgverleners tot gespreksleider moreel beraad?

Dit proefschrift bestaat uit drie delen. Het eerste deel bevat drie studies die zich richten op het stimuleren van morele reflectie en expertise in de zorg door middel van moreel beraad. Het tweede deel beschrijft het spanningsveld tussen theorie en praktijk van het organiseren, implementeren en inbedden van moreel beraad. Het derde deel gaat over het ontwikkelingsproces van methoden en instrumenten om zorgprofessionals op te leiden tot
gespreksleider moreel beraad. Hoewel ieder deel zijn eigen focus heeft, komen in de meeste hoofdstukken meerdere van de genoemde leerprocessen aan de orde, en wordt geregeld de onderlinge relatie tussen de drie thematiserend.

Deel I Het bevorderen van morele reflectie in de praktijk van de gezondheidszorg

Het eerste deel gaat over de ontwikkeling van de theorie en praktijk van het bevorderen van morele reflectie door middel van moreel beraad. Hoofdstuk 2 beschrijft het proces van het organiseren van moreel beraad in zorginstellingen in Nederland en geeft een voorbeeld van twee projecten in twee verschillende psychiatrische zorginstellingen, inclusief een pilot trainingsprogramma voor gespreksleider moreel beraad. Zowel het project als de training zijn geëvalueerd met behulp van kwantitatief en kwalitatief onderzoek volgens de methodiek van Responsieve Evaluatie. De resultaten van het onderzoek laten zien dat de organisatie en inbedding van moreel beraad gemakkelijk onderschat worden. Het implementeren van moreel beraad vraagt meer dan alleen het organiseren van een project en een training voor gespreksleiders moreel beraad. Het is een complex en langdurig proces dat vraagt om een continue ondersteuning en begeleiding van getrainde gespreksleiders en een voortdurend monitoren van de kwaliteit van moreel beraad.

In de meer traditionele manier van (medische) ethiek onderwijs speelt het verwerven van kennis van ethische theorieën een belangrijke rol. Hoofdstuk 3 beschrijft moreel beraad als een alternatieve manier voor een meer contextuele manier van ethiekonderwijs. Moreel beraad heeft wortels in de pragmatische hermeneutiek en de dialogische ethiek. Beide benaderingen benadrukken dat betekenisgeving altijd gerelateerd is aan concrete morele ervaringen en een resultaat is van gezamenlijke leerprocessen. Het hoofdstuk beschrijft een voorbeeld van de theorie en praktijk van moreel beraad in een Nederlandse instelling voor psychiatrie. Het laat zien wat zorgprofessionals leren in afdelingsoverstijgende groepen waarin ethiekonderwijs
wordt gefaciliteerd door middel van moreel beraad. De resultaten van de studie beschrijven de morele competenties en de verandering in houding van de deelnemers aan moreel beraad. Het hoofdstuk beschrijft tevens dat het organiseren van ethiekonderwijs in afdelingsoverstijgende groepen als nadeel heeft dat morele vragen en onderwerpen los van de context (de afdeling) behandeld en besproken worden. Het succes van het project werd mede bepaald doordat zorgprofessionals in staat waren een verbinding te leggen tussen datgene wat is geleerd in moreel beraad en hun eigen werk of afdeling. Ook de structurele verbinding tussen moreel beraad en de kwaliteitsbeleid van de zorginstelling bleek een belangrijke voorwaarde voor het slagen van het project.

Hoofdstuk 4 beschrijft een moreel beraad sessie in een Nederlands hospice waarin een dilemma van een arts over een euthanasieverzoek centraal staat. Wanneer een patiënt een euthanasieverzoek doet kan dit leiden tot een dilemma bij de arts; hij of zij voelt aan de ene kant de morele plicht om het leven niet te beëindigen, maar wil aan de andere kant de patiënt ook verlossen uit zijn lijden. Moreel beraad als vorm van klinische ethiekondersteuning kan zorgprofessionals helpen in het omgaan met dergelijke morele vragen en dilemma's. De moreel beraad sessie laat het belang zien van het betrekken van ervaringen, ideeën en emoties van alle betrokkenen in een casus. Hierdoor wordt iedere deelnemer aan het moreel beraad in zijn morele expertise bekrachtigd, ontstaat er een verdieping in de dialoog en wordt een gezamenlijke verantwoordelijkheid gecreëerd in de zorg voor de patiënt.

