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Exploring the Potential of Clinical Ethics Support Services for a Small Animal Hospital

Master thesis

University of Veterinary Medicine Vienna

submitted by

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Vienna, April 2020

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Acknowledgements

I would like to thank my supervisor Univ.-Prof. Dr. Herwig Grimm for his constructive, precise and friendly support, his engagement with the project and for inspiring me to enter the world of applied ethics.

I am immensely grateful to my co-supervisor Dr.med.vet. Svenja Springer for always being there to answer questions and provide support, for her enthusiasm and her helpful input and for the hours she put into reading, commenting on and discussing drafts of the thesis.

I would also like to thank the other members of the Unit of Ethics and Human-Animal Studies at the Messerli Research Institute for their enthusiastic teaching throughout the IMHAI master program, for their help with various questions, smaller or bigger, and for providing a supportive, welcoming and friendly work environment.

I would like to thank the University Clinic for Small Animals at the University of Veterinary Medicine, Vienna, and all involved staff for their cooperation with regards to the observational study and all participants who took part in the study.

I would like to thank Assoc. Prof. Dr. Franck L. B. Meijboom for reviewing this thesis.

There are many more that have contributed to this thesis in different ways. I am grateful to all lecturers of the IMHAI master program who have taught with engagement and passion for their respective topics.

I would like to thank my friends for always sharing the exciting highs and the challenging lows through all our adventures in life. I would like to thank my sister Mareile for having inspired me to follow my own path and for her support and understanding along the rocky bits of that route. I would like to thank my parents for supporting me in all my endeavours.

And I would like to thank my fiancé Richard for the endless inspiring conversations, the happiness we have together and the love and understanding that we share during all challenges, thesis-related or otherwise.

Beyond that, I am grateful to all the animal companions that have been part of my life in various ways. They remind me of why I am doing this. For Jemmy and Sally.

Table of contents

1. Introduction

Medical care involves complex decisions that often have ethical dimensions related to issues such as quality of life, scarce resources or conflicting obligations (e.g. Rollin 2006, Molewijk et al. 2011, Kipperman et al. 2018, Yeates 2019). This applies to both, human and veterinary medical care. In the context of veterinary medicine decisions are complicated by the triangular relationship of patient, client and veterinarian, resulting in the question of who should be the veterinarian's primary concern, the owner or the patient (Yeates 2013, chaps. 1.1-1.2, Kimera and Mlangwa 2016). Technological advances and sophisticated treatment options have further increased the complexity of decision-making in veterinary medicine in recent years and can lead to conflicts between a client's wishes, for example, for the continuation of treatment, and acting in the animal's best interest (see e.g. Rosoff et al. 2018, Springer et al. 2019b). These conflicts can be a source of stress for the veterinary professionals involved (Batchelor and McKeegan 2012). Rollin has introduced the term "moral stress" (Rollin 1987, p. 119) for situations where one is prevented from acting according to what one thinks ought to be done. As a primary example, he refers to the issue of so-called convenience euthanasia, where a veterinarian is requested to kill a healthy animal at the owner's will (Rollin 2006, pp. 115–116).

However, not all ethically difficult issues necessarily involve a situation where one is prevented from what one thinks ought to be done. A dilemma between different values or obligations can render the actor unsure about which option should be chosen when each option would entail the infringement of an important value or norm and no option seems to accommodate for all (see also section 2.1.4 for a discussion of the term 'dilemma'). Sometimes determining measures such as the quality of life of a patient can be difficult and leave those involved without a precise assessment of what would be best for the patient. Therefore, when I refer to 'ethical challenges' in this work, I use the term to capture all kinds of different problems or questions that have ethical dimensions.

Ethical challenges are not the only stressful factor in veterinarians' professional lives who also face other issues such as long working hours, managerial responsibilities and the fear of making professional mistakes (Bartram et al. 2009, Smith et al. 2009, O'Connor 2019).

However, studies in different countries have highlighted the importance of difficult ethical decisions and ethical dilemmas in veterinary medicine and their contribution to stress in the profession (e.g. Batchelor and McKeegan 2012, Kondrup et al. 2016, Kipperman et al. 2018, Moses et al. 2018). Given the high prevalence of stress amongst veterinarians, recognising and addressing ethical challenges as one source of stress is important and not only benefits the veterinarians but also their patients (Kahler 2015).

As a response to ethical challenges in the clinical context, clinical ethics support services (CESS) have been introduced, beginning in the human medical sector in the 1970s, and more recently also in veterinary medicine (see e.g. Fournier 2016, Molewijk et al. 2016, Rosoff et al. 2018, Springer et al. 2018). CESS are understood here as institutional services that can be contacted when assistance is needed in handling ethical challenges in the clinical context. They usually comprise ethics committees, lone ethicists or teams of clinical ethicists (Molewijk et al. 2016). In this work, 'the ethicist' shall refer to the clinical ethicist in the way it is understood in the respective method, which differs, as will become clear in section 2. The aim in all CESS is to assist healthcare professionals (and in some cases families and patients) with difficult ethical decisions, questions and dilemmas (Molewijk et al. 2016). Better patient care is the overall desired outcome (Fournier 2016). The models and methods that are used in CESS vary. They can broadly be categorised into moral case deliberation (MCD), which focuses more on general moral questions derived from previous or potential cases and the training of ethical reflection skills, and clinical ethics consultation (CEC), which focuses on the decision-making for an ongoing case (see e.g. Fournier 2016). An in-depth analysis of the suitability and appropriateness of different methods for the veterinary medical context has been lacking so far. The question is of relevance since the models and methods differ not only in practical aspects but also in their underlying conceptions of ethics.

The aim of this thesis is to explore the potential of different models and methods of clinical ethics support services in a small animal hospital by addressing the following two questions. (1) What are the underlying conceptions of ethics in different models and methods of clinical ethics support services? (2) What is the potential that different models and methods of CESS have for addressing ethical challenges in the small animal hospital setting?

The first question will be addressed by a theoretical analysis of different models and methods of CESS in human medicine in order to draw conclusions about their underlying conceptions of ethics. This analysis focuses on literature about CESS in the human medical sector since methods and models in veterinary medicine have not been described in much detail and are so far mainly based on approaches from human medicine.

The second part of the thesis will address the different models and methods of CESS (and their underlying conceptions of ethics) from a practical side and assess the potential for a CESS in a small animal hospital. In order to determine requirements and demands for a CESS in the veterinary clinical context, an empirical study is conducted. Problem areas and underlying aims of the veterinarians with regards to decisions in the clinical context are identified based on an observational study of veterinarians' morning and midday meetings in a small animal hospital. The findings are discussed in the light of existing CESS in human and veterinary medical care and the thesis concludes with argumentation for which model or method of those presented appears preferable for a small animal hospital.

2. Philosophical analysis | What are the underlying conceptions of ethics in different models and methods of clinical ethics support services?

2.1. Models and methods of clinical ethics support services in human medical care

Clinical ethics support services (CESS) have spread in human medical care starting with a multidisciplinary approach in the 1970s in the USA (Fournier 2016). Since then a multitude of models and methods have emerged, either in response to each other or based on the professional background of those developing them, whether they were, for example nurses, physicians or philosophers (Fournier 2016). The overall goals of CESS are to improve the quality of care for patients and to support healthcare professionals in dealing with ethically challenging situations and decisions (Fournier 2016).

The organically grown variety of approaches leads to a difficulty in classifying them in strictly distinct models or methods. The categorisation is complicated by the fact that the models can overlap and change the specific method they are using or the goal they are trying to reach, such as from general training in ethical reflection to a case discussion or vice versa. Fournier discusses the diversity of methods and models in CESS and describes it as "truly difficult to survey the methods exhaustively, or even to identify a basis on which to compare them" (Fournier 2016, p. 561).

Having said that, different though overall similar attempts have been made to broadly categorise models and methods of CESS (e.g. Fournier 2016, Molewijk et al. 2016, Rasoal et al. 2017). Most relevant for my work from Fournier's review (2016) on models and methods in clinical ethics is the main line of distinction between *clinical ethics consultations* (CEC) and *moral case deliberation* (MCD) as a starting point for discussing the different models and methods (see also Table 1). This distinction, however, should not be viewed as a strict line; in practice, overlaps and similarities in methods may still occur across this division (e.g. Springer et al. 2018).

Broadly speaking, methods summarised here under the umbrella term of clinical ethics consultation (CEC) aim for a decision for an ongoing ethically complex case in the clinical practice and are thereby focused on a specific patient and involved parties such as responsible physicians and/or family members, whereas MCD aims at training ethical reflection skills as

well as attitude and character by deliberating upon a question or case resulting from practical experiences of the healthcare professionals (Fournier 2016, Stolper et al. 2016). Although MCD is often classified as a teaching tool for clinical ethics there is also an argument for viewing it as a clinical ethics support service, since it can be used to arrive at a justified decision for an ongoing case, depending on the method employed, and helps healthcare professionals in dealing with ethical challenges and in improving patient care through a dialogical learning process (Molewijk et al. 2008a, 2016, van der Dam et al. 2013, Stolper et al. 2016).

In this work, when referring to moral case deliberation, I refer to it as the approach practised and described mostly in the Netherlands by Margreet Stolper, Bert Molewijk and Guy Widdershoven from the Department of Medical Humanities of the VU Medical Center in Amsterdam and associated or collaborating colleagues (see e.g. Molewijk et al. 2008a, 2008b, Porz et al. 2011, Stolper et al. 2016).

To highlight the differences between MCD and CEC Table 1 presents an overview of the results of comparing MCD and CEC. Table 1 does not necessarily cover all models and methods that are used in CESS but focuses on the selection that will be analysed in more detail in the following sections.

When considering the less defined term of 'ethical deliberation', additional approaches can be found as Nora and colleagues (2015) present in their integrative literature review on 'ethical deliberation' in the context of nursing. They discuss ethical deliberation as described by Diego Gracia, which is similar to moral case deliberation and therefore not focused on for the rest of the thesis (e.g. Gracia 2003); casuistry, which relies on the comparative analysis of the given case with previous cases and their solutions; and principlism which refers to applying pre-given principles (such as the four principles of biomedical ethics by Beauchamp and Childress (2009)) to an ethically challenging case or question in order to come to a decision (Nora et al. 2015). The latter two are sometimes also used as strategies in other approaches in clinical ethics support services and are therefore not discussed further individually in the following.

In the sections following Table 1 I will describe a selection of approaches in CESS in more detail using an anonymised clinical case example from human medicine.

Table 1: Overview of results of describing and comparing moral case deliberation (MCD) and clinical ethics consultation (CEC) (see sections 2.1.2 to 2.1.3)

	MCD	CEC
Aim	▪ Training of healthcare professionals in ethical reflection to uncover contextual moral wisdom ▪ Development of healthcare professionals' characters & attitudes	▪ Ethically justified decision for an ongoing case
Instruments	▪ Group deliberations on a concrete case or question related to practice ▪ Structured by a specific conversation method ▪ Guided by a trained facilitator	▪ Structured decision-making processes (depending on the different approaches) ▪ Consideration of given frameworks such as guidelines, policies and accepted norms ▪ Impartial facilitation or "expert input" and/or recommendations from ethicists ▪ Exploration of values and interests of those involved in a case either in group meetings or in individual meetings between ethicist and stakeholders
Timing relative to case/ question	Prospectively as well as retrospectively related to past cases with regular meetings	Mostly prospectively on request for ongoing cases
Initiator	One of the involved healthcare professionals, depending on the respective implementation also patients/ surrogate decision-makers	One of the involved healthcare professionals, depending on the respective implementation also patients/ surrogate decision-makers

Participants	Multidisciplinary group meeting of healthcare professionals and sometimes patients/surrogate decision-makers in presence of ethicist/ facilitator	Varies between: ▪ Group meetings of healthcare professionals and sometimes patients/surrogate decision-makers in presence of ethicist/ facilitator ▪ Meetings of ethicist with individual stakeholders ▪ (Additional) case conferences with lay people not involved in the case
Role of Ethicist	Facilitator that structures the dialogue without major contribution to content	Ranging from advising moral expert over (patient) advocate to impartial mediator
Examples of Methods	▪ Dilemma method (Molewijk et al. 2008a, Stolper et al. 2016) ▪ Socratic dialogue (e.g. Fitzgerald and van Hooft 2000, Steinkamp and Gordijn 2003, Molewijk et al. 2008a) ▪ Nijmegen method (discussed in Steinkamp and Gordijn 2003) ▪ Hermeneutic method (discussed in Steinkamp and Gordijn 2003)	▪ *CASES* facilitation (ASBH 2011, NCEHC 2015) ▪ *Commitment model* (Fournier et al. 2015) ▪ Bioethics mediation (Fiester 2014) ▪ *Hub and Spokes Strategy* (MacRae et al. 2005) ▪ Providing moral expertise

The following literature has been utilised to develop this table: Birnbacher 1999, 2012, Fitzgerald and van Hooft 2000, Steinkamp and Gordijn 2003, MacRae et al. 2005, Fox et al. 2007, Molewijk et al. 2008a, 2008b, 2016, ASBH 2011, Porz et al. 2011, van der Dam et al. 2013, Fiester 2014, Fournier et al. 2015, NCEHC 2015, Stolper et al. 2015, 2016, Fournier 2016, Iltis and Sheehan 2016, Rasoal et al. 2017, Robinson et al. 2017, Spronk et al. 2017.

2.1.1. A case example

The following case example is taken from a report of the Massachusetts General Hospital Optimum Care Committee (Robinson et al. 2017). The details of the case and of the people involved have been changed by the original authors to protect the confidentiality of patients and family members. The case example has been slightly modified for this thesis, where indicated, and will be used to illustrate the different models and methods that are presented in more detail in the following sections.

> "[A] mother of two elementary school children, was admitted with declining functional status and progressive dyspnea from breast cancer. [...] [T]he patient's spouse and healthcare agent, did not seem to accept his wife's prognosis or terminal condition. Up until the day of admission, [the spouse] had been force-feeding his wife and had been demanding that she walk in order to avoid wheelchair dependence, despite her discomfort. During the hospitalization, he intervened to limit treatments aimed at pain and symptom management and insisted upon nebulizer treatments, which appeared to cause his wife discomfort. Clinicians believed that while medical interventions had become increasingly burdensome to the patient, it was difficult for her to express disagreement with her husband. And, as the patient's health worsened, she became increasingly unable to speak on her own behalf." (Robinson et al. 2017, pp. 144–145).

For the purpose of illustrating the following models and methods of CESS that focus on prospective decision-making, we will assume, as scenario A, that the clinical ethics support is requested "to assist the medical team in mediating ongoing conflict with [the patient's] spouse, specifically his insistence on mechanical ventilation for her impending respiratory failure and CPR in the event of cardiac arrest, as well as his refusal of pain medications for her" (Robinson et al. 2017, p. 145).

As another possible scenario (scenario B) that will be more relevant for a subset of models that work retrospectively, we will assume that the patient has passed away after weeks of ongoing conflict that have left the healthcare professionals troubled and unsure about the proceedings of the case.

The next section will present different methods of CEC and how they would address the described case example.

2.1.2. Selected methods of clinical ethics consultation (CEC)

Clinical ethics consultations (CEC) focus on supporting the decision-making process in a specific case that is morally challenging. It happens "in real-time, requiring a specific medical decision for one specific patient" (Fournier 2016, p.557). Examples for topics are questions, concerns or dilemmas related to end-of-life decisions about continuing or discontinuing care, identifying appropriate surrogate decision-makers (Robinson et al. 2017), informed consent and decision capacity as well as issues of resource allocation (Molewijk et al. 2016). Clinical ethics consultation can be performed by lone ethicists, small teams of ethicists or sometimes ethics committees and has a variety of different roles in different countries (as reviewed by Rasoal et al. 2017). Ethics committees can have additional functions, such as the provision of education, seminars and workshops for hospital employees, reviewing research protocols, contributing to the development of hospital policies and guidelines or providing an opinion on general ethical issues such as disclosure of medical information against patients' wishes (reviewed in Rasoal et al. 2017). Since those functions are not the focus of this work, committees are included only in their function of providing clinical ethics consultation and therefore not described separately as done by some other authors (Molewijk et al. 2016, Rasoal et al. 2017).

In the following, six different approaches of clinical ethics consultations are used to exemplify some of the possible methods and procedures used.

2.1.2.1. *CASES* approach of facilitation

Background and aim. The *CASES* approach described in *Ethics Consultation - Responding to Ethics Questions in Health Care* is one procedure how ethics consultation can be conducted (NCEHC 2015). It was published by the U.S. Department of Veterans Affairs' National Center for Ethics in Health Care as a guideline for ethics consultation in healthcare facilities and, according to the authors, should be seen as "a primer, to be read initially in its entirety by everyone who participates in ethics consultation" (NCEHC 2015, p. vi). The aim of the *CASES* approach is to "effectively resolve ethical concerns in ethics consultation" (NCEHC

2015, p. 20) by providing guidance to the ethics consultant in form of a step-by-step protocol similar to other standard formats clinicians use in clinical practice.

Overview of method. The abbreviation *CASES* stands for **c**larifying the consultation request, **a**ssembling the relevant information, **s**ynthesising the information, **e**xplaining the synthesis and **s**upporting the consultation process (NCEHC 2015, p. viii). Ideally the process results in an agreement between the different parties on how to proceed in a specific case.

The recommended method for supporting the actual decision-making by the relevant party during the "synthesising the information"-phase is the so-called facilitation of moral deliberation. This facilitation method is prominently advocated by the American Society for Bioethics and Humanities (ASBH) in their report on the *Core Competencies for Healthcare Ethics Consultation* (ASBH 2011). At the core of this approach lies the facilitation of ethical decision-making within a framework of ethically acceptable options independent of the opinion of the ethics consultant:

> "However, the consultant should refrain from unduly influencing the patient's decision. There is a fine line between educating (which may involve some degree of persuasion) and manipulating. Ethics consultants need to be sensitive to their personal moral values and should take care not to impose their own values on other parties." (ASBH 2011, p. 9).

Some understand this as "facilitating the decision-making process whatever its outcome" (Fournier 2016, p. 557). This is, however, not entirely true, since the outcome has to lie within the borders of what is ethically acceptable. Determining what is ethically acceptable is one of the tasks of the consultant which is done by applying their "ethics knowledge" (NCEHC 2015, p. 29) of existing guidelines, ethics codes, institutional policies and previous cases that have become an authoritative standard (NCEHC 2015, pp. 29–30).

Procedure illustrated by case example. Coming back to our case example described in section 2.1.1 a typical (but hypothetical) consultation for scenario A can look as presented in the following.

The consultant has been requested by the responsible physician to assist with the conflict between a terminally ill cancer patient's husband and the healthcare team (the service should equally be accessible to patients, families and other staff). The involved parties disagree on the use of pain medication and potential cardiopulmonary resuscitation (CPR) and/or mechanical ventilation. Whereas the husband insists on the latter two and refuses the administration of pain medication, the healthcare team is worried that these decisions are not in the interest of the patient nor following her will.

Step 1: Clarify the consultation request. In a consultation following the *CASES* approach the consultant (it can also be a team of consultants) first clarifies the consultation request (NCEHC 2015, pp. 20–28). The consultant characterises the consultation request to assess whether the question or request is about resolving ethical concerns as opposed to other issues such as allegations of misconduct or purely medical questions (NCEHC 2015, pp. 20–21). The consultant should assist the requester in articulating "the nature of their concern, and help clarify the values uncertainty or conflict" (NCEHC 2015, p. 21).

The consultant also assesses whether the question or concern is related to an ongoing case or a general healthcare ethics related question (NCEHC 2015, pp. 22–23). In case consultations, as in the case example given in section 2.1.1, it is important to follow all steps of the *CASES* approach (NCEHC 2015, pp. 22–23). Any case consultation should be recorded in form of structured notes in the health record of the patient (NCEHC 2015, p. 22). In other types of consultations such as reviewing policies from a healthcare ethics perspective, the approach can be modified to fit the needs of the request (NCEHC 2015, p. 23).

The consultant determines which approach is the best for this specific request, whether the individual, team or committee model would be best suitable (NCEHC 2015, p. 24). For our example we assume the consultant decides to use the individual consultant model. It is further important to explain to the requester the process of the consultation, its time frame and very importantly the goals of the consultation process (NCEHC 2015, p. 24). Any misconceptions need to be corrected. These misconceptions often relate to the goals of the consultation. It should be clarified, for example, that the consultant is not automatically agreeing with one side (either patient or healthcare professionals), nor will the consultant "tell the requester what

to do" (NCEHC 2015, p. 24) or "tell someone he or she is being unethical" (NCEHC 2015, p. 24).

The consultant will then address "the single most difficult, yet most important, part of the ethics consultation" (NCEHC 2015, p. 26), the formulation of the ethics question. The ethics question should help everyone involved to concentrate on the central values perspectives and the finding of a resolution (NCEHC 2015, p. 26). The *CASES* approach recommends to formulate the ethics question for case consultations in one of the following two formats:

> "1. Given that [first central values perspective] but [second central values perspective], what decisions or actions are ethically justifiable?
>
> 2. Given that [first central values perspective] but [second central values perspective], is it ethically justifiable to [decision or action]?" (format edited for clarity from NCEHC 2015, p. 26).

The *CASES* approach further recommends a five-step process to arrive at the ethics question starting with the ethics consultation request and the description of the case by the requester (NCEHC 2015, p. 25). In the second step the "consultant elicits value labels from the requester" (NCEHC 2015, p. 25). Those are, for example, "truth-telling" (NCEHC 2015, p. 25) or fairness, and represent "strongly held beliefs, ideals, principles, or standards" (NCEHC 2015, p. 25). In the next step, the consultant establishes the values perspective that describes the values from the viewpoints of those involved (NCEHC 2015, p. 25). The requester assists with this and identifies the most central values perspectives with the consultant in the next step. The consultant then brings the two central values perspectives into one statement before finally formulating the ethics question.

In our case example the ethics question can be formulated as one of the following two suggestions (see NCEHC 2015, p. 26).

> *Given that* the healthcare team has doubts about whether the spouse as the surrogate decision-maker acts either following previously expressed preferences of the patient or in the best interest of the patient, and that the team thinks that the pain and discomfort of the patient should be recognised and treated, *but* the decision-making authority of

the appointed surrogate decision-maker, the spouse, who refuses such pain medication and insists on medical interventions aimed at prolonging the life of the patient such as CPR and mechanical ventilation, should be respected*, what decisions or actions are ethically justifiable?*

Given that the healthcare team has doubts about whether the spouse as the surrogate decision-maker acts either following previously expressed preferences of the patient or in the best interest of the patient, and that the team thinks that the pain and discomfort of the patient should be recognised and treated, *but* the decision-making authority of the appointed surrogate decision-maker, the spouse, who refuses such pain medication and insists on medical interventions aimed at prolonging the life of the patient such as CPR and mechanical ventilation, should be respected, *is it ethically justified to* write a 'do-not-resuscitate-order' (DNR order) by the physician against the spouse's wish and further insist on pain treatment for the patient?

Step 2: Assemble all relevant information. After having formulated the ethics question for the consultation, the consultant in the second step of the *CASES* approach assembles all relevant information by reviewing the medical record of the patient, by interviewing the patient, relevant family members or friends as well as the healthcare professionals (NCEHC 2015, pp. 28–35). These interviews are conducted individually, however, group discussions are possible at this stage though not advised (NCEHC 2015, p. 35). During the interview the consultant is careful to distinguish values from facts by asking questions on what the interviewee means when using value-laden terms like ‘quality of life’ or ‘futile’ in relation to treatment (NCEHC 2015, p. 34). The consultant makes sure that the information is accurate and that she understands the medical situation, in this case the severity of the illness and that the patient will inevitably die from her condition.

A fourth source of relevant information for the consultant is her so-called "ethics knowledge" (NCEHC 2015, p. 29). She will consider and review all sources that could provide guidance on the ethical question such as the organisational policies on life-sustaining treatment, professional codes of ethics, statutes, published ethics literature or cases that have become an authoritative standard (NCEHC 2015, p. 30). The consultant also has a basic knowledge of

relevant laws so that she is able to assess when legal advice from an authorised source is necessary (NCEHC 2015, p. 30).

