Relevance of a normative framework for evaluating the impact of clinical ethics support services in healthcare

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Evaluating the impact of clinical ethics support services remains a challenging task.[1] Against this background, we applaud the authors for developing a theoretical framework that aims to explain how repeated moral case deliberations may promote 'practical wisdom' in healthcare professionals and improve the quality of care in health facilities.[2] In our view, it is of particular value to draw attention to the learning processes that may be induced by ethics support services. Understanding such learning processes on the individual and organisational level is a prerequisite for longitudinal research designs that may be suitable to study the impact of specific ethics support services on criteria deemed relevant in patient care.[3]

In our comment, we would like to focus on one aspect, which we deem necessary to be able to explain the possible impact of ethics support on the quality of healthcare. This is the need for being explicit regarding the normative framework underlying a specific ethics support service. In this respect, Kok *et al* seem to propose quality pluralism and context specificity and conclude that what is best in healthcare has to be determined in each case individually on the basis of its specific features. For example, respecting patients' statements regarding their preferences may be of particular relevance in some cases but inappropriate in other cases. Further, they seem to imply that since there is pluralism and context specificity, we cannot or need not establish an explicit normative framework for healthcare that applies to all contexts and cases. Rather, they argue for a collection of case deliberations that is supposed to serve as orientation for further case deliberations and decision making in health facilities. By practising moral case deliberations, healthcare professionals gain experience and acquire skills in recognising consistent patterns of morally relevant features across different cases, which helps them to solve new cases. For instance, if we learnt in previous cases how certain contextual features bear on the ethical significance of patient preferences, this might be helpful for deciding whether to follow certain patient requests in further cases in similar contexts.

We certainly agree with the authors that experience matters. Whatever method is used in clinical ethics consultation, it needs practice to be able to use it with some mastery in complex, real cases. However, training does not replace ethical justification. A normative framework is also essential for ethical learning processes. In our view, common patterns that can be recognised in different case deliberations are really patterns of the normative framework that—explicitly or implicitly—has been used across these cases, although in context-specific ways. With ongoing case deliberations, we learn more and more how the reliance on a particular normative framework lends moral significance to different contexts and facts, and we are increasingly able to judge different cases systematically, consistently and coherently on grounds of the framework. This is also key for evaluating the impact of ethics support services on the quality of healthcare decision making. If they promote the ability and frequency of healthcare professionals to reflect carefully and methodologically on the specifics of a range of cases in accordance with a clear, explicit and established normative framework, it promotes well-grounded reasonable decision making.

Having emphasised the need for being explicit about a normative framework for clinical ethics support and the evaluation of quality of patient care, we argue that the paper of Kok *et al* with regard to the underlying normative framework remains rather vague. On one hand, it seems that the authors follow the method prominently established by Widdershoven and colleagues.[4] If this was the case, an obvious challenge is that this method lacks reference to a normative framework in the sense of an ethical theory within analytical philosophy. Instead, the method relies on the personal moral experiences and considerations of the participants, aiming at a better mutual understanding by a structured, group-wise reflection led by a facilitator. This approach seems to be difficult to bring in line with predefined quality criteria of healthcare because the focus of moral case deliberation rather seems to be on developing self-confidence when managing ethically difficult situations and mutual understanding of each other's reasoning.[5] Unless the team members remain unchanged, it is also unlikely that repeated moral case deliberation will lead to systematic progress because, with each new participant, the dialogical fusion of the participant's moral horizons will need to start over again. Moreover, it is not clear how the participants can be sure to contribute to the quality of care if there is lack of reference to external normative standards. On the other hand, it seems that Kok *et al* propose the casuistic method as an attempt to fix the aforementioned limitation. However, and similar to moral case deliberation, analogical reasoning without reference to an explicit normative framework seems to be difficult to reconcile with external quality standards in patient care. Second, a casuistic approach seems incompatible with moral case deliberation. As a hermeneutic approach, moral case deliberation seems not compatible with an approach according to which moral meaning can be analytically assigned to contextual features of cases by reference to norms or paradigmatic cases. Rather, moral meaning arises between, and remains relative to, individuals who coordinate their understandings of a case by joint deliberation.

In conclusion, we believe that Kok *et al* present excellent work with regard to conceptualising in more detail possible active factors of specific clinical ethics support service which possibly contribute to quality of care. However, to be able to capture the contribution to quality more clearly and to identify

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possible criteria to measure the impact of clinical ethics support service on the quality of patient care, we consider it necessary to be explicit regarding the normative framework underlying the specific clinical ethics support services.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Commissioned; internally peer reviewed.

To cite Rauprich O, Marckmann G, Schildmann J. *J Med Ethics* 2022;**48**:987–988.

Received 31 October 2022
Accepted 3 November 2022

► http://dx.doi.org/10.1136/medethics-2021-107943

J Med Ethics 2022;**48**:987–988.
doi:10.1136/jme-2022-108733

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