

VU Research Portal

Outcomes of Moral Case Deliberation

de Snoo-Trimpp, J.C.

2020

document version

Publisher's PDF, also known as Version of record

[Link to publication in VU Research Portal](#)

citation for published version (APA)

de Snoo-Trimpp, J. C. (2020). *Outcomes of Moral Case Deliberation: Using, testing and improving the Euro-MCD Instrument to evaluate Clinical Ethics Support*. [PhD-Thesis - Research and graduation internal, Vrije Universiteit Amsterdam].

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal

Take down policy

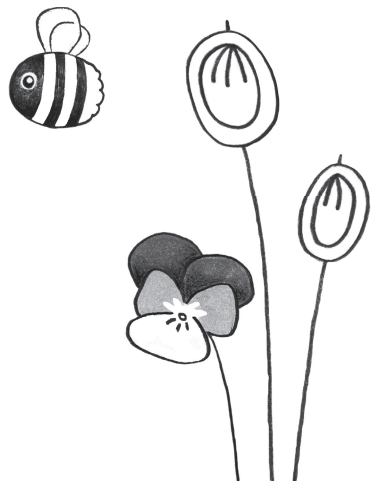
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

E-mail address:

vuresearchportal.ub@vu.nl

1

General introduction



Healthcare professionals can be confronted with ethically difficult situations in their daily practice, for instance when dilemmas arise on what is good care for a specific patient. Moral questions may arise, like to what extent should you try to convince a patient to comply with a treatment? Clinical ethics support (CES) services like moral case deliberation (MCD) aim to help healthcare professionals to handle these challenging situations. Evaluating outcomes of CES is increasingly needed to monitor and foster the added value of CES.

This thesis is about assessing outcomes of CES, in particular of MCD, and about revising an existing instrument for this (the Euro-MCD, published in 2014). In the first part of this introductory chapter, the field of CES and MCD and the need for evaluation research are described to show the context of the current study. The second part concerns the normative presuppositions of this study by describing theoretical viewpoints of performing evaluation research in this field. Thirdly, the original Euro-MCD Instrument from 2014 is presented, including a short description of the Euro-MCD revision project. Lastly, the outline and research questions of the thesis are presented.

Clinical ethics support and moral case deliberation

Services providing CES are regularly organized within many healthcare settings in Europe: academic and non-academic hospitals, mental healthcare institutions, nursing homes, community care and care institutions for people with mental disabilities (Slowther et al. 2012; Dauwerse et al. 2014; Hem et al. 2015; Bartholdson et al. 2016; Reiter-Theil & Schürmann 2016; Rasoal et al. 2017; Schochow et al. 2019). The implementation of CES services is increasingly endorsed by national laws (Hajibabaei et al. 2016), and recommended by public advisory boards (Munk 2005; Førde & Pedersen) and accreditation guidelines for healthcare institutions (JCAHO 2015). CES support can be provided in many forms: from individual ethics consultations to ethics committees and moral case deliberation sessions (Slowther et al. 2012; Aulisio 2016; Molewijk et al. 2017). In this thesis, we will focus on the latter, moral case deliberation (MCD).

MCD¹ is a reflective group dialogue about a moral question that is or has been experienced by one or more participant(s) in a concrete situation (Molewijk et al. 2008). An important theoretical background of MCD is hermeneutic philosophy, which assumes that moral understanding and moral learning start with focusing on concrete experiences (Widdershoven & Molewijk 2010). Participation in MCD means that a group

1 MCD is used here as an umbrella term, covering 'ethics rounds' (Svantesson 2008, Silén et al. 2014), 'ethics case reflection sessions' (Bartholdson et al. 2016) and 'ethics reflection groups' (Lillemoen & Pedersen 2015)

of people reflects on their experience in a specific situation from practice and considers what is morally at stake and what good care could entail in that situation (Widdershoven & Metselaar 2012). In MCD, understanding what is morally right starts with experience and exchanging experiences with others in an open dialogue (Widdershoven & Molewijk 2010). As such, ethical expertise on what is morally right is already present *within* the group of professionals participating in MCD, and is not provided only by an external ethicist (Metselaar et al. 2015). The dialogue within an MCD session is led by a (trained) facilitator who often uses a specific conversation method for structuring the moral inquiry (Stolper et al. 2015). MCD is especially common in the Netherlands (Dauwerse et al. 2014) and Scandinavian countries like Sweden (Svantesson et al. 2018) and Norway (Hem et al. 2018).