After a thorough assembly of the information the consultant summarises them for the final consultation report. She further reviews and adjusts the ethical question if needed which is not the case in our example.

Step 3: Synthesis of information. In the third step, the synthesis of information, the consultant determines that a formal meeting with the healthcare team and the husband is a necessary step to bring everyone to the same level of information. These formal meetings can also aim at resolving the conflict completely or at simply establishing trust or opening up the communication and can be structured to the specific goal of the session, however, they are not always required (NCEHC 2015, p. 36). In this case the consultant deems it necessary for the healthcare professionals to clarify the severity of the patient's condition and the very likely death that will result from it. The consultant will furthermore bring her findings from the hospital's policy on life-sustaining treatment.

After the formal meeting, the consultant will engage in ethical analysis of the case, that means she "uses systematic methods of reasoning to apply relevant ethics knowledge to consultation-specific information for the purpose of responding to an ethics question. This process involves rigorous, critical thinking to develop and then weigh ethical arguments and counterarguments that are based on consideration of principles, rules, duties, likely consequences, and analogous cases" (NCEHC 2015, p. 37). The consultant will consider different perspectives and approaches during her analysis, assess the strength of the arguments and then weigh them to come to a conclusion on the ethically allowable options (NCEHC 2015, pp. 39–41).

The next important step is to identify the ethically appropriate decision-maker which depends on the question or decision that needs a solution (NCEHC 2015, p. 41). After a careful analysis of the situation the consultant in this case identifies the patient's spouse as the ethically appropriate decision-maker to decide about the acceptance or refusal of specific treatments such as CPR.

The consultant then engages in the facilitation of moral deliberation. She carefully guides the spouse through the decision-making by asking, for example, "What would your [wife] tell us

to do if [she] was able to talk to us?" (NCEHC 2015, p. 42). The consultant makes sure to inform the husband about the boundaries of what is ethically acceptable, and explains that the surrogate decision-maker is required by the hospital policy to follow the patient's wishes and preferences and should they be unknown, decide in the patient's best interest. The consultant does not give her personal opinion or values but only relies on her ethics knowledge to determine what is ethically justifiable to respect the authority of the ethically appropriate decision-maker (NCEHC 2015, p. 43).

Based on the decision of the husband the consultant will write a recommendation about how to proceed. In cases where the ethically appropriate decision-maker insists on an ethically unjustifiable decision the consultant should appeal to a higher institutional authority and should provide recommendations on how to proceed in the decision-making process (NCEHC 2015).

Step 4: Explaining the synthesis. In the fourth phase of the *CASES* approach ("explaining the synthesis") the consultant will explain the recommendation and decision made to the involved parties (NCEHC 2015, pp. 43–46). This will again take place in individual meetings to give the involved stakeholders a chance to clarify any concerns or questions (NCEHC 2015, p. 44). Finally, the whole process will be documented by the consultant and added to the medical record of the patient (NCEHC 2015, pp. 45–46).

Step 5: Support the consultation process. The last step for the consultant will be to support the consultation process by following up with the participants, by evaluating and adjusting the consultation process and by identifying potential underlying systems issues (NCEHC 2015, pp. 46–48).

2.1.2.2. The *Commitment model*

Background and aim. Fournier and colleagues (2015) propose another approach to CEC that they have named the *Commitment model*. The method was developed in the Clinical Ethics Center in Paris in the early 2000s. This method includes the involvement of a case conference of a non-case-associated "ethically sensitive group of people, illustrative of the diversity of society and free to express their opinion because they have no professional position to defend" (Fournier et al. 2015, p. 293). This case conference serves as a platform to discuss the case

and bring forward ethical arguments and positions. The members of the case conferences do not formulate a recommendation nor aim to solve the question of the case as a group (Fournier et al. 2015, p. 20). The different positions will, however, be presented to those involved in the case to help them reflect upon their positions (Fournier et al. 2015, pp. 291, 293). The case conference adds political and social dimensions to a case that cannot usually be found in CEC; it aims at enabling the visibility of gaps between the values in a society and those of healthcare professionals (Fournier et al. 2015).

Procedure illustrated by case example. Based on an example case described by Fournier and colleagues (2015) the following procedure can plausibly be expected when following the *Commitment model* in scenario A of our case example (see 2.1.1.).

The healthcare professionals have asked for a clinical ethics consultation because they are unsure how to balance the husband's requests with the needs of the patient with regards to a DNR order and pain medication.

Step 1: Meeting stakeholders. The ethics consultants, a philosopher and a physician in this case, first meet with the husband in the ethics centre away from the patient's rooms (the consultants always operate as a at best multidisciplinary team (Fournier et al. 2015, p. 291)). They give him an opportunity to voice his concerns and explain his position so that they can adequately represent his arguments and thoughts at the case conference (Fournier et al. 2015, p. 290). They make sure he feels understood and heard. In general, the perspective of the patients is very important in the *Commitment model* because they are seen as the ones suffering the most from the decision (Fournier et al. 2015, p. 290). Since the patient herself cannot speak for up for her wishes anymore, it is difficult to take her view in to account directly. The consultants nevertheless make sure to meet her to get a first-hand impression of her circumstances and how they might affect those around her (Fournier et al. 2015, p. 291). After that they meet with all involved healthcare professionals to equally pay attention to their positions and arguments. According to Fournier and colleagues the consultants can be emotionally engaged and should acknowledge that they are part of the decision-making process as "third-party agents" (Fournier et al. 2015, p. 291). However, they should

nevertheless be neutral with regards to the involvement and make sure that the "attention is distributed equally to the concerns of all parties involved" (Fournier et al. 2015, p. 291).

Step 2: Case conference. The next step in the process is the case conference where the consultants present the case to other members of the conference (Fournier et al. 2015). The members should roughly reflect the societal diversity (Fournier et al. 2015, p. 294). All members of the conference bring forward their ethical arguments and positions. As individuals with their own backgrounds and beliefs they are all "genuinely pursuing the best ethical solution, given the context, at least from his or her own enlightened point of view, and each is expected to express his or her own ethical arguments and position" (Fournier et al. 2015, p. 293). The idea of the conference is not to find a solution as a group but to provide new insights and arguments for the involved stakeholders. Therefore there is also no "formal recommendation" (Fournier et al. 2015, p. 293) following from the case conference.

Step 3: Reporting on the case conference. After the case conference, the ethics consultants are meeting again with the husband and the healthcare professionals individually. They present the arguments and positions and the "collective response to the ethics of the case at hand" (Fournier et al. 2015, p. 293). It is possible that the husband reconsiders his position on the DNR order due to the arguments from other people that are not directly involved with the case. However, the decision remains with him and is not made by the ethics consultants. It might be easier for the healthcare professionals to understand the husband's position when they see the potential diversity of positions in the case conference. They may, however, also feel reassured in their position depending on the outcome of the case conference.

Step 4: Follow up. Due to the engagement of the ethics consultants the follow-up after the case consultation has ended is an important part of the consultation process (Fournier et al. 2015, p. 292). The consultants will stay in contact to know about what became of the situation and what impact the case consultation had on it. Ideally there will be follow-up meetings with those involved, both the healthcare team and the patient/family, to learn about their own impression of how the case consultation influenced them and the situation (Fournier et al. 2015).

2.1.2.3. The *Hub and Spokes Strategy*

Background and aim. The *Hub and Spokes Strategy* has been implemented at the Joint Centre for Bioethics at the University of Toronto in seven affiliated hospitals (as of 2005) in response to various challenges to what they call the "traditional ethics committees that rely on volunteer members with little training or resources in ethics" (MacRae et al. 2005, p. 257). They aimed at developing a bioethics service that would be "integrated, sustainable, and accountable" (MacRae et al. 2005, p. 256) and that would highlight that ethics is not merely an addition to everyday clinical life but "an integrated part of everyone's role" (MacRae et al. 2005, p. 259). The *Hub and Spokes Strategy* is an approach to structuring and integrating bioethics in the organisational network and less of a method on how to conduct consultations.

MacRae and colleagues argue that lone ethicists are not able to fulfil the many tasks demanded of them because they neither have the special knowledge in all relevant medical fields nor the time to provide ethics services as well as education and research, especially when they are situated in a big multisite hospital (MacRae et al. 2005, p. 257). In addition to that, an ethicist requires some kind of peer support which is not given if they are the only ethicist employed in a hospital (MacRae et al. 2005, p. 257). MacRae and colleagues (2005) furthermore call for an integration of ethics into the entire organisational structure, something that would require coordination of the different ways in which services provide assistance with ethics related matters (such as chaplaincy, risk management, patient relations or informal local clinician opinion leaders). Again, they think that single ethicists cannot achieve this alone (MacRae et al. 2005, p. 257). According to MacRae and colleagues a lot of ethicists struggle with a lack of support from their organisation and as a consequence with a lack of sustainability of their work as well as an inability to focus on their actual tasks instead of issues related to credibility, resources and interpersonal relationships (MacRae et al. 2005, p. 257). Additionally, MacRae and colleagues aim to address the challenge of accountability of ethics support services by establishing a unified reporting system that allows for the evaluation of the ethics services provided (MacRae et al. 2005, pp. 257–258).

Overview of method. The idea of the *Hub and Spokes Strategy* is to have a bioethics expert as the hub that guides, builds and supports the ethics network in an organisation that is build

up by spokes with different functions and roles that have some relation to bioethics (e.g. nurses, physicians, social workers) (MacRae et al. 2005). These spokes bring in their specialised knowledge of their work contexts and are responsible for implementing ethics policies as well as providing "ethics support and education in their various areas of service" (MacRae et al. 2005, p. 258). The bioethics expert at the core may come from a range of disciplines such as law, medicine, nursing, philosophy or theology but should have a graduate training in bioethics at a Master's level and "significant clinical bioethics expertise" (MacRae et al. 2005, p. 258). The spokes can have different functions according to their training and available time and educational resources (MacRae et al. 2005, p. 259). Some of them can also conduct consultations. Overall, this network of ethics resources should allow for communication in all directions and enable an integration of ethics throughout the organisational structure (MacRae et al. 2005).

Though not explicitly stated, the description of the approach by MacRae and colleagues seems to mainly aim at providing ethics support services upon request of healthcare professionals (and not so much patients) as they highlight the importance of the recognition of the spokes by colleagues as "ethics resource leaders" (MacRae et al. 2005, p. 259).

Procedure illustrated by case example. With regards to the case example from 2.1.1 in scenario A it is plausible that the responsible physician contacts the spoke in their department, in this case, the head of the unit, in order to seek help in the decision-making process with regards to pain medication and the DNR order of the ill patient that the patient's husband refuses (a different requester would be possible as well). In some cases, the spoke might feel too involved to be impartial in a consultation and therefore refer the case to the hub, the bioethicist (MacRae et al. 2005, p. 259). How the actual consultation would proceed depends on the method employed which as stated earlier is not what the *Hub and Spokes Strategy* describes. One possibility is that it would follow a similar protocol as described in the *CASES* approach of facilitation. This will however also depend on the training and expertise of the specific spoke offering the service. To increase the accountability of ethics consultations support services MacRae and colleagues suggest discussing and peer reviewing consultations afterwards in a clinical ethics forum that includes the hub, the spokes, a senior management

representative and representations of the patient, the family or lay people as well as other key stakeholders (MacRae et al. 2005, p. 260).

2.1.2.4. Moral expertise

Background and aim. Moral expertise has been presented as one method of clinical ethics consultation where the consultant provides recommendations for an ethically challenging case based on their superior moral expertise (Fournier 2016). I will understand moral expertise here as described by Birnbacher:

> "A moral expert would be one who knows which norms and values are the correct ones, in a sense of 'correct' by which correctness is understood as something more ambitious than simple conformity with widely accepted standards." (Birnbacher 2012, p. 240).

The idea that a clinical ethicist can have some kind of expertise, that healthcare professionals do not have (without additional training in ethics or moral philosophy) and that enables the ethicist to arrive at the morally correct decision is reflected in this approach. Since the question of decisional authority has been an important issue in the practice and discussion of clinical ethics support services (Fournier 2016), this method shall briefly be addressed here, although it may be declining in practice with other more facilitation-oriented approaches on the rise (see e.g. *CASES* approach, 2.1.2.1). Historically, CECs have been criticised for moving decisional authority away from healthcare professionals when committees or lone ethicists with a different professional background would analyse ethically difficult cases (Fournier 2016). While Steinkamp and Gordijn have claimed that the debate is settled nowadays with the agreement that "ethics consultation should not be an activity of external experts or ethics committees alone" (Steinkamp and Gordijn 2003, p. 235) but should include all healthcare professionals with responsibilities towards a case, the question of the exact definitions of the roles of both consultants as well as participating healthcare professionals leaves room for differing degrees or understandings of moral expertise on the side of the consultants.

Interpreting the clinical ethicist as a moral expert rests on two main assumptions: (1) there is a moral truth (as opposed to multiple acceptable options) and (2) the ethicist possesses some

kind of expertise that makes them more likely to arrive at this moral truth (see also 2.1.4 and a discussion of ethics expertise by Iltis and Sheehan (2016)). The broad debate on whether moral expertise can exist will be touched upon in the discussion of key criteria to distinguish models and methods of CESS and what they reveal about the underlying conception of ethics in section 2.1.4.

The notion of moral expertise (on the side of the consultants) can be implicit in single-action recommendations from an expert consultant, a group of consultants or an ethics committee if the recommendation meets certain criteria. It depends, firstly, on who the author of a recommendation is and, secondly, on the level of normativity the recommendation comprises. A third aspect is the authoritative power of a recommendation. However, in the majority of cases clinical ethics support services do not carry (legal) force and recommendations do not need to be followed by the decision-maker in a case (Rosoff et al. 2018). Fiester argues that with no data suggesting otherwise, it would be contradictory to assume that CEC recommendations are not implemented in practice since the parties involved had been seeking a consultation because they could not make a decision on their own (Fiester 2014, p. 503).

With regards to the first of the above-mentioned criteria, the extent to which the ethics expert is the (sole) author of a recommendation plays a role. A single-action recommendation resulting from a group decision of all stakeholders involved argues less for an assumption of (exclusive) moral expertise on the side of the ethicist(s) than a single-action recommendation from a committee, lone ethicist or group of ethicists that analyse a case they are not directly involved with as healthcare professionals. Fox and colleagues (2007) found in a national survey on CECs in the USA that although information gathering for a case involved stakeholders to varying degrees, the actual recommendations were made by the committees or consultants, in some cases even by voting within a committee.

The second criterion, the degree of normativity in the recommendation, equally influences how much moral expertise is attributed to the one making the recommendation. A recommendation with an actual decision, such as implementing a DNR order in our case example (see 2.1.1), carries more moral judgement than merely advising the parties to talk to each other. Since the latter is a rather unlikely recommendation as it does not solve the issue

at hand nor provide new ideas, (single-action) recommendations can be expected to at least contain some normative decisions related to a case.

Fox and colleagues report that on average 46 % of cases resulted in a single-action recommendation, 41 % of the time a range of acceptable actions were recommended and in 13 % of cases no recommendation was made (Fox et al. 2007, p. 18).

Taken together, this suggests that the notion of moral expertise on the side of the consultants is still at least implicitly prevalent in the practice of some CECs.

Procedure illustrated with case example. In the case example of a terminally ill patient for whom the spouse refuses full pain medication and a DNR order (see section 2.1.1), using a method with the idea that the ethicist is the moral expert in this situation, can look like the following. The consultant meets with the healthcare professionals, as well as the patient's spouse to collect information about the case from different views. She also consults the medical record of the patient before she engages in reflection of the different norms and principles that play a role here, and identifies the autonomy of the surrogate decision-maker and acting in the patient's best interest as the two main conflicting norms. She then arrives at the decision that the patient's best interest should prevail and therefore strongly recommends extended pain medication and a DNR order.

2.1.2.5. Bioethics mediation

Background and aim. Bioethics mediation has been presented as an alternative to the more traditional version of CEC that provides recommendations. Other approaches such as the ASBH facilitation method, that is also used in the *CASES* approach, view it as one of different skills or techniques a clinical ethics consultant should be able to use but not as a stand-alone method (ASBH 2011, p. 55). The bioethics mediation method assumes that there can be "genuine ethical ambiguities" (Fiester 2014, p. 504) in clinical practice. In these cases "there is more than one applicable moral principle, the relevant moral principles often conflict, and more than one ethically justified option exists as a legitimate outcome of the conflict" (Fiester 2014, p. 504).

The mediators do not provide recommendations since that would mean to prioritise one set of values over another which conflicts with the fundamental idea of mediation. The goal of bioethics mediation is a "shared resolution that meets the needs of all stakeholders" (Fiester 2014, p. 507) . The ideal is a "consensus about *outcome* even if there is no consensus about the values or beliefs surrounding the case" (Fiester 2014, p. 507).

Procedure illustrated with case example. In the scenario A of our case example of the husband refusing the pain medication and the DNR order for his wife, the ethics consultant, or the team of ethics consultants, would conduct group meetings with the husband as well as the healthcare professionals involved. The consultants will help the parties to uncover and articulate the values, emotions, interests and principles that are involved in this situation but may be hidden. The consultants make sure that every voice is equally articulated and heard (Fiester 2014). These two aspects are summarised as performing "moral archaeology" (Fiester 2014, p. 507) and acting as an "ecumenical advocate" (Fiester 2014, p. 507).

This process aims at helping the husband to discover his underlying reasons for his refusal and can help him to realise that the motives and intention of him as well as the healthcare professionals are not so far away from each other. This process can lead to a mending of relationships through mutual understanding and perspective sharing, a possibility for closure and the reduction of frustration and resentment that can otherwise result from a solution presented by an outside party (Fiester 2014). Ideally the healthcare team and the husband would find a consensus on how to proceed further with the treatment of the patient.

Having presented a set of different approaches to CEC that mostly focus on ongoing cases, the next section will now address a different model of CESS, moral case deliberation, and two of its methods that can be used to address cases pro- and retrospectively.

2.1.3. Selected methods of moral case deliberation (MCD)

Moral case deliberation generally consists of multidisciplinary group deliberations on moral questions related to actual cases guided by a trained facilitator. The question to be addressed can be prospectively related to a decision that needs to be made but the question can also result from previous cases and MCD is then used retrospectively to improve moral competencies by addressing moral unease or clarifying conceptual uncertainty (Steinkamp

and Gordijn 2003, Molewijk et al. 2008a). Typical questions come in the form of "What should we consider as the morally right thing to do in this specific situation and how should we do it rightly?" (Molewijk et al. 2008a, p. 58).

Moral case deliberation, as described here, was implemented and further developed in the Netherlands by Margreet Stolper, Bert Molewijk, Guy Widdershoven and associated colleagues mostly in the context of chronic care facilities (see e.g. Molewijk et al. 2008b, Porz et al. 2011, van der Dam et al. 2013, Stolper et al. 2016, Spronk et al. 2017).

Moral case deliberation uses a minimal input facilitation style in which the ethical work is done mostly by the participants themselves (e.g. Porz et al. 2011, Stolper et al. 2016). It aims at finding an answer to a moral question that is depending on and valid for a given institutional, historical and, very importantly, social context (Porz et al. 2011, Stolper et al. 2016). As Porz and colleagues phrase it with regards to their work as clinical ethicists in the Netherlands and Switzerland:

> "Our proceedings in case discussions, our work in ethics committees, our research and teaching are framed by our assumptions that moral agents are *not* independent, *not* asocial, *not* timeless and *not* space-free individuals, rather the opposite" (Porz et al. 2011, p. 356).

The lines between MCD as a teaching tool and MCD as a clinical ethics support service are fluent and also depend on the method chosen (Stolper et al. 2016). The dilemma method for ongoing cases has been described by Stolper and colleagues (2016) and will be discussed in more detail below. From a review by Steinkamp and Gordijn (2003) three additional methods can be identified as methods for moral case deliberation: The Nijmegen Method, the Hermeneutic dialogue and the Socratic dialogue. The methods differ in their focus and their approach to the moral question at stake. Broadly speaking the Nijmegen Method and the Dilemma method are focusing on decision-making in an ongoing case whereas the Hermeneutic dialogue and the Socratic dialogue are used mostly retrospectively in addressing moral unease and exploring concepts and principles (Steinkamp and Gordijn 2003, Molewijk et al. 2008a).

The dilemma method and the Socratic dialogue are described in more detail in the following since these are two methods often used for moral case deliberation that furthermore cover both prospective decision-making (dilemma method) as well as retrospective analysis of ethically challenging situations (Socratic dialogue).

2.1.3.1. Dilemma method

Background and aim. The dilemma method in moral case deliberation has been described as a way to reach a "well-considered decision" (Molewijk et al. 2008a, p. 58). Moral case deliberation and in specific the dilemma method focuses on a concrete situation or case and on the participants' "*personal* moral experiences" (Stolper et al. 2016, p. 3). The result of the deliberation process is always a temporary answer applicable within the specific context (Stolper et al. 2016). Principles or values such as 'autonomy' can be used within the deliberation but they are always further explored by having the participants explain what the respective value or principle means to them in this specific situation (Stolper et al. 2016).

The theory of the dilemma method as practiced, for example, in the Netherlands by working groups related to Margreet Stolper, Guy Widdershoven and Bert Molewijk and presented among others by Porz and colleagues (2011) is based on narrative ethics and philosophical hermeneutics. Narrative elements in clinical ethics in the form of storytelling by those involved in a case uncover "implicit and explicit values of the storytellers" (Porz et al. 2011, p. 356) and are seen as important because we, as human moral agents, develop our morality in the context and history that arises from our relationships to others (Porz et al. 2011). In other words, "ethics is socially embedded" (Porz et al. 2011, p. 356) and should be deliberated upon with regards to its social context.

Porz and colleagues say that "stories are not arbitrary, but carry meaning and values, that they have a beginning and an ending, and a certain relation to reality" (Porz et al. 2011, p. 357). The notion of storytelling needs to be carefully introduced in the clinical setting as it is so different from the usual way of discussing cases and making evidence based decisions in medicine, which is often not possible in situations of complex moral dilemmas (Porz et al. 2011).

Basing the dilemma method (and MCD in general) on philosophical hermeneutics means that it emphasises the role of language and dialogue in understanding and interpreting practical human experiences and situations in the clinics (Porz et al. 2011, p. 356). It relies on openness to others and the willingness to consider their points of view which then results in learning about a situation or moral problem (Porz et al. 2011).

The expertise of the facilitator lies in guiding the process of the deliberation, in understanding its background and the assumptions it is built upon as well as knowing about and being able to explain ethical terms and concepts such as the differences between an ethical and a practical question and the meaning of values and norms (Stolper et al. 2016). More than anything the facilitator should guide the participants with a Socratic attitude "to question rather than to argue" (Stolper et al. 2016, p. 8). Ethical theories and concepts can be used within moral case deliberation and the dilemma method but they are not considered as a given reference framework that needs to be applied to any case or judgment within the case discussion (Stolper et al. 2016). They may rather be used to inform or criticise during the reflection process (Stolper et al. 2016).

Overview of method. In practice, the dilemma method consists of ten steps that have been illustrated with a case study by Stolper and colleagues (2016). The ten steps are (1) introduction, (2) presentation of the case, (3) formulating the moral question and the dilemma, (4) clarification in order to place oneself in the situation of the case presenter, (5) analysing the case in terms of perspectives, values and norms, (6) looking for alternatives, (7) making an individual choice and making explicit one's consideration, (8) dialogical inquiry, (9) conclusion and (10) evaluation (Stolper et al. 2016). The steps are to be seen as a guideline which should never be more important than what is being said during the deliberation. The facilitator needs to be able to "apply the method in a context-sensitive way" (Stolper et al. 2016, p. 9). The goal is a "joint inquiry and dialogue rather than following mechanically the method step by step" (Stolper et al. 2016, p. 9).

