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# Implementing moral case deliberation in Dutch health care; improving moral competency of professionals and the quality of care

\_ Original article

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**Abstract** \_German and French abstracts see p. 62

**Background:** Moral case deliberation (MCD) consists of the systematic reflection on actual moral questions from health care professionals, facilitated by an ethicist. There exists little published information on the clinical practice and empirical research of MCD.

**Objectives:** The objectives of this paper are: A) to give a definition of MCD; B) to describe its theoretical background; C) to describe a 4-year MCD implementation project in a psychiatric hospital; D) to present the first results of a study on the quality and results of MCD sessions.

**Methods:** The MCD sessions were studied by means of: a) Applying the Maastricht evaluation questionnaire for participants of MCD sessions; b) Interviewing involved stakeholders (e.g. facilitators of MCD, the hospital's director); and c) Analysis of MCD reports, facilitators's informal notes, and reports of in-between evaluative meetings.

**Results:** Both qualitative and quantitative results of the 220 questionnaires of 50 MCDs showed that the MCDs were regarded as very useful. Most participants saw the relevance of MCD for their daily work high and judged the quality of the dialogue positively. Their open, straight, constructive communicating and moral sensitivity increased; their presuppositions, prejudices and automatic responses decreased.

**Discussion:** Future implementation research has to find out what the long term impact will be on the quality of care. Therefore, the next step in this project will focus on (methodology for) research on the follow up of outcomes of MCD and the integration of these outcomes with institutional policy issues.

**Key words:** moral deliberation; dialogical ethics; empirical research; implementation; clinical ethics

Health care is an inherently moral profession. Good care always involves, implicitly or explicitly, choosing a moral position. This applies to all kind of employees. In doing so, health care employees can not simply use external, ready-made protocols, professional rules or moral standards. Defining morally good care is an ongoing contextual process, based on concrete experiences with different stakeholders (e.g. care givers, patients, managers etc.). In this process, employees are, and will be, confronted with moral issues. Although employees deal with moral issues every day (even if they are not aware of the moral dimension of their thoughts and behaviour), normally the opportunity for systematically dealing with moral issues is lacking. Recently, specific moral deliberation methods have been developed in order to support employees in dealing with these moral issues in a more reflective, dialogical and constructive way (1–5, 7, 9).

In Dutch health care institutions, clinical ethics committees are giving up their former distant expert role and their focus on policy and guidelines. They transform into a steering group which aims to develop the moral competencies of

health care professionals, and to guarantee an ethics climate throughout the whole institution (10). In order to support this transformation of the role of clinical ethics committees a practical guidebook for moral case deliberation has been developed (2). In 2005, a national survey of the Centre for Ethics in Health Care (C.E.G.) demonstrated the underdeveloped status of ethics within Dutch health care institutions. The authors called for more attention for moral deliberation among health care professionals (11). At the same time, the Dutch Minister of Health Care signalled the need for more thoughtful consideration of the structure of moral deliberation within health care institutions (12). Since 2004, every 3 months expert meetings on moral deliberation take place at the Department of Ethics at the Ministry of Health. Furthermore, national working conferences on moral deliberation for health care professionals are organized every six months. In line with these developments, various health care institutions have started moral deliberation projects with the assistance of clinical ethicists from universities. A variety of rationales for these projects are mentioned, such as: improv-

ing the moral competencies of the health care professionals, improving the quality of care processes, increasing the transparency of decision-making processes, making explicit the rationale of professional behaviour, fostering a culture of critical yet constructive dialogue among multi-disciplinary professionals, and enhancing the quality of management. So far, there is little empirical research on the process and outcome of moral deliberation. This paper first gives a definition of moral case deliberation. Next, it goes into the theoretical background of moral case deliberation. It also presents an example of a moral deliberation project. Furthermore, it gives first qualitative and quantitative results of a research project on quality and results of moral deliberation.

### What is moral deliberation?

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 (3 – 5, 7)<sup>1</sup>. Most questions concern «What should we consider as the morally right thing to do in this specific situation and how should we do it rightly?» Three 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's moral competencies, 3) to reflect on institutional or organizational issues and to improve the quality of care at that level.

