

## “Here’s My Dilemma”. Moral Case Deliberation as a Platform for Discussing Everyday Ethics in Elderly Care

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**Abstract** Our study presents an overview of the issues that were brought forward by participants of a moral case deliberation (MCD) project in two elderly care organizations. The overview was inductively derived from all case descriptions (N = 202) provided by participants of seven mixed MCD groups, consisting of care providers from various professional backgrounds, from nursing assistant to physician. The MCD groups were part of a larger MCD project within two care institutions (residential homes and nursing homes). Care providers are confronted with a wide variety of largely everyday ethical issues. We distinguished three main categories: ‘resident’s behavior’, ‘divergent perspectives on good care’ and ‘organizational context’. The overview can be used for agendasetting when institutions wish to stimulate reflection and deliberation. It is important that an agenda is constructed from the bottom-up and open to a variety of issues. In addition, organizing reflection and deliberation requires effort to identify moral questions in practice whilst at the same time maintaining the connection with the organizational context and existing communication structures. Once care providers are used to dealing with divergent

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perspectives, inviting different perspectives (e.g. family members) to take part in the deliberation, might help to identify and address ethical ‘blind spots’.

**Keywords** Ethical issues · Clinical ethics · Moral case deliberation ·  
ursing home · Care home · Elderly care

## Introduction

The literature on ethical issues in elderly care covers a wide range of topics, typically described against the background of demographic, socio-cultural, technological and political developments. The aging population in western societies presents ethical issues particularly in relation to the allocation of services and intergenerational justice [27], and to matters of life and death (such as euthanasia or resuscitation). These primary substantive issues are compounded by secondary issues: negative images of older people in society, not just amongst the general population but also among the care workers dealing with older people, for example nurses [22, 33] give rise to ageism and discrimination [13]. These wide ethical issues, however, are traditionally the domain of academic ethicists, because of their controversial and often technical nature. They have become more prominent in recent years because of medical developments and life-sustaining technologies [27]. The debates have branched out into more overt technology discussions, for example with the application of robots and sensor-augmented environments both at home and within institutions [9, 34].

It has been argued that ethical issues in the context of long-term (elderly) care are different from those arising in acute care [13]. Instead of temporarily getting treatment and being cured older people in nursing or care homes are *living* in an institution until their last day, facing deterioration rather than cure [6, 17]. This calls for a different ethical framework in which the emphasis shifts from upholding individual rights to meeting the residents’ needs in congruence with their life story and sharing responsibilities between resident, family and staff [17]. Instead of the extraordinary cases studied by ethicists, issues that arise in the context of daily life, care and diverse relationships, are of prime concern to professional caregivers. To help them deal with these issues better, new forms of ethics support in care organizations have been developed as an alternative or complementary to the more traditional ethics committee. One of these forms of ethics support is Moral Case Deliberation (MCD) [2, 25].

This paper reports on the content of MCD as part of a larger evaluation study on the introduction of MCD in two elderly care organizations in the Netherlands. The central question in this study is what the issues are that professional caregivers wish to discuss in MCD.

In the international literature ethical questions that arise on a day-to-day basis are captured in the concept of ‘everyday ethics’. Since Kane and Caplan [16] published their book, *Everyday Ethics*, several papers have been published on different aspects of ‘everyday ethics’ in various care settings covering a range from home-care [12] and day-care [11] to assisted-living [24] and nursing home care [4, 5]. Some

publications focus on one perspective, for example that of the caregiver [7, 8], other articles explore the differences and similarities of more than one perspective, e.g. the resident, family members and caregivers [36].

Up to now very few studies have been published on the issues that are subject of ethical deliberation on the workforce. Bolmsjö et al. present their teleological model applying it to three different types of ethical problems in dementia care [4]. The aim of our study is to demonstrate the great variety and richness of issues which are brought forward within the context of MCD.

### MCD as an Intervention for Ethics Support

Moral case deliberation fits within the recent shift to dialogical ethics [2]. Instead of leaving the deliberation to an expert or a committee, in MCD the care-providers deliberate with peers on their own moral issues. The deliberation takes about 2 h (although sessions can also be shorter or longer) and is facilitated by trained facilitator. This can be an ethicist but can also be a professional within the care organization, who is especially trained in clinical ethics and conversation methods. The facilitator's job is to foster a sincere and constructive dialogue among participants, to keep the focus on the moral dimension of the case and to help the group with planning actions in order to improve the quality of care [2].