Deel II Het organiseren van ethiek in de gezondheidzorg

Het tweede deel in dit proefschrift richt zich op de organisatie van klinische ethiekondersteuning in de gezondheidzorg. Hoofdstuk 5 beschrijft een implementatie project in een academisch ziekenhuis in Nederland en het spanningsveld tussen de theorie en praktijk van moreel beraad. Het gaat in op de uitdagingen bij het in praktijk brengen van de filosofische aspiraties van moreel beraad tijdens het implementeren van moreel beraad in een
academische ziekenhuis. Het vertragen in het denken, het ‘gelijk zijn’ in de dialoog en het gezamenlijke eigenaarschap kan als tegennatuurlijk worden ervaren in een dergelijke setting, waar urgentie vaak een belangrijke rol speelt bij beslissingen. Toch blijkt uit de resultaten dat de filosofische pijlers van moreel beraad kunnen bijdragen aan het omgaan met de uitdagingen in en de samenwerking met een academisch ziekenhuis. Kennis over het spanningsveld tussen theorie en praktijk en manieren om daar mee om te gaan zijn essentieel in de implementatie van moreel beraad.

**Hoofdstuk 6** beschrijft resultaten van een landelijk studie naar klinische ethiekondersteuning in Nederland. Het geeft een overzicht van de state-of-art van moreel beraad en richt zich op de prevalentie en karakteristieken van moreel beraad in de gezondheidszorg. De resultaten laten zien dat moreel beraad veel voorkomt in Nederlandse zorginstellingen en vaak ook een aanleiding vormt om ethiek beleid te ontwikkelen. Moreel beraad is prominent aanwezig in de psychiatrie, in de zorg voor mensen met een verstandelijke beperking en in ziekenhuizen. De verschillen tussen zorginstellingen die moreel beraad faciliteren en zorginstellingen die dat niet doen, zijn: de omvang van de instelling, het soort problematiek en de ideologische achtergrond. Opvallend is dat moreel beraad vaak langer dan 3 jaar wordt georganiseerd, dat een hoog percentage van de deelnemers bestaat uit zorgverleners en midden-management, en dat moreel beraad zowel ge-agendeerd als adhoc georganiseerd wordt. Verder laten de resultaten zien dat het ‘integreren in bestaand beleid’ en ‘sleutelfiguren’ bevorderend zijn voor de positie en organisatie van moreel beraad in een zorginstelling.

**Deel III De ontwikkeling van methoden en instrumenten voor het opleiden van gespreksleiders moreel beraad.**

Het derde deel van dit proefschrift gaat over (de ontwikkeling van) methoden en instrumenten die reflectieprocessen en morele expertise stimuleren door middel van moreel beraad.
Hoofdstuk 7 beschrijft de ontwikkeling van de training voor gespreksleiders moreel beraad in de afgelopen 10 jaar. Door de groeiende interesse in moreel beraad en de vraag om moreel beraad sterker te verbinden met de dagelijkse zorgpraktijk, ontstond de behoefte aan het opleiden van zorgprofessionals tot gespreksleider moreel beraad. Dit hoofdstuk beschrijft een trainingsprogramma waarin een mix van theorie en praktijk wordt aangeboden, met als doel: het ontwikkelen van kennis, vaardigheden en attitude van de gespreksleider moreel beraad. Het hoofdstuk laat zien hoe gedurende de jaren de training door ervaring in het trainen en in het faciliteren van de training, samen met de cursisten en organisatoren in zorginstellingen, al doende vorm heeft gekregen.

