Erasmus Mundus Master in Applied Ethics
Year: 2010/2011

University of Utrecht

Master thesis

Title:

Should moral case deliberation be part of clinical practice?
A review of certain assumptions within the concept of moral case deliberation

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Summary

Healthcare professions are known to be inherently moral. They confront on a daily basis essential ethical problems. However, my experience as a nurse shows a different reality. In practice healthcare professionals often have difficulty to even identify the ethical problem before attempting to resolve the situation. In a plethora of literature moral case deliberation (MCD) is discussed as method to address these limitations of healthcare professionals. In general MCD can be defined as a discussion with the different parties involved about the ethical issues of a real case in clinical practice.

In order to achieve a more comprehensive understanding of MCD I identified MCD's main features and reviewed two methods (Clinical pragmatism and the Hermeneutic method) as examples. This review unfolded certain assumed normative ideas more or less common in many models of MCD. However it is unclear how to understand these normative ideas and as to whether they should indeed guide MCD.

Throughout the thesis I concentrate on some of these assumptions. I focused on the three, which I considered the most relevant for the implementation of MCD into clinical practice: 1) the involvement of everyone concerned the case, 2) consensus as an ideal within MCD and 3) MCD improves decision making. The aim of the thesis was to reflect on how these assumptions could be reasonably understood and to outline remaining ambiguities and points for critique in their application within MCD. Hence I am not arguing whether MCD should be part of clinical practice or not, I am critically reviewing the process of MCD within clinical practice.

Finally, in the thesis it is illustrated that for each assumption various plausible explanations are possible, which all might have a role in practice. The usefulness of MCD might depend on what relevance these explanations are given in practice.
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CHAPTER 1: INTRODUCTION

A 36-years-old woman had battled breast cancer since 2005. She was diagnosed the same time when she gave birth to her daughter. Despite surgical and chemotherapeutical treatment her conditions worsened and at the end of the year 2009 she was recovered in the Palliative Care Unit where I was employed as a general nurse. Her disease related physical symptoms were pain, nausea, severe cachectic state and asthenia. Although the palliative care team succeeded in alleviating the physical pain, the patient described an unbearable social-psychological pain, consisting in the feeling of loss of her life and her family. Being in a state of total physical and psychological depravation she could no longer bear to continue her life this way and asked for terminal sedation as last resort. Terminal sedation was the patient’s wish, however, it was not clear whether this would be the most appropriate intervention or whether other options should have been more explored.

Following a psychiatric consultation to exclude possible depression and a review of the case by the hospital intern ethical committee, which on the basis of the physicians’ deontological codex and the principle of autonomy supported the patient's decision, her request for terminal sedation was granted. Despite the fact that the major ethical considerations appeared to have been explored, the staff were retained a moral uneasiness. Firstly the nurses felt that their professional and moral opinion was not sought and/or taken on board during the decision making process. They felt that the decision making process had not permitted them to voice their viewpoints on the issue in question. Secondly, in the absence of feedback and reassurance from the team, the physician did not feel supported in his final decision. The failure of the team to support the physician was due to their lack of confidence in what the correct decision should be. The nurses were not part to the decision making process or how the final decision was arrived at and as a result it made it difficult for them to carry out the orders in question. The nursing staff felt demoralised at having to carry out orders when they were not party to or concurrent with the decision. Hence, despite the ethical consultation, there was a general perception that a decision was taken without having clearly considered the ethical problem and ethically relevant perspectives. The main concerns were as follows: Were all the values considered? Was the family’s and/or the caregivers values considered? Were the values of relevant healthcare professionals considered?

Healthcare professionals are known to be inherently moral. They confront essential ethical

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1 Terminal sedation means to sedate the patient up until her death.
problems on a daily basis. Nevertheless, as the example above shows, healthcare professionals are often incapable or insecure about how to approach these issues properly. There might be many reasons for this. Firstly, the increased variation of ethical problems in clinical practice and secondly the increase in the complexity of each case. The healthcare sector has experienced many considerable changes in the last fifty years. The significant development in medical treatments might have lead to more complex ethical dilemmas. Consider cardio-pulmonary resuscitation for example. Although this is a procedure which saves many lives, its use in patient with cancer is not clear-cut. In addition, the occupational profile of doctors, nurses and other healthcare professionals has changed over the years. There is an increased awareness of one's own responsibility in making decisions and carrying out interventions. A referral to a system of decision hierarchy is no longer considered adequate. Changes in ethical conviction also challenge the ethical approach in healthcare. An example is the centralisation of the patient's autonomy, which queries the usual paternalism in healthcare and again adds factors to be considered (Steinkamp and Gordijn, 2010).

Clinical practice demands continuous ethical decisions making in different scenarios and among different people to determine what the right thing to do would be. Therefore it might be considered as essential to have an understanding of the different ethical realms of our healthcare profession and an ability to approach the decision-making in an appropriated way. Otherwise unsatisfactory decisions might be reached and repeated leading to moral unease about the decision and subliminal conflicts within the team and different professions.

In determining how to resolve these ethical challenges, I encountered much literature dealing with the implementation of moral case deliberation (MCD) in clinical practice. The interest in MCD increased considerably in recent years in the Netherlands and Germany as a method of dealing with ethical problems (Abma et al. 2008, 2009 and 2010; Gracia, 2001 and 2003; Steinkamp and Gordijn 2003 and 2010, 2010; Molewijk et al, 2008a and 2008b; Weidema et al. 2010). Moral case deliberation can be roughly understood as a method to approach ethical issues within clinical practice where they take place. Central to case deliberation is the critical consideration of different factual and moral perspectives of the persons concerned in the case. It is expected that MCD can give a relevant contribution in the appropriated approach of ethical issues in clinical practice.
1.1. **AIM OF THE THESIS**

In researching MCD I have a keen interest in its use in view of my professional background and my experience in the healthcare sector. In this thesis I propose to explore the method and its use in clinical practice.

Reviewing the literature of MCD it seemed to me that particular areas of this method are built on certain assumed normative ideas, which presuppose certain conditions for the efficiency of the method. These assumptions created various questions and the interest to have a better look at them. Hence, this thesis does not aim to give a clear “yes” or “no” answer to the question whether MCD should form part of clinical practice, but I will examine how the assumptions can be reasonably understood. I will determine whether there are possible uncertainties in the need of further investigation. I would also like to determine whether there are specific aspects of the assumptions which should be viewed more cautiously and further critically reviewed before used in practice.

The first part of this thesis is engaged to give a general outline of MCD. The second part will have focus on three of these encountered assumptions. As the aim of this thesis is a more practical one, I will touch upon the philosophical background of MCD only as much as it is needed for the general understanding of the concept.

MCD in itself does not exist as one uniform method, but is split up in different sub-methods, varying in procedure and aims. Therefore, to give an example of the structure and different aims of MCD, I will present two methods of MCD: Clinical pragmatism (described by Fins et al. 2003) and the Hermeneutic method (described by Steinkamp and Grodijn, 2010). The reason for this choice is foremost a personal interest, as I find them relevant for my professional realm. However, I see them also as representative examples for demonstrating key features of MCD.

I am especially interested in learning about the aims of the two methods, their requirements and certain presuppositions they include. The content of this thesis treats less the specific details of the various steps in each method, as this might be less relevant for the general understanding. On that basis I will present a short outline of the general concept of MCD, including relevant viewpoints such as the ones of Tineke Abma and Bert Molewijk. I propose to make a case highlighting the fact that certain realms of MCD seem to be based on certain assumptions, which are not fully clear and/or explained in the literature. I select three different assumptions which I think are relevant and useful to analyse and investigate in relation to the practical implication in daily clinical practice.
MCD or certain methods of it presuppose that to an appropriated handling of ethical problems within clinical practice following features should be relevant:

a) everyone concerned with the case should be equally involved
b) consensus is an ideal within MCD
c) MCD improves decision-making

The first assumption encountered pertains to the equal involvement of all parties concerned in the case. I make a distinction between an instrumental and an intrinsic reason for involvement. Furthermore, I will examine what this differentiation would mean for the different persons involved. Another point I will consider who should be involved and in a second step I will investigate what equal involvement would mean.

The next assumption, I will investigate, deals with the role of consensus in MCD: I will analyse whether the notion of consensus is really an ideal or whether there should be some scepticism when one talks about consensus in deliberation, especially in terms of arriving at the right decision.

The final assumption is about decision-making. I analyse mainly the questions in what way MCD would improve decision-making. In this connection, I focus especially on the meaning of improvement.

In conclusion, this thesis helps to show that for each assumption various plausible explanations are possible. The usefulness of MCD in clinical practice might depend on what relevance these explanation is given in practice.
CHAPTER 2: METHODS OF MORAL CASE DELIBERATION

In the last few years it seems that MCD gained on recognition as a method to approach ethical issues in clinical practice. Major recent work about this method was carried out especially in the Netherlands, where in this method is now promoted by the government (Weidema et al., 2010). MCD is being increasingly considered for clinical practice in Germany also (Steinkamp and Gordijn, 2010).