The reflection, which usually takes 45 minutes to 120 minutes, is facilitated by a trained facilitator and structured by means of a selected conversation method (for examples of conversation methods see: 2, 4, 13). 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. The expertise of the facilitator consists in, 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. For example, some methods (e.g. the dilemma method) focus on the case itself and work towards a well-considered decision, while other methods (e.g. the Socratic Method) use the case as a means to enhance moral competencies of the health caregivers (4).

### Theoretical background of moral deliberation: pragmatic hermeneutics and dialogical ethics

The background of our approach to moral deliberation is a combination of pragmatic hermeneutics and dialogical ethics. Both approaches stress the importance of practical processes of interactive meaning-making, always related to concrete problems. They require openness towards the views of others. Hermeneutics is critical of all attempts to frame the problem in terms of strictly defined principles and to solve it through abstract procedures (14, 15). It is sceptical about interpretations which are general and a-historical. 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. This typically takes place in a dialogue. One of the fundamental claims of hermeneutic ethics is that ethics and morality start with actual experience, not with theories or concepts. Theories and concepts are useful, but ultimately they should be based upon and useful for concrete practices. This approach to ethics goes back to Aristotle. He claimed that (moral) wisdom and (moral) knowledge originate from reflections on and within concrete situations. There is no moral truth independent from experience. The meaning and construction of morality is inherently contextual and temporal. The meaning of the good life is not given beforehand, but arises out of dialogue among open-minded people in practice. Within this dialogue, knowledge from ethical theories may play a role but it cannot claim epistemological authority. Sharing stories and narratives are important strategies in constructing moral convictions and beliefs (16, 17). As a consequence, moral case deliberation always starts with concrete experiences (and not with hypothetical thought experiments or concepts of theories from ethics).

### A moral deliberation project in psychiatry

Moral deliberation can be done on an incidental basis. In order to have longer lasting results, however, it should be organized in a more structural way. This is done in so-called moral deliberation projects. In general, a moral deliberation project aims at improving the overall ethics quality of (the organisation) of care at three levels: offering time, methods and facilitators to reflect on complex or problematic moral cases (case level), improve the moral competencies of the employees of the health care institution (professional level), and

1 Moral deliberation differs with clinical ethics consultation (5). 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?» in a morally and legally appropriate way (25, 26). It seems as if the ethics consultant focuses more on the answer to the question «What is morally right?» whereas the facilitator within moral deliberation focuses more on the process by which the group members reach this answer on their own.

developing an integrated ethics policy and ethics climate throughout the whole organisation (institutional level) (5). GGNet, a large mental health care institution in the east of the Netherlands, is one of the leaders in the Netherlands with respect to the structural implementation of moral deliberation. The moral deliberation group within GGNet is responsible for the facilitation and implementation of these moral deliberations. This group consists of an ethicist from the moral deliberation group of the Maastricht University, and four GGNet employees who had been trained in facilitating moral deliberation (a nurse practitioner, a sociologist/philosopher, two theologians, and a nursing teacher). A PhD student has been added to this group for four years in order to facilitate, monitor and study the implementation and the results of the moral deliberations.

The implementation of a moral deliberation project consists of several phases. After an investigation of the moral culture and ethics policy of the institution, the researcher and the stakeholders shape a project plan together. Then the moral deliberation group will start facilitating moral deliberations among teams. Next, a core group of experienced employees are trained as facilitators. Finally, the focus shifts to the implementation and embedding of structural attention for moral issues within the institution. The current moral deliberation project within GGNet started in 2005 and follows these steps. At this moment, the train-the-facilitator program (spread out over 7 months) has started (4).

Most of the moral deliberations in the GGNet project were related to another project, which dealt with the reduction of restraints. This so-called Intensive Psychiatry Project had a specific normative aim, namely to improve the quality of restraints and to decrease the amount of restraining events<sup>2</sup>. Within that project, moral deliberation sessions were used to: A) facilitate reflection on good care in general and restraints in particular; B) increase the moral competency of the health care professionals; C) improve multidisciplinary cooperation; and D) improve the quality of care in general (and the quality of restraints in particular). Most moral deliberation sessions took place on a regular basis (e.g. every 4 weeks a 90 minutes session), prepared by the GGNet moral deliberation group and the moral deliberation coordinator of the particular ward. After receiving a specific training and ongoing support from the moral deliberation group, this coordinator played an important role in the connection between moral deliberation and the actual work processes on

the ward. In order to study the quality and results of the moral deliberations, a PhD student performed a research project, based upon the methodology of Responsive Evaluation (6, 18 – 20).

