Moral case deliberation

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ABSTRACT

Ethical dilemmas in general are characterised by a choice between two mutually excluding options neither of which is satisfactory, because there always will be a form of moral damage. Within the context of medicine several ethics support services have been developed to support healthcare professionals in dealing with ethical dilemmas, including moral case deliberation. In this article, we describe how moral case deliberation works in daily practice, illustrated with a case example from the neurology ward. The article is meant as an introduction to moral case deliberation according to the dilemma method. We show its relevance to the clinic and the context needed to put it into practice.

INTRODUCTION

Sometimes decisions in neurology can be tough. For example, should a neurologist offer presymptomatic genetic testing to the family members of someone with familial motor neurone disease?[1] Or should the medical team withdraw specific treatment, for example, antibiotics, from a patient in a persistent vegetative state?[2] Ethical dilemmas characteristically have a choice between two mutually excluding options (yes or no), neither of which is satisfactory, because there will always be some adverse consequences or harm. Given the difficult nature of ethical dilemmas, and the fact that medical evidence and professional guidelines do not guarantee a final answer to the dilemma, it is best that the whole team should reflect upon the decision about what to do, even though eventually it is one of the medical staff members who has to make the final decision. Hearing different perspectives on what is morally right usually makes the final decision richer and more founded.

Internationally, several ethics support services have been developed to support healthcare professionals when dealing with their ethical dilemmas.[3] Moral case deliberation is one such method of ethics support.[4] Within this framework, participants (physicians, nurses, social workers, and so on) reflect upon a specific moral question that derives from a concrete experience, with the conversation method specifically structured and led by a trained facilitator. The facilitator is neutral and gives no direct advice on the case but supports participants' moral inquiry through a structured dialogue. The aim is to have an open and equal exchange of ideas in order to find answers to the moral question within the case, to improve decision-making processes and to develop moral competencies further among healthcare professionals. It is not about 'winning' or 'losing' an argument; consensus is not required.

There are several ways to perform moral case deliberation,[5] of which the dilemma method is best known.[6] Here we describe how this method works in practice, illustrated with a case example from a general hospital in the western part of the Netherlands. We will also mention some preconditions for using this method in clinical practice. This article is meant as a practical introduction to the relevance of moral case deliberation for neurologists, and to provide context to put this method of ethics support into practice. We use a specific moral case deliberation session on the intensive care unit to show how the process works and the kind of results it might bring.

THE DILEMMA METHOD

A moral case deliberation using the dilemma method usually has 8–12 participants, including the case presenter and the facilitator. The case presenter is usually a physician or a nurse who faces an ethical dilemma. The facilitator is either an external expert (usually an ethicist) or a healthcare professional from the institution itself, trained and certified as moral case deliberation facilitator.[7] Within a fixed time window (1.0–1.5 hours) the different steps of the method are applied.

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Setting

The moral case deliberation took place at the intensive care unit of a large teaching hospital in Amsterdam, The Netherlands. The goal was to discuss a current case. There were 10 participants, including 6 residents, 2 nurses, a neurologist and an intensive care unit doctor. A neurologist facilitated the session, having previously attended a bespoke specialised training course at the VU Medical Center, Amsterdam.[8]

Step 1: introduction

During the first step, the facilitator explains the aim and procedure of moral case deliberation, addressing such issues as: what is moral case deliberation, what is the aim of this specific meeting for the participants, what is the importance of dialogue for a constructive moral inquiry, what are the mutual expectations (eg, open and honest communication, learn from various kinds of reasoning), and then explained the steps in the method. The facilitator also introduces the occasion and the context of the deliberation.

In this particular case, the motive for presenting the dilemma was that a decision was needed concerning the further treatment of a patient on the intensive care unit.

Step 2: presentation of the case

A neurology resident (the case presenter) briefly sketches the case: a 32-year-old male rugby player of Moroccan–Dutch descent who had collapsed during a game. His medical history was unremarkable. His teammates started cardiopulmonary resuscitation when they found him unconscious on the ground with no pulse. After about 10 min the paramedics arrived: they gave two shots of epinephrine 1 mg by intravenous access; he was then defibrillated for ventricular fibrillation.