Along general lines MCD can be defined as a discussion about ethical issues of a real case in clinical practice. Central to the deliberation is the consideration and evaluation of different arguments through dialogue among the different parties involved in the case. It aims to help to approach ethical issue in the form of structured conversation method (Abma et al., 2009; Moleweijk et al., 2008b; Steinkamp and Gordijn, 2010).

In order to give an outline of how different methods work, how they are structured in practice and what their essential aims could be, I will initially present two different methods of MCD. Although this description is meant to give a rough outline of two models, it is important to be mindful of the fact that different variations of the methods themselves exist. Depending on the clinical environment and the different settings of health care delivery the models might be amended. In addition to the two models presented, several other methods for MCD exist (Steinkamp and Gordijn, 2003). Sometimes the methods overlap in their structure and in their aims. For instance, the aim of the Hermeneutic method might be identified in most of the other methods.

Without devaluing other methods, I chose Clinical pragmatism and the Hermeneutic method as examples for MCD methods. In my opinion, they are at present the closest to meeting the most urgent ethical needs of the various parties in clinical practice. I draw this conclusion, in first instance, from my personal experience as a nurse. As explained already in the introduction, both my colleagues of the multidisciplinary team and I experienced problems with moral decision making to the extent that we had difficulty even identifying the moral problem in the first instance. The final decision often felt unsatisfactory as it was not evident that it had been properly and duly considered. Accordingly, moral remorse or residue lingered amongst the team. The team were unable to address the underlying reasons for their dissatisfaction and resolve the issue. I see it therefore as most useful for my practice to learn about the methods which specifically aim to support decision-making and
which facilitate an understanding of the ethical problem behind the feeling of moral intuition.

My views concur with the results of the research undertaken by Svantesson et al. (2008)\(^2\). Their investigation of a “Swedish nurses' and doctors' experience from one model of ethics rounds” (p. 399) results among others in a voiced need of ethical solutions\(^3\) and for clarification and a better understanding of the ethical scenarios.

Further, we will see that the “better understanding”, the main aim of the Hermeneutic method, also facilitates an understanding of the general perception of MCD. By describing this method I propose to illustrate the concept of understanding already at the beginning of the process. Understanding, in my opinion, is a fundamental precondition to be able to approach an ethical case in an appropriate manner. Without understanding a disease, one might not be able to treat it properly. The same applies to ethical problems. Without understanding the background of one's ethical conviction one might not be able to deal with an ethical problem adequately\(^4\). Hence, better understanding should not only stimulate a broadened thinking but it should also improve the capability to identify the ethical problem and to create appropriate arguments for distinguished ethical positions.

During the description of these two methods, certain deficiencies of the methods will be alluded to. However, given that my aim is to come to a better insight in MCD, I will not discuss such weaknesses in-depth. Others, such as consensus within Clinical pragmatism will be addressed at a later point. The aim of presenting these two methods is to give some examples of MCD and to deduce from there a general, broader concept of MCD.

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\(^2\) The research consisted in the qualitative evaluation (through interviewing the participants) of various MCD sessions implemented in clinical practice. The sessions took place in a nephrology department.

\(^3\) Interestingly this was mainly expressed by nurses, but that would be might be subject of another thesis.

\(^4\) Of course there is still the possibility of guessing and formal decisions such as referring to ethics committees or to postpone the decision. I doubt, however, whether this would really correspond the idea of the inhered morality of a healthcare professional.
2.1. CLINICAL PRAGMATISM

I will start with Clinical pragmatism, as it was one of the first developed methods for MCD in clinical practice. Clinical pragmatism has its roots in the United States of America (Steinkamp and Grodijn, 2003).

My analysis is based on the description of Clinical Pragmatism made by Joseph Fins et al. (2003), one of the main proponents of Clinical Pragmatism. Fins and his team conceptualized this method in the Cornell Medical Centre, New York City and contributed with several publications to the practical implication of this method (Steinkamp and Grodijn, 2003). They deduce their method from John Dewey's theory of pragmatism (Miller et al., 1996; Jansen, 1998), which is characterized by the attempt to connect ethics and science. Following Dewey, an ethical assessment is always context-bound. Deliberation, thus, will be activated by an ethical problem developed in a certain context with different parties involved. It tries to find an answer applicable to this specific context. Therefore it is essential to consider in the discussion beside the different ethical aspects also the different scientific facts. However, in Dewey’s conviction moral beliefs, opinions, norms and principles have to be treated as hypotheses and it depends on their experimentation in practice if they are applicable, if they need further elaboration or should even be rejected.

In view of this background, Fins' et al. clinical pragmatism is an attempt to solve ethical problems in health care by integrating clinical and ethical thinking. Problem-solving is regarded as an interactive process among the parties concerned in the case. They maintain that “because it [ethical deliberation] concerns shared problems in social contexts, [it] is a cooperative, communal activity” (Miller et al., 1996, p. 50). Clinical pragmatism refuses to accept a pre-built solution by external experts. The whole deliberation process is held among all people involved in the case. Fins et al. (2003) concurs with this: “Moral problem solving is located within the context of reciprocity, in which all concerned parties are entitled to be heard [...]” (p. 30). In Clinical Pragmatism ethicists do not play the role of an external consultant giving advice, but are integrated in the deliberation as a facilitator with expertise.

The aim of Clinical pragmatism is an ethically acceptable consensus regarding how to solve the ethical problem. They reject moral principles and norms as a reference point for the soundness of a decision and consider consensus sufficient to reach a morally acceptable decision. They do not claim that their result would be the right decision. However, they are content to make a decision based on the fact that everyone agrees that their decision represents an ethical reasonable and
maybe in practice the most feasible choice.

To achieve this aim, Clinical pragmatism is built up in different interconnected steps (Fins et al. 2003). Firstly, it is necessary to collect all relevant case data in order to assess the case properly. It is important that the medical condition and prognosis is not considered in isolation. It is necessary to assess the social patterns, such as family dynamics or living conditions. Secondly, it is essential to allow all parties involved the opportunity to participate. This method tries to identify all moral relevant considerations in connection with the case. This includes all moral values, principles, standards and ethical guidelines, such as professional ethics and value agreements. Moral intuition and its narratives, as part of the ethical experience in the healthcare environment, also figures. Additionally, to make the approach even more integrative, Clinical pragmatism also takes on an element of casuistry by comparing the case with other similar ones, as an option to solve the problem (Steinkamp and Grodijn, 2003). Having explored all aspects of the scenario, possible goals of treatment and care will be evaluated and determined. Discussion and negotiation will eventually lead to an agreed intervention, which then will be implemented in practice. Fins et al. (2003) make clear that this negotiation requires from the participants not only good communication skills but also the capacity to see and understand the other's viewpoint and to consider changing one’s own viewpoint in the perspective of the received information. Finally, the implemented result of the deliberation remains open for evaluation. Under a periodic review the intervention can, if needed, be modified and adapted to newly developed conditions.

In summary, the key to Clinical pragmatism is to solve ethical conflicts by seeking consensus on the basis of a thorough process of inquiry, discussion, negotiation and reflective evaluation. In approaching a solution, it attempts not only to include all relevant facts but also all moral values, principles and norms, which might influence the case. All parties may express their opinion and contribute to the final solution. In that way Clinical pragmatism emphasizes the responsibility and relevance of each one in contributing to the whole decision-making process. Its final aim is to reach an ethically acceptable consensus among the different parties for a practical solution of the problem. Clinical pragmatism “seeks solutions that are workable in the real contexts of clinical settings in which clinicians and patients interact” (Fins et al., 2003, p. 29).

The method in the Netherlands developed Nijmegen method is similar to this method (Steinkamp and Gordijn, 2010). Although this method has similar steps the intended outcome can be different. The goal of the Nijmegen method is to reach a decision, whereby consensus is seen as important but not essential. However, it remains quite unclear when a decision is reached, leaving it
at the end to the weight of arguments if a certain form of action can be accounted for or not.

### 2.2 HERMENEUTIC METHOD

The Hermeneutic method is different to Clinical Pragmatism. While Clinical pragmatism aims to resolve ethical conflicts through consensus amongst the various people involved in a specific case, the Hermeneutic method aims at better understanding of why a particular situation is perceived as ethically problematic in a specific case. The Hermeneutic method extracts its ideas from hermeneutic ethics. Hermeneutic ethics is about the understanding and interpretation of one's own and others' moral experience. Personal moral experience is classified as a valuable item, not only for oneself but also for others. Attempts to understand and analyse this experience might facilitate to recognise the possible ethical truth of the other's perspective (Lesch, 2006; Porz and Widdershoven, 2010).