## Methods

Research activities were performed by a PhD student, an external researcher, and the senior ethicist from the Maastricht University who acted as the project leader of the moral deliberation group. The PhD student formulated the procedures with respect to the research activities. The research data were collected by the moral deliberation facilitators and the local coordinator at each ward. The external researcher analyzed the acquired data, held the interviews and described the data. In order to have a member check (a standard procedure for validating qualitative research results) two steps were performed. First the analyses and research reports were individually presented to all the involved facilitators and local coordinators; their comments were included. Second, a discussion with all facilitators together was organised in order to reflect upon the research report.

In line with the Dutch Medical Research Involving Human Subjects Act (WMO), this research was exempted from a formal IRB review.

Quantitative research activities included the Maastricht evaluation questionnaire for anonymous participants of every moral case deliberation (see Appendix A)<sup>3</sup>. This two-page questionnaire consisted of closed and open questions. It contained items (some of them presented on a 10-point scale) about the general evaluation of the moral case deliberation, the role of the facilitator, the quality of the dialogue, outcomes of the MCD, the lessons participants learned (or did not learn), and the influence on participants' professional work. General descriptive statistical analyses were done by using SPSS 14.0.

We made use of four kinds of qualitative research activities (22, 23). In the first place, a qualitative analysis of the answers on the open questions in the Maastricht evaluation questionnaire was performed with the software program of Mind Mapping<sup>®</sup> (24). All answers to the open questions were divided into thematic categories of answers. Second, the external researcher performed in-depth interviews with various stakeholders within the psychiatric hospital about their expectations of and experiences with moral deliberation and the moral deliberation project (see Appendix B). Third, the external researcher executed an explorative analysis of all written reports of the moral deliberation sessions. Fourth, the external researcher studied the self reports of the facilitators and the notes of evaluative meetings with the coordinators and managers at the several wards.

2 This may be seen as contrary to the basic (theoretical) assumptions of dialogical ethics. After all, a genuine dialogue is open and one should not start a moral deliberation session with stating that restraints are always morally bad and that decreasing the amount of restraints is always morally better. What is morally good should get defined within concrete situations and by means of a dialogue. Ergo, the ultimate answer to the question whether restraints are morally wrong (or good) depends on the concrete circumstances and the dialogue of the involved stakeholders. Hence, one should prevent any instrumental use of the (participants within a) moral deliberation. In order to guarantee a good and qualitative dialogue, moral deliberation sessions should entail a 'free moral space' (21). These basic assumptions were discussed with the board of directors and the division managers and one agreed upon these methodological and moral conditions.

3 This questionnaire has been tested in two pilots (see references 4 & 5).

## Results

During the time of this study, 50 moral deliberations were registered, of which 41 had been organized in 5 specific wards and 9 were incidental MCD sessions elsewhere. These 50 MCD sessions were evaluated with 220 questionnaires. The exact response rate could not be calculated since the attendance lists of the MCD sessions were not always complete (estimated non-response: 35%). In this section, four kinds of results are presented: A) the general quantitative evaluation of the MCD sessions, B) a qualitative evaluation of the MCD sessions, C) an enumeration of some of the moral topics that were discussed, and D) the reported influence from the moral deliberation sessions on the regular work processes of the health care employees.

### General quantitative evaluation of the moral deliberation sessions

Participants of the MCD sessions evaluated the sessions in general with 7.62 (all answers on 1 – 10 scale). On average, they evaluated the quality of the dialogue during the MCD with 8.11 (items included issues like: no interruptions, good listening, respecting other opinions, etc). About 85% of the participants (187 out of 220) expected that the MCD sessions influenced their daily work. The MCD sessions related strongly to the daily activities of the participants (8.06) and really touched upon the heart of their work (7.87). Participants reported relatively serious difficulties with recognizing moral issues within their work (3.81), formulating good moral questions (which they had to prepare for each MCD session) (5.27), and changing their initial moral judgment (4.18). The facilitators were evaluated positively (7.95). On average (9 items), the facilitators received a 7.82 (see appendix A). With respect to the results of the MCD sessions (regarding the moral case), participants reported a serious increase of insight in the moral issue (7.95), a reasonable degree of consensus (7.3), and a relatively low score for getting an answer with respect to the moral question (6.65).