Hoofdstuk 8 beschrijft een gespreksmethode, de dilemma methode, die veel wordt gebruikt door gespreksleiders moreel beraad. Deze methode richt zich op concrete en persoonlijke dilemma’s uit de praktijk van zorgprofessionals. Het hoofdstuk beschrijft de theoretische achtergrond van de methode en legt door middel van een voorbeeld uit hoe de methode in de praktijk wordt gebruikt. Het voorbeeld beschrijft specifieke didactische elementen van moreel beraad en de dilemma methode waardoor het zich goed leent voor ethiekonderwijs in een klinische setting. De resultaten van het onderzoek laten zien dat deelnemers in moreel beraad beter in staat zijn om morele thema’s in de dagelijkse praktijk te herkennen, dat ze beter en meer verschillende perspectieven kunnen onderscheiden, en dat hun denken meer is gestructureerd. Verder legt het hoofdstuk uit wat de rol van een gespreksleider omvat; hij of zij richt zich niet op het uitleggen van morele theorieën en concepten maar faciliteert de dialoog en helpt daarmee deelnemers aan moreel beraad te reflecteren op hun handelen, vooronderstellingen en denken over morele kwesties.

In het laatste hoofdstuk, hoofdstuk 9, worden bevindingen en antwoorden op de onderzoeksvragen gepresenteerd. Het hoofdstuk is gebaseerd op de gedachte dat door reflectie en de dialoog kennis wordt gegenereerd. Het reflecteert op de ervaringen van verschillende stakeholders in de afzonderlijke onderzoeken over het stimuleren van morele reflectie, de organisatie van ethiek en het opleiden van gespreksleiders moreel beraad. Bij het beantwoorden van de onderzoeksvragen en de reflectie op de (leer)ervaringen
wordt het werk van Donald Alan Schön over ervaringsgericht leren gebruikt. Daarbij wordt besproken hoe zijn theorie de resultaten kan verdiepen en welk licht de bevindingen werpen op zijn theorie.

De resultaten van de onderzoeken over de leerprocessen in *het stimuleren van morele reflectie door middel van moreel beraad* laten het belang zien van een reflectieve praktijk en een gelijke stem voor alle deelnemers in moreel beraad, en de noodzaak om reflectie te verbinden met de dagelijkse praktijk van zorgprofessionals.

De resultaten van de onderzoeken over de leerprocessen in *het organiseren van ethiek* laten zien dat er verschillende manieren zijn waarop klinische ethiekondersteuning een bijdrage kan leveren aan structurele praktijken van reflectie. Moreel beraad is een manier om reflectie in de zorg te bevorderen die complementair is aan andere vormen van klinische ethiekondersteuning. Verder laten de bevindingen zien dat de implementatie van vormen van reflectie, zoals moreel beraad, eigenaarschap vragen en een blijvende leeromgeving nodig hebben.

De resultaten van de onderzoeken over *leerprocessen in het trainen van zorgprofessionals tot gespreksleider moreel beraad* beschrijven een verandering in benadering van onderwijs en het overdragen van expertise: van ‘doen door te leren’ naar ‘leren door te doen’. Deze transitie impliceert een verandering in de rol van trainer: van expert-docent naar Socratische coach. De resultaten hebben tevens geleid tot organisatorische aspecten van de training, zoals de instap-eis, een follow-up programma en de heroverweging van het gespreksleiderschap bij cursisten op een invloedrijke positie in de zorgorganisatie.

Geconcludeerd wordt dat het concept ‘alle doende leren’ in de drie leerprocessen een cruciale rol speelt. Elk van der leerprocessen wordt gekenmerkt door een ervaringsgerichte aanpak, waarin persoonlijke ervaringen en de reflectie op deze ervaringen gebruikt worden als bron voor praktische (morele) kennis. Het gaat om een continu proces van al doende leren; een cyclisch proces waarin zorgprofessionals en onderzoekers samenwerken en elkaar beïnvloeden. Een cruciaal element in de leerprocessen is de rol en bijdrage van anderen, die direct of indirect betrokken zijn geweest.