With better understanding, I think in this context is mainly meant that the person/group with moral uneasiness will be in a position to express the uneasiness in addition to identifying the reason for this uneasiness. I believe that the Hermeneutic method contributes to a better understanding not only of one's own viewpoint, but through critical confrontation, the viewpoint of others. Understanding might give the insight that there are various acceptable ways how an ethical issue can be interpreted and approached. Further, understanding might also comprise the realisation in the group that at the very end not so much ones ethical values are conflicting, but how each person weigh them within the specific case. Understanding serves to highlight the various viewpoints and the conflicting issues within an ethical problem. Conversely understanding however also serves to emphasis the common ground in the decision making process.

Starting point of the Hermeneutic method is not a concrete question regarding what to do in a certain situation, but a sense of moral uneasiness on the part of one person or several members of the healthcare team (Steinkamp and Gordijn, 2003). The Hermeneutic method is suitable for situations where it is about understanding a moral uneasiness and clarifying the situation itself where it developed.

The Hermeneutic Method does not aim to find a direct solution to the problem thus differing from Clinical Pragmatism and the Nijmegen method. Notwithstanding these differences, the Hermeneutic method may influence decision making in an indirect manner. The Hermeneutic
method might produce a general improved understanding of clinical practice with its moral dimensions and hence influence the quality of decision-making in the long run (Steinkamp and Grodijn, 2003).

The Hermeneutic method is described by Steinkamp and Gordijn (2010) as an attempt to interpret the basic moral intuition of healthcare professionals in respect of ethical problems. I think, moral intuition is understood here as immediate moral beliefs invoked by a case, culture, society and work. In clinical practice intuition might be a determining factor in decision-making. Although this would per se not be a bad thing, it might be questioned if intuition can stand as an ethically valid argument for a decision, as the comprehension for it might be partly or completely lacking. Intuition might base on cultural convictions which not necessarily have to be correct. Hence it would need some critical reflection and evaluation before accepting it. An individual might sense that it would be morally wrong to continue treatment in a terminally ill person leading the individual in question to arrive at a decision to cease treatment. It is not clear if a decision of this nature was formed on the basis of beneficence, quality of life, futility or the wish of the patient, which are all different possible approaches with different meanings of the same situation. The Hermeneutic method aims to create better general understanding and clarity of the ethical issue and the caused ethical reaction within the case. The starting point for the Hermeneutic method (Steinkamp and Gordijn, 2010) is a moral intuition respective a case, which still needs to clarify the meaning of the intuition and the causing moral issue.

The Hermeneutic method Steinkamp and Gordijn (2010) sets out the structural characteristics of the method in the book “Ethik in Klinik und Pflegeeinrichtung; Ein Arbeitsbuch” (Steinkamp and Gordijn, 2010) emphasise the fact that there are different models dealing with structuring the discussion. They acknowledge that their model is just one of different ways in which the discussion can be structured.

The Hermeneutic method starts from a concrete case, similar to Clinical pragmatism. While the elevation of all case related facts is considered important, it is secondary to the collection of the different moral opinions within the group. The Hermeneutic method is more about collecting different narratives of the situation. Telling the story about a situation where moral uneasiness was experienced, is seen as a way to express morality. Hermeneutic ethics assumes that by telling the

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5 As described in the model of the Philosophy Department of the University of Nijmegen.
6 Different to Clinical pragmatism where the ethical question is already defined and moral intuitions are considered as part of the clinical assessment.
7 “Ethics in clinic and care facility; An Exercise Book” (free translation by the author).
story one imparts some of his/her morality (by the way how it is told, by emphasizing certain aspects of the story, etc.). To be able to understand and reach the person's fundamental morality, morality still has to be defined and explained clearly. To do so the method collects different perspectives from the case. Further, it encourages the participants to inter-change certain elements within the story, such as the development and the people involved. This might facilitate to a more holistic understanding of the starting situation. The next step seeks to define a more general ethical problem in such a way, that the case could stand as an example for it. This approach should assist making the ethical problem more evident. The last step consists in the translation of the ethical problem in the language of different ethical concepts, such as norms, duties, rights, values, ideals and virtues. It is hoped that this method would facilitate a better understanding of what this problem means using the different ethical approach. Finally, the ethical perception before and after the discussion is compared. This comparison should train the ethical consciousness and constructs a more fundamental ethical basis for further decision-making.

It is considered as essential that the concerned parties participate actively in the case discussion. As in Clinical pragmatism, the Hermeneutic method defends the position, that the ethicist’s role is the one of a facilitator, supporting the participants in exploring a better understanding.

Steinkamp and Gordijn (2010) describe the Hermeneutic method as a more retrospective form of case deliberation explaining why certain actions were undertaken in practice and the different considerations involved in such decisions. Nevertheless, it could also be used for a prospective approach. While the Hermeneutic method can be used on its own, it also can be applied in combination with other normative methods, such as Clinical Pragmatism. These methods might complement each other in addressing difficult cases. A more comprehensive picture of the case can be achieved, by adding a more interpretative and reflective method to the pure decision orientated methods.
### 2.3. GENERAL CONCEPT OF MORAL CASE DELIBERATION

As I have already mentioned, moral case deliberation can be defined as a discussion among different parties about a real case in clinical practice in the attempt to bring some more light into the related ethical issue and support the handling with ethical issues.

With the two practical methods of MCD in mind, I will now focus my attention on the general concept of MCD. As established the two methods of MCD differ in content and in focus. Yet, they also have more features in common than just a general stepwise and overall simple structure, which is aimed to help clarifying the complex case and organizing the dynamics of the groups (Molewijk et al., 2008b).

One of the main characteristics of MCD is the notion of focusing on a real clinical scenario (Abma et al., 2008, 2009 and 2010; Molewijk et al., 2008a and 2008b; Steinkamp and Grodijn, 2003). MCD is very context bound and focuses on concrete experience, instead of abstract ethical theory. By doing so, the methods attempt to address the complexity of healthcare, which can only be comprehended when kept close to the context of real cases. This concurs with the views expressed by Abma et al., 2008, 2009 and 2010; Molewijk et al., 2008a and 2008b; Steinkamp and Grodijn, 2003. According to them, in addressing the complexity of healthcare, one needs to consider advancing technology and treatments, expanding multidisciplinary teams, differing professional ethics and duties, limited resources within the healthcare sector and the patient’s own expectations,
beliefs and values. Ethical deliberation in clinical practice aims to identify different perspectives which influence practical moral judgements through the examination of concrete moral questions and problems. In other words, MCD attempts to collate different moral perspectives from the relevant stakeholders to ensure that the case is accurate as possible. Supporters of MCD suggest that this method is an acknowledgement that ethics and practice are deeply entwined. They assert that one can not be adequately accomplished without the other. Historically healthcare seems to have concentrated mainly on the knowledge of ethics; MCD now especially concentrates on context-bound knowledge (Abma et al., 2009 and 2010). Following Abma et al. (2009 and 2010) it is not possible to get a whole picture of nowadays ethical issues in healthcare from a position outside the context, without considering one's own moral experience. There appears to be a need for healthcare workers to move from an external and theoretical knowledge base to incorporate internal knowledge which is created by personal experience. This internal knowledge can only be achieved through active involvement of the parties concerned in the case. Moral knowledge is closely connected to and develops out of context.

The presence of a facilitator within the discussion is another common feature. In general, the methods are guided by a facilitator who coordinates the discussion and assists the participants to articulate their moral statement. Ethicists might carry out this role in MCD, however they do not act as consultants, providing the needed ethical knowledge and give advice regarding the solution. Instead, they facilitate the different parties to explore and identify the ethical considerations. Healthcare professionals and others are seen as the proper subjects to start deliberation as they, different to the external ethicist, are in immediate contact with the relevant context (Abma et al., 2009 and 2010; Molewijk et al., 2008a and 2008b; Steinkamp and Grodijn, 2003). Although it might not be necessary for the facilitator to be an ethicist, it can be argued that the facilitator should be a person trained in clinical ethics and inter personal skills to support critical reflection, to articulate the moral intuitions and to foster a sincere and constructive dialogue among the different participants (Weidema, 2010; Abma et al. 2010). For MCD to be successful it might not be essential to engage a facilitator. However to reach the same level of quality would require participants to have the necessary inter personal skills to lead a dialogue, to afford all parties the space required to express oneself and to support each other in analysing the ethical issues. A neutral person might be beneficial in the initial stages of implementing MCD as this phase can be problematic due to the dynamics of social relationships and power unbalances. These initial problems may improve over the time to the extent that a facilitator might no longer be required.
Another common feature of MCD is the need to involve all concerned parties in the discussion (Abma et al., 2008, 2009 and 2010; Gracia, 2001 and 2003; Steinkamp and Grodijn, 2010; Molewijk et al., 2008a and 2008b; Weidema, 2010). The role of the parties in question might be to reflect together systematically upon the ethical issue by bringing up all relevant factual and moral topics. Everyone should have an equal say (Abma et al., 2010). It is generally assumed that only through the input of all a general picture of the case reality and its complexity can be made. Despite the fact that MCD seems to embrace this as a basic condition, these parties are not always easily identified. Especially in respective of the involvement of the patient the opinions are divided.

