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Clinical Ethics: Methods

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Abstract

Since its inception, Clinical Ethics has developed in a great variety of ways. A main line of division between all the methods adopted is between the ones that proposed clinical ethics consultations (CEC) and those that can be classified as moral case deliberation approaches (MCD). The first ones are centered on the patient and consist in helping an ongoing medical decision-making process that raises an ethical issue. The latter are more focused on the healthcare teams. They intend to help them in better dealing with the moral issues they face in their clinical work. Both of them are part of all the sorts of supports and services in Clinical Ethics (CESS) that can be proposed. In this entry, the different methods used for practicing Clinical Ethics will be presented with their main similarities and differences. It will be shown that the choice of method is often due to very local and contextual considerations and that at the end the specific method used matters little, as long as it contributes to a better quality of care for patients and a better awareness of the ethical challenges involved in clinical practice for the healthcare teams.

Keywords

Clinical Ethics; Ethics cases; Clinical ethics consultations (CEC); Moral case deliberation (MCD); Clinical ethics supports and services (CESS)

Introduction

Singer, Pellegrino, and Siegler, who pioneered the field of clinical ethics in the USA in the late 1970s, defined its goal as follows: "to improve the quality of patient care by identifying, analysing, and attempting to resolve the ethical problems that arise in (medical) practice" (Singer et al. 2001). This definition clearly positions Clinical Ethics at the bedside, a characteristic that sets it apart from other concerns in bioethics in general. However, Singer's statement does not specify the various methods that can be used to pursue the goal he defines. Since its inception, the field of clinical ethics has developed in a great variety of ways. At least North America and Europe present significant differences in approach.

A main line of division between all the methods adopted in Clinical Ethics is between case-based or casuistic methods on the one hand, which mainly consist in helping the

H. Ten Have (ed.), *Encyclopedia of Global Bioethics*,
DOI 10.1007/978-3-319-05544-2_89-1

medical decision-making process in a specific clinical case, and other noncasuistic methods on the other hand. The ultimate goal of the latter is also to improve the quality of clinical care, but they are not centered upon the decision to be made for a single patient, in a specific clinical situation. Nevertheless, some of these methods often claim to be casuistic too, because they are intended to help healthcare teams facing a moral question they face during their clinical practice. Here, the "case" can be represented by the problematic moral question they face: for example, "In psychiatric settings, to what degree is the use of coercion ethical?" Another classic example is "In clinical settings, how far does the right to conscientious objection extend?"

Another way of distinguishing the main existing methods developed in Clinical Ethics is between the ones in which it is crucial to meet with the patient(s) and/or his representatives directly concerned by the ethical dilemma for which the ethics team is called and those in which the objective mainly consists in training the health care workers in moral deliberation, using one method or another, but without any need to meet with the patient and/or his representatives. Moreover, many of the ethics teams who opt for methods aimed at increasing the moral deliberation skills of health care workers considered it superfluous or even counterproductive to meet with the patient and/or his representatives. They reason that ethics should be an occasion to detach, to some degree, from the daily course of clinics, and to level the playing field. On the opposite end of the spectrum, the supporters of a more "hands-on" conception of Clinical Ethics reject the Moral Deliberation approach as too theoretical. They say it is not pragmatic enough to be at all useful in real clinical life.

Finally, a third way of characterizing methods in Clinical Ethics is to differentiate between those which offer counseling from a lone ethics consultant or facilitator and those which provide the help of a whole ethics group or ethics committee. Either of these two approaches can be applied, regardless of how Clinical Ethics is conceived in the first place: as a means of making a decision for a specific patient or as a means of facilitating an ethical conversation within a healthcare team facing a concrete moral question in clinical practice.

The first part of this entry will briefly describe the historical background in which successive and even opposite approaches to Clinical Ethics emerged. The second part is a survey of the main methods commonly practiced by Clinical Ethics teams today. The methods that can be classified, as applying to clinical ethics consultations on the one hand (CEC) will be differentiated from those, on the other hand, that can be grouped in the category of moral case deliberation (MCD). Both of them are part of all the sorts of supports and services in Clinical Ethics (CESS) that can be proposed. Even within the two main categories of Clinical Ethics methods that are CEC on the one hand and MCD on the other hand, different practices have been developed in response to specific local and contextual considerations. Finally, and to conclude, it will be argued that the specific method used to practice Clinical Ethics matters little, as long as it fulfills both of the following requirements: (a) it must contribute to a better quality of care for patients, care that is more respectful of their own personal values; (b) and it must also help people, namely, health care team members, to become more aware of the ethical challenges involved in day-to-day clinical practice and medical decision-making.

