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ORIGINAL PAPER

Enacting Ethics: Bottom-up Involvement in Implementing Moral Case Deliberation

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Abstract In moral case deliberation (MCD), healthcare professionals meet to reflect upon *their* moral questions supported by a structured conversation method and non-directive conversation facilitator. An increasing number of Dutch healthcare institutions work with MCD to (1) deal with moral questions, (2) improve reflection skills, interdisciplinary cooperation and decision-making, and (3) develop policy. Despite positive evaluations of MCD, organization and implementation of MCD appears difficult, depending on individuals or external experts. Studies on MCD implementation processes have not yet been published. The aim of this study is to describe MCD implementation processes from the perspective of nurses who co-organize MCD meetings, so called '*local coordinators*'. Various qualitative methods were used within the framework of a responsive evaluation research design. The results demonstrate that local coordinators work hard on the pragmatic implementation of MCD. They do not emphasize the ethical and normative underpinnings of MCD, but create organizational conditions to foster a learning

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process, engagement and continuity. Local coordinators indicate MCD needs firm back-up from management regulations. These pragmatic action-oriented implementation strategies are as important as ideological reasons for MCD implementation. Advocates of clinical ethics support should pro-actively facilitate these strategies for both practical *and* ethical reasons.

Keywords Work floor involvement · Clinical ethics · Co-ownership · Hidden voices · Implementation · Moral case deliberation · Participation · Responsive evaluation

Introduction

In moral case deliberation (MCD), a group of healthcare professionals meets to systematically reflect upon a moral question that arises from a concrete case in their own practice. A specifically trained discussion leader—often, but not necessarily, a philosopher or an ethicist—watches over the content, process and product of the MCD meeting. The facilitator is non-directive regarding the content, helping participants in the deliberation process to make it a *moral* inquiry and to keep an eye on the focus and quality of the dialogue [20]. An MCD meeting addresses questions concerning good care (''What is morally the right thing to do in this situation and how should we do it rightly?''). Philosophical or conceptual questions can also be investigated (e.g. ''What is respect?'' ''What does understanding mean?''). Three central, often co-existing, goals of MCD are: (a) to reflect on the case and to improve the quality of care within that case; (b) to reflect on what it means to be a good professional and to enhance professional's moral competencies, (c) to reflect on institutional or organizational issues and improve the moral quality of care at that level [3].

MCD is based on various traditions ranging from hermeneutics, dialogical ethics and care ethics [9, 14, 15, 21, 29, 30, 35]. According to these roots, a MCD starts with paying attention to the history, circumstances and context in which a moral question occurs [3]. Deliberating from this viewpoint implies starting with the concrete, contextualized and practical cases of caregivers, leading to contextual knowledge. Participants are urged to remain open and receptive towards new options, perspectives and possibilities rather than to fixed principles [14]. Pragmatic hermeneutics is sceptical about a theoretical approach of an ethical dilemma, as moral knowledge is and should always be embedded in the experience of the persons involved [37].

Over the past years, there is a growing interest in ethics support in general and MCD in particular. The Dutch government stimulates MCD to assist professionals in the development of their moral competence on the work floor [1]. MCD implies an answer to this advice. As experience increases, evaluation studies report professionals and institutions highly appreciate MCD [18, 19, 26]. Though interest in and evaluation of MCD as a specific kind of ethics support is increasing, little is published on how to organize and implement these activities [18, 19, 31, 36]. Practice shows organization and implementation of ethics support activities are vulnerable, often depending on individual enthusiasm and expertise. Also, people

responsible for organizing MCD struggle where to place MCD within the organizational structure. Successes and pitfalls in implementation have not been documented by solid data collection. This article tries to fill that gap by enhancing insight in the organization and implementation of MCD. It will do so by presenting a case example, concerning the implementation of MCD within an institution for mental healthcare. In this example nurses from the teams in which MCD is taking place, are actively involved in, and responsible for, organizing the sessions. These nurses are called the 'local coordinators'.

The article is organized as follows: first the institutional context for the implementation of MCD project will be presented. This is followed by a description of the research methodology. Subsequently, results are presented and analyzed. Finally conclusions are highlighted.