### Qualitative evaluation of the moral deliberation sessions

Almost all respondents reported that the MCD sessions were useful and relevant for their work. Participants appreciated the fact that they could *share experiences* around critical cases (respondents indicate usually there is no pre-structured time in which critical experiences can be shared). Second, they appreciated the *systematic and thorough reflection on one case* (rather than just superficially touch upon all kind of different cases in one meeting). Participants said they learned to see various aspects and arguments of a single moral case. Individuals also said they would never reach such a rich analysis

of a single case on their own. A third group of answers pointed at *the improvement of participants' moral competency*: (the MCD sessions improved my awareness of my behaviour and my thinking). They also mentioned they learned to listen critically and sincerely, to postpone their moral judgments, to become aware of the perspectives of the others, and to strengthen the aim of understanding (rather than trying to convince the other). Associated with this was the improvement of employees' constructive assertiveness; they felt more secure to share their uncertainty and their questions (uncertainty and asking questions are fundamental preconditions of learning and dialogue). A fourth category of answers concerned *the improvement of both the cooperation and the dialogue among (multidisciplinary) team members*. Team members may be inclined to have different interests, unequal power relations and prejudices regarding the arguments of the others (in particular among different disciplines). Through the methodology and the codes of conduct of the MCD sessions, participants became more open-minded, constructive and still critical. A concrete example is the reflection on the conceptual and moral status of (making an agreement) and on the process of decision-making in general.

In rare cases, a single participant reported negative aspects of the MCD session. These aspects concerned the justification of MCD in general (The professional knowledge, the codes of conduct or the law is very clear about this subject so why should we share this?) or (This is time consuming and in contrast with the justified fact that health care insurance companies and the managers force us to spend our time only if we achieve results).<sup>4</sup> Some aspects concerned the results of the MCD session (We did not reach consensus) or (Too much reflection, too little decisions). Other critical aspects referred to the lack of the presence or commitment of the manager and other disciplines such as the psychiatrist or psychotherapist.

### Some of the moral topics that were discussed

The choice for moral questions and the content of the moral cases were biased by the fact that most of the MCD sessions took place within the institutional project of the (moral) quality of restraints. Accordingly, approximately 50% to 60% of the cases touched upon restraints (e.g. timing of restraints, execution of restraints, justification of restraints). Other moral themes that received relatively much attention were: treating clients and colleagues respectfully, the twilight zone between respect for autonomy and good care for clients, (limits of) responsibilities of health care professionals, (tensions regarding) cooperation and respect among colleagues. When we look at the formulation of the moral questions, we can see that particular methods of moral deliberation led to particular formulations of the moral question at stake. The Socratic dialogue resulted in conceptual and fundamental

4 More often the opposite reasoning was found: (The MCD sessions are important to us since more and more we are forced to produce results rather than good care) or (Only by means of spending some time for reflection or dialogue, results and the quality of the results can be guaranteed).

questions, the Dilemma method resulted in more concrete questions. Some of the questions were:

- What is a right timing to start applying restraining methods? To what extent should we try to prevent restraints?
- When has freedom precedence above safety?
- What is a professionally and morally right assessment of a threatening situation?
- Is it morally justified that the fear of inexperienced young nurse-students or the information on incidents of patient's previous history, sooner and more often lead to restraining interventions?
- When am I allowed to touch the patient if I want to comfort him/her?
- To what extent is a patient morally allowed to refuse a treatment offer?
- Should we treat a patient who commits a crime as a (mentally ill) patient or as a criminal? Therapy or jail?
- To what extent are we as care givers morally responsible for possible harm of an autonomous patient who consciously has chosen for risky behaviour?
- Is paying attention to the sexual desires of patients' meddlesomeness or good care without taboo?
- When should we use force in order to put a patient under the shower?
- What is respect?