Dialogue is another characteristic of MCD. Literature (Abma et al. 2008; Gracia, 2001; Molewijk, 2008a and 2008b; Steinkamp and Gordijn, 2010; Svantesson, 2008; Weidema, 2010) highlight dialogue as communication tool as a means of achieving the best possible outcome. According to them, only dialogue can give the space to confront in a efficient way ethical issues. Dialogue is considered a necessary to create a basic ground for the appropriate way to achieve the method's aim. These positive effects seem to be confirmed by a qualitative investigation from Bert Molewijk et al. (2008a) where the interviewed participants of MCD stated that they learned “to listen critically and sincerely, to postpone their moral judgements, to become aware of the perspectives of the others, and to strengthen the aim of understanding […]” (p. 60).

Dialogue is described by Tineke Abma et al. (2008) as critical conversation and an examination of different viewpoints. It differs from a debate. Dialogue is about opening oneself to the others' viewpoint whereas a debate is concerned with judgements and attempts to convince the other party of one’s viewpoint. In MCD the judgement is suspended until all opinions and arguments have been listened to and have been evaluated (Abma's et al., 2008). According to Abma et al. (2008) MCD is to listening openly, yet critically, to another and explaining ones own viewpoint with rational and reasonable arguments. MCD is not concerned with convincing the other party of one’s view. Dialogue should be constructive The key to MCD is to explore it and to accept each other’s point of view. In dialogue it is not about how to defend one’s own position in the best way but to review it critically together with others. Dialogue should heighten awareness and understanding. As described by Gracia (2001) dialogue in MCD does not exclude disagreement but it is an admission that nobody has the moral truth. Each participant’s point of view is subject to continuous critical reflection, examination and adaptation to newly acquired knowledge. Dialogue

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8 Molewijk’s et al. (2008a) qualitative research evaluated resulting MCD reports (50) and interviews with the different stakeholders from a 4-year MCD implementation project in a psychiatric hospital in The Netherlands.
which is properly managed “implies that participants change in the process; they will listen to each other, learn about each other's experiences and frustrations, and add new experiences and stories to their existing repertoire” (Abma et al., 2010; p. 249).

The final similarity which I will discuss is a general attempt of MCD to enhance the management of ethical issues within clinical practice and to help health care professionals to deal with moral dilemma in a constructive manner. I would argue that in general the different methods include beside their own established aims also the aim to improve decision-making in a direct (the method itself aims a decision) or indirect (through deliberation the healthcare professionals is enabled to make a decision in clinical practice) way.

The view of Abma et al. (2009 and 2010) and Molewijk et al. (2008a and 2008b), one of the actual strong promoters of MCD in the Dutch clinical practice, corresponds with the firstly outlined features. However, it seems to differ in the main aim. Their research comprises several sessions of MCD carried out in different wards (mainly on psychiatric wards) in excess of a year. The experience of the different participants was evaluated through questionnaires and focus groups. Participants considered the attention to moral intuitions and the deliberative character of the method as beneficial according to their results.

Out of these results Abma et al. (2009 and 2010) and Molewijk et al. (2008a and 2008b) draw several conclusions. They define the general goals of MCD as follows: 1) to reflect on the clinical case to improve the practical and moral quality of care and 2) to enhance the healthcare professional's moral competencies. Health care professions cannot be separated from their ethical responsibility. The quality of their moral competencies (such as knowledge, attitude and skills) play a major role in the ability to deal with ethical issues in clinical practice.

According to Abma's et al. (2009 and 2010) and Molewijk's et al. (2008a and 2008b) good care is the objective of MCD. From their point of view this aim can be achieved through different methods of MCD. Different methods can be engaged to suit different practical situations (e.g. methods to reach a decision or methods to enhance moral understanding and competencies). Depending on the situational aim, one can choose from the different methods of MCD. The focus is either directed at the product (which can be a decision or compromise for example) representing good care or the process (such as training competencies or self-reflection), leading to good care, depending on the method adopted. However Abma et al. (2009 and 2010) and Molewijk (2008a and 2008b) conclude that on the bottom line and foremost all different methods of MCD contribute to an overall better understanding of the case and of the different viewpoints and with that to good
This focus of understanding makes their approach similar to the Hermeneutic method, with the difference that the outcome of it is good care\(^9\), while Steinkamp and Gordijn (2010) connect understanding to an eventually better decision-making. I believe that good decision-making and good care are very closely connected. However, it is not clear if decision-making can and should be judged only through the resulting care. Or can there be also other criteria, such as that the decision can be well justified to others or that everyone was involved in the process?

The relationship between good care and good decision-making can also be understood in another second way. And I think Abma et al. (2009 and 2010) and Molewijk et al. (2008a and 2008b) focus especially on this second way. Decision-making might not only have as outcome good care, but it might be interpreted as part of the process of good care. In that way good care would be explained as something more general, as an attitude which includes different aspects and not only as an outcome. Decision-making is an essential factor in healthcare. Every action is preceded by a decision. It can be suggested that good care includes cautious and well-considered decision-making and is not only a product of decision-making. I think it is relevant to critically review decision-making as it seems to be or a precondition and an important part of good care. I believe that then in a second step is relevant to explore the relationship between good care and MCD. However, such analysis is beyond the scope of this thesis.

\(^9\) It could be argued if better understanding alone is enough to improve care. If attitude, actions and culture do not change the quality of care probably remains also at the same level (and moral distress might even increase).
CHAPTER 3: ASSUMPTIONS

By investigating for the former chapter, I encountered several normative ideas which seem to be common in most models of MCD. These ideas are presented explicitly or assumed more implicitly. These normative beliefs about MCD may not be self-evident in terms of how to understand them, and whether they should indeed guide MCD. As long as there are assumptions within the concept, its use in practice might still not be clear and this can lead to an inadequate application or expectation of the concept. I have chosen three assumptions, which I think might play a role in the implication and understanding of MCD in clinical practice. MCD or certain methods of it appear to presuppose that certain features belong to an appropriated handling of ethical problems within clinical practice:

a) everyone concerned the case should be involved (equally)
b) consensus is an ideal within MCD
c) MCD improves decision-making.

MCD seems to rely on the importance of the involvement of all parties concerned in the case. In the literature it is suggested that all facts and moral issues are brought to light through appropriated involvement (see for example Steinkamp and Gordijn, 2010). The involvement of all can also be viewed as an intrinsic good in itself providing respect for the different parties concerned with the case. However, Abma et al. (2008, 2010) and Gracia (2003) claim that there should be an equal involvement of all stakeholders. I would question whether all parties should be equally considered. For instance, equality might depend on where the responsibility for decision-making resides (e.g. the physician or the patient) and the capacity of ethical understanding of certain stakeholders. The question remains who exactly these moral agents should be and, whether the patient should be included or not. Should MCD be seen more as a professional reflection or a professional-patient interaction?

Assuming that it is relevant to involve all stakeholders in MCD, it is not clear in any of the investigated methods what involvement practically means. It is not clear if physical presence is adequate or if everybody should give a statement.

Second, I will investigate the role of consensus in MCD. In the context of Clinical pragmatism I will pose the question of whether consensus should be seen really as an ideal that can be achieved in MCD. Other methods view consensus as positive, however it is not essential. I will
investigate whether Clinical Pragmatism overemphasises consensus and whether the others are actually underestimating the importance of consensus. To do so I would like to pursue the questions if consensus leads to a right decision, of if there is a difference between a morally right answer and an answer everybody agrees on. I will also examine what happens if no consensus is reached?

Finally, I will evaluate if MCD improves decision-making. I will seek to establish in what way it would improve decision-making. The improvement could be judged by the outcome or by the process of decision-making. What would be the difference? Steinkamp and Gordijn (2010), for example, describe as aim a well considered decision, but what would that mean?

I will investigate and clarify the aforementioned questions throughout this work. I hope to clarify some of the ambiguities within listed assumptions. Concluding, I would like to see what these results could mean for the implication of MCD in clinical practice.
CHAPTER 4: DISCUSSION OF DIFFERENT ASSUMPTIONS

It might be evident from the earlier part of the thesis that the aforementioned assumptions are all interconnected. One assumption might lead to another and the presence of one assumption might complement another. This might be recognized also throughout the following discussion.

4.1. Assumption 1: All people concerned in the case should be involved equally

One of the most prominent features in MCD is the involvement of all relevant parties in the case. Independent of the author it is always described as an essential factor of MCD. Abma et al. (2009) and Gracia (2003) concur strongly with this assumption. However, they take the issue even a step further and argue for an equal involvement of all stakeholders. Before discussing a given equality of the stakeholders in MCD, I believe it is imperative to explore why the involvement each party should be relevant in the first place. Two plausible explanations for all parties involved are identified. Firstly party involvement is important to collect relevant data in relation to the case. Secondly, the process of involvement is regarded as showing respect to all stakeholders. The analysis of these two arguments might also help to clarify the prevailing discussion who should be involved. It remains then as another additional question if the different parties should be involved equally in the discussion. I will now analysis each of these points in detail.

