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ORIGINAL ARTICLE

Good Care in Ongoing Dialogue. Improving the Quality of Care Through Moral Deliberation and Responsive Evaluation

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Abstract Recently, moral deliberation within care institutions is gaining more attention in medical ethics. Ongoing dialogues about ethical issues are considered as a vehicle for quality improvement of health care practices. The rise of ethical conversation methods can be understood against the broader development within medical ethics in which interaction and dialogue are seen as alternatives for both theoretical or individual reflection on ethical questions. In other disciplines, intersubjectivity is also seen as a way to handle practical problems, and methodologies have emerged to deal with dynamic processes of practice improvement. An example is responsive evaluation. In this article we investigate the relationship between moral deliberation and responsive evaluation, describe their common basis in dialogical ethics and pragmatic hermeneutics, and explore the relevance of both for improving the quality of care. The synergy between the approaches is illustrated by a case example in which both play a distinct and complementary role. It concerns the implementation of quality criteria for coercion in Dutch psychiatry.

Keywords Coercion · Dialogical ethics · Dialogue · Moral deliberation · Pragmatic hermeneutics · Responsive evaluation · Psychiatry

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Introduction

Caring is an inherently moral profession. Care always involves, implicitly or explicitly, choosing a moral position. In doing so, caregivers cannot simply use external, ready-made moral standards. Defining morally good care is and ought to be a contextual process, based on concrete experiences from caregivers. Attending to the particulars of a situation, is required to be able to adjust one's care to the needs of a patient while acknowledging the perspectives of other participants. Just applying general principles and standards is not adequate [7,10]; it is the dialectic between the detailed circumstances of the actual case and the general principles that fosters a morally right action. Therefore, caregivers are, and will be, confronted with moral dilemmas, again and again. Recently, ethical training models and moral deliberation methods have been developed in order to support caregivers in dealing with these moral dilemmas in a more reflexive, collective and constructive way [30, 32, 44, 47, 50, 55]. The aim of these training models and deliberation methods is primarily to help caregivers in dealing with moral dilemmas, and to assist them to define good care in an ongoing dialogical process.

The rise of moral deliberation methods in both health care practices and academic ethics centres can be understood against the broader development within medical and bioethics. This development is characterized by an increasing acknowledgement of the moral intuitions of practitioners, the value of human judgement in the light of particular contextual circumstances and the importance of an equal collaboration and dialogue among ethicists, caregivers, patients and other stakeholders [50, 51]. The emphasis shifts to intersubjective relationships and dialogical aspects of decision-making with caregivers and other participants in concrete situations. Approaches in ethics that deal with this dialogical approach, both theoretically and practically, include hermeneutics, pragmatism, discourse ethics and the ethics of care. These approaches in ethics aim to develop a communicative climate in which all voices and perspectives gain a serious hearing [28].

The rising attention for dialogue and interaction is not exclusive for the field of ethics. In other disciplines intersubjectivity is also seen as a way to handle problems in practice. An example is the field of evaluation [4]. While evaluation is often considered as a form of measurement of preordained program goals, a responsive approach to evaluation starts from the notion that evaluation is a process of negotiation about issues of as many stakeholders as possible [20]. Responsive evaluation has been developed in the field of (arts) education [42]. In the meantime the approach has been applied in other fields, among them health care [27, 49], and connected with notions of narrative and dialogue [1, 2, 4]. Responsive evaluation has a process-oriented character. The purpose is not to explain and control practices, but to foster quality improvement of practices through reflections and ongoing dialogues among stakeholders. In responsive evaluation dialogues are not restricted to a communal reflection on an ethical issue, but entail a cyclical process in which stakeholders come to an understanding of their practice through several interview and focus group rounds.

In this article we compare the ideas behind moral deliberation and responsive evaluation, and explore the relevance of both for improving the quality of care in

health care settings. We begin with a presentation of moral deliberation against the backdrop of the dialogical shift in medical ethics, followed by a presentation of the core concepts of a responsive approach to evaluation. The common basis of moral deliberation and responsive evaluation in dialogical ethics will be described in the next section. There we also identify differences between these approaches to improve health care practices. Next, a case example is used to illustrate what moral deliberation and responsive methodology in ethics mean in practice. Finally, we discuss how the combination of moral deliberation and responsive evaluation can function as a way to improve the quality of care through ongoing dialogical processes.