The sessions for moral case deliberations can have lengths of 45 min to a day and are best done on a regular basis (Molewijk et al. 2008b, Stolper et al. 2016). The dilemma method is particularly useful for acute cases where a decision needs to be made and the participants (or

at least the participant bringing the case up in a session) feel confronted with a moral dilemma.

Procedure illustrated with case example. We will look at scenario A of the case example (see section 2.1.1) in the context of the dilemma method and assume that one of the nurses has brought up the case in one of the regular moral case deliberation sessions. Patients or patient surrogates can be part of the deliberation sessions, in our case example, however, we assume that the patient's husband refuses to take part in the session.

The deliberation is guided by a trained facilitator who we assume to be employed as an ethicist by the hospital. The participants of the deliberation sit in a circle during the session which is will take about 90 minutes as that is the average an MCD session usually takes (Stolper et al. 2016, p. 3).

Step1: Introduction. The session starts off with the facilitator introducing the procedure and the aim of moral case deliberation, highlighting the confidentiality of the meeting as well as briefly explaining the issue that will be addressed in the session, in this case the conflict between the patient's husband and the healthcare team (Stolper et al. 2016, p. 3). The aim for the session is determined by the group (Stolper et al. 2016, p. 3); in this case, a decision on how to proceed with the patient's husband and the treatment of the patient with regards to pain medication and the DNR order.

Step 2: Presentation of the case. In the second step, the case presenter, a nurse in our case example, is asked to describe the case from her perspective (Stolper et al. 2016, p. 4). The nurse begins by telling her version of the events starting with the admission of the patient and how her own distress increased every time she noticed the patient's pain and her own helplessness because they were not allowed to give her stronger pain medication. She might describe how she slowly became more and more frustrated and angry with the patient's spouse but also with the doctors for not being able to convince the spouse of the necessity of pain medication and the seriousness of his wife's condition. The facilitator encourages her to describe the situation when she felt the conflict most strongly, including her feelings in that situation. The nurse describes a situation when she met the patient's husband a few days ago and tried to make him understand how much his wife was suffering in her current state and

that a stronger pain medication would bring her relief. But the husband refused and accused the nurse of exaggerating and giving up on his wife too easily. And he also insisted on a resuscitation of his wife should that be necessary at some point, which the nurse describes as troubling to her since she knows about the strain it puts on the patient. She goes on to say that a resuscitation is futile in her opinion in this case since the woman will die rather soon from her illness in any case.

The facilitator explicitly includes feelings in the request for the case description since they enhance the understanding of the moral discomfort and can hint at hidden values of the case presenter (Stolper et al. 2016, p. 4). In this case, the uneasiness with the possible resuscitation seems to refer to the value of an undisturbed or dignified death for the patient.

Step 3: Formulating moral question and dilemma. In the third step, the moral question is formulated by the nurse presenting the case with the help of the other participants (Stolper et al. 2016, p. 4). The nurse might formulate the question in this case as "Do we have to follow the wishes of the patient's husband?" Then, the two alternative opposing actions that compose the dilemma are formulated as experienced by the nurse: (a) I, as part of the healthcare team, stick to the wishes of the patient's husband, do not increase the pain medication and support a resuscitation of the patient if necessary, or (b) I, as part of the healthcare team, increase the pain medication and follow a DNR order issued by the responsible doctor.

Next, the case presenter is asked to compose a list of the negative consequences of each option on a flipchart (Stolper et al. 2016, p. 4). Plausible examples for those are the following.

For option (a): When I follow the husband's wishes, the patient is suffering unnecessarily and might have a painful and undignified death.

For option (b): When we as a healthcare team do not follow the husband's wishes and do not resuscitate the patient we ignore his desire to keep his wife alive as long as possible without knowing the preferences of the patient.

The formulation of the question and the two opposing alternatives by the case presenter are meant to help the other participants understand what is at stake for the case presenter in this situation (Stolper et al. 2016, p. 4).

Step 4: Clarification. The fourth step of the dilemma method is the clarification of the case for the other participants who are invited to ask questions (Stolper et al. 2016, p. 4). They ask, for example, how well the patient's husband has been informed about the state of his wife, how willing he seemed to listen or whether the patient has ever mentioned any treatment preferences to the case presenter or anyone of the healthcare team when she was still able to communicate. The questions should focus on the experience of the dilemma by the case presenter and not on how other people feel as that will be the focus of a later step (Stolper et al. 2016, p. 5). The aim of this step is for the other participants to be able to put themselves in the situation of the nurse and understand her dilemma because they will be asked to provide an answer as if it was their dilemma at a later step (Stolper et al. 2016, p. 5).

Step 5: Analysing perspectives, values, norms. In step five the participants are asked to develop a list of all stakeholders in the case and name the values that are relevant to the respective perspective (Stolper et al. 2016, p. 5). One value mentioned by the case presenter, the nurse, can be 'protection of the patient'. The values should always be linked to the concrete situation out of which they arise (as opposed to be taken from theory and applied to the case) (Stolper et al. 2016, p. 5). Therefore, participants are also asked to formulate a concrete "normative rule of action (norm) which follows from the value" (Stolper et al. 2016, p. 5). In our example, 'I should make sure that the patient is protected from unnecessary suffering' is a norm that can be expected to come up. Among others, another value held by the case presenter can be 'autonomy' and 'I should respect the wishes of the patient's husband as her surrogate decision-maker.' The facilitator’s task includes challenging the participants, if necessary, as to whether the absent perspectives are represented enough, in this case the patient's husband (Stolper et al. 2016, p. 5).

Step 6: Looking for alternatives. In the next step of the dilemma method, step six, the participants are asked to brainstorm other alternatives to the two options presented as the dilemma, without focusing on their feasibility or desirability (Stolper et al. 2016, p. 6). Ideas for alternatives are among others, having another MCD session with the patient's husband being present or talking to other relatives of the patient about her preferences.

Step 7: Individual choices and considerations. In step seven, the participants are asked to take pen and paper and answer the moral question with their own personal reasoning and values following five steps:

> "a) It is morally justified that I choose option … (A, B or an alternative).
>
> b) Because of…. (which value or norm?)
>
> c) Despite of…. (which value or norm?)
>
> d) How can you limit the damage of your choice mentioned under c?
>
> e) What do you need to act according your answer under 'a'?" (Stolper et al. 2016, p. 6).

In our case example, one of the doctors involved in the case answers: 'a) I think it is morally justified to choose option (a) (following the husband's wishes), b) because of the autonomy of the patient's surrogate decision-maker, c) despite the patient's discomfort, d) I would try again to discuss the use of pain medication and potential preferences the patient might have shared earlier with the husband and e) I need the healthcare team to accept the husband's choices to decrease the tension around the patient.'

The facilitator notes down all the choices and answers that the participants provide (Stolper et al. 2016, p. 6). The aim is for each participant to examine their own thinking and reasoning, not to give advice to the case presenter (Stolper et al. 2016, p. 6). This is also where referrals to given frameworks such as hospital policies or laws can be made (Stolper et al. 2016, p. 6).

Step 8: Dialogical inquiry. In step eight, the dialogical inquiry, the different answers of the participants are looked at in more detail and the participants are asked to explain what the specific values mean to them in this situation (Stolper et al. 2016, p. 6). Sometimes the same values are used for choosing different options and a dialogue about the understanding of the values and different positions can help the participants to reflect upon their own values and those of others (Stolper et al. 2016, p. 7).

The doctor whose answer was given above may say that she thinks the autonomy of the surrogate decision-maker should be respected and that means the husband should be allowed to make decisions for his wife. However, as another participant points out, autonomy is valuable because it reflects the autonomy of the patient, which is why a surrogate decision-

maker should decide according to the will of the patient and, if that will is not known, in the best interest of the patient. Some participants, including the case presenter, are not sure the husband is doing that. Respecting the autonomy of the patient can mean something different than following the husband's wishes. It can also mean that more efforts should be made to find out about the wishes of the patient.

One crucial factor in this dialogue is that it should be open, constructive and critical and it should not turn into a discussion where participants try to convince each other of the superiority of their solution or opinion (Stolper et al. 2016, p. 7). The goal is exchange and reflection.

Step 9: Conclusion. After the dialogical inquiry, the next step, step nine, would be the conclusion of the MCD session. The participants are asked to bring together what they have taken from the session (Stolper et al. 2016, p. 7). The facilitator brings up the moral question from the beginning and a decision for it can be made but a consensus is not strictly necessary (Stolper et al. 2016, p. 7). In the best case a plan of action is made that incorporates the insights from the MCD session (which can also be that there is no consensus on the issue) (Stolper et al. 2016, p. 7). Sometimes the insights from an MCD session can also inspire the development of a policy or are helpful for future similar cases (Stolper et al. 2016, p. 7). It is important for the facilitator to remain critical and encourage another dialogical reflection with questions if necessary (Stolper et al. 2016, p. 7). Depending on the time limitations this step is longer or shorter, sometimes follow-up sessions are part of the action plan or necessary to extend on the reflection (Stolper et al. 2016, p. 7).

Step 10: Evaluation. The last step of the dilemma method is the evaluation of the process and the results of the MCD session. The participants are asked to share how they experienced the process and how they evaluate what they have taken from the MCD session (Stolper et al. 2016, p. 7).

2.1.3.2. Socratic dialogue

Background and aim. The method of the Socratic dialogue "is used more as a learning tool for helping healthcare professionals sharpen their abilities to think in moral terms than for advising an ongoing decision-making process" (Fournier 2016, p.560). It aims at "conceptual

clarification, finding conceptual consensus, and critical reflection on the logic of someone's thinking process" (Molewijk et al. 2008a). The method was invented and further developed by German philosopher Leonard Nelson (1882-1927) and Gustav Heckmann (1898-1996). It was originally used in school classes and university seminars to deliberate on practical questions in a philosophical manner without much input given by texts or a teacher by but instead using the intellectual effort of the individual learner (Birnbacher 1999, Steinkamp and Gordijn 2003). The method is inspired by the Socratic idea (as found in Plato's work) of the accessibility of moral truth to anyone with a minimal intellect and the willingness to put in the effort of uncovering the truth that might be "hidden behind a veil of convention, prejudice and illusion" (Birnbacher 1999, p. 219). The way to do this with the Socratic dialogue is to engage in a disciplined group deliberation. The method is nowadays also discussed and used in the context of medical ethics, the research on ethical concepts and, as presented here, in moral case deliberation of actual cases (Birnbacher 1999, Fitzgerald and van Hooft 2000, Aizawa et al. 2013).

The Socratic dialogue is an inductive process that starts off with a general question, moves to a specific judgement for an experienced case example and from that judgement derives general rules and principles (Birnbacher 1999). Such questions are, for example, "In decisions concerning end of life care, should patient autonomy always prevail?" (Steinkamp and Gordijn 2003, p. 243) or "What is of fundamental importance in life?" (Fitzgerald and van Hooft 2000, p. 484).

The facilitator acts as a “Socratic midwife” (Stolper et al. 2015, p. 3) that enables healthcare professionals to deliberate on their experiences and values related to a specific question or case. The facilitator does not give any substantial advice or value judgements (Molewijk et al. 2008a). The expertise of the facilitator consists of knowledge of ethical concepts and theories that inform questions but that are not used as fixed given principles detached from context (Porz et al. 2011, Stolper et al. 2016). Furthermore, the facilitator is familiar with the clinical setting, understands the communication methods and has the ability to use them to support the participants in their joint moral deliberation process (Porz et al. 2011, Stolper et al. 2015).

The Socratic dialogue is similar to the dilemma method in that it rests on the same foundation of using narrative elements and hermeneutical inquiry in its process (Molewijk et al. 2008b). The Socratic dialogue is always seen as a joint group process where the answer to a moral question is uncovered by a dialogical process between the participants and not merely by reasoning or the application of theoretical concepts and theories (Steinkamp and Gordijn 2003, Stolper et al. 2016, p. 2). Assuming a variety of possible solutions to a moral problem, "the way to explore these solutions is not longer an analysis of reason alone but a getting involved in communication" (Steinkamp and Gordijn 2003, p. 244).

Overview of method. The procedure of the Socratic dialogue can broadly be separated into four steps: (1) finding the general philosophically relevant question (which in the original form of the Socratic dialogue should be agreed upon by the participants), (2) choosing and explaining one example from the experiences of the participants, (3) identifying implicit values and considerations in answering the question for the specific example, (4) deriving general rules and principles from the example to answer the initial question (Birnbacher 1999, Fitzgerald and van Hooft 2000, Steinkamp and Gordijn 2003).

Procedure illustrated with case example. Since the Socratic dialogue is used retrospectively to deal with residual unease or questions resulting from morally difficult situations, we will consider scenario B of the case example (see section 2.1.1), in which the patient has passed away after weeks of ongoing conflict between the patient's spouse and the healthcare professionals about the patient's treatment such as mechanical ventilation and pain medication, and repeated cardiopulmonary resuscitation. Since the healthcare team is still troubled by the case and unsure about what would have been the right thing to do, they bring up the case in one of their regular moral case deliberation sessions.

Step 1: Finding the general philosophically relevant question. All healthcare professionals that were involved in the case are invited to the session. We assume that the topic and the question for this session have been fixed before and that therefore the patient's husband was invited to take part in the session as well. We, however, assume further that since he is in grieve and still angry with the healthcare team, he refuses to take part in the MCD. In general, a Socratic dialogue profits form a heterogeneous group of participants with diverse

backgrounds, expectations and communication styles, but Birnbacher also points out that "it is always difficult to integrate participants with radically divergent background or purely formal motivation such as the wish to get acquainted with the method without an intrinsic interest in the issues discussed" (Birnbacher 1999, p. 223). The ideal numbers of participants are given as six to ten (Fitzgerald and van Hooft 2000, p. 484) and not more than twelve (Birnbacher 1999, p. 223).

One plausible question for the MCD session in which the Socratic dialogue is employed as a conversation method for the case example, can be; 'Should a patient's surrogate decision-maker's wishes always prevail?' (see also Steinkamp and Gordijn 2003, p. 243).

Step 2: Choosing and explaining example from practice. The example situation that is used to deliberate upon, is the case example as presented by one of the participants. Clarity is one of the key aspects in the Socratic dialogue which means that the other participants are invited to ask questions until everyone can imagine the described example as if experienced by themselves (Birnbacher 1999, p. 221, Fitzgerald and van Hooft 2000). In this case, since all the healthcare professionals are directly involved in the same case, this is easier than in cases where the example is not experienced by everyone in the group. It is the facilitators task to make sure that every participant can follow and understands every point made (Birnbacher 1999). The facilitator will also take notes on a flipchart during the process (Fitzgerald and van Hooft 2000).

Step 3: Identifying implicit values and considerations. The group engages in a dialogue about the reasoning for the decisions that were made in this case and by that tries to come to a joint judgement on whether the patient's surrogate decision-maker's wishes should have prevailed in this concrete example or not. This process involves uncovering values and considerations that underlie the reasoning and it "moves slowly and systematically, so that all participants gain insight into the content of the dialogue" (Fitzgerald and van Hooft 2000, p. 483). In general, the Socratic dialogue tries to reach a consensus among the participants (Fitzgerald and van Hooft 2000). Some, however, point out that such a consensus may not always be possible and should therefore not be an absolute necessity in a Socratic dialogue (see e.g. Birnbacher 1999, Steinkamp and Gordijn 2003).

Step 4: Deriving general rules and principles. The next phase involves abstracting to more general rules and principles and answering the original question (Birnbacher 1999). This is done by drawing on the findings within the context of the specific example. In our case example, one of the findings is assumed to be, that in this case the surrogate decision-maker's wishes should not have been followed since they were not in line with what was in the patient's best interest (given that the patient's wishes were unknown to healthcare professionals and husband alike). From this, the rule, that decisions should always be made in the patient's best interest rather than following the wishes of a surrogate decision-maker, can be abstracted. The underlying principle can be that of patient autonomy. Again, a consensus of the group on how to answer the general question - 'Should a patient's surrogate decision-maker's wishes always prevail?' – would be aimed at during the Socratic dialogue.

2.1.4. Key criteria to distinguish CESS and underlying conceptions of ethics

In the following the main criteria by which the presented models and methods of CESS differ will be discussed with regards to what they tell us about the underlying conceptions of ethics. Table 2 provides an overview of criteria that can be used to distinguish models and methods of CESS.

Table 2: Results of comparing models and methods in CESS and analysing criteria by which they differ

Method		Time resources						Aim & procedure													
		Point in Time		Frequency		Duration		Aim of Method				Starting point		Preferred result			Information gathering			Principles and policies	
		Retrospectively	Prospectively	On demand	Regularly	Up to 1.5 h per session	> 1.5 h per session	Decision for an ongoing case	Training in ethical deliberation	(Group) deliberation & analysis of a case	Character, attitudes & relationships	Moral uncertainty	Moral dilemma	Ethically justified decision	Clarity and understanding	Consensus	Group meetings	Individual meetings	Patient's medical record	Mainly to inform questions	Fixed normative framework
MCD	Dilemma method	0	2	1	2	2	2	2	2	2	2	1	2	2	2	1	2	0	0	2	0
	Socratic dialogue	2	0	0	2	1	2	0	2	2	2	2	1	0	2	1 2	2	0	0	2	0
CEC	Bioethics mediation	0	2	2	0	2	2	2	0	2	2	0	2	2	2	2	2	1	1	0	2
	CASES approach of facilitation	1	2	2	0	2	1	2	1	1	1	2	2	2	1	(2)	1	2	2	0	2
	Hub and Spokes Strategy	1	2	2	1 2	0 1 2	0 1 2	2	1	1?	2?	2	2	2	2	?	0 1 2	0 1 2	0 1 2	0?	2?
	Commitment model	0	2	2	0	0	2	2	0	2	1	2	2	1	2	1	1	2	0 1	1	0
	Moral expertise	0	2	2	0	0 1 2	0 1 2	2	0	1	0	1	2	2	1	0	1	2	2	0	2

Table 2 ***continued***

Method		Participants															
		Participants of the CESS process					Role of ethicist						Background of ethicist				
		Clinical ethicist/ facilitator	Healthcare professionals	Patients/ surrogate decision-maker	Others involved in the case	Others *not* involved in the case	Mediator	Facilitator – critical, no normative content	Facilitator – limited normative content	Patient advocate	"Moral expert"*	Makes normative recommendation	HCP[#] + specific training	HCP	Philosophy/ethics + specific training	Philosophy/ethics	Other
MCD	Dilemma method	2	2	(2)	2	0	0	2	0	0	0	0	2	0	2	0	1
	Socratic dialogue	2	2	1	2	0	0	2	0	0	0	0	2	0	2	0	1
CEC	Bioethics mediation	2	2	2	2	0	2	0	0	0	0	0	2	0	2	0	1
	CASES approach of facilitation	2	2	2	2	0	1	0	2	0	0	1	2	0	2	0	2?
	Hub and Spokes Strategy	2	2	2?	2?	1?	1?	0?	2?	0?	0?	0 1 2?	2	0	2	0	2
	Commitment model	2	2	2	2	2	0	2	2	2	0	0	2	2?	2	2?	2?
	Moral expertise	2	2	2	2	0	0	0	0	0	2	2	1	0	2	0 1	0

Number code: 0: no; 1: possible, but not in the focus; 2: “yes”; (2): ideally yes; 0/1/2: depends on implementation or unclear from reviewed literature; ?: unclear from literature. * "Moral expert" is used here to refer to an ethicist who is assumed to arrive at more accurate moral judgments than non-experts based on reasoning skills and knowledge of and experience with ethical arguments and theories. [#] HCP: healthcare professional.

The following literature was utilised for this table: Birnbacher 1999, 2012, Fitzgerald and van Hooft 2000, Ach and Runtenberg 2002, Steinkamp and Gordijn 2003, MacRae et al. 2005, Fox et al. 2007, Morgan and McDonald 2007, Molewijk et al. 2008a, 2008b, 2016, Archard 2011, ASBH 2011, Fiester 2011, 2014, Porz et al. 2011, Cowley 2012, van der Dam et al. 2013, Gordon 2014, Fournier et al. 2015, NCEHC 2015, Stolper et al. 2015, 2016, Vogelstein 2015, Fournier 2016, Iltis and Sheehan 2016, Rasmussen 2016, Rasoal et al. 2017, Robinson et al. 2017, Spronk et al. 2017

This list of criteria to describe models and methods of CESS is by no means exhaustive. However, the criteria were chosen to represent aspects where models and methods differed; aspects where no (major) differences were found were excluded from the table, such as the possible requester of a CESS which in most models and methods would be healthcare professionals as well as patients and families. The criteria reveal different aspects of the underlying conception of ethics of different models and methods of CESS and will be addressed one after the other in the following.

Time resources. The point in time when a CESS is requested or becomes active is telling in so far as using a CESS retrospectively can be understood as training the participants to be better equipped to handle future cases, indicating that ethical decision-making can be practised and improved. The same can be said about implementing regular meetings independent of acute cases that require a decision.

Focussing on cases retrospectively as opposed to addressing ongoing cases further suggests that there is a genuine plurality of ethical options, so that there is less of a necessity to make sure that a specific ethically correct decision is arrived at for ongoing cases. It might be enough to understand specific decisions afterwards and alleviate moral uncertainties by clarifying and understanding the different stakeholders' values and arguments. This, however, does not exclude the possibility of realising that a decision has not been ethically acceptable to the participants in a certain case (e.g. if it was made for practical instead of ethical reasons).

Aim & procedure. The criteria representing aims and procedures of the methods and models indicate assumptions about what is understood as ethics by the different approaches. Aiming at a training of the participants in ethical deliberation highlights an understanding of ethics that assumes that healthcare professionals can be enabled to perform ethical deliberation and can, on the long run, be empowered to be less dependent on a CESS. Aiming at developing character, attitudes and relationships of participants similarly emphasises the importance (and possibility) of training the individual healthcare professionals as opposed to relying on an ethicist to solve their moral challenges. Taking relationships into account further underlines the importance of social context for a decision to be ethical or at least desirable. An account

of ethics that understands the morally correct thing to do as universal and independent of the particular individuals involved would put less emphasise on context and relationships.

Whether or not a method assumes that there are genuine moral dilemmas (or synonymously ethical dilemmas) also relies on what is defined as such. Morgan and McDonald give a definition of what constitutes a moral dilemma:

> "A moral dilemma, in a strict sense, is a conflict between responsibilities or obligations of exactly equal moral weight. In a wider sense, moral dilemmas occur when there are competing responsibilities with no obvious way to prioritize one responsibility over others." (Morgan and McDonald 2007, p. 165).

The methods in CESS differ with regards to whether or not they assume the possibility of genuine dilemmas with no ethically right or wrong decision or whether all dilemmas can ultimately be solved by somehow prioritising the right responsibilities, values, principles etc. Some methods are more precise than others as to what they understand as a moral dilemma. Bioethics mediation, for example, strongly emphasises the existence of genuine moral dilemmas (Fiester 2011, 2014), whereas relying on the clinical ethicist as a moral expert suggests that such a moral expert would be able to identify which responsibilities or values should be prioritised (see also Fig. 1).

Aiming at a decision for an ongoing case either represents an understanding of ethics as resulting in one of many possible ethical solutions or in *the* one correct decision.

The information gathering process differed mostly between meetings with individual stakeholders such as patients and physicians, and group meetings with all involved stakeholders. Individual meetings were sometimes, e.g. in the *Commitment model*, seen as beneficial to enable especially patients to speak openly (Fournier et al. 2015) whereas in other approaches such as the dilemma method, the information gathering process as part of the group deliberation is an integral aspect of arriving at moral wisdom through communication (Porz et al. 2011). All presented methods, however, agree on considering different perspectives, which illustrates that they understand the emergence of an ethical challenge as contextual.

When a consultation of the patient's medical record by the ethicist is not required this results in more responsibility on the side of the participants as opposed to the ethicist. Factual information can still play a role but is then shared by the participants. In cases where the ethicists have more decisional authority, they are also more likely to directly consult the patient's medical record.

