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The discovery of deliberation. From ambiguity to appreciation through the learning process of doing Moral Case Deliberation in Dutch elderly care

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A B S T R A C T

In the field of bioethics a trend can be noticed toward deliberative and collective forms of moral reflection among practitioners. Moral Case Deliberation (MCD) is an example of this development and currently introduced in an increasing number of health care organizations in the Netherlands, including elderly care. The purpose of this article is to evaluate the process of implementation of MCD focusing on the learning experiences of practitioners over time. The article is grounded in a naturalistic evaluation of the implementation of MCD in two elderly care institutions between 2006 and 2012. Methods included interviews, participant observations and focus groups. The results indicate that gaining experience with MCD brought about a learning process in which both the learning of competence for reflection and deliberation (e.g. an exploratory attitude) and experiencing the benefits (e.g. relief of moral distress) were key elements. We conclude that doing ethics is the best way to motivate practitioners to engage in moral deliberations on the work floor. Gaining practical experience should be explicitly stimulated bottom-up and facilitated top-down.

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Introduction

The field of bioethics has seen several developments over the past decades, that have deepened and broadened its scope (Jonsen, 2007). Three of these developments together reflect a specialization (or maybe a shift) of bioethics descending from the 'academic ivory towers' into the health care practices where bioethics is actually *done*. One development is the rise of empirical ethics and clinical ethics in order to make ethical theory and principles more relevant for practice, and to acknowledge and build on moral intuitions and experiential knowledge of practitioners. This is illustrated by the move in ethics education from using theoretical textbooks to a focus on real cases from the clinical context (Agich, 1990). A second development is the increased attention for everyday ethical issues next to the 'big', controversial or dramatic medical ethical issues, such as euthanasia or withholding treatment (Kane & Caplan, 1990). This has resulted in a new agenda for ethics, including themes like family care, diversity and empowerment. A third development is the rise of more democratic, interactive, dialogical approaches in bioethics (Abma, Molewijk, & Widdershoven, 2009; De Vries et al., 2010; Irvine, Kerridge, & McPhee, 2004). While ethics used to be equated with individual reflection, ethics has now become group work, engaging the work-floor in communal reflections on moral issues. Needless to say that this has had implications for the role of the ethicist; a transition can be noticed from the ethicist as expert to the facilitator of moral deliberations. In the USA it has been suggested to replace ethics consultations, leading to recommendations that may be rejected or considered a mandate, by bioethics mediation (Fiester, 2007).

In the Netherlands these developments have paved the way for the development and expansion of Moral Case Deliberation (MCD) projects in health care institutions, supported by the Dutch government. Explicit attention for moral issues in health care is

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expected to actively contribute to enhancing the quality of care (Ministry of Health Welfare and Sport, 2005). MCD aims to facilitate the reflection and deliberation on moral issues in the work-place under guidance of a trained facilitator.

Currently MCD is introduced in a broad spectrum of care organizations, including general hospitals and long-term care facilities. The study presented here, involves the introduction of MCD within residential elderly care, where the need for ethics support is not always articulated, and existing support mechanisms do not always match with the everyday questions or the type of workers (Dauwerse, Van der Dam, & Abma, 2012). It is the first study that extensively reports on the experiences with MCD in the practice of elderly care. Other forms of ethics support in elderly care have been discussed in the international literature (Bolmsjo, Edberg, & Sandman, 2006; Powers, 2000; Vanlaere, Coucke, & Gastmans, 2010). These studies highlight the design of the intervention. Less attention is given to how the intervention is received in practice and to the developments that take place upon implementation.

The purpose of this article is to evaluate the implementation of MCD within two elderly care institutions and to present lessons learned from organizing this kind of clinical ethics support in elderly care. Key to the learning process that took place when MCD was implemented was the gaining of experience with reflection and deliberation: learning the tricks of the trade and seeing the benefits.