Moral Deliberation and the Dialogical Shift in Medical Ethics

A moral case deliberation consists of a meeting with health caregivers who systematically reflect on one of *their* moral questions within a concrete clinical case from their practice [47]. Most questions concern "What should we consider as the morally right thing to do in this specific situation and how should we do it rightly?" However, also more philosophical or conceptual questions are at stake (e.g. "What is respect?" "What does understanding mean?"). Three central, often co-existing, goals of moral case deliberation are: (1) to reflect on the case and to improve the quality of care within that case; (2) to reflect on what it means to be a good professional and to enhance professional's moral competencies, (3) to reflect on institutional or organizational issues and improve the moral quality of care at that level.[1]

The reflection, which takes 45 min to 1 day, is facilitated by a trained facilitator and structured by means of a selected conversation method (for examples of conversation methods see: [30, 43, 44, 46, 47]). The facilitator, an ethicist or someone who is trained in clinical ethics and conversation methods, does not give substantial advice and does not morally justify or legitimize a specific decision. The expertise of the facilitator consists of, among other things, fostering a sincere and constructive dialogue among the participants, keeping an eye on the moral dimension of the case, supporting the joint reasoning process, and helping the group in planning actions in order to improve the quality of care. Methods are chosen because of the specific goal of a moral case deliberation. For example, some methods (e.g. the dilemma method) focus on the case itself and work towards a well-considered decision, while other methods (e.g. the Socratic method) use the case as a means to enhance moral competencies of the health caregivers [47, 56].

[1] Moral case deliberation differs in this respect significantly from clinical ethics consultation. With respect to ethics consultation, the ASBH taskforce on the Core Competencies for Health Care Ethics Consultation describes a more procedural and expert approach of the ethics consultant when discussing 'the ethics facilitation approach'. A central goal of the ethics consultant is to answer the question "Who is the appropriate decision maker?" in a morally and legally right way [6, 8, 15]. It seems as if the ethics consultant focuses more on the answer of the question 'What *is* (italic, BM) morally right?' while the facilitator within the moral case deliberation focuses more on the systematic process in which group members reach that answer by themselves through dialogical processes.

The increased attention for moral deliberation, both in the field of health care settings, and in the field of academic ethics, reflects a recent trend towards dialogical ethics [52]. With the rise of medical ethics in the sixties, a new sub-discipline evolved in which ethical theories were applied to the field of medicine. This lead to a new type of ethics: *applied* ethics [9, 13, 23]. Applied ethics claimed to be practical and respectful for practices. However, this confidence changed into more reservation when it became clear that most examples of applied ethics start from theory, and merely see practice as the object of normative analysis and judgment [36]. Theoretically, the epistemological framework of moral principles (e.g. their authoritative status and their universalistic de-contextualized claims) is one-sided. Methodologically, the question remains when a certain principle is valid and how it should get applied in concrete complex situations. These criticisms and problems gave way to forms of ethics which are contextual and open to practical experience and to learning from experience through dialogue with others.

One of the fundamental epistemological claims of dialogical ethics is that ethics and morality start with actual experience, not with theories or concepts. Theories and concepts are useful, but they should be grounded in real-life practices [14, 31]. This approach to ethics goes back to Aristotle. He claimed that (moral) wisdom and (moral) knowledge originate from reflections on and within concrete situations. There is no moral truth independent from experience. The meaning and construction of morality is inherently contextual and temporal. Moral decisions, Aristotle further emphasized, are not a product of instrumental reasoning (*techne*), calculation or logic (*episteme*), but flow from wise judgement, perceptiveness, imaginative understanding and an engagement with practice (*phronesis*). Judgement starts by taking into account the concrete details of a particular case. At the same time, judgement requires reflection upon general principles and standards. It is the dialectic between the detailed circumstances of the actual case and the general principles that fosters a morally right action. Dialogical ethics takes this Aristotelian approach to ethics (sometimes called virtue ethics) a step further emphasizing the interrelatedness and dialogical nature of human beings and the necessity of intersubjective decision-making; moral judgements arise out of dialogue among open-minded people in practice. Within this dialogue, knowledge from ethical theories may play a role but it cannot claim epistemological authority. Sharing stories and narratives are important strategies in constructing moral convictions and beliefs [39, 49]. As a consequence, moral case deliberation always starts with concrete experiences (and not with hypothetical thought experiments).