The role of principles and guidelines clearly points towards different understandings of ethics. As Ach and Runtenberg (2002) put it, the difference lies in whether frameworks are merely applied or are subject to critique themselves. Whereas those methods embracing the use of pre-existing principles and norms seem to assume that there is an applicable ethical framework independent of the individuals in a case, those that do not embrace a pre-given framework see the ethical problem as well as the solution as developed within the respective individual context.

Using principles, guidelines, previous cases and the like (what is called "ethics knowledge" in the *CASES* approach of facilitation) requires a justification for what exactly to include and consider. In any case, the application of principles and guidelines to find what is generally ethically acceptable does not mean that one cannot encounter moral dilemmas since frameworks can lack the precise way in which to prioritise principles, norms or values. Fig. 1 depicts the role of principles and norms in finding an ethical solution. Assuming the problem has an ethical dimension (and is not, for example, a purely legal or medical question that is better addressed by different means), principles, guidelines and norms are applied in methods such as the *CASES* approach, bioethics mediation and moral expertise to further characterise the problem and assess whether it comprises a genuine ethical dilemma which affects how the problem is handled by the respective method. Moral case deliberation, however, does not use pre-given frameworks to characterise the problem but directly moves into the facilitation of a group deliberation.

Participants. Methods of CESS differ in who they include in the process and how. Most methods consider different stakeholders of a case such as healthcare professionals, patients and family and others that are involved. The *Commitment model* includes lay people in a case conference and by that aims at incorporating the perspective of the society into ethical

decision-making (Fournier et al. 2015). This political dimension is not required for methods that understand an ethical solution as being highly contextual, such as moral case deliberation, where the perspective of those involved matters more than that of outsiders.

Of course, there is also a difference in whether participants are merely included to share their perspective as part of the information gathering process or whether they are actively participating in the decision-making or solution-forging process. The latter reflects an understanding of ethics as a social endeavour. This is linked to the role of the ethicist.

In the two extremes the ethicist is either a mere facilitator without offering content related input (such as in moral case deliberation) or a moral expert that arrives at the ethically correct solution after considering all aspects of a case. As discussed in section 2.1.2.4 this approach seems less common nowadays but can still be implicitly present in single-action recommendations that can be part of, among others, the *CASES* approach of facilitation. It also serves as a contrast to the more nuanced interpretations of the role of the ethicist in the other approaches.

The mediator provides no input as to which option of multiple ethically acceptable ones the participants should choose. They, however, assess whether options are within what is generally ethically acceptable (based on, for example, widely accepted principles) (see e.g. Fiester 2014). In this way they are only neutral towards potential options when a genuine moral dilemma is identified. The role of the ethicist as a mediator rests on ethical pluralism as the background for decisions to be made. The consensus of those involved defines what a ‘good’ solution is.

The understanding of the facilitator as the *Socratic midwife* in MCD includes varies skills related to guiding the participants as well as knowledge of the clinical background and ethical theories and principles (Stolper et al. 2016). However, the aim of moral case deliberation is not to apply principles or ethical theories onto a case and walk away with a solution but to explore the ethical challenge from within and generate ethical wisdom through practical experience and dialogue (Stolper et al. 2016). The distinctiveness of moral case deliberation lies in the importance that those actually experiencing the ethical challenge are the ones developing the answer to it:

> "In moral deliberation the practitioners are seen as the experts of their own professional world, they are supposed to develop the answers to their moral questions in interaction with each other." (Porz et al. 2011, pp. 356–357).

A different understanding of the facilitator can be found, for example, in the *CASES* approach of facilitation; the facilitator that provides limited normative content and that applies pre-given frameworks onto a case in order to assess ethically acceptable options. With regards to the latter they act similar to a mediator. However, mediation is seen as only one of different communication techniques in the *CASES* model of facilitation that employs this type of facilitator (ASBH 2011, NCEHC 2015). The difference between a mediator as understood in bioethics mediation and the facilitator of the *CASES* approach seems to lie less in the conception of the ethicist's attitude which in both cases is understood as being neutral and refraining from imposing personal values, but in the starting point, the procedure of the consultation and the practical implementation. Fig. 1 highlights the starting point, the problem, as the difference between *CASES* facilitation and bioethics mediation. Bioethics mediation starts off with genuine moral dilemmas, which are only one possible starting point in the *CASES* approach of facilitation. Which principles and norms are viewed as generally accepted and are therefore applied to an ethical problem can, of course, differ depending on the respective implementation of the method. Identifying a single decision-maker (*CASES*) as opposed to finding a consensus in a group (mediation) is another difference between the two methods.

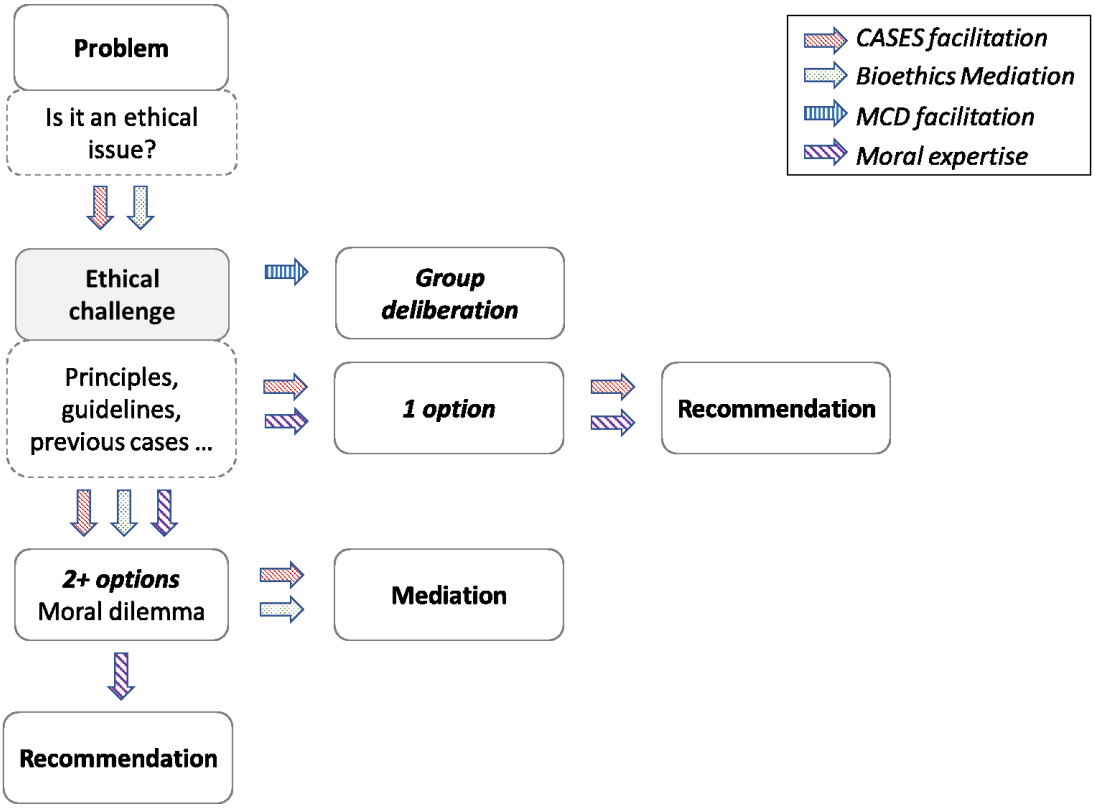

Fig. 1: Model of *CASES* facilitation, bioethics mediation, MCD facilitation and moral expertise contrasted

Conceptualising role of the clinical ethics consultant as a moral expert who is able to arrive at the morally right thing to do in a given case, relies on the assumptions that there is one correct answer, one moral truth, that can be identified with the expertise the consultant possesses (which, for example, can be reasoning skills and knowledge of ethical theories). The concept of ethical and moral expertise is highly debated (see e.g. Archard 2011, Birnbacher 2012, Cowley 2012, Gordon 2014, Vogelstein 2015, Iltis and Sheehan 2016, Rasmussen 2016 and others). Fully capturing the discussion goes beyond the scope of this thesis, however, a brief account of the debate shall be given in the following.

One problem that the debate on whether or not moral expertise exists, suffers from is the lack of a shared meaning of the concept. According to Vogelstein (2015) ethical expertise can be understood as the skill of moral reasoning and the knowledge of moral arguments (on bioethical issues) and moral (bioethics) concepts. Vogelstein further explains the "standard

argument" (Vogelstein 2015, p. 325) for ethical expertise of bioethicists and argues that bioethicists due to their skills and knowledge are more likely to arrive at a well-reasoned view on bioethical matters than non-bioethicists (though the latter are not necessarily excluded from possessing ethical expertise, but they are less likely to have it) (Vogelstein 2015). And since "positions that are supported by the best reasons and arguments are more likely to be true than those that are not, the bioethics expert is at a significant advantage when it comes to arriving at the truth on such issues" (Vogelstein 2015, p. 326). He refers to experts in bioethics as “moral experts” (Vogelstein 2015, p. 324). This can be understood as a Neo-Kantian approach to ethics which "holds that reason both contains and confers access to truth. Truth however is thought to exist timelessly before, and independently of, experience" (Steinkamp and Gordijn 2003, p. 243).

However, the link between reasoning skills and knowledge of ethical theories and arriving at the morally right thing to do is far from certain “partly because in meta-ethics both the nature of ethics and the existence of standards in ethics are contested” (Iltis and Sheehan 2016, p. 421). Even if ethicists are more skilled when it comes to reasoning and providing a coherent justification for their positions, their positions are not necessarily any closer to the truth than those of non-ethicists, because the premises they rely on can still be wrong, as Birnbacher (2012) points out:

> “*Ethical* expertise must not be mistaken for *moral* expertise. Ethical expertise concerns the correctness of which judgements follow from what premises but not the correctness of these judgements absolutely.” (Birnbacher 2012, p. 242).

Iltis and Sheehan (2016) further point out that, even if one accepts that experts in moral philosophy are moral experts who are more likely to arrive at the moral truth, it still remains questionable whether clinical ethicists are moral experts in this sense because many of them are not experts in moral philosophy. The survey among North American hospitals by Fox and colleagues supports that claim by showing that only "5% of ethics consultation providers had completed a fellowship or graduate degree program in bioethics, 41% had learned to perform

ethics consultation with formal, direct supervision by an experienced member of an ECS, and 45% had learned independently, without formal, direct supervision by an experienced member of an ECS" (Fox et al. 2007, p. 17).

The required professional background of the ethicist is another criterion where models and methods of CESS differ and it is strongly linked to the understanding of their role. All methods of CESS presented here, require some kind of training of the ethicist, an understanding of the clinical setting and the knowledge of how to conduct the respective method of CESS. The exact nature of the required background of the ethicist depends strongly on the ethicist's role and can include healthcare professionals with additional training in how to facilitate, mediate or arrive at ethically sound conclusions, as well as philosophers or other professions that work in the clinical setting such as social workers (see, for example, the *Hub and Spokes Strategy*, 2.1.2.3). The fact that all methods require some level of additional expertise at least about the respective approach, highlights that they all have a procedural understanding of ethics; they rely (more or less strictly) on their advocated procedure to arrive at an ethical solution.

Taken together the main differences with regards to the underlying conceptions of ethics in different models and methods of CESS are the understanding of moral truth as either singular or pluralistic, the role of guidelines, norms and rules, and the different means with which to identify the morally right thing to do which range from reasoning by an (external) ethicist, over forging a consensus of outcome, facilitating an individual's or a group decision, to group deliberation of those involved in a concrete case.

2.2. Conclusion of philosophical analysis

The description and analysis of different models and methods of CESS in human medicine has shown that different approaches to the aim of improving patient care by providing a means to handle ethical challenges are possible and that these approaches differ in their practical implementation as well as their underlying conceptions of ethics which is reflected in their understanding of the role of the ethicist and the advised way of reaching an ethical solution.

The assumptions about what constitutes a good way to find an ethical solution do not only shape the implementation of a CESS but are also vital in developing a way to evaluate the effectiveness of such a service (see e.g. Schildmann et al. 2013). This is strongly related to the goal the CESS tries to reach. Fournier (2016) concludes that all CESS in order to be successful need to ultimately aim at improving patient care and that the context is a deciding factor in which model or method gets employed to achieve this goal.

I argue that the methods cannot be seen as equals because the underlying differences in their understanding of ethics are too important to be overlooked. Given the dependency of some approaches on pre-given frameworks and the reliance of others on deliberations of those involved in a case it seems unlikely that they would all reach the same decision for a specific case. A choice between the methods should therefore not be based purely on contextual factors such as convenience or time available but always consider the conception of ethics that it is based upon and assess whether that is in line with what is aimed for. In any case, a CESS should be aware of and transparent about its assumptions and premises and not leave these unquestioned.

In the second part of this thesis, ideas of how to utilise a clinical ethics support service in a small animal hospital will be developed based on existing literature on veterinary CESS and an empirical study that revealed problems and aims of veterinarians in decisions for ongoing cases. The potential of different models and methods of CESS to address these problems and their related aims are discussed before the work concludes with argumentation for which of the presented models or methods appears preferable for a small animal hospital.

3. Ideas of utilization | What is the potential that different models and methods of CESS have for addressing ethical challenges in the small animal hospital setting?

3.1. Clinical ethics support services in veterinary medicine

In the following I will present current ways in which clinical ethics support services are utilised in veterinary medicine and, in the next step, identify potentials for a CESS in a small animal hospital based on an observational study that focused on challenges in decision-making processes in the veterinary hospital.

To date the number of clinical ethics support services in veterinary medicine that have been published about is rather small. However, the need for ways of dealing with ethical challenges that arise in veterinary care on a regular basis and are increased in complexity by technological advances (Batchelor and McKeegan 2012, Kipperman et al. 2018, Springer et al. 2019b), can be expected to rather increase making also clinical ethics support services an option that will most likely gain relevance in the future.

The tertiary care veterinary hospital at the North Carolina State University has presented their implementation of a CESS in form of an ethics committee that provides ethics consultations to healthcare staff and advice to the management with regards to policy reviews and developments (Rosoff et al. 2018, Adin et al. 2019).

Rosoff and colleagues describe their CEC to be based on the common characteristics of its counterpart from human medicine which they identify as having an “advisory” (Rosoff et al. 2018, p. 48) role with no decision-making power, as providing recommendations based on “carefully reasoned arguments often citing published literature, relevant statutes and case law, and the like” (Rosoff et al. 2018, p. 48) and as aiming at a consensus within the committee whose recommendations should therefore seem “valid and fair” (Rosoff et al. 2018, p. 48) to all parties. According to Rosoff and colleagues one of the major functions of clinical ethics committees is to “facilitate communication and discussions, in that they can help relieve the tension between conflicting values and ideals, or simply assist to clarify who should make certain medical decisions for a loved one” (Rosoff et al. 2018, p. 48).

They refer to the *CASES* approach of facilitation as an important approach used in human medical care and furthermore cite the core competencies for healthcare ethics consultation published by the ASBH as learning goals for their committee's members (ASBH 2011, NCEHC 2015, Adin et al. 2019).

The committee in at the North Carolina State University consists of various different veterinary healthcare professionals as well as community members without a background in veterinary medicine (Rosoff et al. 2018). The initial training of the committee members comprised self-study of veterinary and medical ethics literature with subsequent discussion, example case discussions and support from the first author, the Director of the Clinical Ethics Program at Duke University Hospital (Rosoff et al. 2018, Adin et al. 2019).

They acknowledge the challenge that it "may be virtually impossible to set a universal set of standards by which normative judgments of veterinary clinical ethics can be made beyond the minimums required by law and the professional ethical duties of veterinarians as licensed professionals within states" (Rosoff et al. 2018, p. 49). As guiding factors for their recommendations, they cite "animal welfare, futility of treatment, and use of limited resources while maintaining a devotion to considering any number of culturally sensitive factors that might impact the options that could reasonably be put forward to the stake holders in the case" (Rosoff et al. 2018, p. 50). They further mention an adjusted principlism as a possibility and emphasise that financial constraints are taken into account in their choice of acceptable options as well (Rosoff et al. 2018, Adin et al. 2019).

Consultations in this setup can be requested via email or phone to the CEC coordinator, a social worker, by "any faculty member, hospital staff member, or fourth-year (veterinary) student" (Rosoff et al. 2018, p. 49) and "are performed within 24 hours of a request, and urgent consultations within 4 hours" (Rosoff et al. 2018, p. 49). They report to have provided eight consultations within eight months and describe the implementation as an "initial success" (Adin et al. 2019, p. 57).

In response to Rosoff and colleagues' article, Moses (2018) shared insights from her own experience as an ethics consultant. Moses is a practising veterinarian and "fellowship trained at Harvard's Center for Bioethics and currently an affiliated scholar both at Harvard and with

Yale's Interdisciplinary Center for Bioethics" (Moses 2018). In her response, she points to challenges associated with providing ethics consultations, such as a lack of awareness of ethical aspects and short hospital stays, but she does not provide insights into which methods or models she uses other than that she offers consultations as a lone ethicist in veterinary hospitals as well as animal shelters, zoos and animal welfare organisations (Moses 2018).

The Equine Hospital Ethics Working Group at the University of Veterinary Medicine, Vienna, is another example of a veterinary CESS that has been published about (Springer et al. 2018). The group consists of an ethicist, veterinarians and animal caretakers who meet on request when a challenging case requires a decision (Springer et al. 2018). The ethicist acts as a neutral facilitator that supports the participants in the process of analysing a case and finding ethical solutions for it (Springer et al. 2018). The authors presenting the Ethics Working Group describe their approach as on the one hand being close to the facilitation model described by the ASBH and as on the other hand comprising elements of moral case deliberation (Springer et al. 2018).

Next to the small number of veterinary CESS that have been published about, one can assume that there are more that may be less structured and less institutionalised, or that have simply not been published about. In addition to that, discussing with veterinary colleagues (without a professional ethics background or substantial training in ethics) is a common way to seek support for challenging cases as was shown for US and Austrian veterinarians (Moses et al. 2018, Springer et al. 2019a).

3.2. Observational study in a small animal hospital

3.2.1. Introduction to observational study

In order to apply the findings of the theoretical analysis of CESS in human medicine to the context of veterinary medicine in a small animal hospital, it was important to regard the unique challenges associated with this setting.

Even though veterinary medicine and human medicine have a lot in common, veterinary medicine comes with its own unique sets of complications that further differ for different

veterinary professional branches from, for example, veterinarians in a small animal hospital to large animal veterinarians working in a farming setting. Two influential differences, that set veterinary medicine apart from human medicine, are the triangular relationship between patient, veterinarian and owner, and the varying relationships between patient owners and their animals, that can influence the former's willingness to agree to treatments (e.g. Yeates 2013, chaps. 1.1-1.2, Kimera and Mlangwa 2016, Rosoff et al. 2018).

These differences hinder the direct transfer of models and methods of clinical ethics support services from human medicine, as presented in the previous part of the thesis, to veterinary medicine. One of the limitations is the inclusion of the patient into meetings during the course of a CESS in veterinary medicine. The patient may be present as a reminder of their needs but the animal patient will not take part in a discussion. In veterinary medicine the perspective of the patient will therefore always be shared by a proxy during discussions. Similar situations can, of course, occur in human medicine when the patient is unconscious or otherwise unable to communicate wishes and has not previously shared their preferences with regards to treatments. Whereas the prevalence of cases like that can be addressed to some extent by measures such as advance directives in human medicine, the problem results from a structural feature of veterinary medicine and can therefore not be avoided.

To gain insights into the complexity of veterinary decision-making an observational study with a passive participant observer was conducted during morning and midday meetings in which veterinarians presented and discussed ongoing cases as part of their clinical routine. The goal of the observational study was to identify the potential for clinical ethics support services in veterinary medicine by observing how decisions are made in the clinical routine, which challenges veterinarians face in relation to cases and decisions and how they discuss and reflect upon these challenges during case discussions. The two research questions of the observational study were:

1. Which issues are discussed as challenges in relation to cases or decisions and in relation to the interaction with each other during the case discussions?

2. Which problems become apparent through the observation and reflective analysis of form and content of the case discussions and are not openly discussed by the participants?

The answers to these questions were expected to be useful in identifying the potential for CESS in the small animal hospital context.

3.2.1.1. Participant observational study

Observational studies are part of empirical, qualitative social research. They can be categorized mainly based on five different criteria which are the participation of the observer, whether the observation is overt (with those observed knowing about it) or covert, whether someone else or the observer is being observed, whether the observation takes place in a natural setting or in a laboratory experiment and to which degree the observation is structured (Schnell et al. 2013, chap. 7.2.1., Diekmann 2016, chap. 4).

In the case of a participant observational study, the observer is part of the social situation. The degree of interaction can vary widely from passively observing as a visitor to inhabiting an active role such as a child care worker in a kindergarten (Diekmann 2016, p. 564). In the study presented here, the observer was present as a guest who visibly took notes but remained passive in the discussions, in order to limit the influence on the interactions. The method used in the study presented here therefore classifies as an overt observation by a passive participant observer in a natural social situation.

Participant observation as a method of data collection is mostly used to research an unknown (sub)culture by observing its members in their natural environment (Lamnek and Krell 2016, chap. 11). It attaches great importance to the social factor in constituting the reality of those observed (Lamnek and Krell 2016, chap. 11). This method is often used when the fields of interest are otherwise hard to enter into or where something yet unknown is to be researched (Schnell et al. 2013, chap. 7.2.6, Lamnek and Krell 2016, chap. 11).

The degree of structuration of the observation can vary from completely unstructured to using an observation guide to having a highly structured observation scheme with precise categories into which each observed event is classified (Diekmann 2016, pp. 569–575). However, the latter is rather uncommon in participant observation since it is very intense during the observation and requires knowledge about what is going to be observed as well as pre-tests of the categorisation system so as to be able to predefine categories accounting for every observed behaviour or event (Schnell et al. 2013, chap. 7.2.2, Diekmann 2016, chap. 5). In

addition to that, notes are mostly taken retrospectively in participant observation which makes an accurate categorisation difficult (Diekmann 2016, pp. 570–571). In the case of the study presented here, a semi-structured approach was chosen using a question catalogue of 17 questions to guide and focus the observation of the meetings on aspects relevant to answer the two research questions.

3.2.1.2. Why an observational study?

The exploratory observational study was conducted as an overt, semi-structured observation by a passive participant observer in a natural social situation. Observing the discussions as opposed to interviewing participants has the advantage of going beyond challenges the veterinarians are aware of or willing to discuss with each other or an interviewer. Observational studies can be expected to be more valid than interviews under certain circumstances (Diekmann 2016, chap. 5, pp. 572–575). Furthermore, choosing a different approach such as interviews with the veterinarians would have come with a different challenge: the potential lack of awareness of ethical dimensions of problems they face in the clinical routine. Moses reports, based on her experience as an ethics consultant and veterinarian in the USA, that many moral challenges in veterinary practice are not identified as such by the veterinarians:

> "Since starting to perform ethics consultation in the past few years and giving frequent workshops in navigating ethical dilemmas in veterinary practice, I've come to understand that an obstacle to the widespread acceptance of ethical consultation in veterinary medicine is a deep lack of ethical literacy in my profession." (Moses 2018, p. 68).

Moses (2018) continues to give reasons for this lack of awareness of ethical dimensions in clinical challenges by pointing out that many veterinarians (in the US) do not receive any education in how to resolve interprofessional or interpersonal conflicts with ethical dimensions.

Observing the discussions as opposed to directly asking the participants was therefore expected to render a more comprehensive picture of the challenges associated with clinical decision-making and veterinary routine in a small animal hospital.

Besides, since the veterinarians in the small animal hospital are not yet in contact with clinical ethics support services, asking them how they assess the usefulness of CESS in their clinical contexts would have provided only limited insights into the potential of CESS in small animal hospitals.