When he arrived at the emergency department, his airway was secured by intubation, his arterial oxygen saturation was 100%, his breath sounds were symmetrical and vesicular, his pulse was 101/min and blood pressure 70/40 mm Hg. His plasma glucose was 11.2 mmol/L. On neurological examination, his Glasgow Coma Scale score was E1 M1 Vtube with unequal pupils (right > left) that were unresponsive to light.

Five minutes later, he again developed ventricular fibrillation, and cardiopulmonary resuscitation was restarted. This time it took 30 min before cardiac output was restored. After being stabilised, an echocardiogram was normal and a CT scan of head showed diffuse brain swelling with loss of distinction between grey and white matter. He was transferred to the intensive care unit for further care and monitoring.

On day 2, he had a spontaneous ventilatory drive, a Glasgow Coma Scale score of E1 M2 V1 and equal pupils that were unresponsive to light. The medical team tested somatosensory-evoked potentials to try to determine his neurological prognosis, but unfortunately technical disturbance rendered the result useless. The medical team then did not know whether to withdraw supporting treatment because of a poor neurological prognosis. His family members had stated that according to their faith (Islam) everything must be done to keep him alive; according to them, only Allah decides when it is time to die.

Step 3: formulating the moral question and the dilemma

The facilitator invites the neurology resident to formulate the moral dilemma, in as concrete a way as possible, and encourages the group to help her. With the group's help, she formulates the following question: 'Should I continue treatment (A) or should I stop (B) supporting treatment (ie, remove tracheal tube and supportive medication)?'

The facilitator also enquires about the potential moral damage involved with either decision. The case presenter, assisted by the group, mentions the following:

A. When the medical team continues supporting treatment, in the long term the patient may enter a persistent vegetative state (or 'unresponsive wakefulness syndrome'). The patient would be persistently unaware, there would likely be a considerable burden to his family members, and a hospital bed would remain occupied.
B. When the medical team stops the supporting treatment, the patient will die because of respiratory failure or a cardiac arrest. There would likely be moral distress and grief in the family members in general, and more specifically they might regard this as violating their beliefs based on the Islam. This in turn might lead to a conflict between the medical team and the relatives.

Step 4: clarification in order to place oneself in the situation of the case presenter

The facilitator invites the participants to ask the case presenter further questions in order to obtain the information needed to immerse themselves in the situation, and to prepare their personal answer to the formulated dilemma. This is a crucial step in the moral case deliberation since participants do not judge the case presenter and their behaviour or choice, but rather reflect on their own moral views of the problem (this is also done to create a safe atmosphere within moral case deliberation). This phase is also called 'empathising'.

A selection of the questions asked includes: 'how did the patient function before?' (Answer: 'he functioned independently in activities of daily living'). 'Did he ever speak to his family members about this sort of situation and what he would have wanted?' (Answer: 'he did not'). 'What are the cultural differences in dealing with these types of situations?' (Answer: 'the family has great difficulties giving up medical support

Table 1 Norms and values from different perspectives. The different options (A and B) are matched with the different values. According to the moral case deliberation participants, some values refer both to A and B

Perspective	Value	Norm
Patient	Well-being Respect for my faith	I should receive adequate medical care. Only Allah should decide about end of life.
Doctors (neurologist/ intensive care unit doctor)	Empathy (B) Patience (B) Providing good care (A) Efficiency (A)	I should take the relatives' values\norms into account. If there is time I should not make rash decisions. I should follow treatment protocols. I should use means in a cost-effective manner.
Nurses	Harmony (B) Caring (A/B)	I should try to avoid conflict between the medical team and the patient/ relatives. I should make the relatives feel safe/like they are in good hands.
Relative(s)	Involvement (A/B) Family bond/relations (B) Respect (A/B)	I should participate in shared decision-making. I should stand up my family members. I should be heard.

according to their faith'). 'What is his neurological prognosis based on his present clinical situation (ie, two days after cardiopulmonary resuscitation; E1 M1 Vtube with absent pupillary light responses with no reliable somatosensory evoked potentials)?' (Answer: 'if his motor score is ≤2 or his pupils are unresponsive to light or his corneal reflexes are absent, ≥72 hours after cardiopulmonary resuscitation, his neurological prognosis is highly unfavourable. Currently these 72 hours have not yet passed as he was admitted only two days ago').