Responsive Evaluation: A Process-Oriented Dialogical Methodology

Responsive evaluation is a process-oriented methodology in which evaluation is reframed from the measurement of program effectiveness on the basis of policy goals to the engagement of stakeholders about their issues of concern [4, 19, 20, 42]. Responsive-constructivist approaches aim to enhance the personal and mutual understanding of a situation by fostering ongoing *dialogues* about relevant *issues* among various *stakeholders*.

Stakeholders are groups of people whose interests are at stake. In a responsive approach stakeholders should actively participate in the evaluation process; they are involved in the formulation of questions, the selection of participants and the interpretation of findings [17]. Stakeholders become active and equal partners in the evaluation. Deliberate attention should be paid to the identification of 'victims' or 'silenced voices,' those whose interests are at stake but remain unheard [29], because they are often hard to find, for example, because they want to remain anonymous or because they fear sanctions. Having identified the relevant stakeholders the next step is to gather information about the issues of concern of the various stakeholders. There is a whole set of techniques to identify stakeholder issues ranging from in-depth interviews, brainstorming sessions and discussion meetings to focus groups. Participants should share their issues and concerns, but also respond to those of others to obtain an understanding of important issues for other stakeholders.

The underlying notion is that each stakeholder group has its own interests, values and perspectives, and that the evaluator, instead of pre-ordaining the evaluation by formulating evaluation criteria in advance, should acknowledge this plurality. Methodologically the acknowledgement of plurality implies that the 'design' gradually emerges in conversation with the stakeholders. Metaphorically one may compare the designing process in a responsive evaluation with improvisational dance [24]. Whereas the minuet prescribes the definite steps, definite turns and foot and arm movements, improvisation is spontaneous and reflexive of the social condition. The evaluator charts the progress and examines the route of the study as it proceeds by keeping track of his or her role in the research process.

Having identified the issues per stakeholder group the next step is to create conditions and to organize dialogues and interactions between groups of stakeholders whose interests may diverse. Interaction between stakeholder groups is a deliberative process. Deliberation refers to the interaction and dialogue between participants. They do not just accept each other's beliefs and persuasions, but will explore these. Listening, probing and dialogue characterize this process, rather than confronting, attacking and defending. Central features of dialogue are openness, respect, inclusion and engagement [4, 18]. Dialogue may lead to consensus. Absence of consensus is, however, not problematic; on the contrary, differences stimulate a learning process [53, 54]. Conditions for dialogue are the willingness of stakeholders to participate, to share power and to change in the process [4].

In a responsive evaluation one especially has to be aware of power relations [27]. One should try to find means to give voice to people and groups that are less powerful creating a safe environment. One way to do this is to have in depth interviews with them; via interviews people gain personal acknowledgement for their experiences [26]. If a face-to-face encounter is impossible given asymmetries between stakeholder groups, one may organize a virtual meeting to stimulate a learning process between participants [53]. Experiences that have been exchanged in the safe environment of homogeneous groups are then introduced as issues in other stakeholder groups. By presenting such issues through stories, a climate of open discussion and dialogue may be fostered [1, 2]. Active engagement of as many stakeholders as possible and deliberation minimizes the chance of bias and

domination of one party. Of course, bringing people to the table does not imply that everyone gains a hearing. The moderator of the dialogues should therefore be alert for subtle mechanisms of exclusion. Afterwards, it needs to be checked whether the dialogical process was really open. A careful reading of the transcript can do this.

In a responsive approach roles of the evaluator include the one of interpreter, educator, facilitator and Socratic guide. The role of interpreter indicates that the evaluator has to endow meanings to issues. The role of educator refers to the creation of understanding by explicating various experiences to involved groups. Facilitator refers to the organization of the dialogue and the creation of required conditions. In the role of Socratic guide the evaluator will probe into taken for granted ideas, final truths and certainties, and bring in new meanings and perspectives [41].

Comparing Moral Deliberation and Responsive Evaluation

Moral deliberation and responsive evaluation are both approaches that aim to improve practices, more specifically the quality of care in health care settings. They have a common basis in dialogical ethics [16]. Key assumptions that are shared include the theoretical notion of dialogue as a social learning process, practical rationality, and the value of experiential knowledge. Methodologically both moral deliberation and responsive evaluation are open processes, facilitated by the ethicist or evaluator as facilitator. After having described the common basis and theoretical notions below, we will set out to identify differences between moral deliberation and responsive evaluation.