Implementing MCD Within a Institution for Mental Healthcare

Within GGNet, a large mental healthcare institution in the east of the Netherlands, MCD was introduced in 2004 as part of a project on the reduction of coercion. Within this context, healthcare professionals from diverse teams reflected upon the moral issues in restraint or coercion casuistry. Over the years, MCD expanded throughout the organization, also detached from the original project. MCD was facilitated on either an ongoing basis, in a serial sequence, or once only. Nowadays, sessions are being held in the contexts of healthcare professionals (multi- and monodisciplinairy), with clients, family members, staff services and management. GGNet also facilitates an in-company training by which employees qualify to be professional facilitators of MCD. Furthermore, GGNet facilitates research concerning the implementation process of MCD together with the Moral Deliberation Group of the Free University Medical Centre at Amsterdam. All activities are monitored by the GGNet MCD Group. Since its start in 2004, hundreds of registered MCD sessions were held throughout the whole of the organization.

By these MCD activities, GGNet built up a lot of experience and collected data concerning its content, organization and motivation for practice [18]. In this contribution, part of this data concerning organizational aspects in MCD is presented.

Typical for organizing MCD at GGNet, is the involvement of the so called *local coordinator*: The GGNet MCD Group introduced this role as a means to support the organization and implementation of MCD and as a way of stimulating the co-ownership of MCD amongst team members. Every team initiating six sessions or more, applies one member of the nursing team to take care of the practicalities concerning the sessions. Tasks of the local coordinators concern for example: reminding participants of a scheduled session, reminding the person who is scheduled to write a case, making sure evaluation forms and reports are being spread etcetera. Also, the local coordinator is the spokesperson between the ward and the GGNet MCD Group, the researcher and the conversation facilitator. At the moment eleven local coordinators, appointed by the team manager, are actively involved in MCD. These local coordinators are subject in this paper, presenting *their* perspective on implementation of MCD. As they come from the nursing team,

focussing onto their perspectives of implementation of MCD provides insights from the shop floor. Presenting implementation from this perspective shows what ethics can learn from this stakeholder group in terms of enacting ethics by experiential learning, leading into increasing co-ownership amongst nurses of both the implementation process and the activity involved.

Methodology: Monitoring and Facilitating Implementation Processes Through Responsive Evaluation

Theory and Design

To monitor the implementation proceedings a responsive process evaluation was chosen. This design is driven by the same democratic, participative and dialogical values as MCD [3, 38]. Using a responsive evaluation strategy, active inclusion of an optimum of stakeholders is obtained, thereby meeting democratic, dialogic and participative principles in implementation simultaneously. In responsive evaluation the issues (expectations, concerns, controversies) of all stakeholders are investigated to obtain a rich understanding of the evaluated practice from their insiders' perspectives [27, 28]. Responsive evaluation (compare Guba and Lincoln's Fourth Generation Evaluation 1989) [12] insistently includes the voices of all stakeholders in the evaluated process; not only as information givers, but also as advisors and partners [10]. Its aim is to enhance the mutual understanding between stakeholder groups as a vehicle for practice improvement. The process is cyclical: stakeholder issues are first gathered and discussed among groups with converging interests (homogeneous groups), and later used as input for hermeneutic dialogues between groups with diverging interests (heterogeneous groups). These dialogues do not aim to generate consensus per se, but to collect meaningful issues that rise for the stakeholders themselves. Also the meetings aim to stimulate people involved to mutual learning by responding to the various perspectives presented during the gatherings [2, 11]. Evaluation activities obtain several purposes simultaneously, including the collection of empirical data as well as facilitating mutual learning amongst stakeholders during these conversations. Therefore in the case of this research project, both the research process and the implementation of MCD are allied and both impinge each other.

Following a responsive methodology, the research design develops in conversation with the stakeholders using the same moral competences as in MCD such as learning from other perspectives and postponing personal judgements. And like MCD, responsive evaluation meets well with the principles of hermeneutic ethics using dialogue as the main vehicle [16, 25]. Issues at stake derive from the given context and from the stakeholders themselves, emerging in dialogues that reflect diversity in perspectives, history and meaning. Acknowledgement of this plurality of perspectives results in a bottom-up formulated definition of—in this case—the concept of implementation, not from a preconceived view on the concept detached from practice or people involved. This way, congruence between conceptualization of the evaluated object (i.e. implementation of MCD) and the evaluation design (i.e. responsive evaluation) is aspired.

Evaluation Procedure

On behalf of the responsive evaluation process five stakeholder groups were distinguished: MCD participants (including client participants), local coordinators, conversation facilitators, managers and policy makers involved in the implementation of MCD (such as: Board of Directors/members of the MCD Group). This article deals with the perspective of the local coordinators. Eleven of them are active within GGNet.