Het hoofdstuk gaat tevens in op sterke en zwakke punten van de gehanteerde onderzoeksmethodologie. Tevens worden aanbevelingen voor de praktijk en voor toekomstig onderzoek geformuleerd. Een aanbeveling
voor morele reflectie in de praktijk betreft het bevorderen van ervaring en onderzoek op het gebied van participatie van patiënten in klinische ethiekondersteuning in het algemeen en moreel beraad in het bijzonder.

Een aanbeveling voor de praktijk van het organiseren van klinische ethiek is het opzetten van een lerend netwerk waarin zorginstellingen hun ervaringen met en kennis over (het organiseren van) klinische ethiekondersteuning kunnen uitwisselen en van elkaar kunnen leren. Onderzoek naar het organiseren van klinische ethiekondersteuning dient zich te richten op weerstand en op de ontwikkeling van manieren om daar mee om te gaan.

Een aanbeveling voor de praktijk van het opleiden van gespreksleiders moreel beraad betreft het ontwikkelen en testen van didactische instrumenten gericht op het bevorderen van ‘reflection-on-action’ (reflectie op het handelen) en ‘reflection-in-action’ (reflectie in het handelen) van cursisten en gespreksleiders. Een voorbeeld is het gebruik van een portfolio. Ten slotte wordt aanbevolen onderzoek te doen naar de rol van theorie in moreel beraad en in ervaringsgericht leren.
Dankwoord

In de afgelopen jaren is mij vaak de vraag gesteld ‘wanneer ben je begonnen met je promotietraject?’ Ik heb er lang over nagedacht maar kan me het precieze moment niet herinneren. Mijn ‘besluit’ om te promoveren is ‘al doende’ genomen. De passie en ervaring met moreel beraad en het plezier in het doen van onderzoek in de praktijk groeiden gaandeweg; het ging als vanzelf en op een gegeven moment was ik bezig met een promotietraject. Eén van de conclusies van dit proefschrift is de cruciale rol die anderen hebben gespeeld in leerprocessen. Dit geldt ook zondermeer voor mijn promotietraject; zonder anderen om mij heen was dit boekje er niet geweest!

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Maria Margaretha (Margreet) Stolper was born on the 28th of May 1977 in Hardenberg, The Netherlands. After her graduation from high school at Greijdanus College in Zwolle, in 1995 she started her study on Psycho-motoric Therapy at the Academy for Sports (CALO) in Zwolle. She finished her bachelor Degree in 1999 and started the study on Health Science at the University of Maastricht. In 2003 she successfully finished her study with a master thesis about meaning-making of chronic pain patients in the context of a cognitive-behavioral therapy. After her graduation she started working for 3 years as a psycho-motoric therapist in a psychiatric hospital in Heerlen. During the same time, in 2004, she started working as a junior researcher at the Department of Health, Ethics and Society (HES) at the University of Maastricht. In 2009 she continued her work as a researcher at the Department of Medical Humanities at VU University medical centre in Amsterdam. Her PhD work concerns the development of the theory and practice of Moral Case Deliberation (MCD) in health care. Alongside her PhD work, she was a facilitator of MCD, a project leader in projects about implementing MCD in health care institutions and a trainer for health care professionals to become facilitators of MCD. Since 2009, she is a member of a Medical Ethics Committee in psychiatric hospital in the role of external advisor on ethics. Currently she works as a researcher at the Department of Medical Humanities. Margreet is married to Dario Di Maio and mother of two sons, Levi and Matteo.
Moral Case Deliberation is a form of Clinical Ethics Support, which focuses on stimulating reflection and joint learning processes of health care professionals on moral issues stemming from practical experiences. ‘Learning by doing’ played a crucial role in the development of the theory and practice of Moral Case Deliberation and making it work in health care. This experience-based approach uses practical experiences and the reflection upon these experiences as a source for generating knowledge. It provides insights into the three domains of fostering moral learning, organizing clinical ethics and training health care professionals as facilitators of Moral Case Deliberation.