A key assumption of moral deliberation is that good care is both the process and the outcome of reflective dialogues between caregivers, between caregivers and their clients, and other participants. In dialogues people will exchange experiences and perspectives, and this will help them to gain a better, fuller understanding of moral complex situations. Moral deliberation aims to articulate and explore the various, sometimes conflicting, perspectives on a case under consideration. This resonates with the hermeneutic understanding of dialogue in responsive evaluation. Dialogue is not seen as an instrument or technique to reach better decisions; it is rather understood as an ongoing, social learning process in which participants develop new, and richer understandings of their practice. Responsive evaluation does not aim to reveal the nature of reality in terms of law-like generalizations about cause-and-effect relations from an outsider position, but assists various stakeholders to understand their practice from multiple perspectives. In dialogical interactions these multiple perspectives may evolve into new perspectives if participants are willing to acknowledge the limits of their own perspective and to change in interactions.

Moral deliberation is grounded in the assumption that good care gets defined and redefined in concrete situations. General, abstract ethical principles about good care may inform individuals and groups, but always need to be adjusted to the particulars of concrete caring situations. Good care is seen as a conversation between general ethical principles and professional standards on the one hand, and the particulars of the situation and constraints on the other hand [38]. Confronted with difficult situations, caregivers cannot just sit back and think about their practice. There is, so

to say, an urgency to act and to find answers to the particulars of the situation. This situation does not stand on its own, but is influenced by organizational constraints. Moral case deliberation therefore also includes reflection on the context and conditions for good care. The central moral question is framed as follows: What should *I* do for *this* person, at *this* particular moment and in *this* location? Ethics is not solely a matter of finding general rules and principles, but in essence a matter of practical rationality. This resonates with the aim of responsive evaluation to understand the particulars of situations. Responsive evaluation is not interested in the typical or universal, but in the atypical, specifics of the case at hand. It asks the question: What is the value of *this* program/practice at *this* moment, at *this* location from the perspectives of various stakeholders [41]. Like moral deliberation, a responsive evaluation will result in context-bound knowledge.

In moral deliberation the moral considerations of participants are appreciated as relevant and valid, because they are grounded in the complexities of day-to-day caring. Ethical reasoning is not an exclusive formal analytical skill of the ethicist as expert, but moral reasoning is part of being human. We all confront morally complex situations and will think and reflect—informally, intuitively—and consider what is good and just in a situation. We may develop and enhance our moral understanding by reading literature, watching movies, we may be educated and trained, but basically we are all competent moral agents given our practical experiences in dealing with moral issues. This idea resonates with the underlying assumption of responsive evaluation that all human beings are competent evaluators. Stakeholders in a responsive evaluation do not need to be experts, they can rely on their experiential knowledge. Experiential knowledge is personal, insiders knowledge that develops in concrete situations, in confrontation with practical problems. Experiential knowledge of clients, for example, includes knowledge how to deal with a disability or illness in life (versus knowledge about the disease). It is broad, and concerns all the domains of life [21]. Experiential knowledge translates into experiential expertise after reflection, analysis and conversations with peers. So, expert knowledge is redefined in both moral deliberation and responsive evaluation as including experiential knowledge.

Methodologically, moral deliberation and responsive evaluation are basically open and cyclical processes. Ethical principles and evaluation criteria are not pre-ordained; rather the issues and perspectives evolve in the process. This openness is required to engage, and to be able to acknowledge the various perspectives and values of as many participants in the process. It is not to say that the methodology of moral deliberation and responsive evaluation are unsystematic or unscientific. The steps in the process are clearly defined, as are the actions that need to be taken. Basically, the steps in the process are cyclical, that is to say that findings from the first step form the input for the next step, etcetera. This cyclical way of working helps to foster interaction, to gain responses to findings, to develop new notions and understandings along the way. It facilitates the ongoing dialogues between groups. A safe environment, not passing on judgements and openness are conditions that help to foster these processes. The central place of dialogues as interactive processes implies that ethicists in moral deliberations and responsive evaluators do not primarily act as experts, but rather as facilitators of interactions between groups of

Table 1 Common grounds

	Moral deliberation	Responsive evaluation
Ongoing dialogue	Collective reflection on good care	Learning about program quality
Practical rationality	Contextual understanding of good care	The value of this program
Experiential knowledge	Moral considerations of caregivers	Stakeholder issues
Open, cyclical process	Caregivers respond to each other	Stakeholder interactions
Equality stakeholders	Every caregiver is morally equal	All stakeholders have a 'say'
Multiple perspectives	Various views on good care	Various angles on the program
Process facilitation	Ethicist as facilitator	Evaluator as facilitator

people. Instead of judging a situation from an outsider position, an engagement in the practice under consideration is required. This engagement can best be understood as a multiple partiality; one will try to develop an emphatic relationship simultaneously with all stakeholders participating in the process.

