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Introduction

Clinical decision-making in ethical dilemmas often is difficult due to its complexity of different perspectives, motives, and assumptions of the persons involved. The ways decisions are made nowadays have changed dramatically. While some decades ago physicians took over responsibility and often also the decision-making itself with a paternalistic attitude, nowadays the notion of "shared decision making" and the concept of "informed consent" has become important in daily clinical life.[1]

One method of decision-making for ethically controversial cases is ethics case discussion, often performed by moderators on the wards.[2] Usually ethics case discussions are done prospectively with the involved professionals taking part, and sometimes also while relatives are present. Other methods, such as ethics case discussions in the clinical ethics committees or retrospective case discussions, are not discussed here.

Several methods used in the course of ethics case discussions are known: some with a kind of checklist, some with a procedure list, or with both (e.g. the Nijmegen chart, the Bochumer Arbeitsbogen).[3] The relevance and problems of casuistry as such have been widely discussed elsewhere.[4]

In this paper, I will introduce a 4-step approach of ethics case discussion. I will focus on the prospective case discussion, although the model can easily be used for retrospective discussions as well. This model has been applied and proved useful in ethics case discussions as well as for training purposes.

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[1] Simon, Gillen [2001]; Vollmann [2008].

[2] DEK [1997]; Molewijk et al. [2008]; Steinkamp, Gordijn [2005]; Jonsen [2005].

[3] Berkowitz, Dubler [2004]; Dörries [2008]; Dubler, Liebman [2004]; Dubler, Liebman [2009]; Molewijk et al. [2008]; Steinkamp, Gordijn [2005]; Viafora [1999]; Vollmann [2008b].

[4] e.g. Jonsen [2005]; Neitzke [2005].

Ethics case discussion

Ethical approaches

In ethics case discussion, the special task is to solve a moral dilemma by means of a discourse about the norms involved. For practical reasons, the discussions mainly do not involve ultimate truths, but the discourse is based on meta-ethics. A wide range of normative approaches is used. Often a principle-based approach is applied. Well-known principles, such as autonomy, beneficence, non-maleficence and justice are often at stake. Other participants may focus on human dignity; some stress virtues like veracity or discretion; others concentrate on responsibility. Some point out the context of the discourse in an ethics of care approach.

Course of the ethics case discussion

Usually, a health care professional (or a patient or his relative, respectively) calls for an ethics case discussion. Participants are professionals involved in the treatment and care of the patient; sometimes relatives are present as well. A specially trained moderator and co-moderator, respectively – both are appointed by the hospital and work in other units there – join the team.

The moderation takes place in a separate room on the ward (or in other places of the hospital). It usually takes a maximum of one hour. Participants come from different professional backgrounds. A summary is written including patient's name, time, date, participants, the relevant ethical question(s), result, and the recommendation. This is added to the patient chart. Sometimes ethical case discussions need to be resumed some days later.

Role of the moderator

The role of the moderator is a kind of "mediator". Although he or she has a personal point of view on the case, this is not relevant: it is the team on the ward who needs to discuss and find the appropriate solution. The moderator is only a kind a "catalyst", a neutral third person. His task is to ask open questions. Moderators need skills in moderation techniques as well as knowledge of clinical ethics. Some knowledge about the basic legal background and the relevant laws and regulations is also required. Usual moderation rules are applied, such as only one person speaking at the time, short replies are desirable, disturbances are solved immediately, and it is appreciated that participants communicate directly with one another.

The co-moderator's task is to observe the discourse, write the summary and support the moderator when needed. Being co-moderator can be an excellent introduction for "newcomers" to learn the procedure of facilitating.

The "4-Step Approach"

Ethics case discussion is a special kind of conflict resolution methodology. Therefore, the course of this well-known approach in professional life can be used as a starting point and then modified later. The course then develops in four steps (table 1).

Table 1: Course of the discussion

ETHICS CASE DISCUSSION	Content	Procedure	Details
Step 1	Present situation	Description of the case	Medical facts including medical indication and prognosis
			Nursing facts
			Legal obligations
		Remaining questions	Discussion ofquestions
		Ethical question	Discussion, definition of the ethical question(s)
Step 2	Analysis	Discussion of the ethical dilemma	Discussion on the practical level
			Discussion on the ethical level (judging, reasoning)
Step 3	Alternatives	Discussion of different solutions	Discussion of a wide range of solutions
			The consequences of the solutions
Step 4	Result	Result of the discussion	Appointment of tasks
		Recommendation of an appropriate action	

In a **first step**, the case is presented by one of the participants, most often the one who called in the ethics consultation. This descriptive part involves the relevant medical and nursing facts. It is most important that in this phase the physicians reason about the medical indication for treatment and about the prognosis of the patient. There should also be an exchange about the legal situation involved. If that cannot be cleared, the discussion might have to be postponed.

The **second step** leaves the descriptive level and the level of the medical facts. It now involves ethical judgements and argumentations. The conflict is usually presented in medical terms and language. The moderator's role is to support

the clarification of the norms behind the argumentations. Often participants present their arguments in different ways in a clinical language while meaning the same, for example, the best interest of the patient. Clarification of these underlying norms by the moderator can be a starting point to solving the conflict. The relevant arguments are then weighted and balanced.

In the **third step**, the alternative ways of solving the case are discussed including their relevant consequences. The arguments of the second step are applied. This step of the discussion opens the participants for the several ways of solution without condemning or rejecting solutions right away. Often at this stage, possible solutions are combined or new solutions are found.