A special feature of the MCD groups in our study was their heterogeneous character [37]. The participants came from different teams and had various professional backgrounds.

## Design and Methods

### Setting: MCD Project in Two Elderly Care Institutions

The data presented here were derived from a larger evaluation study on the implementation of MCD in residential elderly care (two nursing homes and a consortium of care homes in the Netherlands). One nursing home (A) consisted of eight wards in which 270 residents lived and 150 staff members worked. The other nursing home (B) consisted of seven wards in which 180 residents lived and 75 staff members worked. The care home organization consisted of three locations and several assisted-living units. The locations varied from 1 to 3 wards in which in total 250 residents lived and 150 staff members worked.

The project consisted of different phases. In 2006 both organizations started the MCD project with support from an MCD research team. After introducing MCD to the staff in a meeting accessible to all disciplines, in 2007 in each of the institutions mixed MCD groups were created, with participants from different wards and disciplines (see Table 1 for composition).

Within each MCD group a series of 2-h MCD sessions was organized in which ethical issues that the participants experienced in their own daily practice were discussed using a structured conversation method [25]. Over the course of the years 2008–2009 in one of the nursing homes (the other nursing home withdrew from the

**Table 1** Cases per MCD group

Institution	Group	Cases N	Participants	Remark
Nursing home A	A1 (03-12/'07)	48	(auxiliary) Nurses (5) Nurses (2 & 1 RN) Activity therapist Speech therapist Pastor Occupational therapist Nursing home physician	Institution withdrew from project in 2008, cases from 2007 were used
Nursing home B	B1 (05-09/'07)	18	(auxiliary) Nurses (6) Team manager psychogeriatric ward Physiotherapist Social worker Activity therapist Pastor Nursing home physician	Aux. nurses from somatic wards
	B2 (05-09/'07)	13	(auxiliary) Nurses (7) Team manager somatic ward Nurse (RN) Psychologist Activity therapist Nursing home physician	Aux. nurses from psychogeriatric wards
	B3 (01-11/'08)	39	(auxiliary) Nurses (6) Nurse (RN) Physiotherapist Activity therapist Pastor Social worker Nursing home physician	Merged from B1 & B2
Care home	C1 (01/'07–03/'08)	60	(auxiliary) Nurses (6) Nurse (2) Nursing student Activity therapist Social worker Policy advisor	
	C2 (12/'07–04/'08)	20	(auxiliary) Nurses (3) Admissions consultant Receptionist Resident administrator Activity therapist Nurse (2) Student's mentor (2) Policy advisor	Some participants from secondary process. One policy advisor participated in all groups.

**Table 1** continued

Institution	Group	Cases N	Participants	Remark
	C3 (10/08–02/09)	4	(auxiliary) Nurses (4) Nurse Policy advisor	Merged from C1 & C2, continued from March 2009 with team managers as future moderators

project) and in the care home organization MCD was implemented on six wards. In 2010 seven representatives from the institutions, with prior experience in one of the MCD groups, were trained to become MCD facilitators in order to structurally anchor MCD within their organization.

### Data Collection

The evaluation project offered us the opportunity to analyze a large number of case descriptions (N = 202) provided by the participants (N = 60) of seven mixed MCD groups (47 MCD sessions between January 2007 and February 2009, see Table 1).

Before the first meeting participants were asked to provide a description of a situation in which they experienced an ethical dilemma. The request was formulated in plain language: *describe a situation that you were involved in, in which you (or you and your colleagues) struggled with the question ‘what should we do’? Try to formulate a concrete question.* The facilitator distributed all the cases this generated to all participants of the group, so that everyone could read the cases prior to the MCD session. At the meeting the person who had written the case, the ‘case-owner’, briefly presented his or her case orally. During the first meetings all cases that were generated for that meeting were presented and (briefly) discussed, focusing on how to make explicit the ethical question in each case. The discussion of the situations resulted in greater insight into what case descriptions could entail. For example, through the discussion it was concluded that the term *case* is not synonymous with *resident* and that more than one dilemma (case) can arise in caring for one resident. In order to encourage engagement in the deliberations and to increase awareness of ethical issues, participants were asked to present a case at every meeting. The group democratically selected one case and discussed it in depth.