The common grounds between moral deliberation and responsive evaluation are summarized in Table 1. The left column defines the shared underlying theoretical principles of both approaches; the two right columns exemplify the specific interpretation of these principles in both approaches.

The common grounds outlined above demonstrate the possible synergy between moral deliberation and responsive evaluation. That is to say, that the approaches can mutually strengthen each other in a process towards quality improvement of practices. Whereas moral deliberation structures case deliberations about moral issues between practitioners on the work floor, responsive evaluation helps to broaden the process of quality improvement in the setting, including other stakeholders as well, and fostering the interactions between stakeholder groups.

We now explore the differences between these approaches. One may argue that both approaches differ in terms of the objects of dialogue. The dialogues as part of moral case deliberations focus specifically on moral issues. Dialogues in responsive evaluation concentrate on the quality and effectiveness of a practice, and need not to be restricted to moral issues. This distinction should, however, not be exaggerated (i.e. this distinction is not based on fundamental theoretical differences). From a dialogical perspective, ethical issues are always practical and practical issues (such as quality and effectiveness of a practice) are always ethical. Likewise, in a responsive approach, practical issues are always related to different views concerning the way people think they (should) live together and the way in which responsibilities are distributed [41]. Thus, practical issues are inherently moral and vice versa.

Another initial distinction between responsive evaluation and moral deliberation may be found in the primary target population. Moral deliberations are usually carried out with a multi-disciplinary group of caregivers with a professional training and background. Responsive evaluation includes as many stakeholders as possible, including clients, citizens, family members, managers and policymakers. Recently this distinction in target populations of responsive evaluation and moral deliberation is however declining; within the field of moral deliberation policymakers and clients are nowadays also included as participants.

Do both approaches differ in terms of the methods and required expertise? Clearly, moral deliberation uses ethical conversation methods and knowledge of a special kind of moral epistemology. Responsive evaluation is applying social scientific research methods, like interviews, focus groups, and surveys. Although these techniques are different, in both approaches the facilitator (whereas the ethicist or evaluator) of the dialogical process should have additional interpersonal and communicative skills to foster dialogues between groups of people.

Still another distinction can be related to the goals of empowerment. Responsive evaluation aims to foster dialogues between stakeholders, and responsive evaluators will deliberately support groups in vulnerable positions to create fairness in dialogues. Moral deliberation does not focus on the empowerment of groups in vulnerable situations as such. However, in both approaches fairness of the process requires support of weaker groups and therefore often leads to the empowerment of those less heard. Moral reflections and dialogues within responsive evaluation often enhance dialogical capacities of both caregivers and managers to facilitate reflections and negotiations on (conditions for) good care.

Finally, one may question whether the time perspective of the approaches differs. Moral deliberation is often applied as an integral ongoing part of the caring process, at least this is the goal. Responsive evaluation is conducted at certain moments in time to stimulate a systematic reflection. Yet, moral deliberation can also be implemented more incidentally, and responsive evaluation can be repeated successfully. We may conclude that the similarities between the approaches are far greater than the differences.

Case Example: Improving the Quality of Coercion in Psychiatry

We now introduce a case example to illustrate the commonalities of moral deliberation and responsive evaluation. In 1999 the '*Quality of coercion in psychiatry*' project was started to develop and implement quality criteria concerning the use of coercion in Dutch psychiatry. The overall aim of the project was to improve the coercive practice in the mental health sector in the Netherlands. The project was funded by participating institutions, provinces and research funds. It consisted of three phases in which both moral deliberation and responsive evaluation were used. During the first phase (1999–2001) a discussion on coercion was set up in six mental healthcare institutions, and quality criteria were formulated. In the second phase (2002–2004) eleven institutions implemented the quality criteria nationwide. Responsive evaluation played a crucial role in these phases. In the current third phase (2006–2009) over 25 institutions developed projects to reduce the number of coercion events. Moral deliberation was systematically used as an intervention in one of the participating institutions.