MCD can have different forms, as it is applied for diverse cases in a variety of contexts (Lillemoen & Pedersen 2015; Stolper et al. 2015; Tønnessen et al. 2015; Bartholdson et al. 2016; Magelssen et al. 2016; Hem et al. 2018; Svantesson et al. 2018). Also, various conversation methods for MCD exist (Van Dartel & Molewijk 2014). The approach slightly differs between the countries but contains more or less similar steps: 1) describing the case; 2) formulating the moral question; 3) reflecting on relevant facts and weighing relevant values and norms; and 4) drawing conclusions regarding insights and implications. However, there is variety in whether or not MCD facilitators (are trained to) use a specific conversation method, indicating that MCD is performed in various ways.

Need for evaluation research

In line with the increased attention for and provision of MCD – and CES in general –, the need for evaluation research also increased (Pfäfflin et al. 2009; Molewijk et al. 2017; Schildmann et al. 2019b). Since CES services in general aim to help healthcare professionals to deal with ethical issues, we need to know if these professionals are indeed helped by the CES service and if they – or other stakeholders – experience any further benefits or harms. Furthermore, evaluation research can provide important information regarding the quality of a CES service and thereby inform how to further improve the service. Also, insight into how CES services are evaluated informs how CES staff (like ethics consultants or MCD facilitators) could ideally be trained. Lastly, evaluation research might help to both foster and adjust the implementation of a CES service within a healthcare institution by demonstrating its added value and impact. Hence, evaluation research becomes more and more important now CES services increasingly become a recommended service in healthcare.

In the last decades, evaluation studies have been performed in the field of CES in general (Hem et al. 2015; Haltaufderheide et al. 2019; Schildmann et al. 2019a) and MCD in particular. Studies focusing on MCD concerned exploring participants' experiences with MCD (Svantesson et al. 2008a/b; Silén et al. 2016), describing participants' moral reasoning in MCD sessions (Tønnessen et al. 2017; Svantesson et al. 2018), considering approaches to determine the quality of MCD (Jellema et al. 2017; Metselaar et al. 2017) and assessing outcomes of MCD services (Weidema et al. 2013; Söderhamn et al. 2015; Spijkerboer et al. 2017; Haan et al. 2018; Hem et al. 2018). These studies showed valuable insights in how MCD is performed or could be improved. However, clear evidence on outcomes of MCD and insights into the experiences of MCD participants regarding the impact on their daily practice is still lacking. Haan and colleagues (2018) reviewed the available evidence for the impact of MCD in 25 research articles and one of their conclusions was that 'there is limited empirical evidence with regard to the changes that are *actually* brought about in caring practices after the group conversation has taken place'.

One of the reasons for the lack of evidence for the impact of CES activities in general, and MCD in particular, is the complexity of the intervention. Schildmann et al. (2019b) described CES from the perspective of health service research and called CES a 'complex intervention' because all five criteria for complexity as stated by the Medical Research Council (Craig et al. 2008) hold: CES concerns numerous 1) interactions between stakeholders; 2) skills and special professional expertise of those involved; 3) levels of the organization, like healthcare professionals, patients and family members; 4) types of CES and 5) possible outcomes of CES (Schildmann et al. 2019b). Consequently, *evaluation* of a complex intervention is complex. It therefore requires a clear outline of presuppositions, goals and research design, in order to determine appropriate outcomes in a suitable way and to relate these outcomes to CES as intervention.