As stated, the hermeneutic dialectic process of responsive evaluation is cyclical and iterative, so that interviews enabled data collection as well as engaging respondents for both implementation and research activities.[1]

First, five out of the eleven local coordinators for MCD were interviewed individually. The selection of respondents was based on the principle of variety: gathering as many perceptions as possible [12, 17]. After five interviews the data collection ended as repetition of issues that occurred in earlier interviews (i.e. criterion of saturation). Each interview lasted 1–1.5 h and was semi-open; a topic list—based on informal conversations amongst people involved, evaluation forms, internal rapports on MCD and literature—was used to bring in issues, but the interview was primarily structured by the respondent and questions asked were open.

Subsequently, all local coordinators were invited to join a focus group [23]. They never met in such a cross-organizational meeting before. The meeting aimed to validate and further broaden and deepen the issues derived from the individual interviews by stimulating dialogue and confrontation of viewpoints amongst participants. Upcoming issues included: motivating participants, providing a case, support, multidisciplinary compilation, client participation, compulsory attendance, responsibilities of the local coordinators. Some issues spontaneously came up during the focus group meeting, some issues were based upon the analysis of the interviews. After this data collection process, all audiotapes of the interviews and focus group were literally transcribed in order to conserve specific characteristics such as doubts, hesitation and enthusiasm [7].

The focus group was joined by five local coordinators, out of whom two respondents who were interviewed individually earlier. The gathering lasted 2 h and was moderated by the MCD program leader of the GGNet MCD Group and the researcher. The focus group was characterized by an informal atmosphere, to invite respondents to speak out frankly. All in all eight out of the eleven local coordinators were included in the process of collecting data. Analyzing the data, themes that came up were listed related to the process of organizing and implementing MCD. Subsequently, the five individual interviews were reread in order to refine the analysis of the focus group. Finally, all respondents were asked to read the interview analysis to validate and criticize outcomes and conclusions drawn (member check/respondent validation; [7]. Their comments were included in the final analysis.

[1] When referring to respondents, this word indicates members of the focus group or the interview. When referring to participants, this indicates the persons who take part in MCD on the wards.

Results

In this section, the local coordinators speak. In order to structure results, quotes from the interviews were derived and put into three categories: (a) MCD as an activity with distinction (b) Tools for implementation (c) Implementation as work (for an overview: see Table 1). The process of deriving these categories was subject of discussion amongst supervisors, respondents and the MCD Group. Central question is: 'what do local coordinators experience while organizing and implementing MCD?' Themes will be illustrated by quotes from the interviews, a usual strategy in qualitative research. Remarks from the member checks are included.

MCD as an Activity with Distinction

According to local coordinators, MCD has a *status aparte* amongst other regular ward meetings. As the structure and attitude during a MCD conversation differs from (local) conversation routines, MCD participants initially do not easily connect to MCD. Also the *concept* of moral deliberation brings about some questions amongst participants. So how does MCD differ from its fellow ward meetings, according to the local coordinators?

Image of MCD

The *concept* of MCD generates associations of distinction or weight amongst participants. This evokes attractiveness and exquisiteness as a presupposition, yet, the concept also evokes associations of heaviness and difficulty—especially amongst those having little experience with MCD. Due to this, a certain ambiguity is accomplished towards the *image* of MCD, in which the distinctive characteristic

Table 1 Overview of (sub)themes on implementing MCD

Main theme	Sub themes
MCD as an activity with distinction	Image of MCD
	MCD appeals to distinctive skills
	Thorough, in-depth investigation of casuistry
Tools in organizing MCD: support in daily work	Support by key persons
	Scheduling meetings
	Frequency of the sessions
	Compulsory attendance
Implementation as work	Content or continuity?
	Facilitating a learning experience
	Dealing with hierarchy
	Personal involvement
	Practical responsibilities

(Sub)themes concerning implementation of MCD from the perspective of the local coordinators

of MCD is ratified. For beginners, the word *reflection* brings about associations less heavy and reverses the *image* of MCD into a more amendable one.

> Moral case deliberation sounds so… heavy and loaded. That makes it all the lot heavier, actually (…) (FG)[2]

> Moral case deliberation: what does it contain? Móral Cáse Deliberátion! Hm? Sounds very eh…severe, heated. (…) It is *moral* and it is *deliberation*, ouch, ouch!! (…) Yes, a fierce concept. *Reflection* has a different bite (Indiv. IV)[3]

MCD Appeals to Distinctive Skills

Second, MCD requires skills by *mouth*, *letter and attitude* which differ from the daily skills applied to routines in mental healthcare and/or other ward meetings. Examples local coordinators present, are: writing a case, talk to each other with a specific discipline, trying to understand a fellow participant and ask questions rather than trying to convince him or exchanging presumptions. According to the local coordinators, these skills can be experienced as strenuous by the participants, even in long term, ongoing groups.