Coercion is defined as forcing a client to (not) do something. There is no freedom to choose an alternative option [11]. Examples are seclusion, enforced medication and fixation. In the Netherlands most clients in these situations will be secluded (70–80%). Forced interventions have an impact on the client's wellbeing [12, 22], especially when they are not conducted in a careful, humane way. Many clients

have witnessed feelings of powerlessness, fear and anger when undergoing forced interventions [12, 22]. Caregivers also experience intense feelings and emotions in the case of coercion and constraint. They have various, conflicting duties—for example respecting the autonomy of the client as well as protecting the safety of the group of clients and general order—and a forced intervention almost always implies that one of these duties cannot be fulfilled. Decisions with respect to these kind of moral dilemmas therefore tend to be 'tragic'; none of the options is fully satisfying [37]. This creates mixed feelings among caregivers, but they tend not to talk about these ambivalences in public.

Forced interventions are regulated by the *Dutch Institutions Forced Admissions Act* and legally only acceptable in situations of violence or uncontrolled behaviour. However, these interventions have become a structural part of the day-to-day care in Dutch mental health. Recently in the Netherlands caregivers, their professional organizations and national policymakers are beginning to acknowledge that there should be more reflection on the extent to which coercion might harm the well-being of clients [5]. This awareness has been stimulated by recent, comparative studies on the use of seclusion in the European countries [48]. These studies demonstrate that in Dutch mental institutions more clients are secluded than in other European countries.

Responsive Evaluation to Develop and Implement Quality Criteria (Phase 1 and 2)

Against this background, a Responsive Evaluation project was started to develop quality criteria concerning coercion. Although the aim was to reduce the amount of forced interventions, coercion was not completely rejected. Sometimes interventions are needed to protect the individual, others or the public order. The criteria focus on the ethical concern *how* to treat clients in a more humane way if coercion is inevitable and how to prevent coercion (as opposed to the legal question when to intervene).

The quality criteria were developed by researchers from Maastricht University in collaboration with clients, family members and various caregivers (nurses, psychiatrists, psychologists, vicars). Interviews, focus groups and dialogical meetings were organized in six participating mental institutions. This led to the formulation of eight quality criteria in which principles from ethics of care—responsibility, respect, openness and dialogue-were made relevant for coercion in psychiatry [11]. An example of the quality criteria concerns communication. It says that caregivers should communicate with all participants, including the client and family, about the necessity and appropriateness of coercion. Communication also includes sharing information during incidents and listening seriously to clients. If a client does not cooperate or openly protests against coercion, caregivers should find out why he does not accept the restriction. Protest against coercion is a basic right of clients. When clients approve the measures taken, caregivers should check whether or not clients indeed accept them. So, in both cases—protest or approval—caregivers should look behind the response of the client, and start a dialogue to find out what the client needs. Initial protest may then develop into cooperation (and visa versa).

The second step was to implement these quality criteria among 11 psychiatric institutions. A steering and project group were formed. The steering committee was composed of representatives of the Board of Directors from the institutions and representatives of client and family interest groups. The project group consisted of project leaders in the eleven institutions. The implementation process was facilitated by means of responsive evaluation. In each of the institutions to foster dialogues between participants, and nationally aiming at a cross-institutional learning process between stakeholders (project leaders, caregivers, clients and family).

The cross-institutional evaluation was characterized by a phased and cyclical way of working. First of all in-depth interviews with project leaders, local evaluators, team leaders, nurses, psychiatrists and clients were organized to gain more insight in the experiences with the implementation and perceived changes in practice. The evaluator also attended the 2-month project group to monitor discussions and issues at stake. Internal dialogues were organized among stakeholders with the same interests. Project leaders were, for example, asked to respond to cases brought in by themselves. Most of these cases dealt with the process of implementation, such as managing resistance and gaining commitment among various stakeholders inside the hospital. The attendance of these meetings was good (at least ten of the eleven project leaders per meeting) and degree of engagement in conversations high. There was an open and respectful climate. Discussions in the group were very lively, constructive feedback was given, and creative solutions were brought to the fore. It was remarkable that during the conversations many aspects were encountered, like the relationship between caregivers and clients, but also the institutional, societal and political context and professionals codes and regulations. In an oral evaluation the project leaders reported that the collegial meetings kept them informed, inspired and empowered.