MCD: facilitating a dialogical learning process to improve quality of care

In MCD, health care professionals engage in a joint reflection and deliberation about the moral issues they encounter in their daily work. Our approach to MCD is inspired by dialogical ethics and pragmatic hermeneutics, in which the source of morality is located in concrete experiences of all involved stakeholders rather than abstract conceptual analysis by external experts. Hermeneutics presumes that learning in a dialog is facilitated by the confrontation with and opening up to the other's perspectives. Learning from each other is not about leaving one's perspective behind but about bridging the gap between perspectives (Widdershoven & Molewijk, 2010). Starting point for the deliberation is a concrete case, a situation in which a dilemma or a moral question rises, presented by one of the participants. The deliberation is guided by a facilitator (an ethicist or a trained health care worker) and structured using a conversation method (e.g. the Dilemma method, which focuses on the moral question in the case by exploring the perspectives of the stakeholders in the case and the participants present in the deliberation and works toward a decision, or a Socratic dialog, when the emphasis is more on developing professional's competence or a more conceptual moral question is explored). The role of the facilitator is not that of an expert giving advice, but to facilitate dialog and investigation into the case and the moral question. S/he supports the joint reasoning process and, when needed, can help the group in planning actions following the outcome of a deliberation, in order to improve the quality of care.

The dialogical process forms the heart of the dialogical-hermeneutic approach to MCD. Depending on the context and goal of the deliberation the emphasis can be more on the development of moral competencies (e.g. developing an exploratory attitude) or on finding a resolution in the case (Abma et al., 2009). What constitutes a good deliberation is a combination of aspects that relate to both content, process and perspectives. First, a good moral deliberation focuses on the moral dimension of care. The quality of the content of the deliberation depends on the formulation of the moral question on which the moral inquiry will be focused. Sometimes this question is clearly formulated beforehand, but often the formulated question is the result of a dialogical process. The focus on *moral* questions entails that questions of a medical-technical, practical or emotional-psychological kind are not considered appropriate for MCD. Second, a sincere dialog is advanced by the efforts of both the participants and the facilitator. Participants need to listen to one another, be open toward the perspectives of the other participants, postpone their own judgments and must let go the drive to convince the other participants. In other words, participants should take on an exploratory attitude. Third, a good deliberation requires the input of a diversity of perspectives. From a democratic point of view all involved perspectives in the case should be represented in the deliberation. Since inviting all involved perspectives in person often is not possible nor desirable, this democratic aspect should be carefully taken care of within the conversation method (e.g. by means of completing a table of all perspectives and their presumed values and norms in relation to the moral question). From a hermeneutic point of view the presence of participants with different professional backgrounds is beneficial for enriching the dialog.

Design and methods

Setting: introduction of MCD in two elderly care institutions

This paper is based on the experiences of various stakeholders in an MCD project in two Dutch elderly care organizations. One organization (ORG 1) participated with two nursing homes (NH A: 270 residents; NH B 180 residents), the other organization (ORG 2), a care home, participated with three locations (a mix of nursing- and assisted-living units, 250 residents). The project was supported by an MCD research team: a PhD-student (first author) and two senior researchers (4th & 5th author). Apart from some policy development on major ethical issues (euthanasia, do-not-resuscitate orders) the participating institutions had not organized ethics support or systematic reflection and deliberation prior to the MCD project.

The implementation trajectory consisted of four successive, partly overlapping steps, each with different activities. Following the introduction in 2006, in each of the institutions mixed MCD groups (van der Dam et al., 2011) were created, with employees from different wards and disciplines. We deliberately started with motivated participants in order to create an atmosphere of safety and openness, offering room to experiment with MCD. In addition, the mixed composition of the groups, representing as many different disciplines and wards as possible, was expected to foster the dissemination of MCD across the organization. After the first year, NH A withdrew from the project, because of changed organizational priorities. Both in NH B as well as in ORG 2 the two mixed groups that had started simultaneously merged into one group for practical reasons. Over the course of 2008–2009 in NH B and in ORG 2 MCD was implemented on a selection of wards (6 in total). The MCD sessions on the wards were preceded by a clinical site visit, talking to the team members and participating in the practical work on the ward, to make the team aware of issues and investigate together with the team what issues needed to be put on the agenda for deliberation. The final step was to train seven representatives from NH B and ORG 2, with prior MCD experience, to become MCD facilitators. In NH B the continuation of MCD was put on hold in 2011 due to budget cuts. The MCD research team is currently involved in the further embedding of MCD in ORG 2, albeit in a more distanced, advisory role.

Research design and data collection

The first crucial years of the MCD project were accompanied by research activities undertaken by the MCD research team, in close cooperation with stakeholders. Because of the focus of the study on the experiences of the professionals, we concentrated on the

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