Historical Background

The field of biomedical ethics began to develop in the USA, at the beginning of the 1970s. As Adams and Winslade say, "the broad outline of this emergence is fairly clear and recounts the convergence of multiple factors – sociological, technological, and medical" (Adams and Winslade 2011, p. 311). Indeed, ever-expanding technological possibilities offered by medicine combined with huge changes in patient expectations and a marked tendency for the doctor-patient relationship to shed its paternalism and become more respectful of the patient's values and choices led to an increase in the number and scope of moral dilemmas confronting healthcare

professionals in their daily clinical work. The movement led a great number of hospitals to form their own local clinical ethics committees as CESS, in order to help resolve these new moral challenges. Usually, the committees were of multidisciplinary composition, gathering physicians, philosophers, lawyers, theologians, psychologists, or sociologists. The hypothesis was that a broad spectrum of disciplines would be more apt to encompass and consider the multiple dimensions of the ethical challenges arising in practice (Doucet 2015).

However, certain physicians were hostile to the development of such committees. Some of them denounced the intrusion of "strangers at the bedside," as Rothman in the book he published in 2003, entitled as such. These doctors had misgivings about the risk of losing their decisional responsibility, if they shared it with outsiders who lacked any sort of clinical experience. As a result, the new clinical ethics committees gradually abandoned the idea of intervening on individual clinical cases. Instead, they concentrated their efforts on elaborating institutional guidelines for the resolution of ethically problematic transversal issues.

In parallel, the need for counseling persisted, when healthcare teams faced a strong, specific ethical dilemma. For that reason, a new way of offering this kind of help rapidly emerged. It was no longer based on the intervention of a multidisciplinary committee that provided its own interpretation and comprehension of the case. Instead, a sole ethics consultant strove to apply his or her expertise. David Thomasma, a well-known and respected philosopher in the field of bioethics and medical ethics at Loyola University (Chicago, USA), exemplifies this new type of ethics consultation (Doucet 2015).

Mark Siegler, a famous specialist in internal medicine, was among those who criticized the methods of the multidisciplinary bioethics committees in Clinical Ethics and promoted in parallel with Thomasma this new kind of CESS, called clinical ethics consultation (CEC). In 1981, Siegler founded the MacLean Center for Clinical Medical Ethics at the Hospital of the University of Chicago. The new framework and school of thought Siegler developed at MacLean was definitely based on clinical and medical foundations. According to Siegler, ethics and clinics are so tightly intertwined that the development of Clinical Ethics is inconceivable outside medicine. Ethics, he said, is inextricably linked with the central task of the physician, which is to make a medical decision for his patient (Siegler 1978). To present his own views and perspectives on Clinical Ethics, he collaborated with a philosopher, Albert Jonsen, and a lawyer, William Winslade, on a manual entitled *Clinical Ethics: A practical approach to ethical decisions in clinical medicine*, first published in 1984 (Jonsen et al. 2010). The method they promoted for work on difficult ethics cases has been compared to the "workup" procedure medical students learn to use, to evaluate a patient. While this method [Siegler's, Jonsen's, and Winslade's] has deep philosophical roots, a lot of clinicians who use it like the way it parallels the way they think through tough medical cases. In a paper he published with Pellegrino and Singer, both MDs, Siegler denounced his main grievances with the bioethical approach he considered as too remote from the clinical context and the reality of the doctor-patient relationship (Siegler et al. 1990). The three authors recommended easy, reactive methods, implementable by healthcare team members in the down-to-earth environment of the clinical ground. Although the debate promoted by bioethics committees is deep and interesting, they said, it is too theoretical. Doctors-in-training should be learning Clinical Ethics at the bedside. To Siegler's mind, Clinical Ethics skills are just as important as the other clinical skills a doctor should be taught, and the role of senior doctors as mentors for juniors is crucial in this training. Other disciplines, such as philosophy, law, or sociology, are of course useful but more to help deepen the ethical reflection as a sort of back up, not really at the frontline in clinical wards.