#### **Influence on the regular work processes of the health care employees**

Most participants (N=187: 85%) reported they expected or already experienced the MCD sessions influenced their work. A small group (7%) was not (yet) sure about this, and some (3%) thought it would not influence their work at all. A single individual of this last group clarified his/her negative response: «We need to do MCD sessions more often» or «Changes are only possible if all team members and disciplines participate in the MCD session». A first category of influence centres on the *awareness of the existence of various perspectives and alternative behavioural options within one single moral case during daily work processes*. Participants felt less locked up in their (limited) way of thinking when they experienced a moral dilemma. A second category concerned the *quality of cooperation and decision-making*: team members on the ward felt more secure to question behaviour and thinking in a constructive way. Also a more creative and positive attitude and less taboos were mentioned as results of the MCD sessions (i.e. a better and more sincere listening). The participants felt more open-minded for reflection and pos-

sible change of current operating procedures. They were more aware of, and interested in, the opinions and arguments of the others. A third category of answers is related to *the improvement of grounding one owns professional attitude*: professional behaviour was more attached to explicit values and norms (instead of doing things because of routines). Answers belonging to this category also came from participants who noticed that they felt more in contact with their basic passion and motivation for their work. Some other participants realized that fast decision-making and immediate problem-solving processes at first sight seem (time-) efficient, but through the MCD sessions they learned that the opposite could also be true.

Finally, during interviews, facilitators, coordinators and managers emphasized the importance but also difficulty of guaranteeing good organizational conditions for the moral deliberations and the moral deliberation project. Almost every one realized that the results of the MCD sessions could and should have much more consequences for their ward, and also for the other wards within the same division. Some of those who were interviewed said they missed (a philosophy regarding) the interaction and integration between MCD sessions at various wards and quality management and policy issues at the institutional level. According to some respondents, this was connected to the fundamental vulnerability of ethics and moral deliberation in general: «Although moral deliberation is very concrete and focuses on improving the quality of care, people often associate moral deliberation with descriptions like «soft», «vague» and «without obligations». Or: «A positive evaluation of the MCD sessions alone is not enough to guarantee their future existence».

#### **Discussion**

This paper presented the first results of a project that studies the evaluation of moral case deliberation by its participants during a 4-year moral deliberation project in a mental health care institution in the east of the Netherlands (GGNet). The results focused on the quantitative and qualitative evaluation of 50 moral case deliberation sessions which resulted in 220 submitted questionnaires. Subsequently the described results referred to: the general quantitative evaluation of the MCD sessions, the qualitative evaluation of the MCD sessions, the enumeration of some of the moral topics that were discussed, and the reported influence from the moral deliberation sessions on the regular work processes of the health care employees.

GGNet invests in moral deliberation in a very serious, wide and efficient way. It is likely, that this fact contributed to the positive results of this study. Both qualitative and quantitative results showed that the MCD sessions were regarded as useful and the facilitators were evaluated positively. Most participants considered the relevance of MCD for their daily

work to be high and had a positive judgment of the quality of the dialogue during the MCD. They experienced difficulty with finding the moral dimension of the issue and formulating the right moral question. Multidisciplinary participants reported that they learned to share various perspectives on good care within a single case. Their open, straight, constructive communicating and moral sensitivity increased; their presuppositions, prejudices and automatic responses decreased. Central topics, among many others, were: acting in line with agreements, postponing restraints by looking for alternatives, thinking with instead of thinking against the other, cooperation and true dialogue instead of exchange of opinions, improvement of structure, depth and nuances of the decision-making processes, appropriate level of pressure for showering, just allocation of caring time. In interviews, stakeholders said the lasting implementation of moral deliberation within GGNet is not yet guaranteed. They emphasized the inherent organizational vulnerability of ethics and moral deliberation, especially since health care institutions are more and more forced to become focused on efficiency and results (according to pre-defined criteria from providers of care insurances (which are not synonymous with good care)). They pointed at the importance but also difficulty of guaranteeing good organizational conditions for moral deliberation in order to be structurally successful (e.g. the connection with quality management).