Evaluation of MCD is also complex because generally applicable definitions of 'good ethics support' or 'good care' are lacking. In the end, for defining good moral support the perspective of MCD participants is needed: what do they see as fostering moral competence? MCD presupposes that moral expertise is to be found among its participants: they collectively deliberate on what good care would entail in a certain situation (Molewijk et al. 2008; Metselaar et al. 2015). Hence, *only during* the deliberation in MCD among those involved in the specific situation, the answer to what good care would entail is defined and *only then* the specific morally right decision for that particular situation can be formulated (Haan et al. 2018; Schildmann et al. 2019b). Thus, evaluating outcomes of MCD is difficult as there are no given criteria for good ethics support and

for determining the morally right decision for the cases discussed. Whereas evaluation of any intervention would involve (implicit) normative decisions on how to determine what the effect *should* be (and according to whom), the normativity in evaluation of ethics support is especially at stake, 'because as part of CES [Services] we deliberate about good actions, the question of what is morally good and how to determine what is morally good' (Schildmann et al. 2013). Therefore, CES evaluation research requires explicit statements about its normative decisions on what good CES is and which outcomes should be selected by whom (Schildmann et al. 2013; Molewijk et al. 2017). Since we focus on outcomes of MCD, we will now explicitly consider the normativity of our approach to evaluation of MCD in the next section.

Normative presuppositions of evaluating MCD outcomes

In their plea for explicit attention for underlying normativity in CES evaluation research, Schildmann and colleagues (2013) have described three approaches to evaluate CES. These are: 1) descriptive quantitative evaluation, referring to 'numeric data on access, activities, structural features and further aspects according to which the set up and functioning of CES can be characterised'; 2) evaluation of predefined desirable outcomes (according to the ethics support researchers); and 3) evaluation research in which 'quality norms' are reconstructed during the process. The third approach of designing CES evaluation research consists of an open process in which the criteria for outcomes of CES are not determined beforehand but in and during the CES evaluation itself, involving all relevant stakeholders (e.g. experts and end-users), taking into account the specific and variable contexts in which CES is applied. The reason for this open, reflective and deliberative process is the normative presupposition that there are no universal definitions for what good moral support is and for what CES *should* bring about in practice. For this, stakeholders (both CES staff and CES users) should have an important say in the evaluation process.

The third approach of Schildmann et al. (2013) can be recognised in several bottom-up and dialogical approaches to MCD evaluation research (Abma et al. 2009; Metselaar et al. 2017; Haan et al. 2018). In these studies, the focus on MCD participants' perspectives is considered to be crucial for evaluating MCD, because participants are the ones that actually engage in the dialogue within MCD and only they might thus be able to report any changes in how they deal with the situation at hand (Widdershoven & Molewijk 2010). Consequently, in evaluating MCD outcomes, we should take the voice and experience of MCD participants into account in an open and deliberative process, since only then we can define what the outcomes essentially are and should be. The

third approach of Schildmann et al. (2013) fits therefore well as a starting point for our approach to evaluation of MCD outcomes.

Following this line of reasoning: what tool do we need to take the voice and experiences of participants of MCD into account? Qualitative and nuanced research on actual outcomes has been recommended in the literature review on impact of MCD (Haan et al. 2018). A type of this research is responsive evaluation, which involves continuous dialogues among stakeholders, experts and researchers, in which evaluation criteria and outcomes are identified and jointly defined (Abma et al. 2009). Schildmann et al. (2013) have suggested that responsive evaluation is a way to apply their third approach to evaluation research. To gain an overview of what MCD could lead to and to demonstrate the impact of MCD in a systematic way, quantitative research is also needed. In order to justify the implementation of MCD within healthcare settings and to adequately convince healthcare institutions' boards of directors of the benefits of MCD, a standardised and valid instrument can be helpful. Such an instrument can also allow for systematic comparisons among settings where MCD is applied, and to do this at different moments in time. Furthermore, quantified systematic information about outcomes on MCD might indicate possible ways for improvement of the quality of MCD and facilitation styles (e.g. when results show that MCD participants did not experience a certain outcome). Evidence-based quantitative methodologies for CES evaluation are therefore recommended (Svantesson et al. 2014; Schildmann et al. 2019b).