In addition to the above-mentioned reasons arguing for an observational study, other approaches such as interviews or questionnaires would have also been more time-consuming in preparation and analysis and because of that gone beyond the scope of this thesis. It was possible to conduct the observational study at the small animal clinic of the Veterinary University, Vienna, due to being located on the same campus, which further decreased the barrier to conducting the study. Other methods of data collection such as interviews or questionnaires would be useful as a future next step to further investigate the findings from the presented study.

3.2.2. Materials and methods

The observational study was conducted as an overt, semi-structured observation by a passive participant observer in a natural social situation. The observer was present as a visitor during morning and midday meetings of veterinarians in the Division of Small Animal Internal Medicine at the University of Veterinary Medicine, Vienna, on five successive days. The aim of the study was to observe the decision-making process in the clinical routine and gain insights into which challenges veterinarians face in handling cases and decisions in this setting.

3.2.2.1. Role of the observer and mode of documentation

The observer was present in the meetings as a silent, passive participant who was sitting at the side, did not take part in the discussion and was visibly taking notes during the sessions. The interaction with the participants was reduced to politeness such as greeting, saying goodbye and answering (rare) questions or comments directed at the observer. No further conversations were initiated by the observer to limit the influence on the participants.

The observer used pen and paper to take notes during the meetings as well as afterwards when answering the 17 questions for each session. Notes were taken in German. No additional video or audio recording took place.

The notes of the morning sessions were transferred into a digital format before the midday session and were, with indications, further complemented from memory (except for the morning meeting on the third day, where the notes were digitalized in the evening of the same day).

During the first and the fourth morning meeting a second observer was present and took notes. Directly after these sessions the observations were compared and discussed and first ideas and thoughts with regards to the main questions were shared.

3.2.2.2. Setting of observation

The study took place in the morning and midday meetings of veterinarians in the Division of Small Animal Internal Medicine at the University of Veterinary Medicine, Vienna, on five successive days in December 2019. All meetings were conducted in German.

The morning meetings were scheduled from 8:00 am to 9:00 am, with the exception of day 2 and day 4 where they were scheduled for 8:00 am to 8:30 am due to subsequent appointments (on these days the meetings are sometimes continued afterwards). The meetings took place approximately from 8:00 am to 8:30 am with a diversion of not more than four minutes. On one day the meeting took until 8:54 am (day 3). The main focus of the meeting was to brief all participants on the current in-patient cases and on planned steps for the day, as well as to distribute any new cases that may have arrived during the night. The meetings were held in a conference room with a conference table in the middle and additional chairs along the walls of the room (see room layout, Fig. 2A). The observer was seated on one of the chairs along the back of the room where all participants were visible but not all faces could be observed (see Fig. 2A).

The midday meetings were scheduled to begin at 12 pm (noon) with either an open end or a restriction due to subsequent appointments. The meetings actually started between 12:19 and 12:42 pm and took between 59 min and 2 h 20 min. The focus of these meetings was the

detailed discussion of in-patient cases and the planning and discussion of further steps in the diagnosis and treatment of these patients, as part of the clinical routine and the training of the participants by a Senior Clinician (European and/or American Board Certified Specialist). The midday meetings took place in a recreational and office room in the clinic (see layout, Fig. 2B). The observer was sitting near the door in front of a shelf partially shielded from sight by a sofa chair, however, still visible to the participants (see Layout, Fig. 2B).

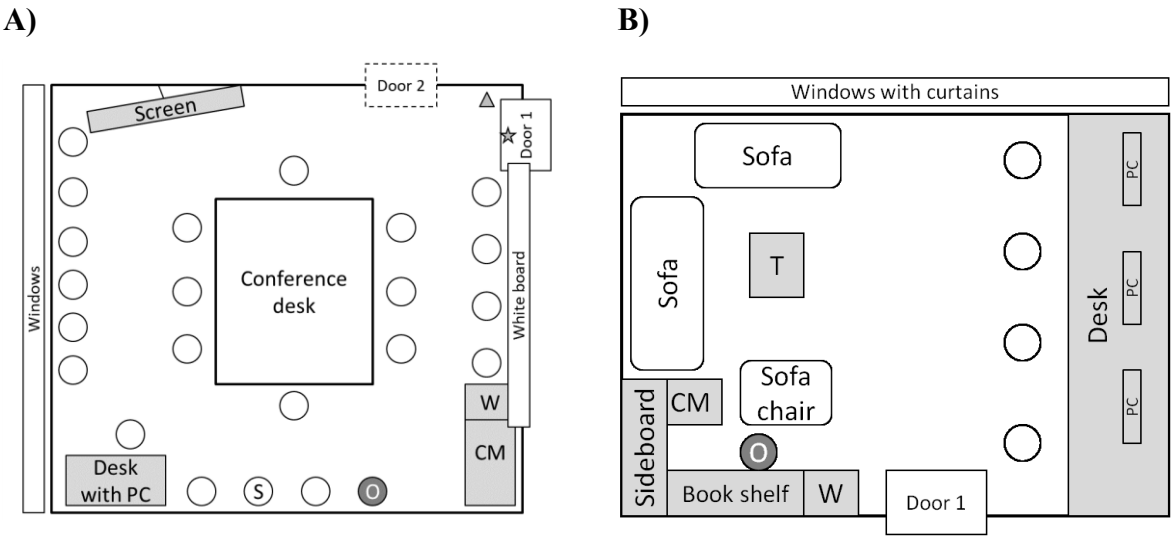

Fig. 2: A) Morning meeting room. B) Midday meeting room.
Circle: Seat. O: Observer. S: Second observer. Triangle: Coat hanger. Star: Clock above door. T: Table. CM: Coffee machine. W: Water fountain. Door 1: Entrance/exit. Door 2: Door to office, not used as general entrance/exit.

3.2.2.3. Participants

Recruitment of participants was based on who was attending the meetings that were observed on that day. The meetings are generally chaired by a Senior Clinician, who is always a European and/or American Board Certified Specialist. The other participants had differing positions within the professional hierarchy with some of them being students (during the morning meetings), interns, residents, scientific personnel and/or in leading positions.

Approval and consent for the observation was attained from the Senior Clinician who was present during all observations. The individual participants were not further informed by the observer about the study in order to limit the influence on their interactions and behaviour. When one of the participants directly asked the observer about the observational study before

a meeting, she replied by saying that she was interested in interaction processes and how decisions are made during the meetings.

Numbers and compositions of participants changed throughout and between the meetings. Some participants attended all morning meetings, mostly those that sat at the main table (see layout, Fig. 2A). The observation was focused on these participants. The number of people attending morning meetings differed between 12 and 20, with people coming and leaving during the meetings (see Table 3). The midday meetings were smaller than the morning meetings and did not include students. The composition changed between days with some participants attending all meetings. The number of people attending midday meetings ranged from 2 to 10 which also changed during the meetings because people joined or left (see Table 3).

Table 3: Numbers of participants at the beginning of each meeting, including maximum and minimum numbers during the sessions.

	Meeting ID	Total (at beginning)	Female	Male	Max	Min	Observer (female)
Morning	MOV-01	13	7	6	15	13	2
	MOV-02	18	15	3	19	17	1
	MOV-03	17	13	4	20	16	1
	MOV-04	14	10	4	15	12	2
	MOV-05	16	9	7	16	16	1
Midday	MIV-01	6	4	2	7	3	1
	MIV-02	9	7	2	10	5	1
	MIV-03	5	3	2	7	4	1
	MIV-04	6	4	2	7	4	1
	MIV-05	5	3	2	8	2	1

3.2.2.4. Structure of observation

The observation was continuous for the duration of the attended meetings and guided by a guideline with 17 questions (attached in appendix). Notes were taken during the meeting and the 17 questions were answered subsequently on the same day and before the next meeting based on memory and notes.

The questions were broadly divided into two categories focussing either on the content and decision-making processes (Q2-Q11) or on the interaction style and form of the discussion (Q12-Q17).

The two main questions that most directly addressed the research questions of this study were questions Q4 and Q5:

(Q4) Which issues are mentioned as problems in relation to cases or decisions?

(Q5) Which additional problems or issues seem apparent without being discussed openly or explicitly?

During the observation, remarks of participants that had a negative connotation in relation to cases or case decisions, and issues that were obviously hindering the participant in achieving something they explicitly or implicitly seem to aim for, were understood and recorded as problems. This categorisation was done intuitively by the observer and, next to focusing on the content of comments, also based on facial expressions or tone of voice of the respective participant. Medical information on cases was only noted down on a basic level or where relevant to problems (also due to a lack of veterinary medical background of the observer) and names of patients were avoided to ensure confidentiality.

The rest of the set of questions (Q2-Q11) that focused on the content of the discussions during the meetings was concerned with how cases were presented, whether and how decisions were made, whether all participants were asked to and/or voiced their opinions, how opinions were justified and whether and how the perspective of the patient owner appeared in the discussion.

The set of questions focussing on the interaction style addressed how much participants interrupted each other, at which volume they spoke, what mood they seemed to be in, what the general atmosphere was like, and by whom (if at all) the discussions were guided.

These questions were complemented by notes on the course and rough contents of the discussions, the setting, the room, perceived air quality and temperature, as well as on interruptions during the meetings such as people entering and/or leaving the room or phones ringing.

3.2.2.5. Data analysis

In a first step, in order to produce an overview of how decisions were made during the meetings, the answers to a subset of questions (Q2-Q3, Q6-Q17) were analysed for midday and morning meetings separately. A brief description of the decision-making processes during the sessions, focussing on aspects relevant for the research questions, is presented in the section of descriptive results (3.2.3.1).

The answers to questions Q4 and Q5 were analysed together for morning and midday meetings, but separately for each question, since they resulted from different degrees of interpretation, with answers to Q4 being close to what was voiced by the participants of the meetings and answers to Q5 being subject to a higher degree of interpretation (such as interpreting frequent phone calls as a problematic interruption of the meeting). The notes taken after each session when answering the question catalogue were used as the main material. They were further complemented by going through the notes taken during the sessions to check if problematic issues had been missed. The resulting problems that related to the decision-making process, either verbalised by the participants (Q4) or interpreted from the observation (Q5), were clustered into categories. In a next step, these categories were further grouped and then merged for both the problems that were verbalised and those that were inferred from the observation to a final list of problem areas (see 3.2.3.2).

In a second analytical step, different aims of the participants that were not explicitly mentioned during the discussions, were reconstructed from the problem areas and analysed in relation to the different stakeholders in a veterinary clinical setting (see 3.2.3.3).

3.2.3. Results

3.2.3.1. Descriptive results: decision-making during the meetings

Description of morning meetings. In the morning meetings the attendants presented the cases that they had been or were responsible for. The cases were presented in a highly structured way, starting with the patient's name, animal type, age, neutering status and other basic information before the clinical status of the patient (its appearance, food consumption, defecation etc.) and its medical history were presented in detail including test results,

diagnostic findings, the current treatment, questions or uncertainties related to diagnosis and treatment and plans for how to proceed with the patient. The other attendants listened to the case presentation, asked questions for clarification and/or commented on the cases or questions asked by the case presenter.

The number of cases presented per meeting differed. The presenters often spoke fast and a lot of information was shared in a short time. Occasionally blood parameters and test results were shown on the screen on the wall. At the end of each meeting the cases were redistributed to the individual veterinarians who took over the responsibility for the case until the next day.

Description of midday meetings. In the midday meetings the attendants presented their cases in detail and discussed results and diagnostic findings, open questions, uncertainties and how to proceed. The presentation followed a similar pattern as in the morning meetings, starting (in most cases) with the name of the patient and basic information before going into details. The discussion of the case took place mainly between the case presenter and the Senior Clinician whose presence marked the start and ending of the meetings. The Senior Clinician commented on suggestions that were made by the case presenter, gave background information, asked questions for clarification or for additional information as well as on medical knowledge.

The other attendants listened, joined in the discussion or were typing and clicking at one of the computers. The attention given to cases by the other attendants seemed to differ based on, among other factors, their level of stress and distraction, e.g. by phone calls or people entering and talking to them, and the duration of the meeting.

Compared to the morning meetings, the midday meetings were longer and the cases were discussed in depth as opposed to being presented and briefly commented on.

Decision-making processes. Decision-making was mostly a part of the midday meetings, where cases were presented and discussed in detail. The discussion took place mainly between the case presenter and the Senior Clinician. Other participants were able to join in a discussion and often did (sometimes also just by nodding), however, their opinions were not explicitly requested and not all participants were actively contributing to the discussion or the decision. The decision about how to proceed with the treatment was based on the presented

plan which was adjusted throughout the discussion. Often the Senior Clinician summarised the plan towards the end of the discussion and the case presenter signalled their agreement. Sometimes decisions were made by the owner (for example, to limit treatment), sometimes different options to present to the owner were agreed upon.

In the morning meetings cases and respective treatment plans were presented. However, decisions were not explicitly discussed but were implicit in the plan that was presented. The plans were often agreed to by the other participants verbally, by nodding or by staying silent. The Senior Clinician's final approval was given before the next case was presented.

Sometimes participants talked to each other in parallel to the main discussion but case discussions seemed to end during the meeting once a decision/ plan was agreed upon. Conversations about the cases were observed to continue when the meeting ended or before it had started, indicating that there may have been additional aspects about a case that the veterinarians felt a need to express.

Interaction style and form of discussion. In general, the attitude towards each other was relaxed, interested and polite to friendly. There were a few cases when a tension between participants seemed to occur. During one of those, one of the veterinarians seemed to disagree with the current and planned treatment of a patient and the veterinarian's suggestions was brushed off with a slightly ironic and dismissive comment. At other times there was some mild tension between participants when one of them was asked something and was not given the chance to think and answer to show their knowledge (midday meeting 4, MIV-04). In another case the same person reacted slightly defensively when their previous treatment attempt was mentioned as having failed (MIV-02). The latter two examples seem related to the general theme of feeling the need to justify one's decisions as well as to present oneself as competent and knowledgeable. For a more detailed discussion of this motif please note the result section below, presenting the identified problem areas (3.2.3.2).

The time spent on a particular case differed between cases.

In general, the volume at which was spoken was normal to low. Very rarely an increase in the volume was noted. This happened mostly when participants briefly started to talk in parallel or a joke had been made. The morning meetings were generally quiet and calm.

Occasionally participants started to speak parallel to each other, mostly but not exclusively during the midday meetings.

A quantifiable recording of interruptions was not performed. However, it seemed that hierarchically higher participants interrupted others more often, sometimes with questions about the case, sometimes unrelated to the case.

3.2.3.2. Problem areas related to cases and decisions

To answer the research questions of the study, that were asking for problems associated with cases and decision-making either discussed by the participants or inferred from the observation, problem areas were identified based on the observations. These were the owner, other medical disciplines, units or veterinarians, medical uncertainty and equivocality, the necessity of justifications, the necessity to appear competent, a lack of medical possibilities, the patient's perspective, structural aspects of clinical routine and breed-specific problems (also listed in Table 4).

Owner. Several factors related to patient owners were mentioned explicitly. One of these were the relationships and interactions with owners. Meeting some owners was ironically described as a pleasure, indicating that it was actually experienced as the opposite (morning meeting 3, MOV-03). Other owners, however, were described as "very, very nice", indicating overall that the evaluation of the interaction with owners or of the owners themselves was of relevance to the veterinarians. A conversation with an owner was described as "very emotional" (MOV-03), another as difficult as the owner was ill and could not finish the conversation on the phone.

The owner as a problem also appeared in the form of financial restrictions, which were frequently part of a case discussion. Occasionally these lead to limitations of treatments or diagnostic procedures. One patient's blood, for example, was analysed only every two days instead of daily which would have been indicated (MIV-01).

Another factor, that was found in answers to questions 4 and 5, was owner behaviour which was sometimes criticized as problematic. Complaints were related to, for example, feeding but also general care for their animals. Less directly but through the tone of voice, owners were

criticized for obtaining an animal as a pet without the appropriate (financial) means to care for them (MOV-01). More abstractly, owners (or those responsible for an animal) were also mentioned as problematic when the possibility of diseases in one patient was discussed in relation to coming from a killing station in an animal shelter outside of Austria (MOV-04).

Owner compliance came up as a problem related to cases. Some owners were "unreliable" in giving the necessary drugs to their animal (MIV-05), others had stopped giving prescribed drugs entirely which lead to medical problems that were now being treated (MOV-02).

Furthermore, owners sometimes had wishes not in line with the recommended treatment, such as taking the patient home earlier than advised (e.g. MIV-05) or euthanising a dog earlier than perceived as necessary by the veterinarians (MIV-05).

Some owners were also perceived as not reliable with regards to the information they provided which was commented on openly or subliminally. One cat's age was highly questioned multiple times, another patient's allegedly improved condition was questioned as well. Other owners were not able to provide information in the first place such as whether their dog had eaten something outside or swallowed a foreign object (MOV-03, MOV-05), or for how long a patient had their symptoms (MIV-02). Sometimes owners only shared important information later which the veterinarians would have appreciated to know immediately (MIV-05).

Additionally, owners could be problematic when they could not be reached by phone when needed (MOV-03).

Other medical disciplines, units or veterinarians. Other medical disciplines or units and other veterinarians were mentioned with regards to their decisions or competence, with regards to a lack of information from their side, as well as with regards to maintaining a functional, positive relationship with them.

Other veterinarians of the clinic as well outside of the clinic were directly and indirectly criticised and disagreements between the units were discussed openly or hinted at subtly.

Borders between units were verbalised, for example, by claiming that a patient would be “a case for the surgical ward” (MOV-05) and by pointing out the delicacy of handling the relationships between units (MIV-05).

This division between units that seemed to be perceived and practised by the participants was further highlighted by abundant criticism of other units and disciplines. The topics of disagreement were among others the continuation of treatment where the participants deemed it questionable to proceed due to the animal’s welfare, the necessity of diagnostic tests, as well as who was considered to be in the best position to arrive at a diagnosis or treatment decision (e.g. MIV-05, MOV-01, MIV-01). Sometimes the criticisms were very blunt, sometimes they were subtler, for example, when participants voiced their lack of understanding for a decision made by another veterinarian (MIV-02, MIV-04) or when they highlighted how a patient was “better” since they were transferred from another unit (MOV-02). Other disciplines that were criticised also included care-taking staff, for example, for the way they were feeding the patients that refused to eat (MOV-03, MIV-05).

Veterinarians outside the clinic were criticised and their decisions and treatments were questioned, among others with regards to previous diagnoses or dosages of medical drugs. However, referring veterinarians also appeared as a challenge with regards to maintaining a functional relationship with them. It was mentioned, for example, that one veterinarian was “complaining about us [the veterinarians in the clinic]” and that this veterinarian should be contacted to avoid that they would refrain from referring patients to the clinic (MIV-01). In another case the owner of a patient was in conflict with the veterinarian previously treating the patient and the participant of the meeting was unsure about how to handle this situation and whether the former veterinarian should still be informed about the patient’s status as they seemed to care about the patient (MIV-05).

Occasionally the veterinarians outside the clinic were a contributing factor to difficulties in the decision-making progress due to missing information about previous treatments, such as the contents of an injection a patient had received prior to being admitted to the hospital (MIV-01, MIV-02, MOV-02). The information had been requested by email but the lack of an answer impacted the diagnosis and decision-making in this case.

Medical uncertainty and equivocality. The meetings, especially those at noon, focused on the discussion of the medical facts and questions related to a case. Diagnostic findings, possible diagnoses as well as treatment plans made up an integral part of the discussions. Beyond the technical medical questions related to each case, which will not be covered in this analysis, several categories of problems became apparent either directly or indirectly. Next to general medical discussion of the cases, the nomenclature for specific diseases was discussed as being problematic because it seemed unclear to the participants (MIV-02). Another category that emerged from verbalised problems, was missing information due to a lack of scientific studies on a specific question but also a disagreement between different studies on the same problem. This re-appeared as an issue discussed by the participants, as the multiple different opinions different veterinarians often have on medical questions (MOV-02) or even on the same patient on two consecutive days (MIV-02). This was summarised here as the category of medical equivocality. It seemed like there was not always a clear answer to how to apply medication or which tests to run (MOV-02, MIV-04). This was not always discussed as a criticism of the other professionals but also as a typical problem of (veterinary) medicine that one had to work with, which is why it was grouped into this problem area and not that of other medical disciplines, units or veterinarians.

Another problem in relation to a case was mentioned as the lack of knowledge about that particular species that was not usually treated by the participants of the meeting (MIV-02). At other times some of the participants seemed to be ignorant of relevant knowledge which was then discussed in the meeting (MOV-03).

Necessity of justifications. The necessity of justifications for decisions made in the treatment of patients was mentioned directly but was also inferred from reactions and comments of the participants.

Legal responsibility came up as a potential problem through mentioning the possibility of being sued if one did not apply medication although it could have been judged as indicated (MIV-05). Additionally, it was pointed out that a signature of the owner needed to be obtained when they decided to take the patient home earlier than advised (MIV-05).

Throughout the discussions unscientific argumentations were criticised, either when coming from the participants or when coming from others outside the clinic such as “self-proclaimed dog whisperers” (MIV-03). Imprecise wording in relation to cases was criticised as well as arguing based on “gut feeling” when the participant was not deemed to have the necessary experience to do so (MIV-02).

The need to justify one’s decisions also became apparent through observing the meetings when participants, for example, claimed a specific treatment that was being criticised had been “an order from above” (MIV-02). Another example was the subliminal questioning of a care taker’s pain assessment in a patient which seemed to be a way of justifying why no pain medication had been given by the veterinarian (MOV-05). In one case discussion, a tension between two participants seemed to arise around which treatments to try, highlighting the necessity to be able to argue convincingly so as to also avoid disagreements between each other (MIV-01).

Necessity to appear competent. Throughout the meetings, especially but not exclusively during the midday meetings, participants seemed to feel the need to make themselves appear competent. This was inferred from the eagerness to comment in discussions and the multiple occasions in which participants were trying to talk when someone else was still speaking. It was more the case for some than for other participants, however, one participant also seemed mildly upset, when they were not given the chance to answer a question on their own and their colleagues were giving visual cues to the correct response (MIV-04).

Lack of medical possibility. The lack of further medical possibilities to treat a patient came up either in a neutral, matter-of-fact way or as an explicit problem the veterinarian was struggling with. In one case the planned euthanasia of a cat was announced as part of the morning meeting without further discussion (MOV-05), in another case, the struggling of the veterinarian with a feeling of powerlessness combined with the urge to do something that would help the patient, was openly acknowledged and discussed (MIV-02).

The patient’s perspective. The potential impairment of a patient’s welfare by them staying in the clinic (and by that away from home) was mentioned more than once. The participants, for example, raised the issue that some patients were very fearful and may be better cared for at

home to help them recover (MIV-03). The welfare of animals also prompted criticism of other units for wanting to continue treatment that was perceived as futile, as well as criticism of an owner whose dog's fur was in such a bad state that the veterinarian decided to shear the patient without consulting the owner (MOV-01, MIV-02).

Other aspects related to the patient's perspective were the unawareness by the patient of what was going on with them (MIV-05) as well as their refusal to eat (e.g. MOV-03, MOV-04). The latter was inherent to the illnesses this specific unit deals with most which are intestinal illnesses that often cause a lack of appetite.

Another factor grouped into the problem area of the patient's perspective was the behaviour of the university dogs that were allegedly "always bullying one of their pack" which may have caused the injuries observed in one of them (MIV-02).

Structural aspects of clinical routine. Structural aspects of the clinical routine emerged as a problem area by being mentioned directly and by being inferred from the observation of the meetings. Directly mentioned was stress in the clinical routine in other units but also for the care takers (MIV-01, MIV-03) as well as time issues such as finding the time to perform a diagnostic procedure where several veterinarians should be present (MOV-03) as well as general time pressure.

The time pressure also affected the meetings, in some of which it was brought up in the discussions for example by pointing out that one participant had "three seconds" left to present their cases (MOV-05). The time pressure was not always explicitly discussed; however, it affected the meetings in multiple ways such as by the coming and going of participants, especially in the midday meetings, by the extremely high speed at which some cases were presented, especially in the morning meetings, and by the parallel use of computers or phones during the meetings, especially during the midday meetings.