All the case descriptions (written and oral) as well as all the conversations about the selected cases in the MCD sessions were collected by the research team. The conversations in the meetings were tape-recorded (after first gaining approval from the group), and these were used to make a meeting report which summarized the discussion and was sent to the participants to gain their approval. The first author acted as a participant observer, taking the role of moderator in all the MCD meetings, and made field notes focusing on the nature of the issues discussed during the meetings. These observations were also used when writing the meeting report.

Data Analysis

The overview of issues was developed from the analyses of the original case descriptions and the discussion in the MCD sessions. For a small number of cases (N = 23) we made use of the meeting report as these cases had only been presented verbally. For the other cases (N = 179), the case description as provided by the participant was used. For nearly a third (N = 63) of the cases this was the only source available. These cases were either not selected for discussion or there was no report available. We checked whether the definition of the moral issue changed during the meeting. In most cases the moral question stayed the same or was slightly adjusted. In a small number of cases (N = 6) the moral question finally turned out to be different from the one originally posed. For the analysis we focused on the adjusted dilemma. See Fig. 1 for the source of the case descriptions.

During the analysis process we followed an inductive approach in order to be as open as possible to the moral issues discussed. The analysis focused on the content

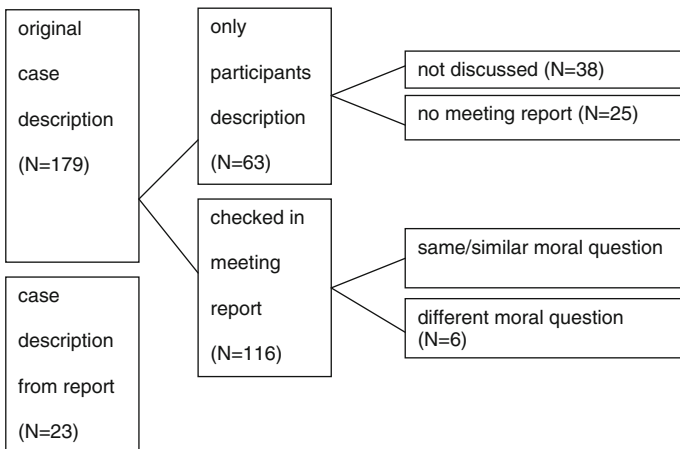
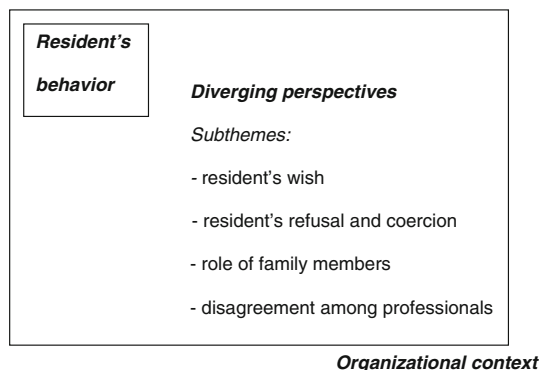


Fig. 1 Source case description

Fig. 2 Themes and subthemes



Organizational context

of the case descriptions [20]. The analysis aimed to identify recurring moral issues (themes) in the case descriptions. This method of analysis is known as conventional qualitative content analysis [14]. The first author coded the case descriptions with the scope of the issues in mind from the experience as moderator of nearly all MCD sessions. Similar cases were clustered, resulting in categories and subcategories. The structure of themes and subthemes was discussed several times with the second and the fourth author, which led to the merging of some of the main categories into three themes (see Fig. 2). A number of cases was categorized under more than one label ( $N = 44$  under two labels;  $N = 3$  under three labels).

### Quality Procedures

To assess the validity of our study we used the checklist published in the BMJ, 2008 [18]. The ‘rock bottom’ of the internal validity in qualitative research is considered to be the ‘member check’ as this procedure helps to eliminate bias [21, 23]. In our study all participants of the MCD sessions received a meeting report. Participants were asked whether they recognized the analysis, and whether it expressed accurately what they had wanted to express. All respondents agreed with the report. During the study process the researcher/first author regularly discussed methodological decisions within the research team. For example, the sampling procedure was discussed, as was the role of the researcher, the risk of over-identification with the respondents and the proper balance between distance and engagement. Another quality assurance procedure was ‘triangulation’: we combined a text analysis with information based on participant observations of all MCD meetings. This combination of sources provided us with a larger scope of information, and enabled us to identify discrepancies. The external validity of the study was fostered by giving a description of the context, thus enabling readers to assess the potential transferability of the results to other elderly care settings.