The learning process in the group of project leaders was intimately connected with and embedded in their practice. For example, participants discussed whether or not an institution should build extra seclusion rooms and a specialized unit for 'difficult' clients. In the case at hand, the Board of Directors wanted to build a specialised seclusion unit as part of a larger reorganization and building plan. In the discussion it soon became clear that the main purpose was to enhance the organizational efficiency. The project leader: '*The management reasons: How should these bricks be piled and what is the most logical and cheap way to do that? There is not much talk about our vision on the quality of care*.' He felt that more seclusion rooms would not help to reduce the rate of seclusions. Participants recognized the case and brought several negative experiences with seclusion units to the fore; clients may experience it as a punishment to go to such a unit, the unit easily becomes a sort of internal police service within the organization and the availability of seclusion rooms will create a need. Participants also questioned the necessity of the reorganization: '*For whom is this? It is certainly not in the interest of the staff and clients!*' They gave the advice to pay more attention to the means to prevent seclusion, such as creating 'healing environments' and enhancing the communication and interaction with clients. Some participants brought to the fore that a specialized intensive care unit that selects new, highly qualified staff members with special education and training would help to enhance the quality of care.

However, this unit should then aim to reduce the amount of seclusions. The discussion helped the project leader in his negotiations with the Board. In the end, the Board decided to built four instead of the planned six seclusion rooms, legitimized by a substantial vision of care, in which attention was given to the prevention of coercion through the implementation of crisis intervention plans. The project leader considered the adjustments as an improvement, which were partly a result of the ongoing dialogues set in motion by the responsive evaluation.

During the process also deliberate attention was paid to the perspective of clients on coercion and client participation. The evaluation team reasoned that it might be difficult for clients to express their concerns in a mixed group of stakeholders within their own hospital and within the project group. They therefore organized internal dialogues among a homogeneous group of clients of the participating institutions selected by the evaluation team, which consisted of a client research partner and academic researcher. A core group of eight clients joined three meetings. From the onset the meetings were meaningful and respectful, according to the participants. In an oral evaluation at the end of three meetings participants said they valued the safe context and atmosphere. Participants felt they listened carefully to each other, valued the positive feedback and felt comfortable to share their personal experiences. Experiences illuminated that client participation in the local implementation projects was in most of the institutions a matter of individuals. Having 'a say' was often no more than responding to fixed plans. These participating individuals felt themselves not informed and supported by other clients. As a result they sometimes dropped out or got sick. Another issue was related to the financial compensation for the participation in the projects; individuals received nothing at all or a very small amount of money. They felt their experiential knowledge was not recognized.

Furthermore clients placed emphasis on the prevention of coercion by improving the liveability in the institutions, the contact and communication between all participants, the variety of treatments and the conditions for good care, such as the expertise and amount of staff. Talking to people, stimulation, motivation and adjustment of the environment should always be tried before the use of constraints and compulsion. Alternatives for coercion that were brought to the fore included the use of a time out or comfort room, taking a walk, the notion that one should not leave the client alone in a seclusion room and that interventions should be adjusted to the preferences of the individual client (some may favour forced medication above seclusion). The issues of the clients, as well as the issues of other stakeholders formed the basis for a document that was presented to the national steering committee. The discussion of the report was also part of the ongoing dialogues within and between various stakeholder groups.

In the presented responsive evaluation a broad array of ideas and stakeholder issues (safety, expertise, communication, conflicting duties, feelings and emotions, prevention and evaluation, conditions) emerged, and various approaches of and perspectives on reduction of coercion came to the fore. These varied from the substitution of interventions (replacing seclusion by forced medication) to the application of crisis plans and active use of the networks of the clients to prevent coercion. In the ongoing dialogues between stakeholders the rich plurality of

perspectives and amount of issues have been structured. Developing a self-reflexive and critical attitude towards one's practice, questioning taken-for-granted routines, talking about sensitive topics and opening up to voices usually not taken into account (client and family) were as important as the developed of new working routines and protocols. We recognized that participants learn the most when being confronted with new viewpoints.

Moral Deliberation as a Means to Foster Good Care Around Coercion (Phase 3)

During the third phase of the quality of coercion project, one institution specifically chose to use Moral Deliberation as a tool to improve care concerning coercion. It concerns a large mental health care institution in the east of the Netherlands (GGnet). [56] The institution played a central role in the whole project since its beginning in 1999. Initially GGnet focused on increasing the awareness, and the knowledge and the technical skills of professionals. Later the organization aimed at changing the attitude of professionals and clients with respect to coercion. Moral case deliberations (among other activities) were considered as the prime vehicle to realize these objectives [33, 34].