The controversies that emerged around the concept of Clinical Ethics and the most valuable ways of enhancing the ethical dimension intrinsic to clinical practice lasted for many years in the USA and are still not entirely resolved.

Moreover, similar disagreements arose in all the countries that came to develop Clinical Ethics, in turn. This was the case in Canada, as Hubert Doucet (2015) explains. And debate is still raging today. The national context may color it to some degree, but the controversy still focuses on the same crucial points as the precedent ones in the USA. On the one hand, health care teams, mainly physicians, are extremely reluctant to allow "strangers" to intervene at the bedside and participate in the decision-making process. The fear of being robbed of one's fundamental professional responsibilities is practically universal, in the profession. Opposition centers on admitting the lone ethics consultant. He or she is presumed to be more intrusive when acting alone to help resolve an ethics dilemma regarding a particular clinical decision. When ethics support is more collegial and concerns a broad, transversal ethical question instead of focusing directly on a crucial clinical case, it is perceived as less of a threat. On the other hand, the inability of ethics committees to provide actionable advice in resolving the ethical dilemmas faced by healthcare teams in their daily clinical practice has also been sharply criticized. These committees are often considered to be too far from the ground to offer any practical assistance to healthcare teams seeking pertinent strategies for resolving the ethical challenges embedded in clinical practice.

Perhaps it is for this reason that a third approach emerged. It is intended to assist healthcare teams by giving them some training in ethics, in order to improve their abilities to deal on their own with the ethical difficulties they encounter in their professional practice. This third way of conceiving Clinical Ethics is at the basis of all the different programs that intend "to improve the moral competency of professionals." The generic term "moral deliberation" will be applied below to cover this family of approaches. Here, the main focus is placed on the healthcare teams. Ultimately, the objective is to improve the quality of care for patients, but the method follows an indirect route to this final destination. The idea is that "Healthcare is an inherently moral profession," to quote Bert Molewijk (Molewijk et al. 2008, p. 57). "Employees are regularly confronted with moral issues." "They need to be supported in dealing with these moral issues in a more reflective, dialogical and constructive way," in relation to what they do spontaneously, using "external, ready-made protocols, professional rules, or even moral standards." There is a need for "more thoughtful consideration of the structure of moral deliberation in the healthcare institutions" (Molewijk et al. 2008, p. 58). To respond to this need, moral deliberation programs were developed.

To sum up what have been said so far, in the clinical ethics consultation model (CEC), the central focus is on the patient and on the medical decision to be made for him, whereas in the moral case deliberation model (MCD) the central focus is on the health care team and on its moral competency. Nevertheless, this apparent distinction is less significant than it might appear *prime facie*. For instance, on the one hand, a strong educational dimension is part of the CEC approach promoted by Siegler: for him, examining the ethical aspect of a medical decision needed to be taken at the bedside is the best way to deepen clinicians' ethics skills, thereby improving their skills as doctors. Mark Siegler argued that ethics is an inherent aspect of good clinical medicine (Siegler 1978). Similarly, the ultimate goal of the MCD approach is to improve the quality of care for patients, just as it is in the CEC model.

From the roots of these historical premises, all sorts of hybrid methods combining aspects of both CEC and MCD have been developed around the world. Essentially, the point is to adapt one or the other model to the specificities of each context. As Hubert Doucet says, "Clinical Ethics always appears in local colors" (Doucet 2015, p. 9). Indeed, each country and each local health care environment in each country has developed a model of CESS appropriate to its own historical, cultural, and ideological context.

At this point, and to conclude about the historical background of the development of Clinical Ethics, it is interesting to stress the fact that the dominant model in CESS in the USA today is the CEC approach, while the MCD method prevails in Europe. Actually, in Europe, it is generally considered that contributing to the development

of a collective ethical reflection on the clinical ground is more useful than helping to resolve a single ethics case. It is true that training entire healthcare teams in ethics might appear to be more effective on the long term. But the European trend might also reflect the tendency in Europe to grant lesser importance to respect for the patient's values as a unique person, as compared to the amount of attention traditionally granted to the rights of the individual in the USA. Over the years, after initially having raised important ideological controversies, the CEC approach has gradually gained acceptance, and it is now in demand, even in Europe (Doucet 2015).