All midday meetings started at least 19 min later than announced and were sometimes limited by subsequent appointments, leaving participants first waiting and also restricted to present and discuss their cases within a given time frame.

Another factor was the high temperature in the meeting room as well as the air that was perceived as being of bad quality by the observer but sometimes also by the participants (MIV-02, MIV-04).

A further interference with the meetings was presented by the frequent phone calls that were sometimes but not always answered. This was not mentioned as problematic by the participants but perceived as potentially distracting by the observer. Similar to this were the interruptions by people coming (or leaving) and occasionally talking to individual participants. In a particular midday meeting that became less strictly structured towards the end, the participants struggled with mixing up details of the cases as "so many had been discussed" (MIV-05). In another meeting a misunderstanding between the participants became apparent as one participant thought they had agreed on a treatment with which the Senior Clinician disagreed (MOV-03).

Another issue that was raised within the problem area of the structural aspects of the clinical routine, were occasional limitations with regards to resources and appliances, such as a specific veterinarian not being available on that day, a sample disappearing on the way to the laboratory or a missing blood test result due to a complicated, unintuitive form that was filled out incorrectly (MOV-05, MIV-04, MOV-04).

Not having enough blood to transfuse to a patient since the other cat of that owner did not have enough blood to donate either, was also clustered as a structural problem which was raised by the participants (MOV-03).

Another issue mentioned by the participants was the necessity that one veterinarian would treat all patients with parvovirus infections to limit the danger of transferring the disease onto unaffected patients (MOV-03) which was commented on as being a little bit unpleasant for that respective veterinarian.

The changing of responsibility for a case between different veterinarians was perceived as potentially problematic by the observer (but not discussed as such by the participants) as it, for example, resulted in the responsible veterinarian not having spoken to the owners and only having information at hand that was passed on through other clinic personnel (MIV-03).

The need to make decisions despite still waiting for information due to the time tests and diagnostic procedures needed, was noted as another problem (MIV-02).

Breed-specific problems. This problem area came up once with regards to the high prevalence of cancer in dogs of the breed Hovawart which was commented on jokingly (MIV-05).

3.2.3.3. Underlying aims reflected by problem areas

In the following section the problem areas are analysed for which underlying aims of the veterinarians they represent in order to assess the potential of CESS in navigating different, potentially conflicting aims. A problem is here understood as a minimal combination of an aim and an obstacle to this achieving this aim (Jackson 1984, as cited by Grimm, 2010, chap. 2). From this follows that for something to be perceived as a problem, either by the veterinarians or by the observer of the meetings, there is a corresponding aim of which the achievement is complicated by the obstacle.

Table 4 shows the problem areas resulting from the observational study and the corresponding underlying aims that are identified from the problems clustered into the different problem areas. The problem areas are understood here as being linked to two main underlying aims: (1) acting in the best interest of the patient and (2) achieving and/or maintaining professional recognition by others. Acting in the best interest of the patient is understood here as improving their health and welfare (as discussed in Yeates 2013, chap. 1). 'Professional recognition' refers to one's professional competencies as a veterinarian being recognised by others.

In the following I will briefly sketch the reasons for attributing the aims to the respective problem areas before I will highlight how the two main aims go beyond the classical veterinary triad of veterinarian, patient and owner.

The owner often appeared as an obstacle to treating the patient, for example, by lack of compliance, limited finances, missing information or suboptimal care for their animals. This is problematic for the veterinarian when they aim at acting in the best interest of the patient. The interaction with owners was sometimes evaluated as negative by the veterinarians which

is interpreted here as an obstacle to the aim of a positive interaction and relationship with owners. This is closely linked to acting in the best interest of the patient, since an owner, that is perceived as difficult can be expected to be less likely to follow the veterinarian's recommendations. However, it is not the same aim, since an owner can be very pleasant to interact with and still not follow the veterinarian's advice or be unable to afford the optimal treatment for a patient. The owner further appeared as an obstacle when they wanted to consult a different specialist before following the veterinarian's advice. The corresponding aim, professional recognition, is impacted by the perceived lack of recognition from the owner.

Table 4: Problem areas and corresponding underlying aims

Problem area as obstacle	Corresponding aim(s)
Owner	▪ Follow 'best interest of the patient' principle ▪ Maintain a positive relationship ▪ Achieving/maintaining professional recognition
Other medical disciplines, units or veterinarians	▪ Follow 'best interest of the patient' principle ▪ Achieving/maintaining professional recognition
Medical uncertainty & equivocality	▪ Follow 'best interest of the patient' principle ▪ Achieving/maintaining professional recognition
Lack of medical possibilities	▪ Follow 'best interest of the patient' principle ▪ Achieving/maintaining professional recognition
Necessity of justifications	▪ Achieving/maintaining professional recognition ▪ Safeguard oneself legally ▪ Positive relationships with colleagues
Necessity to appear competent	▪ Achieving/maintaining professional recognition
Structural aspects of clinical routine	▪ Follow 'best interest of the patient' principle ▪ Achieving/maintaining professional recognition ▪ Pleasant work environment
Patient's perspective	▪ Follow 'best interest of the patient' principle
Breed-specific problems	▪ Follow 'best interest of the patient' principle

Other medical disciplines, units or veterinarians can be obstacles to the aim of acting in the best interest of the patient when their diagnoses and previous treatments are perceived as not optimal which was reflected in questioning or criticising during the meetings. The aim of

maintaining professional recognition is, for example, reflected in the challenge of maintaining a positive relationship with veterinarians outside the hospital which was mentioned during the meetings. Additionally, the issue of clear differentiation between units within the hospital, which was clustered into this problem area, underlines the corresponding aim of achieving and maintaining professional recognition.

Medical uncertainty and equivocality as a problem comprises the aim of acting in the best interest of the patient and the obstacle of uncertainty about what the best treatment is. It can also reflect the aim of achieving and maintaining professional recognition since the latter can be affected when a decision is perceived as questionable by others due to a lack of consensus in the field, for example, about details of dosages of medication.

Lacking medical possibilities to improve a patient's situation can be an obstacle to the aim of acting in the best interest of the patient, especially if it is understood as improving the patient's situation. The issues that were clustered into this problem area were, for example, a participant being upset about not being able to actively do more to help a patient, and the (medically) required euthanasia of patients. Depending on how one understands the best interest of the patient, euthanasia can also be seen as a means to achieve it and not as an obstacle to it, if euthanasia is medically indicated, since death and therefore an end of suffering may be seen as being in the patient's interest. This, however, is only true for medically indicated euthanasia. The lack of medical possibilities can also be an obstacle to gaining professional recognition if the inability to help a patient is not viewed as inevitable but attributed to the individual veterinarian's competence.

The necessity of justification as a problem area in this study comprises different potential obstacles and aims. The need for justification can hinder the aim of achieving and maintaining professional recognition when others such as colleagues do not perceive a veterinarian as convincing. This also became apparent by the reverse process of doubts about other professionals' assessments that were voiced during the meetings. The need to be able to justify decisions was also mentioned with regards to potential liability issues, for example, if something was missed or patients discharged prematurely. The underlying aim is to safeguard oneself legally. Additionally, not arguing convincingly enough has the potential to be an

obstacle to the aim of maintaining positive work relationships with colleagues. In one meeting participants seemed to not fully resolve their disagreement which could affect their relationship in the future. The necessity for justifications is also linked to the aim of acting in the best interest of the patient, however, as a means and not as an obstacle, since a well thought through and justifiable treatment can be expected to be more beneficial for a patient than a randomly chosen one.

The necessity to be appear competent is linked to aiming for professional recognition. Failing at convincing others of one's competence is a clear obstacle to achieving or maintaining professional recognition by them. This seemed to apply within the meetings and outside of them. Similar to the need for justifications, the impact that a lack of perceived competence has on professional recognition also became apparent from the questioning or criticising of others' decisions.

Issues that were clustered as structural aspects of clinical routine have the potential to be obstacles for acting in the best interest of the patient, for example, when information are missing but decisions have to be made. To a lesser degree the aim of achieving and maintaining professional recognition can be affected when there is uncertainty about a decision made together, potentially due to time pressure or distractions during the meetings. Obstacles to the aim of having a pleasant working environment were the distribution of cases among participants or the air quality in the meeting room.

The patient's perspective represents the underlying aim of acting according to the best-interest principle, as some patients did not cope well with being in the hospital which was an obstacle to treating their illness. In this case the latter would be understood as being in the best interest of the patient.

Breed-specific problems comprise obstacles to the improvement of a patient's health which is here understood as being in the best interest of the patient.

Taken together the two main themes that emerge as aims are acting according to the best interest of the patient which is in most cases understood as improving their health and wellbeing, and achieving and maintaining professional recognition. Other aims were

maintaining a positive relationship with owners and colleagues, safeguarding oneself legally and a pleasant work environment.

In the following I will bring the identified aims into the context of the veterinary triad which will highlight aspects that will be relevant for the potential that CESS have for addressing ethical challenges in the clinical practice.

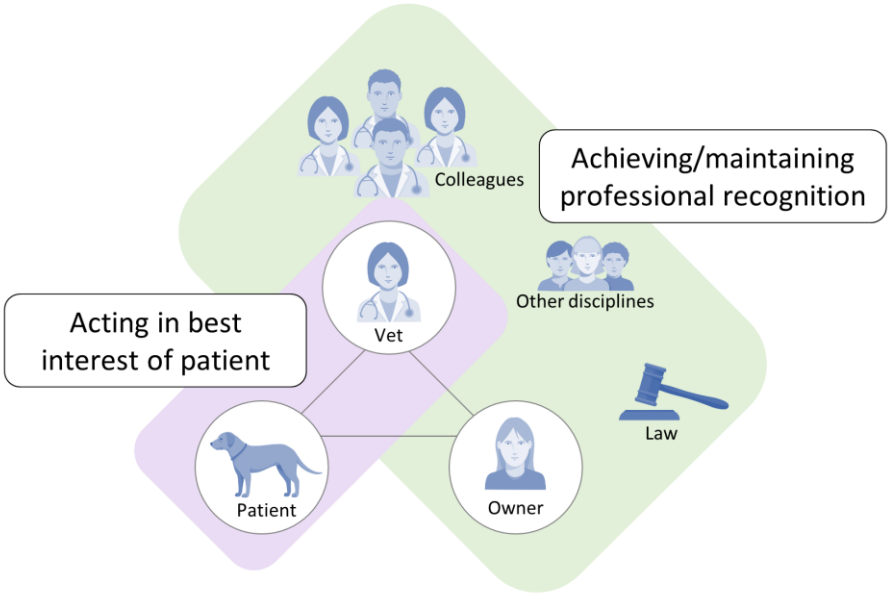

Fig. 3: Aims linked to relationships in the observed veterinary context. Icons © Messerli Research Institute

Fig. 3A shows the veterinary triad between veterinarian, patient and owner, which exists in the context of the veterinary profession (represented by colleagues), other disciplines (such as caregivers or veterinary nurses) and the society (here represented by the law). Both aims develop in relationships, either within the triad or outside of it. Acting according to the best-interest principle is an aim that is established in the relationship between veterinarian and patient. The aim of achieving and maintaining professional recognition is embedded in relationships mainly with other veterinary professionals but also with other disciplines and to some degree the owner and the law. This highlights the importance of relationships in the emergence of problems that veterinarians face in clinical decision-making and the handling of cases. The relevant relationships go beyond the classical triad of veterinarian, owner and

patient. This will be an important aspect in assessing the potential of different models and methods of CESS in a small animal hospital in section 3.3, as it emphasises that problems that veterinarians face, even though they may not all be ethical problems, are related to aims in a wide social context.

3.2.4. Discussion of the observational study

The observational study of veterinarians working in the Clinical Unit of Internal Medicine in a small animal hospital was conducted to gain insights into the challenges associated with decision-making in a small animal hospital, and to subsequently identify the potential for different models and methods of CESS in small animal hospitals. In the following the main findings of the observational study will be discussed against the background of findings from the literature, and limitations of the study are addressed, before the findings will be linked to clinical ethics support services in the next section (3.3).

The problem areas and the underlying aims answer to the two main research questions which were asking for issues discussed as challenges in relation to cases or decisions and in relation to the interaction with each other during the case discussions, as well as problems that only became apparent through the observation and reflective analysis of form and content of the case discussions and that were not openly discussed by the participants.

The owner was identified as a problem area which included issues such as owner compliance, missing information from owners and poor care for their animals. Findings from other studies support the identified aim of a positive relationship with owners and further highlight how the owner can be perceived as an obstacle to the aim of acting in the best interest of the patient. In an online survey among North American veterinarians about 55 % of the respondents reported to sometimes "feel conflicted or upset” because a pet owner refuses what the veterinarian believes to be in the best interest of the patient, about 23 % report to experience this often and about 19 % rarely (Moses et al. 2018, p. 2118). In agreement with this, O’Connor (2019) reports from her qualitative interview study with veterinarians in the UK that all 16 interviewees that worked with clients reported this as a potential source for stress. High client expectations (especially in companion animal practice) as well as dealing with emotional or

angry clients and client complaints were considered as stressful or upsetting (O'Connor 2019).

One important factor in which an owner can be an obstacle to fully patient centred care is by financial constraints. This is a well-documented problem that veterinarians face on a regular basis as the following studies show. An online survey with 195 Danish veterinarians revealed that 33.8 % of the respondents were faced with clients' financial limitations 3 to 4 times a month and 24.6 % of the respondents faced these 5 to 10 times and 19.5 % 1 to 2 times a month (Kondrup et al. 2016). The impact of clients' finances on veterinary decision-making was also documented in a focus group study with Austrian veterinarians (Springer et al. 2019b). Batchelor and McKeegan (2012) found in a small-scale questionnaire study with UK veterinarians that financial limitations were reported to be the most common ethical dilemmas (55.5 %), however, not the most stressful ones. Similarly, Kipperman and colleagues (2018) found that many North American veterinarians encounter situations where financial limitations compromise the care for a patient multiples times a day (36.4 % of respondents) or a few times a week (27.7 %) but these situations were not always experienced as ethical dilemmas and caused less moral stress than other clinical scenarios. As Batchelor and McKeegan (2012) discuss, financial constraints may have been accepted as an unchangeable reality of veterinary medicine and at the same time as being out of the control (and responsibility) of the veterinarian.

That owners can be an obstacle to the aim of achieving and maintaining professional recognition is equally mirrored in the literature. Knights and Clarke (2018) discuss the influence of increased consumer control and evaluation (with the patient owner being the consumer), for example, via social media, with regards to anxiety and insecurity of veterinarians at work. They conclude, based on 75 interviews with veterinarians and non-participant observations, that a shift from the veterinarian as the consulted expert to the veterinarian as a service provider contributes to stress and anxiety among veterinarians (Knights and Clarke 2018). Springer and colleagues (2019b) equally found that patient owners' expectations can be experienced as problematic by veterinarians, especially when owners have previously searched for information and potential diagnoses online. A survey on behalf of the Royal College of Veterinary Surgeons in the UK also identified high client

expectations and demands (53.8% of respondents) as one of the major challenges to the profession (Buzzeo et al. 2014).

Other medical disciplines, units or veterinarians were identified as a problem area in this study when they were either perceived as an obstacle to acting in the best interest of the patient or to achieving and/or maintaining professional recognition. With regards to ethical aspects in decision-making, Kipperman and colleagues (2018) found that 50 % of respondents in an online survey amongst US veterinarians (484 respondents in total, 31 % referral veterinarians) stated that they would prioritise patients, but only 20 % of respondents claimed the same about other veterinarians. This may suggest a discrepancy between self-perception and evaluation by others, indicating that the intention or motives may not be communicated clearly enough between veterinarians (or are not so easy to detect without discussing them). It could also suggest that veterinarians act more critically towards fellow professionals than they do towards themselves. This would be in line with the questioning or criticising of other veterinarians that was observed in the observational study presented here. An alternative explanation for the survey's findings is that a higher proportion of patient-focused veterinarians completed the survey and their assessment of their colleagues was representing the latter's actual priorities.

Another issue that was identified and clustered into the problem area of other medical disciplines, units or veterinarians are the relationships with referring veterinarians outside the hospital that mainly reflected the aim of achieving and maintaining professional recognition. In the case discussions these were linked to communication with the referral veterinarians and the need to maintain a positive relationship so that they would not refrain from referring patients. The literature supports the finding, that the relationship with referring veterinarians are important (e.g. Best et al. 2018a, 2018b). Interestingly, the perceptions of specialist veterinarians (those that patients are referred to) and of referring veterinarians seem to differ regarding the three most important decision-making factors in relation to referring patients, based on a survey among North American equine veterinarians (Best et al. 2018a). Whereas referring veterinarians ranked 'quality of care', 'expertise of clinician' and 'ability of the hospital to provide comprehensive care' highest, specialist veterinarians thought that 'quality of communication and updates from the clinician', 'quality of care' and 'ease of

communication with the clinician' were most important for referring veterinarians (Best et al. 2018a, p. 826). However, poor communication and lack of collegiality between referring veterinarian and specialist were seen as important barriers to referring patients by both groups (Best et al. 2018a). Findings from a focus group study with referring veterinarians about their expectations emphasise the importance of communication and a "collegial relationship with the specialist" (Best et al. 2018b, p. 479).

The necessity to make decisions despite uncertainty came up as a problem in the observational study, either as a result of structural aspects of clinical routine (due to the time diagnostic procedures require), the owner (who might not provide important information) and medical uncertainty and equivocality (for example, due to missing scientific data). Knights and Clarke discuss how veterinarians' training is "heavily based on natural science paradigms of causality, predictability and certainty" (Knights and Clarke 2018, p. 9) and how this collides with the reality of veterinary practice that is often full of uncertainty and unpredictability. This is also reflected in what a veterinarian stated during one of their interviews; "it's very frustrating the amount of uncertainty that we've got, and it would be nice to be more right" (Knights and Clarke 2018, p. 9).

The lack of medical possibilities as a problem may be seen as being reflected in the literature on the effect that having to perform euthanasia has on veterinarians. Kipperman and colleagues (2018), for example, identified euthanasia due to a lack of financial means or willingness of the owner as the most morally stressful of the presented clinical scenarios, even though not the most common one. This, however, needs to be disentangled from the issues identified as problems in the observational studies which related to the inability to help a patient not for contextual but for medical reasons (for example, because it was unclear what the cause of the symptoms was or no further curative therapy was possible). Euthanasia in a narrower sense, referring to killing the patient for medical reasons in the best interest of the patient is not so much seen as a problem but as a powerful tool to help a patient (Rollin 2011, Persson et al. 2020). From 18 participants in a focus group study with UK veterinarians "[a]ll but one reported that they normally did not find euthanasia upsetting, but noted that it could be stressful in some circumstances" (O'Connor 2019, p. 3). However, attitudes towards

euthanasia have also been shown to vary depending on factors such as age and gender making general statements for all veterinarians questionable (Hartnack et al. 2016).

The necessity to justify one's decisions, which came up in different ways during the observational study (e.g. criticism of non-scientific argumentations, the potential for litigation, backing up one's decisions with another veterinarian's assessment) is reflected in the literature in studies showing the importance of potential litigations or client complaints with regards to veterinarians' stress levels. Bartram and colleagues found in their survey of UK veterinarians that "[a]mong respondents who treated clinical cases, the possibility of client complaints or litigation, unexpected clinical outcomes and out-of-hours on-call duties were reported as the greatest contributors to clinical workrelated stress" (Bartram et al. 2009, p. 337). Smith and colleagues (2009) similarly showed that the fear of litigations can be a source of extreme stress for some veterinarians. However, the need to justify one's decisions was also observed with regards to direct colleagues and superiors. This is mirrored in the need to appear competent which became apparent, for example, through some participants' attempts to contribute a lot to discussions and through a participant's unhappiness about not being able to show their knowledge.

An inclination to perfectionism which is suggested to be prevalent among veterinarians may contribute to aiming at achieving and maintaining professional recognition (Knights and Clarke 2018). Knights and Clarke cite an equine veterinarian who states "[w]e view ourselves as high achievers" (Knights and Clarke 2018, p. 8) and go on to discuss the potential reasons for veterinarians feeling anxiety related to the need to always be perfect at what they do:

> "The experience of academic success is internalized and becomes an expectation closely aligned with one's professional identity, but post-education, it is no longer given continual affirmation through exam success, and, therefore, tends to be displaced into a form of self-imposed and self-disciplinary demands for perfectionism in the job." (Knights and Clarke 2018, p. 16)

A veterinarian taking part in a focus group study stated that "…my expectations of myself are a source of pressure for me" (O'Connor 2019, p. 5). Another one said "…that responsibility of

always being right and always making the right judgement call (is stressful)" (O'Connor 2019, p. 5).

The necessity of justifying one's decisions was also linked to the aim of a positive relationship with colleagues in the present study. The importance of positive work relationships is highlighted in the literature (e.g. Black et al. 2011). North American veterinarians have reported to have disagreements with other veterinarians that they share a case with sometimes (42.79 %) or rarely (46.80 %) and 38.63 % rated these disagreements as more distressing than those with owners (35.43 % as less distressing, 25.94 % as about the same) (Moses et al. 2018).

One of the main factors among the **structural aspects of clinical routine** was time pressure in the meetings but also during the clinical routine. A high work load and long hours of work have been found by several studies to be a common reason for stress among veterinary professionals in different countries (see e.g. Bartram et al. 2009, Smith et al. 2009, O'Connor 2019). The observed time pressure is in line with these findings. Occasionally participants were observed to be eating during the meetings suggesting that there was not enough time to take a break at other times. The inability to take breaks during the day has also been described elsewhere; in a survey conducted among Australian veterinarians on the causes for stress during their work, Smith and colleagues found the following to be the most common; "long hours worked per day, not having enough holidays per year, not having enough rest breaks per day, the attitude of customers, lack of recognition from the public and not having enough time per patient" (Smith et al. 2009).

One aspect that is relevant when viewing the findings of the presented observational study in the light of other literature, is that many studies focus on or include small animal practitioners outside a hospital context. This can alter results with regards to stress levels or reasons for stress. Kipperman and colleagues (2018) found that overall general practitioners where reporting more moral stress resulting from scenarios presented in their study than referral practitioners.

A focus group study analysing inputs from (private) clinic owners, small animal veterinarians outside a clinic and those employed in a university hospital, indicated differences in the

challenges they face. A veterinarian employed in the university hospital, for example, said she feels little pressure to use new equipment whereas veterinarians outside the clinical context raised the concern that new equipment may get used unnecessarily because of the need for amortisation (Springer et al. 2019b). However, other reasons such as advancing a new technique, training their specialty skills or publishing on rare cases can be expected to be more likely to lead to overtreatment in an academic hospital compared to general veterinary practices.

Veterinarians in small animal practices on the other hand, are more likely to encounter more cases of owners being unable or unwilling to pay for recommended treatments, the need to amortise expensive new equipment through using it, and, depending on the business model, conflicts with corporate guidelines or expectations (Knights and Clarke 2018, Springer et al. 2019b).

Another difference between veterinarians outside a clinic and those working in their own practice may be the access to support by colleagues and the possibility to discuss cases in such detail as done in the university hospital meetings that were observed for the study discussed here. Talking to colleagues and/or friends and family was reported as the main approach to dealing with (ethical) challenges by North American veterinarians in an online survey (Moses et al. 2018). In a survey among Austrian veterinarians ‘colleagues’ were similarly mentioned most frequently as a support in dealing with end-of-life issues (Springer et al. 2019a). The veterinarians working in an academic teaching hospital seem to therefore have advantages with regards to possibilities for discussing cases (but at the same time might also experience more challenges with regards to multiple colleagues and other professions they are working with).