Step 5: case analysis in terms of perspectives, values and norms

This step is meant to reconstruct values and norms of the persons involved in the case concerning the moral dilemma. 'Values' are fundamental moral motivations; 'norms' are action rules that indicate what has to be done to honour and realise values. First, the group identifies the involved stakeholders (ie, perspectives). They then identify the norms and values of the various stakeholders in the case, and note them schematically (table 1). As the patient and the relatives themselves were not present for the moral case deliberation, the norms and values from their perspective were identified as well as possible. The various values in the scheme were related to the two decisions (A or B).

Step 6: looking for alternatives

After making the values and norms explicit for each stakeholder, the facilitator invites the group to look for alternatives. This is meant as a creative out-of-the-box thinking process, going beyond the (assumptions underlying the) dilemma.

One of the intensive care unit nurses suggests consulting an imam or an intercultural healthcare consultant to mediate between the medical team and the patients' relatives. The imam is a religious professional from the community who has no specific background in medical ethics but has the confidence of the family. The intercultural healthcare consultant is a medical professional working in our hospital who specialises in psychosocial support and coaching of patients coming from cultural minorities, and Muslims in particular. A neurology resident suggests stopping the supporting medical treatment not at once but in a more stepwise manner to give the relatives more time. Another neurology resident suggests seeking a second opinion from a neutral neurologist from a different hospital, or even, if possible, a neurologist with an Islamic background.

Step 7: making an individual choice

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

A. It is morally justified that I choose option … (A, B or an alternative).
B. Because of…. (which value or norm?)
C. Despite of…. (which value or norm?)
D. How can you limit the damage of your choice mentioned under 'C'?
E. What do you need, to act according to your answer under 'A'?

Most participants chose option B, to stop supporting medical treatment:

a. It is justified to stop supporting treatment if his neurological state remains unchanged ≥72 hours after cardiopulmonary resuscitation.
b. Because of providing good care; not letting the patient suffer unnecessary and not make unnecessary costs for the hospital.
c. Despite of keeping a harmonious relation with the relatives and possibly creating a conflict with the relatives.
d. The damage could be limited by consulting an independent mediator.
e. An imam or an intercultural healthcare consultant needs to be present in the discussion with the relatives before stopping supporting treatment.

Participant Y, an intensive care nurse, chose option A:

a. I believe it is justified to continue medical treatment.

b. Because of maintaining a harmonious relationship with the relatives.
c. Despite not following protocolled medical care to stop supportive treatment after 72 hours. We must be able to deviate from a medical protocol if this benefits the patient or, in this case, the relatives.
d. The damage could be limited by discussing with the family members that future complications will no longer be treated and carefully explaining to them the severity of the situation.
e. We need a discussion with the relatives to stress the severity of the patients' situation.

Step 8: dialogical inquiry

In this step, the group examines the differences and similarities in personal perspectives, guided by the facilitator. The goal is to clarify each one's position and thus to gather new insights to come to a good decision, discuss possible consensus, or to find a balanced compromise. It is important to stress that gaining a majority for a certain option does not make it morally justified and that the goal of the moral case deliberation remains learning from the different perspectives and maintaining an open mind for different solutions.