In the next part of this paper, the principal features of these two broad schools of Clinical Ethics methods, CEC and MCD, will be described, along with some of the variants possible. There are many ways to describe these methods: in terms of theoretical background or type of grid they apply to analyse the ethical challenges embedded in the question at stake or in terms of the use of relational ethics or narrative ethics to better understand the position of the different stakeholders concerned by the case. However, the following presentation will not focus on such points but on how the proponents of each method conduct their practice of Clinical Ethics, and on the principal strengths and pitfalls of each method in relation to ethics, according to the global historical and referent framework that has been previously described.

Methods in Clinical Ethics

Methods for Clinical Ethics Consultations (CEC)

The goal of CEC is to help an ongoing decision-making process in clinics that raises an ethical dilemma. In other words, CECs assist in dealing with clinical cases in real time, requiring a specific medical decision for one specific patient. One of the most widely referred methods for CEC is the "facilitation approach" outlined by the ASBH taskforce on the Core Competencies for Health Care Ethics Consultation (ASBH 2011). There are many other ways of doing CEC, however. Inspired by a special issue of the *Journal of Clinical Ethics*, published in 2011 about methods for Clinical Ethics Consultation (JCE 22, no. 4, Winter 2011), a classification of such methods based on three main criteria can be proposed. The criteria being the followings: (1) the consultants' *attitude*, ranging from neutrality to advocacy or engagement, toward the different parties involved (patient, proxies, healthcare professionals); (2) the *method* these consultants use, together with the specific skills and expertise this method requires: mediation, facilitation, or moral expertise; and finally (3) the exact *goal* the consultants pursue. *Goal* is often associated with *method* and ranges from (a) finding the best possible compromise, (b) facilitating the decision-making process whatever its outcome, or (c) proposing recommendations which best correspond to good practices and/or accepted moral principles.

In the ASBH "facilitation" model, the goal for CEC consists in helping to identify and analyze the sources of uncertainty and/or conflict between the values at stake, to clarify the different morally "allowable" options, and finally to facilitate the elaboration of an ethical solution by the involved parties themselves. In accordance with this goal, consultants must be careful to refrain from substituting themselves for the main stakeholders and from being perceived as imposing a moral judgment (ASBH 2011). The recommended attitude for ethics consultants in this model is "neutrality." To be neutral, one must avoid defending a particular notion of the good against another, to reduce the risk of unduly influencing the outcome of the discussion. The goal, as Aulisio says in his comments about the ASBH facilitation model, is to achieve "a fair, inclusive, and transparent discussion (. . .) that empowers the voices of all stakeholders" (Aulisio 2011, p. 352).

Criticizing this first model, some authors, such as Adams and Winslade, defend a second approach. In this new approach, the goal is "moral expertise" rather than facilitation (Adams 2011). The authors argue that when clinicians request an ethics consultation, they expect consultants to "bring a substantial moral

expertise and level the playing field" as opposed to remaining neutral, as recommended by the facilitation model. Without this expertise, ethics consultants fail to help resolve the ethical questions that arise at the bedside, especially in unsettled cases, the ones with which clinicians need assistance. This second model for practicing clinical ethics also has detractors. For example, advocates of facilitation refer to the "moral expertise" model as an "authoritarian approach."

Finally, the third possible goal discussed in the literature for a CEC is "mediation." Autumn Fiester is one of the main ethicists who advocates it (Fiester 2007). She argues on the basis of the conviction that an ethics consultation cannot be considered successful if, at the end, some of the stakeholders in the conflict feel like "winners" and others like "losers." Furthermore, she points out that "many clinical ethics conflicts involve genuine ethical ambivalence" and that, in such cases, "there is more than one ethically justified option as a legitimate outcome of the conflict." The only way to avoid "winners" and "losers," she writes, is "to employ a process that doesn't 'take sides'" but instead "tries to navigate a solution that all parties can share. Bioethics mediation provides such a process" which helps to find an outcome-based "consensus even where consensus about principles or values is not possible" (Fiester 2007, p. 31). However, some ethicists have voiced objections to this search for a compromise as a means of resolving ethical conflicts. They contend that the outcome might not be ethically good enough.