### Ethical Considerations

The participants received a letter with an explanation of the study and an invitation to participate. Participants were required to present their cases in an anonymized way in order to protect the privacy of both the residents and the professionals. After informing the participants about the purpose of the study, explicit (verbal) consent was asked for recording the MCD sessions for the purpose of writing the meeting report and for further scientific research. The presented cases and the meeting reports were not shared with others, and were stored in a secure place only accessible to the researcher. The researcher/first author had no hierarchical working relationship with the participants.

## Results

Analysis of the case descriptions showed that moral questions arise in all kinds of situations in daily practice. Most participants in MCD did not frame these questions

from an ethical perspective. They did not formulate the case in terms of a conflict between values or norms or an ethical dilemma. Instead, they described the situation from a practical perspective and formulated practical questions referring to the gut feelings about a moral problem in the case (for example, referring to “a knot in the stomach”).

Most issues (see Fig. 2) concerned the primary care process, the question being ‘what is good care for this or these resident(s)?’. A small number of issues concerned the secondary care process (e.g. problems with distribution of shifts).

We distinguished three different clusters of problems that caregivers encounter. First, caregivers reported confrontation with resident’s problematic behavior. Second, caregivers found themselves in a difficult situation when different parties involved in a case had divergent views on what constituted ‘good care’ in a particular situation. Third, caregivers were confronted with structural factors and limitations within the organizational context. The amount of care that a certain caregiver (or a team) can give or that a resident can get in a certain setting is limited. Below, the clusters of moral issues will be examined in more detail. In Table 2 several examples of moral issues are shown.

**Table 2** Examples of moral issues

Theme	Issues/moral questions
1. Resident’s behaviour	<p>A resident was eating with her hands and burping during dinner. The team asked to what extent it was acceptable for her fellow residents to have to be confronted with her behavior: could she sit at the same table or should she get a table of her own?</p> <p>A group of care home residents did not want a fellow resident to take part in an activity because they disliked him. They said that they would quit if he joined them. There was, however, one place vacant and the resident had told the activity therapist that he wanted to join the activity.</p> <p>The spouse of a resident had agreed that the nurse would not force her husband to be washed when he started shouting and slapping. However, when she was present when her spouse started behaving inappropriately, she insisted, against the agreement, that the nurse should continue to wash him.</p>
2. Divergent perspectives	<p>A resident of the care home, who was suffering from diabetes, had gained a lot of weight since his admission one year before, but kept drinking alcoholic beverages and eating sweets</p>
a) Resident’s wish	<p>A resident wanted to go out for a walk but doing so would place the resident in great risk of falling.</p> <p>A resident who owned a small low powered car for which you do not need a driver’s license, but unintentionally drove dangerously without regard to the rules of the road.</p> <p>A resident insisted on getting speech therapy in the expectation against hope, that this would improve his condition.</p>
b) Resident’s refusal and coercion	<p>A resident participated in a mobility training program, but showed no motivation to walk when he was on the ward. Should the caregiver should motivate the resident to keep on practicing?</p>



**Table 2** continued

Theme	Issues/moral questions
c) Role of family members	<p>A resident who set value on remaining physically independent nevertheless asked for help with personal care. Some of the nurses in that team were reluctant to assist the resident because they feared that this would make the resident irreversibly dependent on them.</p> <p>A resident, who was ‘a bit of a loner’. To what extent should the staff encourage or even push him, to join the other residents in the community room when having diner.</p> <p>A resident on a rehabilitation unit, whose condition had not improved despite several months of therapy, became nervous and started acting out because of the constant confrontation with her disabilities. However, the family did see improvement and wanted the therapists to continue treatment.</p> <p>A resident in a care home expressed the wish to stay in bed and not participate in activities. Her children requested the nurses to push their mother (the resident) to get out of bed because of their positive experiences with a ‘tight’ day program in similar situations in the past.</p>
d) Disagreement among professionals	<p>A resident in the nursing home wished to have unlimited access to a telephone in his room. His daughter requested the staff not to give her father a telephone, because he would then continuously call her.</p> <p>A team considered stimulating a resident to stay active and visit day care services, but the day care team working with the resident thought that this particular resident could not participate meaningfully in the day care programme anymore and would be better off staying on the ward.</p> <p>A nurse, on behalf of her team, questioned the physician’s decision to start tube-feeding in a resident in the final stage of his illness. The resident died a week later, and the nurses felt that he had needlessly suffered through this treatment.</p>
3. Organizational context	<p>A auxiliary nurse presented the question of how to react, when passing a residents’ room, hearing her colleague becoming very angry with the resident.</p> <p>A nurse questioned whether it was ethically acceptable to ask the son of a resident not to visit his terminally ill mother because the institution was struck by the NORO virus and had responded with a ‘no visit’ policy.</p> <p>The team proposed to move one of the residents from his single room to a four-person room, in order to provide the single room for a terminally ill resident. The resident of the single room, however, resisted the move.</p> <p>A resident who was discharged from the hospital too early, in the opinion of the nurses. The question was how to respond to difficulties in offering the amount of care that resident needed.</p> <p>A supervisor asked to what extent she should let a nursing student bring her private problems into discussions inside the work environment.</p>