Most certainly academic veterinary hospitals are in a privileged position to try out new ways, such as clinical ethics support services, in dealing with ethical challenges and (moral) stress (e.g. Rosoff et al. 2018, Springer and Grimm 2018). How the presented observational study shows potentials for clinical ethics support services will be discussed in section 3.3. after limitations of the study have been addressed in the next section.

3.2.4.1. Limitations of the study

The study presented here, comes with limitations some of which are inherent to participant observational studies and some of which are specific to the study in this setting.

Participant observational studies rely heavily on the observer in terms of perceiving, structuring and recording data so that one of the critical aspects of them is a potential observer bias (Schnell et al. 2013, p. 390f, Diekmann 2016, p. 551). Ways to address the selective perception of an observer include training of the observer, using multiple observers and assessing an interobserver reliability if possible, and using observation guides (Diekmann 2016, p. 551). The question catalogue functioned as an observation guide for the study presented here and helped to focus the observation. In addition to that a second observer was present during two sessions after which results by the two observers were compared and discussed. Video or audio recordings could have further helped in assessing observer reliability.

Recordings would have also allowed for a more detailed and thorough content analysis as opposed to limiting the results to how much the observer was able to write down or remember afterwards when answering the guiding questions. It would have also enabled the observer to spend more time looking at the participants, their facial expressions or gestures, instead of being occupied with writing and looking onto the paper. The frequency of looking up at the participants was irregular. Furthermore, from where the observer was positioned not all faces where visible.

Recordings would have also counteracted the problem of declining attention during the sometimes very long sessions; the longest meeting took 2 h 20 min which will most likely have resulted in a less thorough observation towards the end. However, since notes were taken during the sessions and not only afterwards, the risk of misremembering the meetings due to their length was lowered.

Another issue associated with participant observation is the potential influence that being observed might have on the participants (Schnell et al. 2013, p. 393, see e.g. Diekmann 2016, p. 564). The observer in this study was visible and obviously taking notes but not taking part in the discussion. During the morning meetings the presence of more or less passive

participants, such as students sitting on the chairs along the walls, was common so that an additional person was not expected to attract much attention. During the midday meetings, however, the observer was more obviously present, since there were usually no students joining the discussions. To reduce the influence on the participants the observer was sitting a little away from the participants, however, still visible to those that did not face away.

The natural setting has a clear advantage over interviews or artificial laboratory situations because participants are normally more occupied with their tasks at hand than with the presence of an additional person (see also Schnell et al. 2013, p. 393). Since the observation was kept anonymous and most of the participants seemed to be concerned with the discussion or other tasks, the influence by the observer did not appear very strong. Another evidence towards this was that the participants, except for one, did not seem to pay any attention to the observer nor engage in any conversation before or after the meetings. However, since it was not tested whether the observation influenced content or style of interaction, an influence cannot be excluded. Therefore, the term ‘participation’ was used to describe the observation style. Sowa and colleagues (2013) argue that as soon as the observer is not absent in the observed situation, the observer is participating in the situation. Participating passively refers to the observer reducing any interactions to a minimum, therefore the observer in the study presented here, classifies as a passively participating observer (Sowa et al. 2013).

Participating observational studies benefit from a longer duration of observation (Lüders 2015, p. 391). The duration of the observation was relatively short with five consecutive days. A longer observation time has the potential to reveal other challenges or complications with case decisions that occur less frequently. However, a shorter observation is beneficial with regards to counteracting an effect of getting to used to a setting and losing the outside perspective as the observer which in its extremer forms is also described as ‘going native’ (Schnell et al. 2013, p. 392, Diekmann 2016, p. 564).

Other limitations, that are specific to this particular study and not participation observational studies in general, are described in the following. The study’s results were limited by restricting the observation to one unit’s meetings with a core group of about six people. Age and gender have been identified as relevant with regards to the (moral) stress veterinarians

experience in their professional life (Smith et al. 2009, Batchelor and McKeegan 2012). In addition to that, there is evidence that certain personality traits are associated with higher occupational stress in veterinarians (Dawson and Thompson 2017). Therefore, a greater sample size can increase the representativeness of the results. However, problem areas identified for the participants of this observational study should still be seen as relevant indicators, even if they might not be equally important for all veterinarians.

Including other units into the observation could have resulted in a broader spectrum of challenges also because of different illnesses they focus on.

The setting was further limited to observing veterinarians discussing in-patient cases. This can be expected to represent only some of the (moral) challenges that may arise in a clinical context. Other veterinary professionals such as nursing staff or caretakers may experience other relevant problems, and issues may arise as well with patients that are not admitted to the hospital. In addition to that, the results of this study should not be expected to be representative for veterinarians practising outside the context of an academic animal clinic. However, since the latter was the overall focus of this work, this limitation was deliberately chosen.

Restricting the observation to formal meetings of the veterinarians does not give a complete picture of how cases are discussed since it is likely that the veterinarians talk about the (ethical) challenges they face also, and potentially even more so, throughout informal discussions during the rest of the day. It was noted that the participants talked about cases before and after meetings, the content of those discussions was however not formally observed nor included in the study.

Participant observer studies are often complemented by other methods or used to generate hypotheses that can later be tested with other methods such as interviews or questionnaires (Schnell et al. 2013, chap. 7.2.6). The study presented here should be seen as an exploration study that would ideally be followed up by testing the results with other methods or with a more strictly structured categorisation system (Diekmann 2016, p. 551). One possible follow-up approach are interviews with the participants in which they are asked for the challenges they face during the decision-making processes in the clinical routine. This would have the

additional advantage that any clinical ethics support service could be tailored to their perceived challenges or needs which would enhance the acceptance of such a service. The next section will address the potential for CESS in the small animal hospital setting based on the findings of this observational study and the literature presented in the first part of this thesis in more detail.

3.3. Potential for CESS based on observational study and literature

The first part of the thesis addressed different models and methods of clinical ethics support services and their underlying conceptions of ethics. In the following the potential of applying these models and methods to a veterinary medical context will be discussed based on the findings of the observational study which revealed problems and related aims of veterinarians in a small animal hospital context.

I will begin with structural aspects of the clinical routine. **Time pressure** came up as one of the major structural factors in the clinical routine that can act as an obstacle to achieving the aim of acting in the best interest of the patient. Time pressure applies to the meetings that are currently taking place and would also apply to any additional meetings within the scope of a clinical ethics support service. This argues for a model that uses individual meetings between stakeholders and ethicist as opposed to group meetings since that does not require participants to be available at the same time. The *CASES* approach of facilitation supports this way of information gathering (although it also incorporates group meetings when it is deemed necessary)(NCEHC 2015, see also section 2.1.2.1). Additionally, other approaches which more strongly advocate the ethicist as the ethical expert who arrives at a conclusion after collecting information from those involved, can also be seen as advantageous due to their time saving aspects. They come with a different problem, however; namely the danger of a CESS to be perceived as removing decisional authority from veterinarians (and owners) (see e.g. White 2018). This aspect will be addressed in more detail in the conclusion (0).

Time pressure is inherent to veterinary medicine also because of the fee-for-service model that requires patient owners to pay for the time a patient spends in the clinic. This can contribute to short stays of patients in the clinic which can make a thorough ethical

consultation on an ongoing case impossible because decisions have to be made faster than a consultation could take place, as Moses claims in her response to the presentation of a clinical ethics consultation service in a tertiary care veterinary teaching hospital:

> "Only a small fraction of pet owners are able to afford hospital stays long enough to allow for someone to notice the ethical nature of a conflict, ask for a consultation, and have it done in the time frame during which decisions must be made." (Moses 2018, p. 69).

Adin and colleagues (2019), however, report that the time between a request and a completed consultation in their tertiary care veterinary hospital did not exceed eight hours. They use a consultation model based on the *CASES* approach and the method of facilitation that the American Society for Bioethics and Humanities (ASBH) advocates (ASBH 2011, NCEHC 2015, see also section 3.1). Their approach suggests that with an efficient set-up of a CESS a fast-enough response is achievable.

Corr and colleagues (2018) propose an alternative to a formal clinical ethics support service that would address ethical questions at the beginning of a case, potentially preventing the necessity of a time-consuming consultation later in the process. They suggest the use of a checklist with questions such as the following:

> "Would treatment really be in the animal's interest? What is the expected end state for this animal? What does the animal have to go through on the way? Has an endpoint for treatment been agreed upon? What are the needs and emotional commitments of the owner? Is the owner able, economically and practically, to do what is needed? Are there consequences for other animals or humans?" (Corr et al. 2018, p. 56).

This would not necessarily prevent or solve all conflicts between owners and veterinarians about values or judgments, such as what is understood by the quality of life of a specific patient. However, it could make disagreements more transparent and therefore potentially more easily manageable.

Another way in which CESS can be beneficial in a small animal hospital with regards to the structural factor of time pressure is by enabling deliberations on questions for which there is

normally no time in the clinical routine but which nevertheless affect the aim of acting in the best interest of the patient. Questions such as ‘what do we understand as quality of life for a dog/cat/etc.?’ and ‘how much can an individual patient be burdened for the benefit of other future patients?’ can be addressed by employing a model of moral case deliberation that aims at addressing moral unease or clarifying concepts and questions, such as the Socratic and the Hermeneutic dialogue (see also section 2.1.3). Other methods for moral case deliberation such as the dilemma method can be helpful for veterinarians when used to discuss exemplary cases retrospectively (or to address ongoing cases prospectively). Moral case deliberation rests on the assumption that every case is unique and solutions found for a case are context-dependent (Porz et al. 2011), however, analysing cases can help participants become more aware of their own values, assumptions and the moral dimensions in challenging situations and by that help them deal with future conflicts. Molewijk and colleagues (2008b) report that participants of MCD in a psychiatric hospital have expanded their moral competencies with regards to knowledge and most importantly attitude and skills. The latter are referring to the evaluation that “healthcare professionals learned communication skills (eg non-judgemental listening, asking fundamental questions), reasoning skills (eg logic, connection between moral values and norms, inductive versus deductive reasoning) and moral skills or virtues (eg postponing moral judgments, creating dialogue instead of convincing the other)” (Molewijk et al. 2008b, p. 122). Among other things, participants reported the following: “I’m able to recognise moral dilemmas as such, which makes many cases less emotionally overwhelming” (Molewijk et al. 2008b, p. 122).

Despite its potential, implementing moral case deliberation might be met with scepticism especially when it requires (regular) meetings of about 90 minutes or more. As Moses (2018) reports from her experience in the US, the awareness that challenges are of ethical nature is rather limited among veterinarians and asking them to spend some of their valuable time on something that is not perceived as relevant, can be expected to be difficult (at least in the beginning). Van der Dam and colleagues (2013) report that during their implementation of MCD in two Dutch elderly care institutions, participants had different concerns and sources of reluctance towards MCD, among others the time it would require away from residents and the question of whether MCD was necessary at all. After having taken part in (regular) MCD

meetings, however, participants gave positive feedback about what they learned during the sessions and emphasised how MCD may appear vague but becomes very concrete when it is actually practised (van der Dam et al. 2013).

The challenge of time pressure and the need for fast decisions can also be addressed by multiple less time-consuming approaches that facilitate ethical thinking during clinical routine. The *Hub and Spokes Strategy* is trying to address this by incorporating ethics into the whole clinical organisation (MacRae et al. 2005). A bioethicist at the centre, the hub, is accompanied by various contact persons for ethical matters of different disciplines, the spokes, throughout the organisational structure. The aim is to foster the understanding that ethics is "an integrated part of everyone's role" (MacRae et al. 2005, p. 259).

In summary, time pressure in the clinical routine calls for a CESS that is either flexible and fast in delivering support for ongoing cases due to potentially short hospital stays, or that works retrospectively and equips healthcare professionals for dealing with future cases. It also suggests that multiple smaller approaches are easier to integrate into a clinical routine than one time-consuming activity that has the potential to be rejected due to a combination of time pressure and the lack of a perceived necessity.

Missing information was another issue within structural factors that can cause problems in the clinical routine. Having to make decisions without all information about a case available is strongly linked to time pressure but also includes general **medical uncertainty or equivocality**. A clinical ethics support service is not meant to clarify purely medical questions such as the best way to apply a specific drug. It can, however, assist in assessing which of the seemingly medical questions contain ethical aspects such as ‘what is a desirable outcome of a treatment?’ and ‘which impacts on a patient are acceptable?’. This is an aspect that can be addressed by the above-mentioned checklist that encourages owners and veterinarians to discuss endpoints for treatments and expected outcomes before the onset of a therapy (Corr et al. 2018). As opposed to the checklist, a CESS that includes all stakeholders would have the advantage that it is not limited to the responsible veterinarian, the patient’s owner and to some degree the patient, but that it is open to include other relevant parties such as veterinary nurses and other veterinarians involved in a case, as well as possibly other family members of the

patient's owner. As discussed earlier, the owner-veterinarian-patient triad does not exist in a vacuum and a CESS would do well in acknowledging that.

The **lack of medical possibilities** to improve a patient's health and wellbeing came up as a problem area in the observational study. A clinical ethics support service can, of course, not change what is medically possible, but it can be helpful in defining what can be done and what should be done with regards to the treatment of a specific case. Ethics tools such as the veterinary ethical tool (VET), developed by Grimm and colleagues (2018), can help with this question. The VET assists with arriving at a judgement of whether or not a certain medical intervention should be supported. The tool guides the user with questions on animal-centred, justificatory reasons as well as on secondary, explanatory reasons, and gives an evaluation of the respective answers (from "Consider alternative treatment options", over "Reconsider procedure and the clinician's responsibility" to "Valid reasons for clinical procedure" (Grimm et al. 2018, p. 4)). The questions, such as "Will the proposed treatment improve the patient's quality of life: (a) immediately b) long term" (Grimm et al. 2018, p. 4) guide the decision-making process. The tool does not, however, resolve all uncertainties or potentials for disagreements as, for example, the question of what quality of life means for a specific animal patient leaves room for discussion as different stakeholders can understand it in different ways.

In short, A CESS can be helpful in identifying ethical questions in medical uncertainty and assist in defining what the acceptable medical possibilities for the stakeholders in a given case are.

As shown before, relationships are very important in the context of (ethical) challenges in the clinical context, because they can be the source of problems as well as the context in which aims of veterinarians are established. Therefore, the potential of CESS to help navigating relationships with different stakeholders and their effects on decision-making will be discussed in the following.

Owners and **other veterinary medical disciplines, units or professionals came** up as potential obstacles for acting in the best interest of the patients. **Owner compliance** is a problem where shared decision-making has the potential to decrease frustration on both, the

veterinarian's and the owner's side, as well as to improve care for the patient. Shared decision-making and respective communication skills have been shown to be important with regards to patient compliance and outcome of care in human medicine (as discussed in Kurtz 2006). This suggests that a lack of owner compliance in veterinary medicine can, among other factors, result from a lack of integration of the owner's priorities and values into the decision-making process. Other factors, such as a lack of or a change in financial abilities, insufficient information and a lack of understanding of the severity of a problem can also play into an owner's non-adherence to a treatment plan. Siess and Moyer (2018) from the Department of Psychology at Stony Brook University highlight how owners of patients, that by default act as their surrogate decision-makers, may be unable to grasp the severity of their companion animal's condition due to the distress they find themselves in. This effect is stronger the greater the emotional attachment to an animal is (Siess and Moyer 2018). With regards to owner compliance this means that owners may not have understood the severity of a situation and are therefore less inclined to follow recommendations. Siess and Moyer (2018) see a potential for clinical ethics support services to address this issue and assist with communication between owners and veterinarians.

Specifically including communication training into a CESS argues for a multidisciplinary approach to addressing ethical issues in a small animal hospital, possibly including professionals trained in psychology or other disciplines. The *Hub and Spokes Strategy* incorporates this idea by recruiting spokes from different disciplines (already present at the clinic) that touch on ethical issues such as social workers, chaplains etc. (MacRae et al. 2005, see also section 2.1.2.3). In the case of the small animal hospital, where the observational study took place, all employees have the opportunity to get in contact with the department for staff development or the occupational health physician if they experience (psychological) stress, however, no designated social worker is available for staff or clients.

Clinical ethics support services can support shared decision-making by facilitating the exchange between stakeholders. This effect can be expected to be stronger in approaches that bring stakeholders together in group meetings (e.g. moral case deliberation, bioethics mediation) as opposed to those that work (only) with individual meetings of ethicist and stakeholders (e.g. *CASES* approach, *Commitment model*).

Shared decision-making can also be facilitated by the above-mentioned checklist of questions related to ethical issues that highlight the impact of a treatment onto the involved stakeholders and encourage an agreement between veterinarian and owner on endpoints of treatments and expected outcomes (Corr et al. 2018). This further has the advantage that owners do not have to agree to participating in a CESS but a basic discussion of ethical questions can nevertheless be incorporated into the standard clinical procedure.

Some problems relating from relationships with owners but also other (veterinary) professionals might be solvable by better **understanding the other's perspective** through discussing underlying ideas, motives and aims. The level of depth to which this is done and the way it is addressed varies between different models and methods of CESS.

An (external) ethicist that consults with stakeholders individually, brings information together and analyses them on their own, before presenting a recommendation for ethically acceptable options, probably has a limited effect on mutual understanding between stakeholders that are already in a conflict. When a CESS is requested, it can be expected that stakeholders are aware of the fact that they disagree with each other. They will also be aware of the positions that the other party holds such as a refusal of euthanasia of a severely ill patient. Simply assessing this, will have a limited contribution to improving the relationships between stakeholders when it has been damaged as a result of the conflict.

A clinical ethics support service has the potential to move beyond a portrayal of positions (such as refusal of euthanasia) and go deeper by assessing underlying assumptions, values and understandings. Bioethics mediation, for example, can help to mend relationships as it encourages participants to first uncover implicit and underlying interests, emotions and values and then work towards a consensus, an agreement that all participants are content with because their values and interests are reflected in it (see e.g. Fiester 2014). An owner refusing euthanasia for a severely ill patient might not agree to immediate euthanasia but may be willing to agree to an endpoint defined by a set of parameters (such as level of pain) developed in cooperation with the veterinarian who was worried about overtreatment of the patient. Within a bioethics mediation process it can become clear to owner and veterinarian that both have the best interest of the patient in mind. This insight may have been lost during

the conflict in which the owner had instead come to think that the veterinarian was refusing treatment because there would be more money in other patients.

For a method like bioethics mediation to work, the owner (especially when they are involved in a conflict) needs to take part in the procedure. It is likely that not all owners are willing to do that for various reasons such as time limitations and the lack of a perceived necessity and "there appears to be little leverage or 'power' the veterinarian has to obstruct or reverse the owner's decision" (White 2018, p. 58). Other methods that use meetings with individual stakeholders (e.g. *CASES* approach, *Commitment model*) are more practicable with regards to this.

Nevertheless, studies have shown that veterinarians have an influence on the patient's owner and their decision-making and are sometimes welcomed to do so (see e.g. Christiansen et al. 2015). Even if a CESS would "only" seem to train the veterinarians ability to handle ethical challenges, this can still extend to the owner by positively influencing the interactions between veterinarians and owners. This suggests that also models that would focus more on the veterinary professionals, such as moral case deliberation, can have a positive impact.

Disagreements about the continuation of treatments are certainly not limited to veterinarians and owners. Moses reports from her experience of ethics consultations and practising as a veterinarian that "this issue is a frequent cause of demoralizing schisms between veterinary nursing staff and veterinarians" (Moses 2018, p. 68). During the observational study presented here one case included a clear disagreement between different units. This emphasises Moses' point and argues for a multi-disciplinary participation in the deliberation of ethically challenging cases.

Moral case deliberation has been shown to be successful in fostering understanding between different disciplines which can help reduce conflicts and may also enable participants to find common grounds between stakeholders (van der Dam et al. 2013). Participants of MCD have reported that the multidisciplinary group deliberations improved the collaboration with other disciplines:

> "'A huge advantage of the MCD group was that the different disciplines learned to look at each other differently. So not only, what is my vision, what do I regard important, but that you learn to take more account of the other's view.' (FG, nurse, NH A)" (van der Dam et al. 2013, p. 129).

A different way in which CESS can be of use with regards to navigating different relationships, is by providing space to assess **responsibilities associated with the respective relationships.** The Socratic dialogue, a method of moral case deliberation, can be employed to deliberate on the question of responsibilities with regards to other veterinarians outside the clinic (see also section 2.1.3.2). In the observational study discussed here, there was a case of a veterinarian being insecure about how much information to provide to a referring veterinarian. The owner of the respective patient was accusing the referring veterinarian of having contributed to the medical problem and refused to go back to the practice. The referring veterinarian enquired of the clinic about the status of the patient. This is a good example case for an MCD session using the Socratic dialogue to answer the general question of which obligations the clinical veterinarian has towards referring veterinarians. Porz and colleagues (2011) report a case example for which the use of the dilemma method helped healthcare professionals make explicit and clarify underlying values and norms; in the respective case related to what can be expected of a patient and how they should handle the refusal of the patient to learn about side effects.

Connected to responsibilities in relationships are the aims that have been shown to be embedded in relationships to different stakeholders in section 3.2.3.3. Clinical ethics support services that do not solely focus on a fast decision for an ongoing case but instead provide an occasion to discuss internal and external structures that implicitly or explicitly guide decision-making processes can help veterinarians to be clear about and evaluate these influences on their decisions.

Relationships to other stakeholders such as professionals within the clinic and the patient can equally be discussed during MCD sessions. Participants of the observed meetings mentioned "very emotional" conversations with owners as well as a case in which the veterinarian on the phone was handed over to a caregiver of the patient owner who was not able to talk to the

veterinarian because of illness. In both cases the veterinarians may be left wondering how much they should concern themselves with the owner's problems and how the situation affects the validity of an owner's consent. Should they accept instructions from a caregiver of the owner if the owner is not able to talk themselves and a decision needs to be made quickly?

Issues surrounding informed consent are common in human medicine. Some argue that CESS in human medicine are well equipped to deal with issues related to consent and capacity but that other concerns should be more in focus for a veterinary CESS (Riddle and Riddle 2018). However, questions about informed consent are also very relevant to veterinary medicine and can pose moral challenges in different ways. One of these, next to the examples mentioned above, may be the conflict between an owner's wishes and what the veterinarian perceives to be in the best interest of the patient. Ashall and colleagues (2018) argue that the informed consent by a patient's owner does not have the same justificatory power that informed consent in human medicine has, when one assumes a patient-centred veterinary medicine, since the owner's interests may well differ from that of the patient. A CESS can provide a possibility to discuss issues like that.

Financial limitations of patients' owners as well as more generally costs of treatments were a frequent topic in the case discussions during the observational study. The fee-for-service model of veterinary medicine is one of the major aspects where veterinary and human medicine differ (as discussed by e.g. Moses 2018, Rosoff et al. 2018, Adin et al. 2019). This is emphasised in Austria where health insurances are not yet common and owners need to pay for treatments (Kramer 2018). The result of the financial implication that every decision has on the owner of a patient, is, that as much as they may be seen as a surrogate decision-maker for the animal (see e.g. Siess and Moyer 2018) their role still differs from that of surrogate decision-makers for human patients where financial aspects are less likely to play a decisive role in decisions about treatments. In addition to that, other factors such as emotional attachment to the patient can be expected to influence a surrogate-decision-maker, both in veterinary and in human medicine.

This is of relevance with regards to a clinical ethics support service because it means that attention needs to be paid to whether the **patient's perspective** is adequately represented in a

CESS to ensure patient centred care. Possible ways of doing this are to understand the clinical ethicist as a patient advocate or to use tools that help with assessing an animal's quality of life, such as the HHHHHMM (Hurt, Hunger, Hydration, Hygiene, Happiness, Mobility, More good days than bad) (Villalobos 2011). Engaging with such a designated tool may help owners and veterinarians to focus on the patient's perspective in a more objective way.

The observational study suggests that there is a **need for veterinarians to justify their decisions** objectively and to appear competent in front of others, also to gain and maintain professional recognition. Recognising the ethical nature of challenges can make clear that insecurities about how to proceed with a case do not always result from a lack of facts, knowledge or competence but can be due to a genuine ethical complexity of a situation. Understanding the ethical nature of insecurities, understanding that there is not always a clear right or wrong, can help to talk about related insecurities more openly which in turn supports a constructive way of dealing with insecurities that ultimately benefits all stakeholders (see e.g. van der Dam et al. 2013).