Summarizing, a quantitative evaluation tool on MCD related outcomes was needed that 1) focuses on the perspectives of MCD participants and 2) is developed according to empirically sound methodologies. The development of such a tool requires both qualitative as well as quantitative methods: qualitative for collecting and in-depth understanding of self-reported experiences and quantitative for describing and comparing self-reported outcomes and for testing reliability and validity of the tool's functioning. Besides, developing such a tool would require a close collaboration between experts from different fields (both clinical ethics, health service research and clinimetrics) and MCD participants in various contexts (Schildmann et al. 2019b). These requirements were the basis for Svantesson and colleagues (2014) for developing the Euro-MCD Instrument in 2014: 'a standardised outcome evaluation instrument for MCD that is developed according to rigid methodological standards and at the same time able to capture outcomes in different contexts'.

The Euro-MCD Instrument from 2014

The Euro-MCD Instrument was developed as a response to the lack of and need for validated instruments to collect empirical evidence on MCD outcomes (Svantesson et al. 2014). In line with our approach to evaluation of MCD outcomes as described before, the instrument included the perspectives of MCD participants regarding possible outcomes by suggesting a wide range of possible outcomes, asking to rate the importance of each outcome and offering free writing space for additional outcomes. The Euro-MCD Instrument aimed to systematically collect data both regarding what outcomes are important according to the MCD participants and regarding which outcomes they experienced. The latter was asked both with regard to their experiences *during* the MCD meetings as well as their experiences *beyond* MCD in their daily practice. As such, the instrument was (also) targeted to capture experienced impact in actual caring practices.

Concretely, the Euro-MCD Instrument consists of a list of 26 possible outcomes of MCD. This list was inductively built in a systematic process including a literature review, a Delphi panel with experts and content validity testing among pilot users of the Euro-MCD Instrument. In total, 86 participants from seven European countries contributed to its development. The 26 possible MCD outcomes were categorized into six domains: 1) Enhanced emotional support; 2) Enhanced collaboration; 3) Improved moral reflexivity; 4) Improved moral attitude; 5) Impact on the organizational level and 6) Concrete results (Svantesson et al. 2014). For each outcome, the respondent would be asked to rate the perceived importance, the potentially improved experience both during the MCD sessions and in daily practice after the MCD sessions on a four point Likert-scale. The instrument could be distributed when healthcare professionals have not yet participated in any MCD, asking which outcomes they perceive as important, and after a series of four MCDs, asking again how important the listed MCD outcomes are and asking to what extent they actually experienced these MCD outcomes. The instrument further consisted of some open questions asking to write outcomes down 'in your own words' that are perceived as important and that they have experienced, to collect information about potential MCD outcomes which were not listed yet. Lastly, demographical questions like gender, age and profession were included.

The Euro-MCD Revision Project (2014-2020)

In the presentation of the Euro-MCD Instrument in 2014, the developers already stated that it was not a finished product, but rather the start of a process to test the instrument and collect additional outcomes from healthcare professionals in the field (Svantesson et al. 2014). The Euro-MCD Revision Project, which forms the basis of this thesis, aimed to further validate the Euro-MCD Instrument from 2014. This was done

by analysing the perspectives of MCD participants regarding the relevance of items in a reflective and deliberative process, and by investigating the content validity of the instrument and the clustering of items into interpretable domains. For the latter, insight into (at least) the following aspects of the instrument was needed: possible patterns or clusters of items, both regarding their perceived importance as well as their experience and possible overlap between items or items that do not correlate with any of the other items in order to reduce the number of items (Svantesson et al. 2014).