## Resident's Behavior

Behavior that was perceived as problematic by caregivers and/or fellow residents regularly provoked moral questions. One quarter of the cases ( $N = 52$ ) were about behavioral problems, which were often caused by an underlying disorder, e.g. Alzheimer's disease, Korsakov syndrome, or a psychiatric disorder. A broad spectrum of difficult behaviors was described: residents who were disoriented, suffered from loss of decorum, wandering and 'booking', compulsory behavior, slapping and yelling. Some cases only dealt with a practical or therapeutic question, focusing not on what to do, but on how to do it properly.

Moral dilemmas that were raised by resident's behavior are various. In the first place, questions related to how behavior affected fellow residents. Caregivers are trained to respond to problematic behavior, but fellow residents are often defenseless victims who need protection. This is not only clear in the case of violence, but also when it comes to loss of decorum. In some cases problematic behavior provoked negative or aggressive reactions from fellow residents. Then the question was whether the resident who was acting out needed protection. In other cases the link with an underlying disorder was less clear or even absent. Also, cases were described, in which the resident's behavior crossed the line of what was considered acceptable to the caregiver. The question then was whether it would be (ethically) justified to interrupt assistance with the personal care when a resident would start acting out.

Often it was not the question of whether or not measures should be taken, but to what extent and to what 'cost' or in what way they should be taken. Especially the use of 'rigorous' measures, for example, physical or chemical restraints, were prominent discussion points. In some cases the caregiver's concern was how to reduce the negative consequences of measures taken. For example, how to give a resident who wants to 'escape' from the ward a sense of freedom without letting him or her go outside. In other cases, a shortage of staff or resources made the situation problematic. For example, when two residents with disturbing behavior have to share a room because there are not enough single rooms available.

## Divergent Perspectives on Good Care

The second cluster of moral problems ( $N = 138$ ) regards dealing with divergent perspectives on what is to be considered 'best' for the resident. Four sub-categories are distinguished: resident's wish, resident's refusal and coercion, family members' perspectives, and disagreement among professionals.

### *Residents' Wish*

Moral problems may arise when fulfilling a resident's expressed wish has negative consequences for the resident him or herself or for his or her fellow residents, or when a resident's wish conflicts with the caregiver's professional responsibilities ( $N = 30$ ).

In some cases it was questioned whether going along with the resident's wish would be the right choice, since his or her personal lifestyle could harm his or her health condition or safety. In other cases an underlying (sometimes progressive) disorder like Alzheimer's disease caused professionals to doubt whether it was responsible to fulfill a resident's wish. Equally, the actions of a resident might endanger others.

In other cases the problem was that complying with the resident's wish would cross the line of what was acceptable to the caregiver or would put too much of a (physical) burden on the staff. Two cases expressed the team's awkwardness with an implicit wish of residents to have room and privacy for intimate relationships and sexual contact. In a number of cases the resident's wish was in conflict with agreements documented in the personal care plan. In these cases the case-owner was not part of the (multi-disciplinary) team at the moment the agreement was made. They knew of the agreement but were troubled with the question of whether they should act in conformity with the agreement or should go along with the resident's wish.

### *Resident's Refusal and Coercion*

The refusal of care by the resident is another source of moral problems ( $N = 30$ ). It may relate to various aspects of care, such as personal care, taking care of finance, physical independence, participation in activities, eating and drinking, or treatment. Sometimes residents explicitly refused care that was offered to them; in other cases this was less obvious, but the caregiver/case-owner was concerned that (s)he was being too coercive.