4.1.1 Instrumental use of involvement

Involving all people concerned can be an instrument to reach the aim in a case. The aims can vary. One aim for example could be to increase the sense of connection among the different professionals which then might result in a better collaboration and team performance. This goes along with the results of some qualitative studies published by Svantesson et al. (2008), Weidema

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10 All three researches consisted in the qualitative evaluation (through interviewing the participants and focus groups) of various MCD sessions implemented in clinical practice. The sessions took place in a nephrology department
et al. (2010) and Abma et al. (2009), which demonstrated that improved work satisfaction was attributed to involvement between the different professions. In allowing all parties concerned in the case the opportunity to participate, reciprocal understanding might be improved. Increasing the probability of integrative collaboration among the different professions and improving the likelihood that the goal will be supported by the team.

As in the aforementioned cases the involvement of all parties is utilised principally to improve team issues. According to Steinkamp's and Gordijn's (2010) including all relevant persons in the deliberation might contribute to reach a well considered decision\(^\text{11}\) on behalf of the ethical problem at stake. The previously mentioned attributions represent in their view only additional, positive side effects. In their opinion, in the current complex healthcare situations, it would be impossible for an individual to reveal all relevant aspects for a decision without conferring. The complexity of health can only be represented through involving all. Molewijk's et al. (2008a) study\(^\text{12}\) concurs with these findings. Healthcare workers admit that through sharing experiences with other healthcare professionals, they reached such a rich analysis, which they would have never achieved on their own. However, a question that might arise in this respect is whether all ethical problems in healthcare necessarily show always a high level of complexity, demanding always the involvement of several people for bringing in some clarity. It might be that from the beginning the dilemma of the problem is quite clear cut, yet difficult to decide. Would MCD be needed or helpful also in such cases?

Steinkamp and Gordijn (2010) admit that even with including as many heads as possible it might not be possible to encounter the absolute truth, however it is important to utilise and involve as many people as available to achieve as many inputs to reach as close to the truth as possible. In general these inputs might be summed up in three major groups. The first group of inputs are the inputs of the various observed facts, which can be objectively assessed on behalf of their credibility. Secondly, different expectations might be voiced. For example a physician may concentrate on the prognosis, while a nurse might expect for the future an improvement in the quality of life of the patient and a relative might hope for reconciliation. Thirdly, everyone can bring one's own moral judgement on behalf of the ethical dimensions of the case. These moral judgements can include professional duties and obligations in general and specific to this case, values and the opinion of

\(^{11}\) This concept of a well considered decision will be discussed more in depth in chapter 4.3.

\(^{12}\) Molewijk’s et al. (2008a) qualitative research evaluated resulting MCD reports (50) and interviews with the different stakeholders from a 4-year MCD implementation project in a psychiatric hospital in The Netherlands.
how to weigh the different moral considerations against each other.

Gathering these inputs might allow a look beyond limited professional and personal knowledge and gain the opportunity to have a broad insight into the case. However, there are some drawbacks. The collection of moral beliefs and factual observation from different positions seems *prima facie* helpful to make a situation more transparent. With this in view it appears reasonable to include an additional person in the discussion for their contribution. This may lead to a fourth and fifth person been added to the group. However, it leaves unclear why ideally all parties should be involved. Involving all parties could make it also more difficult to reach a decision. I will demonstrate this utilising the case in the Introduction. The patient expressed on several occasions to different people that she could no longer bear the pain. This affirmation might reinforce the decision to accept her wish of terminal sedation. Yet, it could be also different. While the patient expressed the wish of terminal sedation to the healthcare professionals, she never mentioned it to her relatives, having them falsely believe that she feels fine. This consequential confusion might be even more prominent when verbalising the moral beliefs and judgements of the different parties. Instead of getting a better understanding one might be even more confused and be paralysed by all the inputs, unable to make any decision at all.

Nevertheless, one might take strengthened a decision by knowing that most likely all major counterarguments where appropriately considered. The uncertainty that perspectives have been disregarded might be alleviated in hearing and considering objections and by the ability to articulate reasonable arguments and why perspectives are not applicable or why they are outweighed by another perspective in this particular situation.

### 4.1.2 Intrinsic value of involvement

Another argument for having everybody involved, and different to the one of the instrumental utility, is the argument that it has an intrinsic value. Involving everyone might be seen as a way to respect all stakeholders and might represent each individual’s right to be considered as they are all competent moral agents. The person should not only be involved because it might improve collaboration or because it might lead to a better considered decision. On the contrary, a person should be involved despite the fact that this might further complicate the case. As stated at the beginning, ethics is part of the job in healthcare and concerns everyone in relation with it (Abma et al., 2010). Hence everyone should also be involved when treating ethical issues regarding the
What would it mean if some are not allowed to contribute? If an individual concerned with the case was not involved in the discussion that would suggest that her contribution, her moral opinion would not have been relevant anyway. This suggests that it is others who decide who is taken seriously or not as moral agents. It seems difficult to maintain such a judgement, as every person as moral agent has the same capability to have moral experience and to reflect and reason upon it. Such discrimination as ignoring the individual moral standing of a person would represent an ethical problem in itself, claiming to be able to judge what moral experience is important and which one is not. I will further elaborate later in the thesis about a possible difference in the relevance of the inputs of facts and expectations as they might be profession dependent. However a moral reflection is not profession dependent, but every moral agent is capable to do so. If all professionals face conflicting duties then this is a moral problem for each of them and cannot be assigned to a certain moral “elite” within the healthcare team.

With regards to the case presented at the beginning, let us imagine that actually a discussion was held among the physician and several nurses and they agreed on a decision. The decision was then documented and explained to the rest of the team. However even after the decision been explained, some of the nurse caring for the patient and who have been left out of the decision making process where not at ease with the final outcome. Can their uneasiness just be ignored? Or can any justification be found why their standpoint should not have been relevant? This case can be seen as an example how an individual's ethical problems been considered irrelevant by others in situations with strong moral impact. Would this case not demand to involve the other nurses out of respect to the individual and the moral agency and the person's aligned ethical duties?

This claim of an intrinsic value to participate in the deliberation due to the right of respect might correspond with the professional growth and development of certain healthcare professions, especially nursing. Following Steinkamp and Gordijn (2010) healthcare is moving away from hierarchies to more team work approach to patient care. The order of the doctor is no longer just carried out and accepted but questioned and discussed (Svantesson et al. 2008). In recent years healthcare worker as professional have increased awareness around their own ethical responsibility within their clinical practice. With this increased ethical awareness among healthcare worker this spurs individuals to want to participate in decision-making. Reflecting on the healthcare worker’s ethical responsibility, it might be insufficient to just carry out medical orders without having adequate justification for one's actions. It is not enough for nurses to follow orders. Nurses also
have an ethical responsibility to be fulfilled in clinical practice. From nursing’s development form an auxiliary profession to an autonomous profession, it is no longer sufficient to take orders. It is important that nurses are able to collaborate with professions to ensure the best possible outcome for the patient.

Abma et al. (2009) and Weidema et al. (2010) however make in their discussions clear that this intrinsic value does not belong only to healthcare workers. Each person as moral agent, with her story, beliefs, judgements and capability to reason should be treated with respect and be involved. One might consider it necessary to justify certain judgements out of respect towards other stakeholders. However, the availability to clarify one's choices would represent only part of it. This respect would require the willingness to explain one's conviction and to question and to review and test it critically in the context of the different stakeholders. In order to take an individual seriously as moral agent requires an open mind that everyone involved in the case can contribute. It also requires an acceptance of the fact that one's own justification is not the final truth and might be changed on behalf of the inputs and contributions of other people.

4.1.3 Who should be involved?

Despite the apparently central role of involvement of different parties in the discussion, the proponents of MCD leave it quite open who exactly these parties should be. It could be argued that inclusion depends on the relevance of one’s position within MCD. Especially if we accept the instrumental reason for the involvement. It seems quite obvious that the different healthcare professionals should be involved, as they might make the most relevant contribution towards the ethical case. However it could be argued whether the involvement of a nurse that works only part time is as relevant as the one of the nurse who works full time. In viewing involvement as an intrinsic value then it appears that as a moral agent, everybody has to be involved. However the level of involvement is still subject to debate. Should policy-makers and managers be invited to participate, too? In some way they too are connected to the case and are in a position to relevant input (e.g. about the availability of resources).