Outline of thesis and research questions

This thesis describes the results of testing the Euro-MCD Instrument from 2014 and provides a comprehensive overview of outcomes valued and experienced by MCD participants. In our process of further developing the Euro-MCD Instrument, we facilitated reflective dialogues with MCD participants, MCD experts and among our research team about empirical findings from six Euro-MCD field studies, with ethics theory and theoretical viewpoints on MCD in mind. In the end, this thesis describes this revision process and presents the product of this process – the Euro-MCD 2.0.

The outline of the thesis is as follows. Chapter 2 and Chapter 3 present studies that examined the importance of the predefined outcomes in the Euro-MCD Instrument, according to healthcare professionals who were about to participate in a series of MCD, in order to study and support the content validity of the Euro-MCD Instrument from 2014. Chapter 2 describes the perceptions of Dutch healthcare professionals who were asked to describe important MCD outcomes in their own words and to rate the perceived importance of each predefined MCD outcome in the instrument. In addition, healthcare professionals were interviewed to gain a more in-depth insight into outcomes perceived as important. Chapter 3 describes the perceived importance according to a larger group of respondents from Sweden, Norway and the Netherlands and also presents a comparison between groups of respondents (country, profession, healthcare setting) regarding ratings on the Euro-MCD Instrument.

Next, results are presented of examining potential clustering of outcomes in the Euro-MCD Instrument: regarding the question on *important outcomes* in Chapter 4, and regarding the question on *experienced outcomes* in Chapter 5. Chapter 4 further assesses whether these respondents change in their perceptions on importance after a series of MCD. In Chapter 5, the outcomes experienced *during* the MCD sessions and *afterwards* in daily practice are also described.

In addition, to openly collect outcomes of MCD, to compare these with the outcomes in the Euro-MCD Instrument, and to consider meaningful categorisations of these outcomes, focus group sessions were organised with experienced MCD participants, which is described in Chapter 6. In the end, Chapter 7 presents the revision of the Euro-MCD Instrument by describing the revision process in which the empirical findings and points for discussions, as indicated in the preceding chapters, are integrated and interpreted. As such, this final chapter functions as the General Discussion of the thesis.

The overarching aim of this thesis is to use, test and improve the Euro-MCD Instrument. This aim will be investigated with the following research questions:

- 1. USE:** What are important and experienced outcomes of MCD according to healthcare professionals before and after participation in a series of moral case deliberation? (Chapters 2-6)
- 2. TEST:** What are the correlations among the various MCD outcomes in the Euro-MCD Instrument and which domains can be distinguished? (Chapters 4-5)
- 3. IMPROVE:** How to integrate the empirical findings with reflections and dialogues among researchers and CES experts in order to present a profound and revised Euro-MCD Instrument? (Chapter 7)

In order to answer the research questions, various methodologies were used. In most studies, quantitative data and qualitative studies were combined. Detailed information on methodologies are outlined in the subsequent chapters. Ultimately, the new Euro-MCD 2.0 aims to help evaluation of outcomes in healthcare practices where MCD is applied by providing a profound and practical tool. Also, the thesis contributes to the research field of evaluation of CES by describing a balancing process of combining various methodologies, by developing an exemplary tool for evaluating outcomes and indicating themes for further study and debate.