In a number of cases there was a conflict caused by the resident's wish to remain physically independent, on the one hand, and difficulties, on the other, with the resident caring for him or herself, or for undertaking exercises prescribed by the physiotherapist. These exercises sometimes not only (physically) overstrained the resident, but presented the nurses with physical problems as well. Also, moral questions arose when it came to residents' participation in activities or engaging in social contacts in general.

In some cases, the resident rejected help with taking a shower or putting on clean clothes. These cases were problematic because the lack of personal hygiene could become a nuisance to others (fellow residents, the caregivers or family members). In two cases where the resident refused to eat the case-owner and especially family members were worried about the resident's health. In these cases the resident suffered from Alzheimer's disease but in both cases there was a clear rejection of food. Another type of moral problems concerned the question of whether or not the caregiver should persuade the resident to undergo a medical check or treatment, or to persuade the resident to make use of medical aids such as a hearing aid or elastic compression stockings.

### *Family Members' Perspectives*

A quarter of the moral problems arise from the triad of resident-family-caregiver ( $N = 47$ ). There are various possible ways in which the parties (and their perspectives) relate to each other.

The first source of problems is a conflict of perspectives (and sometimes actions) of family members and the professional caregiver(s). In these cases, the perspective of the resident on the matter was mostly unclear or not explicitly mentioned. The case-owner's problem focused around whether the behavior or suggestions of the family might not harm the resident's interests. In some other cases, the residents' wishes were more or less evident, and in these cases the case-owner felt he should act as an advocate for the resident.

The second source of problems is a conflict of perspectives between the resident and the relatives. This category of problems partly overlaps with the cases described above, but the perspective of the family adds an extra dimension, making the case more complex or putting more pressure on the case-owner, for example, making the case-owner feel stuck between the perspective of the family and the institution's values, which emphasize the importance of client-centered care in its mission statement. In some cases, following the resident's wishes might be harmful to the relatives.

Participants also described cases where the problem was not caused by a divergence of perspectives on good care for the resident. A small number of cases concerned the (negative) attitude (and behavior) of the relatives towards the staff or the residents. Also, problems were raised where family members disagreed among themselves or fight amongst themselves. The case-owner, in these cases, considered whether it was ethically right to interfere in this. Finally, in a number of cases the case-owner considered whether he or she should also deliver care to the resident's relative (for example, a spouse) or not, because this was outside the boundaries of the work description.

### *Disagreement Among Professionals*

Moral issues arise or become more complex when professional caregivers do not agree among themselves ( $N = 31$ ). In these cases the case-owner implicitly or explicitly disapproved of the perspective, the attitude of, or the actions undertaken by his colleague(s). This can be the case between members of different teams, between one of the specialist disciplines and a team, or within a team. In some cases the case-owners explicitly rejected the actions or the attitude of their own colleague(s) and in other cases, the case-owner complained that colleagues did not comply with earlier agreements. In some of the cases, the decision of the physician was questioned. Also, cases were described in which the case-owner explicitly advanced the moral question of whether or not they should address such issues and talk to their colleagues about the contested actions or attitudes.

### *Organizational Context*

The third cluster of moral problems is related to the organizational context ( $N = 59$ ).

In the first place, existing policies, for example, a 'no visit' policy, sometimes were experienced as a source of moral problems. In the second place, caregivers are forced to make tough, often tragic decisions because of contextual limits or scarcity

of staff or space, further complicating situations that were already (morally or practically) problematic. In some cases, the case-owner was confronted with two residents (or a resident and some volunteers) who required the caregiver's attention at the same time. In other cases, the problems were caused by a shortage of single rooms in the nursing home. A number of cases were related to a shortage of staff or cost-cutting. For example, some cases were reported where such resource issues lead to situations in which residents received less attention than was felt to be necessary, where certain activities were put on hold, where cleaning of the rooms was not done properly, or where the reception desk was closed during the evening.

In the third place, the participants described problems that were caused by a mismatch between the care that was needed by a particular resident on the one hand and the possibilities for offering that care on the other hand. For example, cases were raised about circumstances where the resident's condition worsened, requiring a discussion about transferring the resident from the care home to a nursing home. In some of these cases the relatives did not want the resident to be moved, in other cases, the professionals no longer felt able to deliver the required care or felt that the resident's staying in the current setting would not benefit the resident. In a small number of cases the gap between acute care and care home care caused problems.