A much debated topic in this realm is the involvement of patients and their relatives. Also here the distinction between the instrumental and intrinsic justifications might lead to a different conclusion of the relevance of the involvement of patients and relatives. It could be argued that not all parties are needed to achieve the aims. In relation to patient participation in the discussion, there
might be some reservation about whether patient involvement would really enhance to the discussion. On the contrary, it might even frustrate an appropriate deliberation as certain comments might be avoided “to protect” the patient (e.g. when discussing whether a bad prognosis should be communicated to the patient or not). Steinkamp and Gordijn (2010) also express reservation about involving relatives. They attribute this to the fact that deliberation with a patient or the relatives would follow different rules than a deliberation among only the interdisciplinary team. In circumstances where patient details are missing, it is assumed that a well conducted deliberation will lead to this realization. In addition a profounder dialogue with the patient or the relatives might be arranged to obtain this missing information. Though, it remains questionable how much this conversation may be subject to the biased interpretation of the healthcare worker. The patient or relatives is not afforded other opportunities to clarify the missing details.

However, if the involvement of all is regarded as positive then it would follow that no one should be excluded. Mutual respect would not permit the exclusion of anybody from the discussion, independent of one’s contribution or the consequences which such an involvement would bring for the deliberation. This does not imply necessarily that everyone has to be present. The important thing might be that everyone receives the respect as moral agent and the possibility to participate.

4.1.4 Equality in involvement

Up until now I focused on two main arguments a) the justification for involving all parties and b) the significance of this involvement. I will now review the relevance of the position of Abma et al. (2009 and 2010) and Gracia (2001), who defend another point regarding the involvement of stakeholders. Although they agree with Steinkamp and Gordijn (2010) that involving all parties assists in obtaining maximum input, they go a step further and advocate for equality of every participant within the discussion. They conclude that everybody has the same right to have a say, because everybody as a moral agent with moral experience is equal. The focus in discussing ethical issues is not on experts but on the personal experiential knowledge which every moral agent develops in concrete situations. Everyone has practical experience in dealing with moral issues.

This view resembles that of the intrinsic argument of involving stakeholders and Abma et al. (2009 and 2010) build their argument on the same basis as intrinsic value does, namely the respect for the moral agent. However, while the former states that everybody should be respected, Abma et al. (2009 and 2010) argue that every participant carries the same weight.
Here, I believe it might be important to distinguish different levels of equality within the stakeholders before concluding that equality is part of the involvement within MCD. I think there is a relevant difference between being equally involved in the deliberation and being equally involved in the decision. The equality of a say and a judgement during the decision-making process might differ from the equal participation in the final decision. However, I think that there is also a considerable distinction within the say and given judgement of different people.

4.1.5 Equality in making the decision

Marcel Verweij et al. (2000) states that the exploration of moral reason is a joint enterprise and not a matter of everyone for oneself. However, this does not mean that the task of making a decision is a joint enterprise. The task of decision making may vary from the type of decision to be made. If the decision is about a certain treatment, the responsibility to make the decision might belong to the physicians. If the decision relates to the type of care the patient needs then it might reside to the nursing team. Finally if the decision concerns talking to the patient's family it might be a joint responsibility.

Although equality in decision-making might not be maintainable, given that responsibility for the decision making may reside with one person, it does not mean that the involvement of others would be irrelevant in cases where the decision is made by a specific person. It could be argued that irrespective of who is responsible for the decision, it is not possible to ignore other participants in the case also involved in a morally relevant sense. The reasons can be various. It could be because patients are the direct aim of the decided action or because other healthcare professionals are partly responsible for the implementation of the decision. Therefore, even if the final responsibility resides with one person, it does not exclude necessarily the involvement of the different parties (Weidema et al. 2010).

MCD can also be used to test and justify one's judgements to others with respect to the final decision. By justifying one’s choice and being open towards inputs the individual responsible for the decision demonstrates that she takes the other individuals in their moral standing seriously. Given ones increased awareness in regard to ethical responsibility one may wish to consult with others to augment one's viewpoint and to make sure that all relevant points have been considered and understood before the decision is made. This brings us back to the discussion of the instrumental value of involving the different stakeholders. Steinkamp and Gordijn (2010) concur
with this position when they claim that MCD leads to a good decision through the involvement of the different participants. The responsible person or group, who has to make the decision, can do this in a much more conscious and confident way, because the different arguments and counterarguments have been discussed and evaluated. MCD is the realization of one's responsibility and the acknowledgement of the incapacity to grasp it all on one’s own.

4.1.6 Equality in the decision-making process

Although equality might not be achievable in making the final decision, it does not exclude that equality should not be upheld throughout the process. However, there might be certain limitations also within the process. At this point I will reiterate the different inputs that participants can give in a deliberation: factual, moral and expectations. The factual input might be role dependent. It seems difficult to accept that the judgement of a patient's family member regarding a prognosis might be as relevant as the view of the physician. However, this does not preclude further clarifications from being sought. It just means that because of the specific role and the expertise of the participant her input on behalf on a specific argument might be weightier than another person's.

In relation to expectation, everyone can express them. Their relevance in the discussion, though, might depend how plausible and realistic they are in respect of the facts.

The moral input, however, differs from the factual input and expectation. I believe that it is actually this point, which Abma et al. (2009 and 2010) mean when they talk about equal involvement. On a moral level everybody is equal. Everyone is regarded in the case to possess equal capacity of moral experience. The only advantage of expertise one might have here is that one is more capable to express and formulate her moral judgement. Some persons might need help expressing their ethical experience and translating their ethical intuition into ethical understanding and arguments. This, however, does not change their position as competent moral agents. Hence every human involved in a situation is a competent evaluator of a moral situation and has the right to an equal say on the matter.

I will now evaluate these outputs of moral, factual and expectation in relation to the introductory scenario. The participation of all involved does not relieve the burden of responsibility regarding whether to start with the terminal sedation or not form the physician. Deliberation in this a case would contribute to a better understanding of the different facts offered by the different experts and of the different expectations regarding this case. The discussion sets out the moral
viewpoints and critical evaluation of each participant through the comments and interaction of all the different stakeholders. Thereby the nurses can make sure that their responsibility of care in the case and their responsibility for the implementation of the decision is considered within the physician's decision.

### 4.1.7 Conclusion

The key assumption discussed up until now is that all concerned participants in the case should be involved in MCD. Two plausible justifications are given for this assumption. Firstly, involvement might have an instrumental value. By involving many opinions and receiving many inputs it facilitates better reflection on the case’s complexity. As different viewpoints, arguments and critics are considered a better decision might result. The possibility that all this information might also make the problem solving more difficult is not considered in any great deal in literature regarding MCD.

The other plausible justification is that all parties should be involved because it is a good in itself. Involving all would show respect towards the different stakeholders as moral agents.

I believe that it is possible that both are applied simultaneously. It is open to debate to determine whether this should be the case or whether it would be more appropriate to have one lead person responsible for the decision making.

Resulting from above discussion, it is still unclear who should be involved in the process. No reason might be found to exclude certain stakeholders if the involvement stands for an intrinsic value. However if the involvement has just an instrumental value, certain exclusions might be accepted if there is a risk to compromise attaining the posed goals.

The statement of involving the different stakeholders is reiterated by Abma et al. (2009 and 2010) and Gracia (2001) in the claim that everyone should be equally involved. From their literature it remains quite unclear what this equality means. By critically reviewing this claim I came to the conclusion that the claim for equality in MCD might only be fully applied in the case of equal right to be listened and to be understood as moral agent. In decision-making the level of equality depends on how much each person is involved in the final responsibility of the decision. Equality can be expected in expressing moral viewpoints, however from a factual perspective a professional with relevant expertise may have a greater say in the decision.

Further it remains unclear what this involvement means in the practice of MCD. None of the
methods described in the literature address this point in further detail. Does it mean that everyone should give her opinion or is it enough to be just present in the discussion? There might always be the risk that a strong personality might take over the whole discussion, whereas a person less capable to express herself, yet playing a major role in decision-making, might be left out. The question remains when the facilitator (an ethicist or a trained person) should intervene and stop a participant and when she should demand an opinion from a participant merits consideration.

4.2 Assumption 2: consensus is an ideal

As discussed in the previous chapter the responsibility of the final decision can reside with one particular person or group of participants. Nevertheless, consensus seems to be an ideal or at a minimum an achievable outcome of MCD. Consensus is explicitly defined as the aim in Fins' et al. (2003) Clinical pragmatism. In the literature of Abma et al. (2009 and 2010), Molewijk et al. (2008a, 2008b), Steinkamp and Gordijn (2010) consensus is nominated as something achievable or at least something they do not exclude or reject. Yet, they assert that it is not essential to reach an consensus. So the question is if consensus is overestimated in Clinical pragmatism or if the others might not attribute the value it really represents.