REFERENCES

- Abma T.A., Molewijk B., Widdershoven G. (2009). Good care in ongoing Dialogue. Improving Quality of Care Through Moral Deliberation and Responsive Evaluation. *Health Care Analysis*, 17(3):217-35.
- Aulisio M.P. (2016). Why did hospital ethics committees emerge in the US? *AMA Journal of Ethics*, 18(5): 546-553.
- Bartholdson C., Lützn K., Blomgren K., Pergert P. (2016). Clarifying perspectives: Ethics case reflection sessions in childhood cancer care. *Nursing Ethics*, 23(4), 421-431.
- Dauwerse L., Stolper M., Widdershoven G., Molewijk B. (2014). Prevalence and characteristics of moral case deliberation in Dutch health care. *Medicine, Health Care and Philosophy*, 17, 365-375.
- Førde R. & Pedersen R. (2011). Clinical ethics committees in Norway: what do they do, and does it make a difference? *Cambridge Quarterly of Healthcare Ethics*, 20(3), 389-395.
- Haan M.M., Van Gurp J.L.P., Naber S.M., Groenewoud A.S. (2018). Impact of moral case deliberation in healthcare settings: a literature review. *BMC Medical Ethics*, 19:85.
- Haltaufderheide J., Nadolny S., Gysels M., Bausewein C., Vollmann J., Schildmann J. (2019). Outcomes of clinical ethics support near the end of life: A systematic review. *Nursing Ethics*, 1-17.
- Hajibabae F., Joolae S., Cheraghi M.A., Salari P. (2016). Hospital/clinical ethics committees' notion: an overview. *Journal of Medical Ethics and History of Medicine*, 9, 17.
- Hem M.H., Pedersen R., Molewijk B. (2015). Evaluating clinical ethics support in mental healthcare: A systematic literature review. *Nursing Ethics*, 22(4), 452,466.
- Hem M.H., Molewijk B., Gjerberg E., Lillemoen L., Pedersen R. (2018). The significance of ethics reflection groups in mental health care: a focus group study among health care professionals. *BMC Medical Ethics*, 19:54.
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO). (2015). *Comprehensive Accreditation Manual for Hospitals*. Oakbrook Terrace (IL).
- Jellema H., Kremer S., Mackor A-R., Molewijk B. (2017). Evaluating the quality of deliberation in moral case deliberations: a coding scheme. *Bioethics*, 31(4), 277-285.
- Lillemoen L., Pedersen R. (2015). Ethics reflection groups in community health services: an evaluation study. *BMC Medical Ethics*, 16:25.
- Metselaar S., Molewijk B., Widdershoven G. (2015). Beyond recommendation and mediation: Moral case deliberation as moral learning in dialogue. *American Journal Of Bioethics*, 15(1), 50-51.
- Molewijk AC., Abma T., Stolper M., Widdershoven G. (2008). Teaching ethics in the clinic. The theory and practice of moral case deliberation. *Journal of Medical Ethics*, 34, 120-124.
- Molewijk B., Schildmann J., Slowther A. (2017). Integrating theory and data in evaluating clinical ethics support. Still a long way to go. Editorial in *Bioethics*, 31(4), 234-236.
- Munk M.S. (2005). 'Ethiek in zorgopleidingen en zorginstellingen', Centrum voor Ethiek en Gezondheid: Zoetermeer.
- Pfäfflin M., Kobert K., Reiter-Theil S. (2009). Evaluating Clinical Ethics Consultation: A European Perspective. *Cambridge Quarterly of Healthcare Ethics*, 18, 406-419.
- Rasaol D., Skovdahl K., Gifford M., Kihlgren A. (2017). Clinical Ethics Support for Healthcare Personnel: An Integrative Literature Review. *HEC Forum*, 29(4), 313-346.
- Reiter-Theil S. & Schürmann J. (2016). The "Big Five" in 100 Clinical Ethics Consultation Cases. Reviewing three years of ethics support in two Basel University Hospitals. *Bioethica Forum* 9(2), 60-70.
- Schildmann J., Molewijk B., Benaroyo L., Forde R., Neitzke G. (2012). Evaluation of clinical ethics support services and its normativity. *Journal of Medical Ethics*, 39(11), 681-685.
- Schildmann J., Nadolny S., Haltaufderheide J., Gysels M., Vollmann J., Bausewein C. (2019a). Ethical case interventions for adult patients. *Cochrane Database of Systematic Reviews*, 7.
- Schildmann J., Nadolny S., Haltaufderheide J., Gysels M., Vollmann J., Bausewein C. (2019b). Do we understand the intervention? What complex intervention research can teach us for the evaluation of clinical ethics support services (CESS). *BMC Medical Ethics*, 20:48.
- Schochow M., Schnell D., Steger F. (2019). Implementation of Clinical Ethics Consultation in German Hospitals. *Science and Engineering Ethics*, 25(4), 985-991.