Disentangling ethical questions from technical ones may be one of the biggest potentials a CESS has in the setting of a small animal hospital. Moses reports from her experience as an ethics consultant in the US that she "needed to spend as much time explaining what a moral question is and whether the problem at hand is ethical in nature, as on the ethical analysis and recommendations" (Moses 2018, p. 68).

Any CESS that focuses on helping the participants to become aware of their own moral reasoning but also that of others, can prove useful here. Moral case deliberation aims at training moral competencies focussing on skills and attitudes developed by engaging in group deliberations (see e.g. Molewijk et al. 2008b). Bioethics mediation emphasises the importance of group meetings and the development of a consensus by the participants (e.g. Fiester 2014). The *CASES* approach of facilitation recommends group meetings where they are deemed necessary, yet an important part of the ethical "work" is also done by the ethicist who applies their 'ethics knowledge' and analyses the case (NCEHC 2015).

I will summarise what has been discussed so far. When focusing on relationships as the context in which problems arise and aims of veterinarians are embedded, CESS come with the

potential to increase owner compliance by fostering shared decision-making, to reduce disagreements by facilitating an understanding of others' perspectives, to assist veterinarians in clarifying their responsibilities (including issues related to informed consent), to ensure that the patient's perspective is included in decision-making and to reveal the ethical nature of problems and disagreements which supports a constructive way of dealing with them and reduces the burden of having to appear competent at all times. Together with the earlier outlined potential of CESS in relation to structural factors of clinical routine, to produce fast recommendations, to provide space and time to discuss cases and questions retrospectively, to identify ethical issues with regards to medical uncertainty and to define ethically acceptable medical possibilities, this shows a broad potential of CESS in a small animal hospital.

The discussion has so far focused mainly, also due to the nature of the observational study, on the perspective of the veterinarians, the problems they raised or indirectly presented during case discussions and potentials for a CESS based on these problems. It should not be forgotten, however, that the overall aim of clinical ethics support services is to improve patient care (and that veterinarians are not the only professionals in a clinic whose aim this is). A lot of the problems discussed can result in an impairment of veterinary care such as time pressure or difficulties with other stakeholders. Reducing the burden of ethical challenges and moral stress for veterinarians may also help decrease the risk of compassion fatigue and by that benefit patients, veterinarians and owners (Kahler 2015).

This section has discussed the potential of different models and methods of CESS with regards to addressing the identified problem areas and underlying aims, showing that there is a variety of ways how different approaches to CESS can be beneficial in a small animal hospital. What is still missing at this point is an assessment of which of the multiple approaches is preferable from those discussed. This will be addressed in the following section.

4. Conclusion

The previous section addressed the different problem areas and how a CESS in general has the potential to be of help in each. In the following I will bring this work to a conclusion on which of the presented and discussed CESS is the most promising for a small animal hospital setting.

I will argue for moral case deliberation in small animal hospitals by (1) claiming that involving all stakeholders into the decision-making is preferable to an (external) ethicist that provides a recommendation, by (2) showing that MCD has an advantage over bioethics mediation because it does not rely on first identifying what is generally ethically acceptable, and by (3) emphasising how regular meetings and a model that works pro- and retrospectively is advantageous.

Any CESS faces the challenge of being accepted within the hospital setting. Adin and colleagues report, with regards to their newly established CESS at a tertiary veterinary care hospital, the difficulty of a new approach being "introduced into a culture that may be inherently suspicious of unfamiliar processes and wary of individuals who may be perceived as a form of so-called ethics police" (Adin et al. 2019, p. 57). This is line with the developments of clinical ethics support services in human medicine that went through a phase of being perceived as threatening to the authority of the physicians (as discussed in Fournier 2016). To differing degrees this criticism has been taken up by newer approaches such as the *CASES* approach of facilitation that emphasises the importance of not imposing the facilitators values onto the participants (NCEHC 2015). The ethicist, however, still acts as an expert bringing in their 'ethics knowledge' and is expected to give recommendations at the end of a consultation (NCEHC 2015).

A CESS that results in a recommendation of ethically acceptable actions by someone external to the situation in which the problem arises, can be expected to find low acceptance among the veterinarians as such a recommendation can easily be perceived as either an unwelcomed interference by an unqualified party or, if presented with a low level of authority, as yet another opinion of what should be done in addition to the opinion of the owner and maybe even other veterinarians.

One way to address the scepticism towards recommendations by an external ethicist is to employ healthcare professionals from within the clinic as ethicists (or facilitators). The *Hub and Spokes Strategy* suggests to have one bioethicist at the core of a CESS and several representatives and approachable professionals in other roles to facilitate the integration of ethics into the whole organisation (MacRae et al. 2005). This, however, comes with an additional challenge; the recognition of the new role as an ethics support for colleagues that are known in their original role in the clinical context, as Adin and colleagues report:

> "The individuals performing the ethics consultations were selected on the basis of their backgrounds and expertise, and a corollary challenge is to promote acceptance of the authenticity and authority of their advice. This is especially demanding because the members of the committee have other better-known and recognized roles in the organization; hence, assuming the additional mantle of an ethics consultant can engender confusion and suspicion." (Adin et al. 2019, p. 57).

A solution developed within the group of stakeholders in which the problem arises is more likely to be met with acceptance than any recommendation provided by a clinical ethicist that is not part of the situation (even if they might be part of the hospital in general). This argues for a CESS that employs a group-based decision-making process such as bioethics mediation or moral case deliberation.

Not only would such an approach be more likely to be implemented, it also relies on an understanding of an ethical solution as contextual and socially embedded. Since the problems arise within the social context of relationships to different stakeholders and are shaped by the individuals within the respective situation, a solution to the problems should equally be found within this specific context. Moral case deliberation emphasises that moral wisdom is attainable for everyone through group deliberation (Porz et al. 2011). The stakeholders are understood as the experts of their own world and are therefore also the experts in developing a solution (Porz et al. 2011). The facilitator assists in arriving at the solution but they do not provide the direction or final destination in the search of an answer to ethical challenges. This can also encourage ethical thinking on a day-to-day basis as opposed to clinical ethics consultations that may seem "to delegate responsibility elsewhere" (Corr et al. 2018, p. 56).

The above-mentioned points speak in favour of a group-based decision-making during a CESS. In the following I will argue that moral case deliberation is preferable to bioethics mediation because MCD uses frameworks such as principles, guidelines or norms only within the deliberation process and not before in defining the problem.

Bioethics mediation relies on "well-worn ethical norms" (Fiester 2014, p. 508). Defining what these are can be expected to be an even greater challenge in veterinary medicine than it already is in the pluralistic human medical context. The fact that the status of the animal is widely debated and dependent on the relationship a particular animal finds itself in, is part of what makes veterinary medicine abundant with ethical challenges. There is no common ground beyond the legal framework on the moral status of animals and the obligations they are due. Applying principles or pre-given frameworks to define what is 'generally ethically acceptable' before the actual deliberation process as, for example, done in bioethics mediation, is therefore highly questionable in veterinary medicine. The consensus on norms and principles with regards to the treatment of animals is insufficient to have much force in deciding for an individual case because principles need to be vague to be generally accepted such as 'do not harm without a justifiable reason'. I argue that there is no generally acceptable framework that is precise enough to be applied to ethical challenges in the clinical practice without further discussion. A CESS in a small animal hospital should therefore follow a model that, with regards to Fig. 1, takes the turn before defining what is generally ethically acceptable and directly goes into a group deliberation when ethical challenges arise to find out what is ethically acceptable for the stakeholders in this specific situation.

A possible objection to this is that a solution can be facilitated that does not consider any principles, not even vague ones that are generally accepted, but only focuses on the stakeholders' interests. This is also a common objection raised against bioethics mediation (as discussed in Fournier 2016). However, this is not true since principles, norms and guidelines are still part of a deliberation process during MCD. They are either raised and identified by the participants because they use them for explaining their positions or their moral unease, or they can be introduced by the facilitator to inform questions during the group deliberation. Solutions within MCD are therefore not developed in an ethical vacuum ignoring any already existing ideas and frameworks on what should be done, but the understanding of any

principles or values that seem relevant to the participants are explored in detail and in relation to the respective situation.

The advantage of starting from the participants' perspectives is another point that argues for MCD. Using a narrative approach that encourages participants to tell their story in relation to the ethical challenge facilitates the understanding of different perspectives and enables participants to directly dive into their challenges as opposed to first having to deal with detached ethical theory (see e.g. Porz et al. 2011). The narrative approach can foster the realisation that there is a genuine ethical plurality in a situation and it prevents jumping to detached principles too quickly. The latter has the potential to result in comparing and weighing principles whereas analysing a concrete situation and how principles are embedded in it can offer more flexible solutions that do not rely on a final decision on which principle should outweigh which.

Taken together, there are three reasons to prefer MCD over a different group-based CESS; that it does not rely on pre-defined principles, norms and frameworks of what is generally ethically acceptable, that it still allows for the consideration of (pre-given) principles, frameworks or norms within the group deliberation and that it starts from the participants' perspective which has the potential to make ethics more approachable to those that are not familiar in formally engaging with it.

Three additional points speak in favour of MCD; (1) that it provides a suitable environment to discuss issues for which there is not enough time in a stressful clinical routine, (2) that it can be used pro- and retrospectively, and (3) that it trains veterinary professionals and brings benefits also without owner participation.

MCD is normally conducted on a regular basis which gives participants the certainty that there will be a possibility to address issues when there might not have been enough time when the issues occurred. MCD also has the potential to address ongoing cases when the dilemma method is used (see e.g. Stolper et al. 2016). This makes it flexible to address whatever is most urgent for the participants and opens it to a broad range of issues and questions.

Although it benefits from a representation of all stakeholders including the owner, MCD can still bring benefits to the participants when the owner is not present. As discussed earlier

problems and challenges are not limited to the owner but include other professions and clinical disciplines that might be more likely to participate than the owner. In addition to that, any results of MCD with regards to a development of ethical skills can be applied in various contexts and new cases.

The potential unwillingness of the owner to take part in any CESS argues for a combination of MCD with an ethical checklist as proposed by Corr and colleagues (2018) which addresses potential points of conflict between owner and veterinarian at the beginning of a clinical consultation.

In any case, there is a need for support from senior staff and the institution in order for a CESS to be successfully implemented. This has been acknowledged by many different authors with different approaches of CESS (MacRae et al. 2005, van der Dam et al. 2013, Adin et al. 2019). The organisational support is, for example, reflected in providing the time for CESS but also in taking results developed during group deliberations seriously.

In conclusion, I have argued for moral case deliberation as a promising model for a clinical ethics support service in a small animal hospital because it is more likely to be accepted than a clinical ethicist's recommendations, it understands ethics as socially and contextually embedded, it does not rely on a pre-given ethical framework but can still consider principles, norms and guidelines within the deliberation process, it makes ethical deliberation accessible by starting with the participants perspectives and can be used to address cases and questions pro- and retrospectively during regular meetings which can be beneficial also without the participation of the owner. In combination with incorporating value-related questions into the routine clinical consultations with the owner, MCD appears to be a powerful tool in addressing ethical challenges in a small animal hospital.

Future work in this direction can consist of further exploring the requirements of a CESS in clinical practice by means of additional empirical studies that, for example, assess the burden and quality of ethical challenges also of other professionals in the small animal hospital. It would also be interesting to find out what the attitudes of patient owners towards value conflicts with veterinarians are in order to assess to which degree they may be willing to participate in a CESS (specifically in the context of the small animal hospital).

Implementing a CESS in form of moral case deliberation in a veterinary context requires answers to more detailed questions such as, for example, who should attend on a regular basis, how often should meetings take place, how could a facilitator be trained given the lack of existing MCD in the veterinary context and in which way can methods such as the dilemma method be directly transferred or would need adjustments. In order to assess the capacity of MCD to reduce the burden of ethical challenges for veterinarians, patients and other stakeholders in the small animal hospital, trying out MCD sessions with veterinary professionals and an experienced facilitator would be a preferable next step, since any method will only be ultimately successful if it can engage its participants and proof its value to them.

5. Abstract

Ethical challenges arise in both veterinary and human medicine, related to, for example, end-of-life decisions, conflicting obligations or limited resources. In human medicine, different models and methods of clinical ethics support services have been established in order to help healthcare professionals, patients, family members and other stakeholders deal with these ethical issues and improve patient care. First attempts at implementing clinical ethics support services into veterinary medicine have been made and are debated in the thesis, however, a full analysis of the appropriateness of different methods has been lacking so far. The aim of this thesis is to further explore the potential of clinical ethics support services in a small animal hospital by addressing the following two research questions. What are the underlying conceptions of ethics in different methods and models of clinical ethics support services? What is the potential that different models and methods of clinical ethics support services have for addressing ethical challenges in the small animal hospital setting? With regards to the first question a theoretical analysis of existing models and methods in clinical ethics support services in human medicine reveals underlying conceptions of ethics in these approaches. To address the second question, the ideas are transferred into the context of a small animal hospital by first identifying requirements for such a service based on problems veterinarians face with regards to decision-making processes and cases. An observational study is conducted and shows problem areas, based on which two main underlying aims are identified: acting in the best interest of the patient and achieving and/or maintaining professional recognition. The potential that different models and methods have for addressing ethical challenges in the small animal hospital setting is assessed by combining the theoretical and the empirical work. The thesis concludes with argumentation for why moral case deliberation is preferable for a clinical ethics support service in a small animal hospital, compared to the other methods that were presented in this work.

6. Zusammenfassung

Veterinär- und Humanmedizin sind reich an ethischen Herausforderungen, die zum Beispiel auftreten in Bezug auf Entscheidungen am Lebensende von Patientinnen und Patienten, bei knappen Ressourcen oder unterschiedlichen Pflichten, die miteinander in Konflikt stehen. In der Humanmedizin haben sich unterschiedliche Modelle und Methoden der klinischen Ethik etabliert, die Ärztinnen und Ärzte, Patientinnen und Patienten, Familienangehörige und andere Involvierte bei ethisch schwierigen Fällen unterstützen. Es gibt bereits erste Ansätze, die Unterstützung bei ethischen Herausforderungen durch Modelle klinischer Ethik auch in der Veterinärmedizin ankommen zu lassen, allerdings fehlt bisher eine tiefergehende Analyse der Eignung und Angemessenheit der verschiedenen Methoden. Das Ziel dieser Arbeit ist es, das Potential verschiedener Modelle und Methoden der klinischen Ethik in einer Kleintierklinik vertiefend zu untersuchen und anhand der zwei folgenden Forschungsfragen zu bearbeiten. Was ist das zugrunde liegende Ethikverständnis in verschiedenen Modellen und Methoden der klinischen Ethikberatung? Wie groß ist das Potential verschiedener Modelle und Methoden der klinischen Ethik um ethischen Herausforderungen in der Kleintierklinik zu begegnen? Die erste Frage wird durch die theoretische Analyse von existierenden Modellen und Methoden der klinischen Ethikberatung in der Humanmedizin beantwortet. Zur Beantwortung der zweiten Frage, werden die Zugänge aus der Humanmedizin in den Kontext einer Kleintierklinik übertragen. Dafür werden zunächst die Anforderungen aus der Praxis an eine Unterstützung durch Modelle der klinischen Ethik klarer gemacht: eine Beobachtungsstudie von Fallbesprechungen von Tierärztinnen und Tierärzten zeigt Problemfelder und lässt darauf basierend zwei zugrunde liegende Hauptziele der Veterinärmedizinerinnen und -mediziner identifizieren: im Interesse des Patienten zu handeln und professionelle Anerkennung zu erhalten. Das Potential der verschiedenen Modelle und Methoden der klinischen Ethik zur Unterstützung bei ethischen Herausforderungen in der Kleintierklinik wird anhand der Kombination der theoretischen und der empirischen Arbeit eingeschätzt. Die Arbeit schließt mit einer Argumentation dafür, dass die Ethische Falldeliberation (*moral case deliberation*) den anderen vorgestellten Methoden in der Kleintierklinik vorzuziehen ist.

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8. Lists of figures, tables and abbreviations

8.1. List of abbreviations

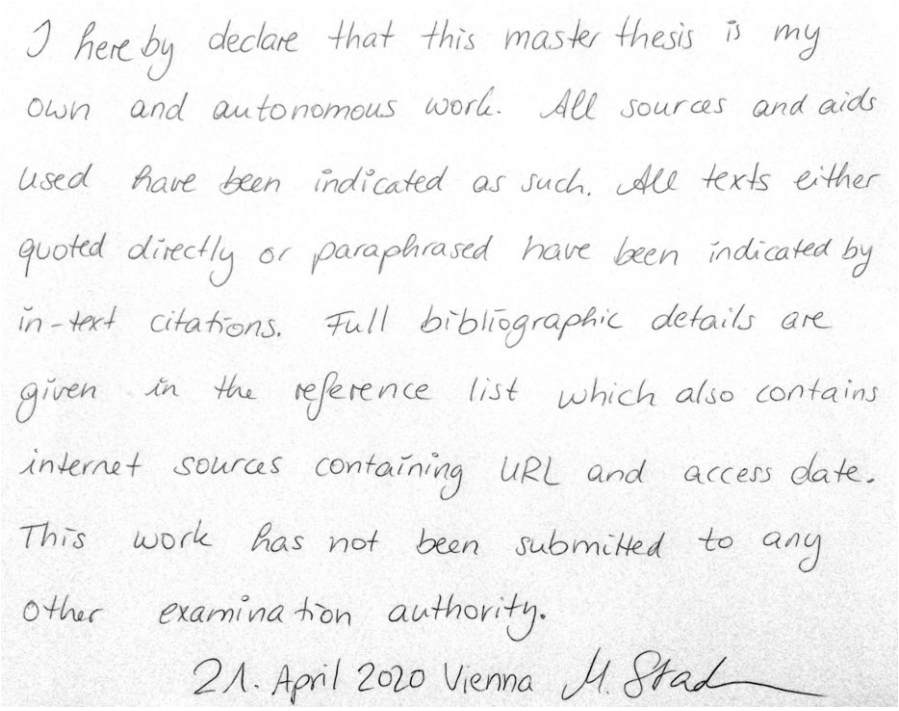
Table 5: List of abbreviations and their meaning

Abbreviation	Meaning
CEC	Clinical ethics consultation
CESS	Clinical ethics support service(s)
CPR	Cardiopulmonary resuscitation
DNR order	Do-not-resuscitate order
HCP	Healthcare professional
MCD	Moral case deliberation
MIV	Midday meeting
MOV	Morning meeting
SDM	Surrogate decision-maker

8.2. List of figures

8.3. List of tables

9. Declaration of autonomous work


I hereby declare that this master thesis is my own and autonomous work. All sources and aids used have been indicated as such. All texts either quoted directly or paraphrased have been indicated by in-text citations. Full bibliographic details are given in the reference list which also contains internet sources containing URL and access date. This work has not been submitted to any other examination authority.

21. April 2020 Vienna M. Stad

10. Appendix

Beobachtungsleitfaden - Morgen- und Mittagsvisite in der Kleintierklinik

Fall	*Inhalt - Was wird gesprochen?*	*Umgang/Form - Wie wird gesprochen?*	*Sonstiges*
Q1 **Welcher Fall** wird diskutiert? --> Tierart, Krankheit, Fragestellung Nu**mmerierung F1, F2, ...**	**Q2** Welche **Aspekte der Fälle/Fragestellungen** werden vorgestellt? **Q3** Wird die **Perspektive des Besitzers** thematisiert und wenn ja, wie? **Q4** Welche **Probleme** werden in Bezug auf die Fälle bzw. auf Entscheidungen thematisiert? **Q5** Welche **Probleme** scheinen darüber hinaus erkennbar **ohne offen thematisiert** zu werden? **Q6** Werden **verschiedene Meinungen** gesammelt, bevor eine Entscheidung diskutiert oder gefällt wird? **Q7** Wird eine **Entscheidung** getroffen? Wenn ja, wie und von wem? **Q8** Haben alle Teilnehmer zum Zeitpunkt einer Entscheidung ihre **Meinung mitgeteilt** auf eine Weise, die vom Entscheidenden wahrgenommen wurde? (z.B. Gesprächsbeitrag, Kopfschütteln, Schulterzucken (die vom Entscheidenden zur Kenntnis genommen wurden)) **Q9** Signalisieren die anderen Beteiligten **Zustimmung oder Ablehnung nach einer Entscheidung** (oder weder noch)? (z.B. Kopfschütteln, Äußerungen, Kopfnicken etc.) **Q10** Diskutieren die Teilnehmer **nach einer Entscheidung** einen Fall weiter? z.B. in kurzen	**Q12 Gesprächsleiter/Moderator?** **Q13** Wie oft **unterbrechen** sich die Teilnehmer gegenseitig (ohne Fortsetzen nach der Unterbrechung)? **Q13.1:** Höhergestellter unterbricht Tiefergestellten **Q13.2:** Tiefergestellter unterbricht Höhergestellten **Q13.3:** Gleichgestellte unterbrechen sich **Q14** **Gesprächslautstärke** - Sprechen (einzelne) Teilnehmer sehr laut oder sehr leise? Wenn ja, **welche und wie**? **Verändert** sich die Lautstärke der Teilnehmer im Verlaufe einer Falldiskussion? **Kodierung** für Lautstärke: **L0:** leise/schlecht verständlich **L1:** normale Gesprächslautstärke **L 2:** laut **L3**: sehr laut **Q15** *Wie lange wird ein Fall diskutiert?)* **Q16** Wie wirken (einzelne) **Teilnehmer?** gestresst/aufgebracht/entspannt Unruhig/konzentriert Offen einander gegenüber/ genervt **Q17** **Gesamtatmosphäre**? (z.B. harmonisch/angespannt etc.)	Beschreibung des Raumes (Größe, Ausstattung, Anordnung, Temperatur, Luftqualität etc.) Evtl. Raumskizze + *Platz für weitere Beobachtungen und nachträgliche Memos*

	Pausen, beim Hinausgehen **Q11** Wie werden Meinungen oder Positionen **begründet**? z.B.: a) mit der **Lebensqualität des Tieres** in Bezug auf **Leiden/Schmerzen** oder unabhängig davon b) mit **medizinischer Expertise** c) mit der M**einung des Besitzers** d) **finanziell** e) mit **Beobachtungen/Interpretationen des Patienten** (z.B. "will nicht mehr leben") f) mit **vorherigen Fällen** g) mit **andere Autoritäten** h) mit **Vorschriften oder Richtlinien** i) mit eigenen **Emotionen und Werten** j) betont **rational** k) **gar nicht** l) anders		

Abkürzung	**Bedeutung**
E	Entscheidung
F1	Fall 1
Q2	Frage 2
OP	Operation
T1, T2, ...	Teilnehmer 1, Teilnehmer 2, ...
Vet, V, *TA*	Tierarzt
B	Besitzer
P, Pa	Patient
EU	Euthanasie
W	Wahrscheinlichkeit

Abbreviation	**Meaning**
D	Decision
C1	Case 1
Q2	Question 2
OP	Operation/ surgery
P1, P2, ..	Participant 1, Participant 2, ...
Vet, V	Veterinarian
O	Owner
P, Pa	Patient
EU	Euthanasia
Prob	Probability

S, Schm	Schmerzen
K	Kosten
MOV-01	Morgenvisite 1
MIV	Mittagsvisite
KL	*Kostenlimitiert*
TQ	*Tierquartier*
US	*Ultraschall*
Parvo	*Parvovirose (hochinfektiöse Durchfallerkrankung)*
kom(m)	*Kommentiert*
VD	*Verdachtsdiagnose*
ICU	*Intensive Care Unit*

In Italics: added during the observations

Pain	Pain
Co	Costs
MOV-01	Morning meeting
MIV	Midday meeting