A point, which could be recognised through the literature, is that neither Clinical pragmatism nor any other encountered method set out consensus *per se* as an aim. Instead, their striving for consensus can be understood as a striving for “a morally satisfactory result reached through a cooperative, open and rational method in which all have expressed persistent confidence through their participation” (Moreno, 1988; p. 430). In that sense, I identified three plausible key reasons why consensus might be seen as something important in MCD:

a) Consensus might be seen as bringing one closer to the right answer.

b) Consensus might strengthen the person/group in her/their task to make a decision.

c) Consensus is important, because it might support good team work.

Additionally, it also raises the question of what should be done if a consensus is not reached. However, before further evaluation, I will have a review of my proposed reasons why consensus would be important.
4.2.1 Consensus leads to the right answer

Within the literature regarding MCD there is no clear definition of consensus. However, from MCD literature I interpret consensus as an agreement on what should be done. I assume that consensus is seen as a potential product of dialogue. In the notion of a properly performed dialogue, which improves general understanding, it can be expected that everyone shifts and adjusts the viewpoint in the light of the different statements and arguments towards each other. Eventually, through improved insight and understanding of each other, the participants might reach a common position (Abma et al., 2008 and 2009; Caws, 1991; Fins et al., 2003).

In the pragmatic approach of Fins et al. (2003) consensus is seen as defining what the right decision is. As they do not accept any other ethical theory, principle or norm to guide their understanding of a right decision, they may accept as right answer, the answer that is best applicable in practice. This may often be the answer all can reasonably agree on.

However, I have reservations as to whether consensus really is able to contribute to make sure that the outcome would be right. First, consensus does not exclude the possibility to agree to a decision out of mere disinterest, timidity to object, trust in the opinion of the others, or even fear of negative consequences if one does not agree. Further a consensus might be reached under the influence of one strong-willed person, able to convince others of one’s ideas (Tong, 1997). In this case, the decision would not be based on a well considered joint reflection (as for example Steinkamp and Gordijn (2010) or Fins et al. (2003) would like to have it). Secondly, where consensus is the aim, problems might be overlooked, important problems may not be addressed and critical voices suppressed, just for the sake of a consense decision (Tong, 1997). Thirdly, in circumstances where a statement is already proven to be true (such as the result of a mathematical calculation) it is pointless to search for a consensus. On the other hand, within an unknown truth, where all parties are in the same position of limited knowledge, consensus would not contribute to the proof of the veracity of the result. Everyone would just express her opinion on what might be right and that would have no evidence for the truth of the outcome (Caws, 1991; Jennings, 1991). Hence, it can say nothing about the rightfulness of a decision. On the contrary, as argued above, a decision might be selected just for the sake of reaching a consensus and not based on clear and reasonable arguments.

Nevertheless, Caws (1991) argues that consensus could be helpful in its negative way, meaning dissent. A disagreement might be helpful to show that issues are still not clear or stimulate the consideration that maybe a decision might be even wrong and lead to further reflection.
Abma et al. (2009), in their discussion about consensus, adopts this positive attitude towards disagreement. Disagreement is not seen as fallacy. On the contrary it is evaluated as a useful starting point for more detailed investigations regarding the arguments and pre-assumptions of the participants.

In addition, Bruce Jennings (1991) highlights the risk, that consensus might diffuse the responsibility for the decision adopted. Consensus is the creation of many heads and built of many parts. Hence nothing can be countered to a participant's statement that the reached consensus does not fully represent one's opinion and moral view. It might be assumed that a democratic agreement removes the responsibility of the moral agent, who then implements the decision, which is not the aim of MCD. This has been discussed in chapter 4.1.

Furthermore, the argument that everyone should be involved with collecting inputs might actually be problematic for consensus. The more moral considerations that are put on the table the more difficult it might become to reach an honest consensus. This can lead to a risk that people might be excluded from the discussion just to reach consensus.

**4.2.2 Consensus strengthens decision-making**

However, consensus may, all the same, do something positive for the personal confidence in the rightness of the result. If one is sufficiently sure of oneself then no further agreement might be needed for one's own decision. In the current complexity in healthcare it might be rather difficult to be fully confident. Consensus gives the participants a feeling of reassurance that they have reached the right decision. Although it might not be rational that agreement strengthens the truthfulness of one's position, it might be reassuring psychologically. Confirmation of one's action seems to compensate one's imperfect knowledge and the limited professional understanding (Caws, 1991). These expectations to consensus are confirmed in the studies of Molewijk (2008a) and Svantesson (2008). Interviewed healthcare professionals expressed a view that they would like to see consensus more often as a result. They felt it would support them in their decision-making in clinical practice.

Yet, this reason supports the same objections as the ones set out against the importance of consensus to reach a right decision. Therefore we cannot really rely on this reason for integrating consensus in MCD.
4.2.3 **Consensus contributes to good team work**

Consensus might contribute to good team-work. Consensus might be aimed out of mutual respect. It gives everyone the feeling that they are taken seriously as professionals. It contributes to the feeling that decisions are supported and improves collaboration. This reason of consensus provides an insight that decisions relating to operational healthcare is mostly made by the multidisciplinary team and not one singular person. Different studies have shown that the lack of a good working relationship can have negative effects on mortality and morbidity (Storch and Kenny, 2007). Hence a good working environment, where everyone is satisfied might be indeed a goal to strive for.

The risk arises that conflicts or critical arguments are suppressed just for the sake of peace and harmony. It is questionable whether good collaboration could only be reached through consensus. It is worth considering whether also clarification of ones viewpoints and better mutual understanding might lead to improved team-work.

4.2.4 **Further considerations regarding consensus**

Up until now it is clear that consensus has to face several difficulties when it is proffered as support for the outcome of a deliberation. This makes its usefulness questionable. Perhaps it is the approach that should be changed. Caws (1991) and Moreno (1988) argue for an interesting position. Their suggestion is to change the role of consensus as the goal of MCD to a condition of MCD. Consensus about the ethical issue might be a useful starting point. Everybody should agree that the issue at stake is actually a relevant issue worth discussing. Also questions should be formed in that way that everyone is able to agree that it is about an ethical topic and not about blaming or criticising somebody. It might be useful to agree already at the beginning on whose is the final decision-making responsibility and what should be accomplished with this deliberation (e.g. to reach a decision today or to clarify why in this case it would be right to continue the treatment). It might be useful to agree these standards prior to the discussion, otherwise the deliberation might not fulfil its planned objective.

The manner in which consensus is relevant in decision making is another interesting point raised by Bruce Jennings (1991). He argues that consensus might not proof the right decision and asserts that it still might gain moral weight, when it can be shown that consensus is the product of a responsible moral deliberation and judgement, where all members are honestly concerned about the
outcome of the case. In that sense, consensus could also be seen as the proof that the decision is well considered and weigh out. This implies that each participant contributes in the best way possible with knowledge and ethical experience in the deliberation. However, a relevant counterargument is discussed by Caws (1991). Certain attitudes are demanded if this approach is to be accepted. These include virtues from the participants to create reliability and trustworthiness among each other, to be sure that the decision really was well considered. It is doubtful that from the beginning of a deliberation the virtuous intention of each person is known and can be shown to everyone. Therefore the assumption that consensus would show a better considered decision is not maintainable until the true commitment is proven.

### 4.2.5 What if no consensus is reached?

Although I have reservations regarding consensus, I do acknowledge that it is still treated as something achievable within healthcare, especially because it is seen a tool to strengthen one’s decision and to improve team work. However, within the plurality of the different moral beliefs and viewpoints I believe it might be likely that no consensus is reached. Hence the question arises what the next step should be where no consensus is reached? In these circumstances, there might be several possibilities. Firstly it may come to a formal or procedural conclusion. This means that the decision might be postponed or referred to an ethics committee or delegated to one of the persons in charge.

Abma et al. (2010) suggests if consensus is not reached then maybe the participants should come to an agreement. I think what Abma et al. mean with this agreement is a compromise. Compromise is based on a willingness to reach a point that is better than the current one for everyone concerned (Scott, 1997). It is a giving in for the sake to reach an acceptable decision for both sides. Compromise might not be the ideal decision. However, it is recognition of the validity of the moral claims of all the different parties and the acknowledgement of a needed decision. Despite the conflict there are still many things in common. This common ground gives the participants the reason to move towards each other.

I think compromise might be required where there is an urgent need for a decision to be undertaken. A further factor for compromise might be the fact that the implementation of the decision is dependent on collaboration. So the physician for example might disagree with the nurse whether to continue a treatment or not. However, they still might agree that everything done should
be to alleviate the patient’s suffering.

A further precondition for compromise might be mutual respect and trust, together with an understanding of one’s own viewpoint and the viewpoint of others. Yet, it could be argued that compromise cannot be achieved without consensus. Before agreeing on a compromise it would already need the consensus that compromise will be accepted as an outcome.