> (…) People who attend after a period of absence, or pupils and such, new colleagues, they find it really tricky. Afterwards they go *pffffft*, because [in moral case deliberation] one must ask questions and speak very open, and one is not allowed to simply state '*well, becàuse!*' (*laughter*). (…). You can see them sweat, thinking: hm, I don't know what to think of this! (FG)

Thorough, In-Depth Investigation of Casuistry

A further distinction of MCD compared to other ward meetings mentioned by local coordinators, is the aim of gaining deeper insight in a case. The level on which an issue is discussed is qualified as *in depth* or *going to the essence* by local coordinators. They define depth as a strong focus on a small part of a concept in a presented case, gaining a glimpse on the essence of a case, and formulating an applicable transition towards daily practice. Depth helps professionals to come to a standstill on issues—typical for MCD and also part of its distinctiveness on the ward routines, according to local coordinators.

> For example: take the word 'respect'. What does that mean to you? Well, when you put ten people in a row answering that question, you gain ten different answers! So eventually you can see that often you *think* you are discussing the same subject, but [in moral case deliberation] it appears you don't!! (FG)

The focus on clarification of concepts does not mean a turn to essences or large concepts. It rather requires valuing apparently small issues. Participants new to

[2] 'FG' refers to the abbreviation *Focus Group*, referring to the original transcript where quotes can be traced.

[3] 'Indiv.' refers to the abbreviation *Individual interview*, followed by the number of the respondent, referring to the original transcript where quotes can be traced.

MCD often do not experience depth when they deliberate on small issues. When apparent trivialities are discussed during a session, participants feel they wasted time. Therefore, going to the essence or gaining depth requires active, personal involvement and willingness from participants: an attitude-related aspect of MCD. Therefore, individual experiences on the intensity of the session may differ:

> [MCD participants stated:] 'Those trivialities, do we rèally have to discuss them!?' Well, gaining depth: [as a local coordinator] try explaining to a group what thàt means! (…). Because exactly those small issues (…) weren't experienced as 'depth' (FG)

Bringing Together a Variety in Contexts

According to the local coordinators, MCD also differs from other ward meetings because a variety of participants deliberates together on an equal basis. Most important is the variety in *contexts* of participants. This variety either can be reached by a mixture of disciplines, or a monodisciplinairy compiled group with people working on different wards:

> I think the surplus value in our group is located in the attendance of a variety of disciplines. I believe if we would do our moral case deliberation solemnly with the nursing team, the usefulness of the sessions would disappear quickly. Because (…) we would linger onto our own viewpoint so to say (FG)

> Many times only nurses attended our moral case deliberation meetings, but as we were coming from three different teams (…) we all brought in a different share (FG)

In sum, local coordinators typify the uniqueness of MCD amongst other ward meetings by four characteristics: concept and image, required skills, in depth reflection and compilation of the group. Combining an image of exquisiteness and heaviness, evoked by these characteristics, reflection becomes both illustrious and something very difficult at the same time. Local coordinators are not experts on these characteristics and cannot reply to all questions or hesitations they come across amongst their fellow-participants, especially when they are new to the matter. Although it seems that participants get used to the specific requirements of MCD sessions overtime, the distinctiveness of MCD always remains till a certain extent. Consequently, motivating participants to participate is not easy. To support this, and to persuade participants of the added value of MCD, local coordinators feel they need 'tools' and support from key persons at the ward. This is addressed in the following section.

Tools in Organizing MCD: Support in Daily Work

A local coordinator represents MCD amongst colleagues. Yet, experience shows he[4] needs tools to support the activity and institutionalize continuity—an important

[4] Local coordinators can either be male or female of course, yet in favour of readability only 'he' is used here.

aspect of implementation according to this respondent group. In the interviews, local coordinators mention a number of those 'tools':

Support by Key Persons

Commitment to, and attendance during MCD of key persons (local manager, psychiatrist etc.) of the ward is of great value to the local coordinators. Their attendance contributes to the seriousness with which the sessions are being attended and appreciated, and to the positive interpretation of the concept of MCD. Attendance of key persons also strengthens the position of the local coordinator as he feels supported by these authorities showing approval for reflection.