In accordance with the positive evaluation so far, GGNet currently started new moral deliberation activities (besides the project of the quality of restraints): a) a seven-month train-the-facilitator program has been started; b) the board of directors and managers will attend 2 MCD sessions each year; c) the board of directors started a 2-year project on sexuality policy in which MCD sessions are planned with psychiatric (ex-) clients and caregivers; d) the board of directors ordered a new 'Ethos' project in which every part of the organization has to plan 1 to 3 MCD's on values which are part of the organization's mission statement in order to develop an institutional code of good behaviour (1 year); e) the moral deliberation group developed a moral deliberation website (with the dilemma of the month); f) every trimester, the moral deliberation group will send a summary report of all moral issues from the MCD sessions to the management team; g) the moral deliberation group started a new semi-experimental research on the effect of MCD sessions on the amount of reflection within teams.

Future research on moral deliberation projects should find out if the continuation and implementation of moral deliberation (e.g. by means of trained facilitators) will be successful. Especially, monitoring of results of and agreements made in MCD sessions and their integration with institutional policy issues (both top-down and bottom-up) need serious attention. Furthermore, alternative less time-consuming methods and activities for dealing with moral issues at the ward are needed in order to improve the moral competency and quality of care during regular work processes. Finally, theoretical frameworks and new research methods are needed in order to study the relationship between (various methods of) moral deliberation, the moral competency of health care employees and the quality of care for clients.

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**Competing interests:** None

## Zusammenfassung

### Die Einführung der moral case deliberation im holländischen Gesundheitswesen: Die Erweiterung der moralischen Kompetenz der qualifizierten Arbeitskräfte und die Verbesserung der Behandlungs- und Pflegequalität

**Hintergrund:** Moral case deliberation (MCD) besteht in der systematischen Reflexion über aktuelle ethische Fragen von Experten des Gesundheitswesens, die von einem Ethiker unterstützt wird. Zurzeit existieren nur wenige Publikationen zur klinischen Anwendung und zur empirischen Erforschung der MCD.

**Ziel:** Die Ziele dieses Artikels bestehen darin, a) die MCD zu definieren, b) den theoretischen Hintergrund zu beschreiben, c) ein vierjähriges Projekt zu beschreiben, das die MCD in einer psychiatrischen Klinik einführen will und d) die ersten Resultate einer Studie über die Qualität der MCD-Sitzungen aufzuzeigen.

**Methode:** Die MCD-Sitzungen wurden anhand von drei verschiedenen Methoden untersucht, bei denen es sich erstens um die Maastrichter Evaluationsfragebögen für die Sitzungsmitglieder handelt, zweitens um Interviews mit den involvierten Personen (z.B. der Moderator der MCD und der Spitaldirektor) und drittens um das Sammeln von MCD-Berichten, Notizen der Moderatoren und Evaluationsberichten.

**Resultat:** Sowohl die qualitativen als auch die quantitativen Ergebnisse der 220 eingereichten Fragebögen von insgesamt 50 MCDs haben aufgezeigt, dass die MCDs als sehr nützlich beurteilt wurden. Die meisten Teilnehmer schätzten die MCD für ihre alltägliche Arbeit und erachteten die Qualität der Dialoge als hoch. Zum einen haben zudem die offene, direkte und konstruktive Kommunikation und das moralische Empfindungsvermögen der Teilnehmer zugenommen und zum anderen sind ihre Vorurteile und unreflektierten Stellungnahmen weniger geworden.

**Diskussion:** Die zukünftige Forschung wird den langfristigen Einfluss der MCD auf die Behandlungs- und Pflegequalität untersuchen müssen. Aus diesem Grund wird der nächste Schritt dieses Projekts darin bestehen, die nächstfolgenden Resultate der MCD's zu evaluieren und diese in die politische Debatte einzubinden.

## Résumé

### Appliquer la délibération morale des cas dans les institutions de santé de Hollande; améliorer la compétence morale des professionnels et la qualité des soins

**Contexte:** La délibération morale des cas (DMC) consiste en la réflexion systématique sur des questions morales concrètes amenées par des professionnels de la santé, et facilitées par un éthicien. Il n'existe que peu d'information publiée sur la pratique clinique, ou sur l'étude empirique, de la DMC.