Although most of the group choose to stop supporting medical treatment based on the fact that it would be medically useless and not in the patient's interests, one nurse suggests continuing supportive treatment. When asked to explain her view further, she says that stopping medical treatment would be too big a step for the relatives to accept and that it would be better to do this in a stepwise manner to possibly avoid conflict. For instance, we could discuss with the relatives that if his clinical situation deteriorates because of a complication, we would not extend the management to treating these complications. Everyone in the group agrees that it is important to maintain a harmonious relationship with the relatives to prevent a possible escalation. After a discussion in the group, one member suggests that a conflict might be prevented by consulting the hospital's intercultural healthcare professional. If the dialogue with the relatives was adequate and within their cultural reference framework they might be able to accept the decision to stop treatment. Thus, the dialogue should be centred around gaining a mutual understanding that the eventual decision should be in the best interests of the patient, both from his perspective (ie, 'Allah should decide when my time has come') and from the medical team's perspective (ie, 'the patient should not be treated unnecessarily').

Step 9: conclusion

The facilitator asks the participants if they now have a different perspective on the case and if so, for what reasons. This phase is also described as 'harvesting'.

In the end, it was a joint decision of the medical team and the family to stop supportive treatment in the presence of an intercultural healthcare consultant to facilitate conversation. This conclusion was based on providing good and efficient medical care while trying to maintain a harmonious relation with the family members. Important to mention: organ donation was discussed with the family but refused on religious grounds.

Step 10: evaluation

The final step is a short evaluation: what are positive and negative aspects of the moral case deliberation, and what can be learnt for a future deliberation exercise? The participants agree that it was useful to evaluate these kinds of ethical decisions and that it offers a good forum to make these decisions. It also serves as a platform to think about alternative options besides the more obvious choices. One of the participants mentions that for similar future situations, we need more education to deal with intercultural differences in medical care.

GOALS OF MORAL CASE DELIBERATION

This case is just one example of the many ethical questions that neurologists, nurses and other team members confront in their daily practice. Moral case deliberation is a practical approach to come to a better understanding of a dilemma, reflecting and deliberating on the values and norms of involved stakeholders and participants. Although the primary goal of the exercise in medical contexts is often to come to a (shared) decision, there can be more solutions to a case. This stimulates the creative and also critical thinking within the team. Moral case deliberation is not about winning or losing an argument, it is about learning about various (opposing) viewpoints.

Moral case deliberation has several secondary goals that are addressed in research that evaluates the method:

1. The process can help prevent moral distress. According to Jameton,[8] moral distress can be defined as '*knowing what to do in an ethical situation, but not being allowed to do it.*' Examples include continued life support when it may not be in the best interests of the patient; inadequate communication about end-of-life care among providers, patients and families; inappropriate use of healthcare resources; inadequate staffing; and false hope given to patients and families. The key element is a sense of helplessness.[9] Moral case deliberation can help recognise and reduce moral distress: reflection can give new energy and insights.
2. Moral case deliberation increases moral competencies. Moral competencies can be divided into knowledge, attitude and skills.[4] With respect to knowledge, participants in the process learn to recognise moral issues, to formulate moral questions or moral dilemmas and to analyse a situation from various perspectives, focusing on values and norms. Regarding attitude, they learn how to

have a moral dialogue, to postpone their initial judgements and to surpass the desire to convince the other. Participants report improvement in various skills: 'communication (eg, non-judgmental listening, asking fundamental questions), reasoning (eg, logic, connection between moral values and norms, inductive versus deductive reasoning) and moral skills or virtues (eg, postponing moral judgments, creating dialogue instead of convincing the other)'.[4] Janssens *et al* also found that moral case deliberation participants experienced increased openness, increased mutual understanding and increased respect for different perspectives and opinions.[10]

3. Moral case deliberation can have a team building function. Research shows that the team aspects of the process help multidisciplinary professionals to learn to understand each other's viewpoints and dilemmas, which creates an atmosphere in which one can actively reflect upon each other's presuppositions in a structured yet constructive and safe way. This also has an effect on the quality of the decision-making processes in a team.
4. Thematic moral case deliberations or a series of them (eg, within a specific project) can be used for formulating, adjusting and implementing policies and guidelines.

HOW TO START

Before starting moral case deliberations in a department, there are two necessary preconditions: (1) the hospital organisation having a positive attitude towards openness and critical reflectivity, which are key features of the process; (2) knowledge and experience to organise and implement the process.