> Condition for the successes we had was the indisputable support of the psychiatrist and team leader. We needed their full support, yes (indiv. I)

> In the beginning of the series the team leader always attended. Actually he did so in order to stress the importance and to stimulate continuity in the sessions (indiv. V)

> I couldn't help thinking she [psychiatrist—FW] had other priorities. And that the moral case deliberation meetings we had were not sufficient, not powerful enough (indiv. I)

Scheduling Meetings

Local coordinators focus on building up a routine in MCD. As routine builds up, MCD becomes a self-evident phenomenon on the ward. However, this requires scheduling sufficient personnel to cover the absence of colleagues during the meeting. Also, the manager must accept individual employees' overtime hours. Local coordinators watch over these agreements and show active involvement when this becomes rocky:

> No. Nobody feels responsible to settle assistance. No. So we [the team, FW] do it ourselves now. Because the team considers reflection of great importance. So yes, we do settle the problem ourselves (FG)

> Well, in our case we do not even have to think about it any more. We just know on Mondays we need an extra day and evening shift (FG)

> As a local coordinator, you must be able to make people enthusiastic (…) just by telling them – in accordance with your team leader – this is *their* time! They can record these hours at any time they like – that should be guaranteed (indiv. II)

Frequency of the Sessions

Within GGNet, frequencies of the sessions of MCD highly fluctuate per ward and may vary from six times a year to every fortnight. Team leaders determine the frequency in their ward; there are no fixed guidelines. Local coordinators show

loyalty towards direct colleagues who feel their available time with clients becomes under pressure by another scheduled meeting ànd towards regulations. They are therefore willing to listen to both stakeholder groups; if for example participants wish to adapt regulations they discuss this with the team leader.

> In our case we decided to do a session once every four weeks. Everybody felt once every fortnight was simply too much, especially the therapists and doctors said so. […] Well, then together we decided: from now on we will come together every four weeks (FG)

Compulsory Attendance

Despite local differences in organization, all team leaders who initiated MCD chose to obligate attendance of the meetings for all nursing staff on duty. Local coordinators experience initial reluctance amongst participants because of this compulsory attendance. To participants it is not always clear why MCD is initiated and why attendance is obliged. Local coordinators nevertheless report that they prefer this compulsory attendance as a regulation because it provides opportunity to participants to *experience* the surplus value of MCD instead of arguing about its value beforehand. Also, regulations like compulsory attendance help local coordinators to address to participants with stoutness and self confidence, regardless the eventual difference in status on the ward:

> In our case attendance was obligatory. So people had to come back to work for it – sometimes for only two hours and this brought up a great deal of resistance (FG)

> In the beginning there was a lot of struggle. People said: what is all that reflection about?! Well, as a local coordinator, you also have to motivate and activate people to arrive 45 min earlier, or to leave 45 min after duty (indiv. II)

> So people must be addressed! And as a coordinator, that is what I do. Yes, I think it part of my job (…). Well, I have no problem with that, no. And moreover, people simply *know* that I am right (indiv. II)

Yet, provided that it is clear when the sessions are scheduled and who will be responsible to bring in the case to be discussed, this obligation is commonly accepted as MCD sessions proceed.

In summary, local coordinators state they need key persons from the ward openly or explicitly supporting MCD and supplying organizational tools to regulate attendance and continuity. These aspects justify the authority of the local coordinators they gain overtime. Without this support, MCD will never root into practice, they feel. While they take care of the preconditions in order to guarantee progression, they need the authority of the superiors to persuade people to attend.

Implementation as Work

Local coordinators conduct the progression of MCD by taking care of preconditions, supported by management regulations. With this, they aim at continuity of MCD on their wards and they do this with vigour and consistency. Motivating participants is an important part of their job, they feel. Not so much for ideological, content related, persuasive reasons, but for pragmatic reasons (it is scheduled) and on behalf of the creation of a social structure in which a learning process is realized. Creating this social structure is an issue throughout the interviews.

Content or Continuity?

The position of local coordinators comes with a number of listed responsibilities. Yet in practice, local coordinators decide individually and based on experience, personal insight and motivation, what responsibilities they add to, or remove from the original list. Large differences in responsibilities can be detected, yet overall, local coordinators take their responsibilities very seriously. Efforts of local coordinators are not so much aimed at the content or ideological background of MCD, but at the notice of *embedding* MCD in a ward routine. They function as floor managers of the organizational process. MCD as a concept might be associated with heaviness and eminence, yet organizing it means simply that there is work to be done! In doing so, they show great loyalty:

> A: (…) Well, one must adopt moral case deliberation as if it were your very own child, otherwise… eh… One must….
> B: You'd better grin and bear it (FG)

> I consider my work as a local coordinator as a responsibility towards my team (indiv. V, r.186–187)

Local coordinators strongly emphasize on continuity and retention of the sessions. They do so in order to persuade participants to sustain social structures by getting people together. In their view, these structures are formative for participants in daily work situations. Their task is to establish conditions for these learning processes