**Objectifs:** Les objectifs de cet article sont: A) fournir une définition de la DMC; B) décrire son assise théorique; C) décrire un projet d'implémentation sur quatre ans de la DMC dans un hôpital psychiatrique; D) présenter les premiers résultats d'une étude sur la qualité des sessions de DMC.

**Méthode:** Les sessions de DMC ont été étudiées: a) en appliquant les questionnaires d'évaluation de Maastricht pour les participants des sessions de DMC; b) par des entretiens de personnes impliquées (par ex. les facilitateurs de DMC, le directeur de l'hôpital); et c) en récoltant les rapports de DMC, les notes informelles des facilitateurs, et les rapports des évaluations intermédiaires.

**Résultats:** Les résultats qualitatifs et quantitatifs des 220 questionnaires sur 50 DMCs montrent que les DMC sont considérées comme très utiles. La plupart des participants voyaient la pertinence de la DMC pour le travail quotidien et en jugeait la qualité positivement. Leur capacité à communiquer de manière ouverte, directe et constructive avait augmenté; leurs présuppositions, préjugés et réponses automatiques avaient diminué.

**Discussion:** L'impact à long terme sur la qualité des soins devra faire l'objet de recherche appliquée future. En conséquence, l'étape suivante de ce projet se concentrera sur (la méthodologie pour) une exploration du suivi des DMC, et l'intégration de ses résultats avec des enjeux de politique institutionnelle.

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## Appendix A

### Maastricht evaluation questionnaire for participants of moral case deliberation sessions

- A. Evaluate this MCD by giving a mark between 1 and 10  
 What was the central issue of this MCD according to you?  
 For what reason was the MCD useful/not useful?  
 What did you learn during this MCD?  
 What should be done now, as a result of this MCD?  
 Was there anything that lacked during this MCD?  
 Which question or case would you like to discuss at a next MCD session?
- B. To what extent did the theme of this MCD relate to your daily activities?  
 Does the theme of this MCD touches upon the heart of your work?  
 How difficult was the moral question during this MCD according to you?  
 Did this MCD result in an answer of the moral question?  
 Did this MCD result in more insight regarding the theme of this MCD?  
 To which degree did the group reach a consensus?
- C. Do you think that MCD in general influences your daily work?  
 If yes, in which way?
- D. All participants got a reasonable change to participate (Give a mark between 1 and 10)  
 Participants did not interrupt each other  
 Participants listened to each other  
 Participants respected each others opinions  
 The order in the group was good  
 Participants were interested in the theme  
 The room was quiet and suitable for MCD
- E. How difficult is it for you to recognize a moral case in your daily work?  
 How difficult is it for you to formulate a good moral question?  
 To what extent has your initial opinion changed during the course of this MCD?  
 To which degree did you become more aware of others opinions and values?  
 To what extent have the moral aspects of the case become clear?  
 What aspect of the case made the case a moral case?
- F. The facilitator looked for an open atmosphere in which I felt secure enough to express myself (Give a mark between 1 and 10)  
 The facilitator encouraged the communications among participants  
 The facilitator stimulated us to reflect upon the moral dimension of the case  
 The facilitator took care for mutual understanding among the participants  
 The facilitator directed the content of the MCD  
 The facilitator often called upon his/her ethics expertise for the course of the MCD  
 The facilitator encouraged our critical reflection  
 The facilitator kept an eye on possible straying regarding the initial moral question  
 The facilitator worked up to a consensus.  
 Evaluate the facilitator by giving a mark between 1 and 10

## Appendix B

### Questions semi-structured interview

1. How is moral deliberation generally understood?
2. How do you understand moral deliberation?
3. How do you think that the hospital understands moral deliberation?
4. In which way do you think that this organization profits from moral deliberation?
5. In which ways can moral deliberation be used within this organization?
6. Do you think some departments/wards need moral deliberation more then others?
7. Which other methods or activities could be used in order reach the same goals as with moral deliberation?
8. When do you consider moral deliberation successful?
9. Which conditions /requirements are needed in order to make moral deliberation successful?
10. How do you understand the results of moral deliberation within GGNet so far?
11. What are pitfalls of this moral deliberation project according to you?