The third criterion for characterizing CEC models, alongside goal and method, is the consultants' attitude toward the involved parties. In its facilitation model, ASBH recommends an attitude of "neutrality" (ASBH 2011). Two other attitudes emerge in the literature: "advocacy" and "engagement." Both admit to some kind of active stance on the part of the consultants with respect to the values at stake and the parties involved, as opposed to neutrality, which, as noted earlier, suggests that consultants actively pursue an ideal of detachment and normative restraint. The ethics consultant acting as a "patient advocate" systematically amplifies the patient's point of view. This attitude considers that the patient's voice and role in the decision-making process are often largely undervalued, in comparison to those of health care professionals. The "engagement" posture advocated by George Agich is another attitude for ethics consultants. Agich points out that the ethics consultant's involvement may "change the case in ways that can be irrevocable and significant. Clinical Ethics thus becomes part of the social construction of meaning that is the clinical case." Construed in this way, Clinical Ethics involves a real "doing" (Agich 2005, p. 10).

Recently, another CEC model was described and positioned in relation to the above models, according to the same three main criteria: attitude, goal, and method. It was developed in Hospital Cochin (Paris, France) and has been proposed to call it the "commitment" model of CEC (Fournier et al. 2015). Its specific characteristic consists in the way it solicits significant involvement from the society at large. In this perspective, Clinical Ethics becomes a sort of social and political enterprise, over and above—and in close interaction with—its main function of finding a solution to difficult clinical cases. Indeed, the model was developed in the aftermath of the first French 2002 law on patients' rights (Law n° 2002–303, CSP), which may explain its social and political dimension. In this model, citizens and laypersons participate at three different levels. First, the clinical ethics consulting team is always collegial and multidisciplinary, because of the importance of the extramedical arguments in any ethics case and because of the richness of nonhealthcare workers being implicated in the reasoning about individual ethics cases. For the same reasons, the ethics group that attends the case conferences during which the ethics cases are discussed is also a very broad, multidisciplinary group, illustrative of the diversity of society. Finally, the third feature reflecting the sociopolitical dimension of the model is the fact that it gives society an opportunity to observe and become aware of the social challenges embedded in the ethical conflicts that arise on the clinical ground. The term "commitment" appears to be the most appropriate to capture the

specific features of this new CEC model and to describe a whole that is perhaps more than the sum of its parts, considering together the attitude of the ethics consultants, the method, and the goal of the model (Fournier et al. 2015).

However, classifying CEC models in terms of attitudes, methods, and goals still fails to account for significant differences that distinguish the existing models or methods. For example, although this analytical grid provides a global overview of what each CEC intends to do and how, it says nothing about two elements underscored as crucial for describing a CEC in the introduction to this paper: (a) does the method impose meetings with the patient and/or her representatives, or can the ethics consult be done in the absence of such meetings? And (b) who assumes the authorship of the ethics recommendation? Does the ethics consultant act alone, as a single expert, or does a team, or even more, a committee, deliberate on the case? As mentioned earlier, all of these configurations exist, and they can all be defended, with very good ethical arguments. In a paper published in 2009, five CECs, each established in a different European country and part of the very young European Clinical Ethics Network (ECEN), were compared, specifically on questions (a) and (b) above. It is fascinating to observe that in just one of the five CECs in the study was there a requirement for meetings with the patient and/or representative (the French setting). In the others, there was usually no meeting, unless the patient and/or representatives were the requestor of the CEC (Fournier et al. 2009). Furthermore, in the same five settings, there was only one in which the ethics consultant worked alone (the German setting). In all the others, the CEC process always involved an ethics team or an ethics committee. The case in question was discussed during an ad hoc ethics conference, and in one setting (the Norwegian setting), the patient and/or representative could be invited to attend (Fournier et al. 2009).

Methods for Moral Case Deliberation (MCD)

MCD differs from CEC in that its main objective is to help healthcare workers reflect on a particular ethical question that emerged in their clinical practice rather than to help a specific medical decision-making process in relation to a real clinical case, while it is the goal of CEC. Bert Molewijk characterizes MCD as a way of answering the following question: "What should we consider as the morally right thing to do when we face this particular moral question ?" (Molewijk et al. 2008, p. 58) There are different methods for MCD, just as there are for CEC. In the review Norbert Steinkamp and Bert Gordijn published on this topic in 2003, they identified three: the Nijmegen method, the Hermeneutic method, and the Socratic dialogue (Steinkamp 2003).