Finally, in some cases moral problems were not directly related to the primary care process. These problems arose from the social climate in the institution or the attitude of colleagues (e.g. when gossiping) or were related to the position of the case-owner.

## Discussion

Our study shows clearly that caregivers in elderly care are confronted with a broad range of moral issues in their daily work. These issues can be framed as 'everyday ethical questions'. The moral question only arose very occasionally in the context of end of life decisions. Even in these cases, the core question differs from the typical medical ethical question: participants focused more on communication than on prolonging or abstaining from treatment. Furthermore, no cases on advance directives were described. The everyday ethical issues that were described are characterized by 'multi-perspectiveness'. It is not only the perspective of the resident and nurse that are important. In a large number of the cases, the perspectives of family member(s) and other caregivers add to the complexity of the issue. Most issues are not related to moral uncertainty in the mind of one person alone, but to problems in dealing with diverging, and often conflicting, perspectives.

In our MCD project we specifically aimed to refrain from abstract academic concepts and to connect to the experiences of the caregivers by focusing on their moral doubts and questions ('*what should I/we do?*'). The case descriptions reflect this practical approach. The participants hardly used ethical concepts such as 'autonomy' or 'beneficence' to describe their moral problems. This is in line with the findings of Powers [31] who describes that nursing home staff participating in an 'ethics project' found it difficult to recognize and reconceptualize their concerns as *ethical* issues. Instead they used common frames of reference, 'folk taxonomies',

such as ‘behavior issues’, ‘treatment issues’ and ‘resource issues’ to express their concerns. This does not mean that they do not experience moral problems or are insensitive to these issues, but rather that they use different labels. This is not merely a difference in concepts. Often, case descriptions touch upon different issues from those discussed in the literature under the heading of autonomy versus beneficence, or autonomy versus justice. If cases do resemble theoretical issues from medical ethics, the presentation tends to be sensitive to complexity and the discussion may lead to different conclusions than those known from the literature.

In the literature there is discussion on what is captured in the concept of a moral issue. Sometimes a moral issue is reduced to a moral *dilemma*, a situation in which one is forced to choose between two options that both generate negative consequences [28]. In everyday speech however, the term dilemma refers to all kinds of situations that are perceived as difficult. Also, in the literature a distinction is made between moral questions and other types of questions, such as legal, medical or practical/therapeutic questions. The participants in our study frequently formulated their questions in practical terms (how should I deal with this?). This does, however, not mean that the case does not contain a moral question or questions. As Molewijk [26] argues, only in the process of deliberation can it become clear whether or not the issue raised concerns a moral question dealing with values. We found that even in the cases which appeared only to be practical, a moral dimension was relevant; in such cases the ‘how to’ question leads to a moral question (what is right?).

Solum et al. [35] state that moral problems in elderly care arise when caregivers know what is best for their clients, but do not act accordingly. They further explain that in such situations the care providers often do not experience an ethical problem, but seem to lack the perseverance required to meet the client’s needs. In our study, we see the opposite: the caregiver knows what is the (ethically) right thing to do, but is not *able to* act accordingly. Contextual factors such as understaffing and shortages hinder caregivers’ efforts to attend to the values at stake. This is in line with other studies, which found that caregivers experience moral distress when they are not able to act according to what they think is ethically right [29]. This is especially the case in elderly care, as the professional standards and expectations in society are high while opportunities to realize these standards are missing [10]. Moral distress can be related to the ethical climate within an institution. A lack of openness and a work environment where caregivers are not stimulated to ask questions cause them to adapt and become routine oriented [15]. Jakobsen found that caregivers had become frustrated and experienced alienation because of the pressure to act against one’s own conscience. Also, personal factors such as a sub-assertive attitude may result in behavior that is incongruent with the caregiver’s moral intuition [26]. Our study also points at another source of moral distress: moral diversity. Some cases addressed unethical behavior of colleagues or behavior motivated by different ethical perspectives. This is stressful since elderly care is based on teamwork, and requires negotiation.