The process requires a so-called reflective organisation[11]: healthcare professionals should be challenged to reflect actively on what they consider as good care. They should ask and be able to answer questions such as: 'what are we doing?', 'what are we good at?', 'what are the main norms and values in our organisation?' A reflective organisation contrasts with a classical or bureaucratic organisation that many hospitals unfortunately still are: a hierarchical structure that leaves little room for critical reflection as if employees were parts of a complex machine.

In addition, moral case deliberation requires facilitators. External experts, such as professional clinical ethicists, can facilitate the sessions. However, from a theoretical as well as a practical perspective, it can be argued that professionals should be able to facilitate the sessions themselves. The arguments include: moral reflection is an inherent part of being a good professional; the implementation of reflection in healthcare requires a direct link with daily practice; the enhancement of ethical or moral reflection and constructive team cooperation among healthcare professionals is an important aim for the process. As moral case deliberation facilitators, healthcare professionals need to be able to guide their colleagues through a process of reflection on a moral question. In order to do this, they need to develop certain skills. For this reason, the VU University Medical Center (VUmc) in Amsterdam, The Netherlands, developed an intensive training programme for facilitators from various kinds of healthcare institutions.[7] In this training programme, healthcare professionals learn to facilitate moral case deliberation sessions. The content and the didactics of the training are based on various philosophical inspirations behind the process, including dialogical ethics, pragmatic hermeneutics and bioethics. It is important to mention that the facilitator needs help from a coordinator for logistics to organise and plan a moral case deliberation and to monitor its results. Lastly, it should be mentioned that moral case deliberation should not be used just for the sake of doing it, but as rapidly available tool for assessing ethical problems in daily practice.

Key points

- Clinical ethics is an emerging field, and moral case deliberation is one way of providing ethics support to an organisation.
- Moral case deliberation, using the dilemma method, is a practical 'hands on' format to discuss ethical problems.
- Its primary goals are to foster understanding of a case and to improve decision-making; secondary goals include preventing moral distress, team building and fostering moral competencies.
- Important preconditions for setting up moral case deliberation include being part of a reflective organisation that wishes to create a climate for improving the quality of care, and having facilitators keen to improve knowledge and education.

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REFERENCES

1 Vajda A, McLaughlin RL, Heverin M, *et al*. Genetic testing in ALS: A survey of current practices. *Neurology* 2017;88:991–9.
2 van Erp WS, Lavrijsen JC, Vos PE, *et al*. The vegetative state: prevalence, misdiagnosis, and treatment limitations. *J Am Med Dir Assoc* 2015;16:85.e9–14.

3 Molewijk B, Slowther A, Aulisio M. Clinical ethics support. In: *Encyclopedia of Global Bioethics*. Have H, ed. Dordrecht: Springer Science and Business Media, 2016:1–8.
4 Molewijk AC, Abma T, Stolper M, *et al*. Teaching ethics in the clinic. The theory and practice of moral case deliberation. *J Med Ethics* 2008;34:120–4.
5 Steinkamp N, Gordijn B. Ethical case deliberation on the ward. A comparison of four methods. *Med Health Care Philos* 2003;6:235-46.
6 Stolper M, Molewijk B, Widdershoven G. Bioethics education in clinical settings: theory and practice of the dilemma method of moral case deliberation. *BMC Med Ethics* 2016;17:45.
7 Stolper M, Molewijk B, Widdershoven G. Learning by doing. Training health care professionals to become facilitator of moral case deliberation. *HEC Forum* 2015;27:47–59.
8 Jameton A. *Nursing practice: the ethical issues*. Engel-wood Cliffs, NJ: Prentice-Hall, 1984.
9 Savel RH, Munro CL. Moral distress, moral courage. *Am J Crit Care* 2015;24:276–8.
10 Janssens R, Zadelhoff E, Loo G, *et al*. Evaluation and perceived results of moral case deliberation in a Dutch organization for elderly care. A quantitative and qualitative study. *Nursing Ethics* 2015;22:870–80.
11 Argyris C, Schön DA. *Organizational learning: a theory of action perspective*. Reading, MA, USA: Addison-Wesley, 1978.

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Notes