The Nijmegen method was principally developed at the end of the 1990s by Henk ten Have, at the Department of Ethics, Philosophy and History of Medicine, University Medical Centre, Nijmegen (The Netherlands). In this method, just as with CEC, the issue is raised by the need to make a specific medical decision. But the question to be answered differs. Instead of "What decision should be made?", the question is "What is the moral value of the decision that I am ready to take?" The method consists in organizing a multidisciplinary team conference (similar to the one used by some CEC teams) during which the health care givers concerned deliberate, with the help of an ethicist or other facilitator, about the difficult clinical case they face. However, the crucial objective of the deliberation is to clarify the clear-cut moral question at stake and to elaborate a moral judgment on it. The focus is not on the clinical decision that should be made. In this perspective, the promoters of the method consider it to be more pertinent and powerful in terms of moral training for the participants, as compared to CEC methods. The Nijmegen method "more clearly stresses the difference between facts and values, while CEC starts from an analogy between scientific hypotheses and ethical principles," they say (Steinkamp and Gordijn 2003, p. 239). The ultimate goal of the conference facilitated by the ethicist is not to help arrive at a decision but to help clarify the ethical challenges embedded in the decision at stake.

The other two MCD methods, the Hermeneutic approach and the Socratic dialogue, are more frequently used retrospectively than prospectively. The objective is to offer assistance when an ethical question emerges on the professional ground, usually at the occasion of a challenging clinical case that the team actually dealt with. Both approaches function as a debriefing, in a way. The deliberation may remain incidental, or it may be the starting point of a more ambitious learning program in MCD.

According to Steinkamp and Gordijn, Hermeneutics is a philosophical method of understanding and interpretation. It consists in exploring the meaning and the content of a moral intuition that emerges due to a morally problematic context. Here, as in the Nijmegen method, the first goal is to identify – and formulate – the ethical question at stake. For the field of Clinical Ethics, Hermeneutics was adapted mainly by French theologian Bruno Cadoré, in the late 1990s (Cadoré 1997). Cadoré proposed to explore the interactions between the broad institutional as well as technological context and the problematic phenomenon. Cadoré's intuition was based on the idea that the changes in the context at large, on both the structure of clinical responsibility and the content of clinicians' morality, had had a major impact, and deserved to be carefully explored. The method is powerful in the sense that it explicitly focuses on the moral unease of the stakeholders and helps them to better understand it and explore/readjust the meaning of their professional commitment. Its main pitfall is that it is highly time consuming and far from being directly, quickly, and truly operative. It is not intended to help reach a medical decision in a specific clinical situation, nor is it intended to help elaborate a normative moral a posteriori judgment about a decision that was taken in a specific case.

The third main method of MCD identified in Steinkamp and Gordijn's review was the Socratic dialogue. Like the Hermeneutics approach, the Socratic dialogue is used more as a learning tool for helping health care professionals sharpen their abilities to think in moral terms than for advising an ongoing decision-making process. In Europe, Guy Widdershoven and his team from the Department of Health, Ethics and Society at Maastricht University (Netherlands) are among those who have based their Clinical Ethics method on the Socratic dialogue (Molewijk et al. 2008). After some years, over the course of which they systematized their tool and approach, they recently renamed it the "MCD (moral case deliberation)" method. They believe it is appropriate either for an incidental discussion about one specific case or for inclusion in a broader *moral deliberation* project. Usually, these *moral deliberation* projects last for 2–4 years, and are intended to enhance moral competencies on three levels: (1) the case level, for helping to resolve individual clinical cases; (2) the professional level, by offering an opportunity for health care givers to engage in deep reflection on the ethical dimension of their career; (3) the institutional level, in "developing an integrated ethics policy and ethics climate in the whole institution" (Molewijk et al. 2008). To date, the Maastricht MCD method has been tested in many clinical wards in different countries, at least in Europe. It seems to be well appreciated on the healthcare ground, especially by nurses.