> We just welcomed an interim social worker [on our ward] and she joins in, too. By attending, people become easy accessible. The same goes for her. (…) You hardly know each other, but (…) you already shared a dialogue together, well, that makes it all the way easier to talk. Because (…) I like to hear the way she approaches a problem, and if we happen to share a shift in the future, well, I at least know a little bit of her way of thinking. I consider this to be… quite a plus of the matter (indiv. II)

Facilitating a Learning Experience

Local coordinators fulfil their responsibilities because of a number of motivational aspects. These are either personal or come from successful outcomes they link to the

learning process in MCD. Local coordinators recognize an increase of joint cooperation amongst multidisciplinary team members. This process is steered by appealing to learning experiences, joint communication and thorough reflection:

> [Moral case deliberation] cultivated mutual understanding. And this understanding came from (…) coming to know why a doctor, well, eventually had come to a certain decision. Because that isn't always clear, is it?! (indiv. IV)

> At some point a patient was admitted into hospital and one [of us – FW] said: (…) 'maybe we should try doing it this way in stead of the other; we once discussed a situation like this within moral case deliberation!' Well that really makes me feel: *(clacks tongue)* tha̋t's it!! This [transfer to practice – FW] is grèat! (indiv. II)

Bringing people of a variety of contexts together nourishes a sense of collectiveness amongst different disciplines working in one team. Solitary working disciplines meet support, understanding and they (re-)connect to the nursing team. Also, reluctance in confronting other—mostly superior—disciplines is abolished by organizing a collective dialogue, based on and aiming at equality. Local coordinators appreciate this highly and report an improvement of team spirit due to the MCD sessions. This strengthens their efforts to do their job as a local coordinator:

> I noticed (…) improvement of interaction with for example our welfare worker. It became easier to drop in (…) to exchange thoughts on a specific client and to think jointly. And I believe this wasn't the case in an earlier stage. At [my ward] this process was very unambiguous. Very perceptible (FG)

> In general, therapists work rather solitary at our ward. And therefore, they often feel they need to solve things on their own. But when they bring in a case on moral case deliberation, many times conclusions are: hey, give us a ring and we will send someone from the nursing team. Or: drop by so that we can discuss it a little to see if we can do things differently (…). They *think* they work solitary, which in a way they do of course, yet still they are part of the team. And by the reflection meetings this bonding is fortified, certainly (FG)

> (…) This doctor (…) stated: 'I have been thinking about it and I decided to join you lot a bit more often to share a cuppa! Because I noticed that contacts improve and that the client is represented much better when discussing cases [in this setting]. Earlier, all this [consultation] happened from a mutual distance'. And this was him [the psychiatrist] speaking! (FG)

Dealing with Hierarchy

Local coordinators highly value variety in participants. In this, they locate potential benefits from the MCD meetings. This implies a variety in hierarchical representation of the disciplines involved in daily care routines: nurses, psychiatrists, secretary workers, management, therapists; ideally all of them are involved in a scheduled MCD session. Given these asymmetries, the local

coordinator focuses on creating conditions to provide a floor for a fair process: everybody should pin the gatherings; all are equal in that. No excuses are being made. Therefore, differences in terms of (hierarchal) position do not keep local coordinators from addressing people when they do not show up or provide no case when it is their turn. The MCD schedule provides authority in those cases and justifies action towards the person concerned. Participants then accept the authority of the local coordinator resulting in increasing self-confidence and a hint of stoutness. In consultation with the local manager, they even might decide in exceptional cases to exclude participation of certain team members when they obstruct the sessions for whatever reason:

> A: Yes, I consider it a matter of principles: you should be there, shouldn't you!? Everybody must return to work in order to attend, so at that scheduled time you should not have to discuss whether this counts as working overtime (…) (FG)

> Well in all honesty, when people start making a real fuss - like that psychiatrist who enduringly refused attendance, and he still does not join. Well, he simply accepts the outcome he is not welcome anymore. I spent so much energy addressing to him, and yes… there came a point at which I decided: okay, this is no longer my job (FG)

Personal Involvement

Accomplishing and witnessing these successes, local coordinators become highly motivated to do their work. They show great willingness to make efforts in the conducting process for MCD. This willingness also brings about personal involvement concerning the amount of success or failure throughout this process. Succeeding in bringing people from a variety of contexts together and seeing the potential harvest grow as the group experience increases, local coordinators take great personal pride and pleasure out of this heart-felt success. Reversibly, they take it as a personal failure for example when a set of sessions ends untimely. Also they feel responsible for a lack of input from participants during a session—also out of compassion with the conversation facilitator:

> Well, I just lóve doing this! (…) I really like to conduct any process! (*laughs*). It's just part of who I am. I just love (…) to activate and to cultivate enthusiasm, to activate participants slipping into the process..! (indiv. II)

> At some point I had a talk at an expertise meeting [on implementation of moral case deliberation, FW], and I told the audience as a local coordinator I saw our ward process was ahead of the plans of the expertise centre. (…) They are now talking about introducing moral case deliberation organization wide. (…) But up here, all is settled! Why should they reinvent the process [elsewhere] if we have so much experience over here they could use? (indiv. II)

> Somehow it slipped through my fingers… or actually it was pulled out [by lack of support from the psychiatrist -FW]. What a shame that was. A cardinal sin. I thought that was really bad (indiv. I)

> I experienced the meetings as very dispassionate, and [as a local coordinator – FW] I felt responsible, thinking: okay, now I need to give a hint or an opening for conversation. Or I must head in something (…). And I watched the conversation leader pulling, pulling, pulling… which made me decide to interfere and bring another issue up or… (indiv. IV)

Practical Responsibilities

Being motivated engages local coordinators to the process of organizing and implementing MCD. In order to keep up the continuity, they show great responsibility towards aspects that support this continuity in terms of preconditions and atmosphere during sessions. As an example of a precondition, providing a case is mentioned. Before the quality of a case is at stake, making sure there *is* a case is priority number one. It contributes to continuity and involvement of participants. Writing a case is one of the skills (by letter) MCD appeals to and therefore sometimes brings up hesitation. As routine in a group increases, participants usually need a simple reminder. But little experienced teams require active motivation of the local coordinator:

> Usually, when no case occurred in time, I send a simple e-mail as a reminder: hey, won't you forget? And this never results into any problem (FG)

> (…) Our routine was to choose a theme in connection with the preceding session, resulting in a new case. And formally…someone from the team had to put that onto paper. But as a local coordinator, I had to pull real hard to motivate a team member to do so. Really hard (FG)

As an alternative, some local coordinators take it as their responsibility to write the cases themselves, leading to lower involvement of the participants.

> I became crafty [in writing cases]. And so I thought: oh, well, let me do it! But eventually [moral deliberation] became *my* thing, while, well, it is a *team* thing of course. (…) And I think that is one of the reasons why MCD up here became a blind alley, eventually (indiv. I)

To sum up, local coordinators feel that by creating a social structure in which a learning process is realized, participants gradually become motivated for MCD. Local coordinators do not use ideological arguments for persuasion, but refer to management regulations and stimulate participants to experience the surplus value of MCD simply by undergoing the experience. Although this study does not focus on results of MCD, local coordinators state they see clear benefits, which motivates them to persist in their efforts. Yet, their personal involvement also makes them vulnerable towards feelings of either personal success or failure, especially when they do not feel support from key persons on the ward.

Discussion

This article deals with the organization and implementation of MCD in a large mental healthcare institution, perceived from the position of the shop floor. Local coordinators, coming from the nursing team, try to optimize conditions for MCD sessions, and thus allow insight into the process of enacting ethics support activities. In their work, they aim for continuity and bringing a variety of contexts together. To them, these are key elements of implementation and preconditions for a successful series of MCD meetings. In the eyes of the local coordinators, sessions bring forth a learning process with potential benefits like: changing social dynamics on the shop floor, lowering mutual thresholds and increasing mutual understanding. The results illuminate local coordinators' pragmatic style and their strong focus on the conductorship MCD meetings require. They know sessions would quickly come to an end if they would not do their diligent job, because participants need time to connect to and experience MCD's potential benefits. MCD requires sustainable practice. Once the routine is settled, work is still needed to keep people motivated. Local coordinators can be typified as facilitators of the organizational process, rather than ambassadors with ideological reasons of MCD.

Care should be taken to generalize the results from this study to the potentials of MCD in general. Although further research on results of MCD and a comparison with other forms of ethic support activities is desirable, the potentials *local coordinators* link to MCD are motivational strengths to them within their particular institutional setting. The results presented are thus context-bound and an expression of the perspective of one stakeholder group, namely the local coordinators. We do, however, belief that the thick description provided in this article enables readers to experience vicariously what it means to be responsible for the implementation of MCD in a mental hospital. This vicarious experience may help readers to transfer knowledge developed in this context by this stakeholder group to their own context. We call this a naturalistic generalization [28] as it is based on informal ways of transferring knowledge, not by the researcher (who only knows the studied context), but by readers who can compare their context with the studied context.