Family members play an important role in the moral problems that caregivers experience [6, 33]. A resident’s family is part of his or her life. Family members have known the resident for a long time and went through a lot before the admission

of the resident to the institution. Therefore caregivers have to deal not only with the resident but also with family members. The family adds another perspective, and the main challenge lies in negotiating caring responsibilities [10, 27]. A resident's family is often the best guide in identifying the values of the resident because of the shared history. Yet, there are situations when the caregiver is better able to identify this, because, for example, (s)he spends more time with the resident, or because in some cases the family projects their perspective onto the resident, and these can be 'colored' by feelings of guilt, mourning, frustration, distrust or idle hope. In addition, caregivers often have to deal with more than one family member, with various perspectives on what is best for the resident.

In a substantial number of cases the source of the moral question lies in the expressed or presumed wish of the resident, manifesting itself in a demand or refusal. These cases reflect, on the one hand, the tension between the societal and institutional emphasis on respect for autonomy, and, on the other, the daily practice where caregivers meet the limits of autonomy. Caregivers feel that they have responsibilities in relation to the well-being of individual residents, but also towards fellow residents. In contrast with a cure setting that is organized around the patient–doctor relationship, an elderly care institution is more like a community [17]. Caregivers have to balance the wishes of the individual resident with the values of other residents. Another aspect of long-term care is the need for narrative integrity [1, 3, 17]. Client-centered care means that caregivers have to do more than just what the resident demands. They are responsible for choices being consistent with the resident's narrative history. In this light it is understandable, as Jakobsen [15] rightly states, that 'although often characterized as a lack of respect for autonomy, defining an action as restraint does not automatically make it wrong' (p. 295) Here we see that the acknowledgement of the complex set of values and moral obligations in practice leads to a reframing of theoretical issues and principles.

### Limitations of the Study

The context of this study, the MCD groups, enabled us to gain insight in the perceived ethical issues and internal critique. Critique from outsiders was not included nor did this study provide us with objective information on ethical problems in long-term elderly care.

In our study all cases represented situations that were perceived as burdensome by the care providers. However, it matters who defines an ethical issue as a problem. Other studies have pointed out that not all ethical issues are noticed by caregivers. Nurses may have perceptions of issues (e.g. the realization of autonomy), that differ from the perceptions of the clients [19, 32]. Moreover, problems experienced by clients or relatives may not be identified by nurses [1, 3, 36]. This might indicate that our overview of issues, although considerably rich in its variety, possibly shows some deficits.

The willingness to report problems might have been higher in our participants than average. This, we think, did not have an effect on the construction of the overview in a qualitative sense. However, the cases in which the participant judges the perspective or behavior of his/her colleagues as unethical may point at a

selection effect of including participants who think of themselves as ethical role models. This might have caused an overrepresentation of cases in which the collaboration between professionals is seen as a problem. Another plausible explanation for these cases is that professionals find it easier to discuss what their colleagues do wrong than to discuss their own personal doubts.

## Conclusions and Recommendations

Institutions that wish to foster moral reflection and deliberation can use the presented overview as an agenda to structure and guide the attention toward ethical issues among the staff. The three main categories represent different assignments for reflection and deliberation and can be used to enhance the sensitivity for moral issues. The overview indicates that in addition to big issues, attention should be paid to everyday ethics: how to deal with clients whose behavior is experienced as problematic, how to communicate with family and colleagues and how to stay motivated and creative in a context of institutional routines and shortages. For a well-balanced agenda it is necessary to be open to a broad diversity of issues and to involve care providers in the (continuous) process of agenda-setting.

In order to connect with everyday practice, we also recommend a broad definition of the term ‘moral issue’. Deliberate effort is then required to extract and articulate moral questions and underlying values from feelings of discomfort and practical questions [30]. At the same time, it should be acknowledged that issues which seem merely practical at first sight might include important ethical aspects. Moreover, moral reflection should not become isolated from the organizational context and the existing communication structure within the institution.

Furthermore, attention should be paid to possible ‘blind spots’ among caregivers. Openness towards diverse viewpoints is a prerequisite for being able to deal with diverging perspectives. This is difficult, yet necessary for increasing the quality of care. We recommend dealing with divergent perspectives through MCD in a safe environment with various professionals, before inviting other parties, for example family members.

To make MCD successful, bottom-up input should be accompanied by top-down support from the management. Top management has to secure the preconditions, such as time and space. Middle management can play an important role in creating a work environment in which asking questions and considering underlying values becomes part of everyday practice, by stimulating dialogue in the team and acting as a role model.

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