4.2.6 Conclusion

The assumption analysed in this section is that consensus is an ideal. I identified three plausible reasons for this: a) consensus might be seen as bringing one closer to the right answer, b) consensus might strengthen the person/group in her/their task to make a decision, c) consensus is relevant for good teamwork. However, there are several weaknesses within consensus, which make it questionable as an ideal. First it does not follow that the outcome from a consensus of different opinions is right. It might be reasonable, as all moral agents involved in the case agree. However this would presuppose that it can be trusted that each participant contributes in one’s best possible way with one’s knowledge and ethical experience. This may be difficult to verify. Hence consensus might be attained for all the wrong reasons: out of mere timidity, to finish the discussion or to avoid conflicts in between team-members.

Nevertheless, I do not want to reject consensus completely as part of MCD. While I am sceptical of the relevance of the role of consensus as an outcome, I acknowledge its relevance as a pre-requisite of MCD. This means that there should be an agreement on what the issue and question at stake is. Further, it might be important to set out the owner of the decision already at the beginning of the discussion.

I do not believe that consensus as outcome should or will be eliminated out of a deliberation. However I would like to argue that consensus should be treated with scepticism. The outcome of consensus, as argued also by Abma et al. (2009), should not be something definite, but should be under continuous reconsideration. Consensus should be considered as something temporary and fragile, which needs to be under continuous reconsideration.

As alternative to consensus I discussed compromise. I see compromise as especially useful in an operational capacity where an immediate decision is required. However, compromise is just a temporary solution of a conflict and hence further discussion should be taken into consideration.
4.3 Assumption 3: MCD improves decision-making

Decision-making is a prominent topic throughout the discussion of involvement and consensus in MCD. In literature MCD is described as a method which improves decision-making (see for example Steinkamp and Gordijn, 2010). However, I suggest that the concept that MCD improves decision-making is not yet fully clear. Considering what does improving mean? What criteria are specified for determining a good decision? I will use the remaining part of the thesis to have a brief look into this topic.

4.3.1 What does improving mean?

Firstly the statement “MCD improves decision-making” assumes that there is a situation to be improved. In relation to the scenario in the introduction and the view of the proponents of MCD there appears to be a need for improvement in decision-making in ethical cases practice (Abma et al. 2010; Steinkamp and Gordijn, 2010). The criteria for improvement in cases may vary depending on what is considered important by different authors and depending on how the starting situation is defined. I believe there can be made two main distinctions how the quality of decision-making can be judged: 1) by evaluating the outcome of the decision or 2) by evaluating the process of how the decision was arrived at.

I believe it might be helpful now to recall the section when I analysed the different features of MCD and discussed briefly decision-making and its link to good care. One can judge decision-making by analysing its outcome or by analysing the process to arrive at the decision. A limitation when decision-making is judged by its care outcome is that it is unclear what good care is. This leads to the question could there be a general definition of good care or should it be situationally defined? After all, each patient is unique with different values and needs, which can change over time.

It is important to treat with caution the statement that the quality of decision-making is determined by the outcome. In a situation where a decision is made to operate a patient with acute appendicitis and the patient dies because of a severe anaphylactic reaction to an unknown allergy from a medication in surgery, the quality of the decision-making is not necessarily defined by the outcome of the case. Good or bad decision-making may have a good or bad outcome based on luck.

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13 see p.18
and chance (Elwyn and Miron-Shatz, 2009). In reviewing the outcome it is impossible to determine the validity of the decision. Elwyn and Miron-Shatz (2009) suggest reviewing the process rather than the outcome for determining the quality of decision-making. An improved decision making process might then facilitate a better decision making.

I believe that also in MCD the improvement of decision-making is linked to the decision making process. Yet, it is not clear in what sense improvement is meant. Several potential criteria could be listed. Firstly, formal aspects could play a role in the quality of the process. Quality could be determined whether everyone concerned with the case was involved. Other criteria might be the resulting transparency and efficiency of the decision-making process. The process could be viewed as a means to identify the conditions and circumstances in which a decision was taken and the improvement of decision-making could be classified through that. Other elements that could show of quality could be that a good decision-making process might lead to a decision that can be well justified to others. Improvement in the criteria in the decision making process could also mean that it facilitates a more consensual decision being made, as argued by Clinical pragmatism.

Steinkamp and Gordijn (2010) see the quality of MCD as a process in the way how it might facilitate a “well considered” decision. They are not very clear what well considered means. I believe that a well considered decision is one which is critically reviewed and accepted among participants involved in the case. It is important that as much relevant information as possible is collected and all viewpoints are considered. While the process of MCD does not assure the right decision, it facilitates a better considered decision in clinical practice as opposed to decision making based on intuition for example.

A different, yet similar criterion is mentioned by Abma et al. (2010). They state that knowledge and wisdom should be taken into consideration to evaluate the quality of decision-making. They assert that this knowledge and wisdom could be trained and developed through the process within MCD. According to Abma et al. (2010), one receives knowledge by collecting all the facts and reaches wisdom through critical auto-reflection and learning from other viewpoints. It is possible that a lack of reflection on the complexity of the case and knowledge of the scenario might result in poor decision making. MCD might help to confront this deficiency.
4.3.2 Conclusion

In this last chapter I discussed the assumption that MCD improves decision-making. I concentrated on the meaning on improvement in decision-making. I evaluated how one could assess whether a good decision is made. I emphasised the point that a good outcome does not necessarily mean that a good decision was made and vice versa. I also reviewed the process of decision making in an attempt to determine if this structure could be incorporated in MCD to assess whether or not a good decision has been made. Various criteria were put forward as a means of improving decision-making. The criteria included formal measures (e.g. the involvement of all, transparency) and general criteria (well considered decision and the implication of knowledge and wisdom).

This process of improvement is contingent on many factors. It is not sufficient to examine one criterion in isolation. I believe that concentrating on one criterion would not be enough to describe improvement of decision-making within MCD, but it might be a combination of different criteria.
CHAPTER 5: CONCLUSION

The scenario in the introduction coupled with my professional experience as a nurse have heightened my ethical awareness and realisation that there are still many difficulties when addressing ethical problems in clinical practice. MCD is an interesting concept and approach in addressing ethical issues in clinical practice. The involvement of all together with dialogue, the context bondage might enhance the way ethical issues are dealt with in clinical practice. Although some features are basically to MCD, the methods might vary in their aims. Clinical pragmatism endeavour to reach a decision through consensus. Whereas the Hermeneutic method takes a more indirect approach to decision making. It is more concerned with improving the participants understanding than reaching consensus.

However, there are several assumed normative ideas within MCD. These assumptions are unclear and their relevance in has not been elaborated upon. The thesis examines three encountered assumptions. These assumptions might have an influence in the answer if MCD should be part of clinical practice. The assumptions reviewed were: 1) the equal involvement of all, 2) consensus as an ideal and 3) the improvement of decision-making.

Regarding the role of the assumptions for the implication in MCD in clinical practice, I cannot come to a conclusion whether MCD should be part of clinical practice or not. The analysis, however, gives some thought provoking impulses, which might be reflected on when applying MCD in clinical practice.

The first assumption considers involvement. It is not evident why everyone should be part of the discussion if the involvement in MCD is assigned only an instrumental role. Not necessarily all parties might be contributory. However, if the involvement is seen as a good in itself to show respect to the other moral agents with their moral experience then indeed could be made a case that this feature is an essential one of MCD. Then MCD would show respect to each individual's moral experience. It also would acknowledge the presence of the different ethical views, perspectives and personal moral responsibility, which must be respected.

The second assumption is consensus as an ideal in MCD. I am, however sceptical of the role of consensus as an ideal. Nevertheless, I still think that consensus might have a role. Consensus might be needed among the different parties on behalf of the ethical problem, before starting a deliberation. It is imperative that participants agree on the ethical question and communicate their
concerns in relation to the problem, to enter in a fruitful discussion. If there is no common ground to start from, it can be difficult to build a dialogue and an interaction which increases comprehension for each other’s viewpoint.

Finally, MCD might have a relevant role to play in clinical practice by improving the process of decision-making. There are various plausible criteria for what would improvement mean. However, what criteria should be fulfilled might depend on the situation and what is put as relevant for a good decision-making process. The ability to fulfil the different criteria for improvement in decision making might be case dependent.

In conclusion, the relevance and application of MCD in clinical practice will depend on the context in which used. In a Catholic hospital, where maybe all healthcare professionals agree on the ethical normative indications of its religious basis, there may be no need to discuss the ethical belief, as they might be already set out and understood. MCD might not be necessary in a ward situation where team members naturally deliberate on the basis of a dialogue without the structure of any method. However, I assume that these cases are in the minority and that ethical pluralism continues to causing ethical conflicts which seem difficult to settle. In light of my experience and the case example given at the beginning of this thesis, interventions such as MCD might be necessary in order to approach ethical issues in a more structured, reflective and considered way. First and foremost MCD should be viewed as a positive method which might enable and empower healthcare professionals to grow and mature professionally in approaching ethical issues. Eventually, it might then be incorporated in the regular care process and become routine rather then exceptional meetings.