Amongst participants, MCD is initially associated with heaviness and trivial discussions about details. Ideological arguments to promote MCD might even work contra-productive and evoke resistance, because they might fuel these associations even stronger. MCD needs to be enacted: the actual meaning and implementation of MCD is revealed in concrete experiences by MCD participants. This pragmatic and action-oriented implementation strategy resonates with a key notion underlying MCD: action provides a valid source of knowledge [24]. Experiences of local coordinators in this research provide us with experiential knowledge concerning the actual process of implementation in practice. Considering this, the pragmatic and sustainable work of local coordinators on behalf of the organizational process, could be just as beneficial to the implementation process of MCD as the efforts of ethics experts who stress the importance of this kind of ethics support for more ideological reasons.

Nevertheless, a pragmatic approach towards the implementation of MCD might conflict with initial ideological fundaments of MCD. For example, would a

compulsory attendance of MCD meetings conflict with the basic notion of equal partnership and a free dialogue within MCD? Future research on organizing ethics support in a pragmatic way requires a thorough reflection upon this tension between pragmatism and idealism of the implementation of ethics support. In terms of implementation theories, these often suggest a technical step-by-step procedure to introduce new routines [33]. In the case of, for example, new techniques for using injection needles is at hand, this strategy seems appropriate. Yet MCD itself fosters methodological reflection amongst participants. Hence, the quality and success of both the MCD and the implementation of MCD is inherently dependent upon its participants. Furthermore, MCD explicitly interferes with local cultural aspects. From a cultural perspective, actors in the implementation process are not rational beings which are automatically persuaded by a pre-defined set of ideological reasons for MCD or a technical step-by-step implementation set up. They are influenced by social contexts and personal values and attracted by alternative reasons as the process evolves [6]. People involved in the implementation process actively relate to that process from different perspectives and backgrounds [22, 34, 36]. Therefore, specific attention should be paid to the local culture and to how people involved relate to the subject of implementation [32]. Support of the implementation process depends on the possibility to appropriate initiatives and adjust them to the shared values, interests, needs and desires of participants.

In line with an *organizational development approach* [8] several authors stress the importance of synchronizing the strategy of implementation with the nature of the initiative that is to be implemented [36]. Implementation of dialogical activities—such as MCD—therefore requires a dialogical and interactive process. Active participation of stakeholders requires inclusion, awareness and acknowledgement of ethnographic characteristics that help initiatives to fit into the local culture and increase co-ownership of the process without violating existing values and structures [36]. A bottom-up strategy and active involvement of team members is crucial to successful implementation of new initiatives. Yet, top-down support is crucial as well [5, 13]. This is illustrated by the vital importance of support from key persons in GGNet. In line with this experience, implementation theories stress that new initiatives both need classic hieratical steering and a process of involvement and ownership of this initiative by its users over time [4]. In this research, this support is shown by presence of the key persons during sessions, but also by firmly stating management regulations such as compulsory attendance by all disciplines.

Conclusion

Promoting ethics support services often refers to ideological reasons, rather than experiential meanings relevant for potential users. No matter how worthwhile these ideological reasons are, actual reasons for ethics support services (such as MCD) emerge in practice as all stakeholders define and re-construct its meaning. Ethicists working in clinical realities should not only be aware of this pragmatic process but should also pro-actively facilitate it. This can be done by paying attention to and

creating space and co-ownership for those who are actually involved in the organization of the ethics support service.

Approaching implementation of ethics support activities like MCD from the perspective of local coordinators shows that organizing ethics support involves a lot of activities. These activities, like settling preconditions for a session, remain invisible when focussing on ideological considerations only. Local coordinators reveal important experiential knowledge on *how to do* ethics support such as MCD. For example: realising what the meaning of a word (like 'moral case deliberation') can do in practice. Local coordinators indicate, *because of* their practical involvement, apparent trivialities having impact on progression of MCD series. Ethicists initiating MCD should seriously take into account the organizational and practical side of the activity to be implemented. Initiatives are and should be translated to the particular context.

In implementing ethics support activities, *meaning and organizational culture* are crucial. The implementation process and its outcome are contextually determined in co-creation by those who will be actually working with the initiative to be implemented [22]. The process of increasing ownership flourishes by involvement of the users throughout the implementation process [20]. For this reason, we advice to include 'tools of improvement'—meaning people from the section, ward or discipline at stake—rather than top-down 'tools of management' exclusively [36]. This is useful, not only for practical, but also for *ethical* reasons. Including members of the team in the implementation process seems a fair choice as *their* local culture is at stake. Especially in ethics support initiatives, maintenance of democratic values in this process is to be respected, meaning: equality of voices, active participation and co-ownership of the process [3].

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