In the **fourth step**, the discussion aims at a consensus for the persons involved in order to be able to act. This step usually ends with a consensus about one of the solutions discussed. In the rare cases where there is no consensus it can be helpful that the arguments are written down. A vote should be avoided as it is not helpful. The moderator sums up the result and – if necessary – appoints tasks.

The four-step approach is framed by an introductory and a concluding part. It begins with an introduction of the participants (and their involvement with the patient) a short description of the ethics discussions' methodology, and the course of the case discussion. The conclusion comprises a word of thanks to the participants and eventually a feedback.

Conclusions and perspectives

This method of ethics case discussions on the wards to solve moral conflicts has several opportunities:

- It gives the decision-making process of ethically difficult cases a structure. Usually those problems are discussed by exchanging only personal statements or giving out instructions about the procedure. Therefore, the usual procedure for decision-making in solving clinical problems is to listen to the facts and to decide immediately (corresponding from step 1 to step 4). The ethics case discussion avoids this direct switching from step 1 to step 4 and includes two more steps to allow for time to think of more solutions in a wider context, to listen to the other arguments and to weight them.
- The ethics case discussion wants to create awareness for the different values lying behind an open conflict in the treatment of the patient. This value conflict is often hidden under the usual way of communication in hospitals. Clarification can then be the starting point to a discussion about relevant norms and values. Knowledge and clarification about the other partici-

pants' arguments often paves the way for previously unknown solutions. Especially the patient's wish often leads to a result.

- Ethics case discussion can first of all improve communication between the patient/relative and the health care professionals as well as among the staff members. Some apparently ethical conflicts turn out to be only communication deficits and can thus be solved without a discussion about norms.
- Ethics case discussions can relieve psychological burdens of all persons involved. In the end, the responsible physician has to decide, but the team and the patient/relative will have had an opportunity to voice their views and concerns. This way, the resolution is based on a more solid ground. It can thus improve the relation between all involved.[5]

However, ethics case discussion also involves several problems:

- There is quite a lot of resistance to be expected in hospitals. This comes mainly from physicians and results in non-participation or circumvention of ethics case discussions.[6] Mostly these reservations are sign of misunderstanding the goals and consequences of ethics case discussions. These are, wrongly, expected to take over the decision-making from the physician in charge and thus cause resistance. The change is however not the take-over of the physician's responsibility, but exchange and weighting of moral arguments.
- Another problem facing the ethics case discussion is the role of the moderator and his position in the hospital's hierarchy.[7] As values in decision-making are personal and can neither be delegated nor ordered, every member of the team has to voice his/her view. Hierarchy becomes only relevant again when the decision is finally made by the physician and becomes legally binding. Noticing the difference between the professional role and the non-hierarchal structure of the ethical case discussion is one main task, especially in the beginning.
- In the beginning of an ethics case discussion service, an important misunderstanding must be cleared up. Hospitals are used to a system of consultants: a surgeon points out the necessity of surgery on an internal ward; a paediatrician orders a diagnostic procedure for a newborn in an obstetric department. Being strongly aware of these procedures, the hospital staff

[5] Boldt [2008].

[6] Dörries [2003].

[7] Dörries [2003].

also calls for clinical ethicists alike, expecting the solving of their moral problems. This, however, is not the case: the working method of the ethicist is moderation of a discussion so that the parties involved can find their own solution. It is applied ethics as discourse ethics.[8]

- Especially in psychiatric hospitals, but also on others, supervision of teams or persons is a method to solve or master problems for the staff. Supervision aims at clarification of emotions and relations. Ethics case discussions can not totally exclude the relational part of the team involved, but its main focus is on values and norms involved and not on the psychological preconditions.[9]
- One problem of ethics case discussion is the insufficient knowledge of ethics, law and moderation techniques when starting ethics case discussions in hospitals.[10] Therefore, persons involved or establishing an ethics counselling service essentially need teaching.[11] The Hannover training programme "Ethics counselling in hospitals" is based on a curriculum by the Akademie für Ethik in der Medizin (AEM), the German scientific association for medical ethics, and teaches the relevant basics in several courses.[12] It is supplemented by in-house teaching in hospitals.[13] Standards and competencies for ethics consultation have been developed in the U.S.,[14] and are currently in progress by a German working party of the AEM.
- When ethics case discussions fail, they fail due to an insufficient demand by the wards. Therefore, when introducing ethics case discussions it has to be carefully and sufficiently included in an overall strategy within the organisation.[15] Ethics counselling is part of the hospital and must therefore incorporate into the structure and need of the hospital. Organisation ethics and ethics case discussions have to be in a constant, controversial as well as constructive dialogue.[16]

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[8] Dörries [2003].

[9] Molewijk et al. [2008]; Vollmann [2008c].

[10] Delfosse [2002]; Post et al. [2007].

[11] Bardon [2004]; Berkowitz, Dubler [2004]; Dörries et al. [2009].

[12] Dörries et al. [2009].

[13] Dörries et al. [2008]; Dörries et al. [2009].

[14] e.g. ASBH [1998].

[15] Winkler [2005].

[16] Spencer et al. [2000].

Summing up, the goal of an ethics case discussion is to find the best decision for the patient and the other persons involved (relatives, doctors, nurses and others) from an ethical point of view, in a communicative respect and from a psychosocial view. In the end, it may not mean changing one's view or even one's own position, but rather to exchange arguments, weight them and come to a consensus as to further action. The latter is important as the topics concern patients and require action. For the moderator an ethics case discussion in this sense is no judgement, no taking over of responsibility for the decision result, no taking over of a leading role, and no team supervision. However, ethics case discussion has become a valuable tool to deal with moral conflicts in hospitals. Opportunities and problems of ethics case discussions are discussed. A 4-step approach for structuring the course of an ethics case discussion is presented.

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