- Silén M., Ramklint M., Hansson M.G., Haglund K. (2016). Ethics rounds: An appreciated form of ethics support. *Nursing Ethics*, 23(2), 203-213.
- Slowther A.M., McClimans L., Price C. (2012). Development of clinical ethics services in the UK: a national survey. *Journal of Medical Ethics*, 38(4), 210-214.
- Söderhamn U., Kjølsvetd H.T., Slettebø Å. (2015). Evaluation of ethical reflections in community healthcare: A mixed-methods study. *Nursing Ethics*, 22(2), 194-204.
- Spijkerboer R.P., Van der Stel J.C., Widdershoven G.A.M., Molewijk A.C. (2017). Does Moral Case Deliberation Help Professionals in Care for the Homeless in Dealing with Their Dilemmas? A Mixed-Methods Responsive Study. *HEC Forum*, 29(1), 21-41.
- Stolper M., Molewijk B., Widdershoven, G. (2016). Bioethics education in clinical settings: theory and practice of the dilemma method of moral case deliberation. *BMC Medical Ethics*, 17:45.
- Stolper M., Molewijk B., Widdershoven G. (2015). Learning by Doing. Training Health Care Professionals to Become Facilitator of Moral Case Deliberation. *HEC Forum* 27:47-59.
- Svantesson M., Löfmark R., Thorsén H., Kallenberg K., Ahlström G. (2008a). Learning a way through ethical problems: Swedish nurses' and doctors' experiences from one model of ethics rounds. *Journal of Medical Ethics*, 34: 399-406.
- Svantesson M., Anderzén-Carlsson A., Thorsén H., Kallenberg K., Ahlström G. (2008b). Interprofessional ethics rounds concerning dialysis patients: staff's ethical reflections before and after rounds. *Journal of Medical Ethics*, 34: 407-413.
- Svantesson M., Karlsson J., Boitte P., Schildman J., Dauwerse L., Widdershoven G., Pedersen R., Huisman M., Molewijk B. (2014). Outcomes of Moral Case Deliberation – the development of an evaluation instrument for clinical ethics support (the Euro-MCD). *BMC Medical Ethics*, 15, 30.
- Svantesson M., Silén M., James I. (2018). It's not all about moral reasoning: Understanding the content of Moral Case Deliberation. *Nursing Ethics*, 25(2): 212-229.
- Tønnessen S., Ursin G., Brinchmann B.S. (2017). Care-managers' professional choices: ethical dilemmas and conflicting expectations. *BMC Health Services Research*, 17:630.
- Van Dartel H., Molewijk B. (2014). *In gesprek blijven over goede zorg. Overlegmethoden voor moreel beraad*. Amsterdam: Boom Uitgevers.
- Weidema F.C., Molewijk A.C., Kamsteeg F., Widdershoven G.A.M. (2013). Aims and harvest of moral case deliberation. *Nursing Ethics*, 20(6), 617-631.
- Widdershoven G., & Metselaar S. (2012). Gadamer's truth and method and moral case deliberation in clinical ethics. In *Hermeneutics and the humanities: Dialogues with Hans-Georg Gadamer*, ed. M. Kasten, H. Paul, and R. Sneller, 298–300. Leiden University Press: Leiden, The Netherlands.
- Widdershoven G.A.M. & Molewijk B. (2010). Philosophical foundations of clinical ethics: a hermeneutic perspective. In: Schildmann J, Gordon JS, and Vollmann J (eds) *Clinical ethics consultation: theories and methods, implementation, evaluation*. Ashgate: Aldershot, 37–51.