Besides these three main methods of MCD, many other initiatives have been developed to propose some ethics support to healthcare teams and healthcare institutions. They can be classified under the term of Clinical Ethics supports and services (CESS). A recent effort has been initiated in order to evaluate and compare the outcomes of all these different MCD/CESS methods. The question is a tough one, because, as Mia Svantesson et al. say, "there is a lack of clarity and consensuses regarding which MCD outcomes are beneficial. In addition, MCD outcomes might be context-sensitive" (Svantesson et al. 2014, p. 2).

Conclusion

As the foregoing description attests, the range of methods used for offering Clinical Ethics support in healthcare institutions is extremely broad and varied. It is truly difficult to survey the methods exhaustively, or even to identify a basis on which

to compare them. Perhaps this difficulty arises because Clinical Ethics is still a recent and not yet fully standardized activity. With time, the practices might become more comparable. But, more probably, the field will remain as diverse as it is today for years to come. Actually, the source of this diversity may lie in the very nature of ethics. As suggested by Cadoré, the ethical preoccupations that emerge in clinical practice are related to the surrounding context at large in which the health care teams are practicing. Indeed, although this is the case for many other fields of activity, the influence exerted by the sociocultural environment is especially strong in ethics. The hypothesis is that ethical challenges arise precisely at the intersection of, and in the interaction between, a specific field of activity and its sociocultural environment. This could explain why certain ethical questions are especially prone to take on "local color," matching that of the country or even the more local place in which they emerge. To meet the specific local color, the method needs adaptation: hence, the diversity.

Furthermore, CESS leaders come from a variety of professional backgrounds, which might also explain the variety of clinical ethics methods. Matters such as whether the leader is a philosopher, a nurse, or an MD and the personal motivations that drove him or her to invest his or her professional energy in the field seem to make an important difference in the choice of method. Indeed, Siegler's perspectives, in developing his CEC as an MD, were not the same as those of Bert Molewijk, who developed his MCD tool when he was a nurse and philosopher. As noted, Siegler's model, conceived in the 1980s, attempted to remedy the excesses of the 1970s "bioethics" approach promoted by certain philosophers. Siegler brought Clinical Ethics back down to earth, to the bedside, to be taught by and for clinicians to other clinicians. Bert Molewijk, however, has focused on developing a pragmatic tool that is especially useful in helping nurses reflect on the moral dimension embedded in their clinical work. The "commitment" model developed in Paris, was shaped for sure by the importance of the social-political dimension in all the fields of public life in France.

Nevertheless, despite these differences, certain methodological points appear to be crucial to the success of any CESS. Let us stress three of them. The first one is related to the program's justifications and objectives: the goal must clearly be to improve the quality of care for patients. It is important to reiterate that fact, because it is easy for a program to drift into focusing on professionals, losing sight of its real mission to better serve the patients. Even more, improving the quality of patient care should imply greater respect from the health care teams for patient preferences and the moral values on which these preferences are based. Professional and scientific standards demand only that health care teams act with beneficence, but ethical standards demand even more.

Over the years, it seems that another methodological point became consensual for those who practice Clinical Ethics. It consists in privileging some sort of collegial and multidisciplinary approach as opposed to an individual one, by a lone ethicist. Indeed, Clinical Ethics has an institutional role to play, which is easier to endorse by a whole group than by a lonely expert. The group should include some lay people, to avoid isolating the professionals alone among themselves, and to make them more aware of the extramedical dimension of their activity.

Finally, the third crucial point for any CESS reflects the two preceding ones. A Clinical Ethics initiative will fail if it does not bridge the gap between the ethical positions of the healthcare workers and those of the patients. On the ground, divergences between ethical views always reappear, creating tensions. Dealing with this by consistently siding with colleagues is liable to exacerbate these tensions. That is why the two methodological points above are crucial in keeping CESS on course. The recent trend consisting in paying closer attention to the professional integrity of healthcare workers is commendable, but this attention should not endanger the respect due to the values of the individual patient. The patient is the person who must remain the central

focus of any Clinical Ethics initiative – indeed, of any healthcare institution, as a whole.

Cross-References

- ▶ Clinical Ethics: Accreditation
- ▶ Clinical Ethics: Consultation
- ▶ Clinical Ethics: Infrastructures
- ▶ Clinical Ethics: Support
- ▶ Clinical Ethics: Teaching

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