Within GGnet a moral deliberation group is responsible for these moral deliberations. This group consists of an academically based ethicist and five employees who had been trained in moral deliberation (a nurse practitioner, a sociologist/philosopher, two theologians, and a nursing teacher). A PhD student has been added to this group for 4 years in order to facilitate, monitor and study the implementation and the results of the moral deliberations. The implementation of moral deliberation project consists of several phases. After an investigation of the moral culture and ethics policy of the institution stakeholders shape a project plan. Then the moral deliberation group will start facilitating moral deliberations among teams. Next, a core group of experienced employees are trained as facilitator of a moral deliberation. Finally, the focus shifts to the implementation and structural attention for moral issues within in the institution. The current moral deliberation project within GGnet follows these steps.

Since the project has a specific normative aim, namely to decrease the amount of coercion events, we felt it was important to communicate the basic assumptions of dialogical ethics. A *genuine dialogue* is open and one should not start a moral deliberation session with stating that coercion is always morally wrong and that decreasing the amount of coercions is always morally better. What is morally good should get defined within concrete situations and by means of a dialogue.[2] Furthermore, it was made clear that dissents or minority positions should always be taken into consideration. Participants (the facilitator included) should get and pay respect for the moral positions expressed. Moral deliberation sessions should entail a 'free moral space' [25]. The discussion of these assumptions helped to reduce the

[2] This does not exclude that someone can hold the a-priori assumption that coercion is morally wrong, before getting to know the specific circumstances and before starting a dialogue within that specific context.

initial resistance of employees against moral deliberation (‘*as if we are getting a moral teaching class with respect to coercion*’).

The moral deliberation sessions took place on a regular basis, with good preparation. During the actual moral deliberation session, the facilitator introduces[3] the conversation method, explains the difference between dialogue and discussion/arguing, clarifies his own role (not acting as a consultant, not justifying thoughts and actions, not interfering with the content of the case),[4] and manages and clarifies the expectations of the participants with respect to the session. Then, the ‘owner’ of the moral question introduces his moral question. The facilitator refrains from arguing about or passing judgments on the moral question, but invites participants to help their colleague (owner) to formulate his moral question in a good way. Usually, participants find it difficult to postpone their initial judgments, and to start to sincerely ask open questions instead of giving or asking a kind of moral accountability or justification. Then, the other participants can start to formulate clarification questions which they need to get answered in order to construct a balanced moral judgment on the moral question at stake. When the clarification phase is finished, the participants can give their own moral judgment of the case, as if they were in the same situation as the owner of the case (i.e. they do not have to pass judgements on the owner of the case, but they have to present their own, reasoned moral position). This enumeration of different moral positions results in some parts that people seem to agree upon, and some parts that people seem to disagree upon. Disagreements are often the starting point for more detailed investigations regarding the arguments and pre-assumptions of the participants.

Dialogue is a basic requirement for true investigation in openness. As mentioned earlier, the anchor of moral wisdom within moral deliberation lies within the concrete case and the sincere (i.e. not hypothetical or imaginary) insights of participants. An example of the discussions in a moral deliberation session on coercion is the case concerning a young man who had been admitted to the ward since 5 days. On his fifth day, the nurse (presenting the case) came back from holidays. During that day she and her female colleague decided to put the man into the seclusion room in order to prevent aggressive escalations and to maintain the general safety on the ward. The nurse had a sincere concern with respect to the moral justification of her decision. At the end of the moral deliberation session (90 min) participants mentioned that they appreciated the fact that a colleague could openly doubt whether she did the right thing; they considered this as a professional attitude. Furthermore, they felt that the conversation method (i.e. the dialogue) caused enough security to examine each others presuppositions in more depth. They

[3] Facilitators differ in their opinion and expertise with respect to the question how facilitators introduce this information. As a matter of fact, just presenting this information by means of talking might not fit within experiential learning theories and the focus on experience within dialogical ethics. It might be more effective when facilitators explain certain rules or methodologies within moral deliberation when it is actually the case (instead of presenting rules or convictions) and when participants can experience the difference between, for example, various styles of facilitating a moral deliberation.

[4] Each facilitator has his own style and theoretical and methodological convictions; so subtle differences might co-exist within the moral deliberation expert group. Among clinical ethicists, there might even be (interesting) fundamental disagreements about these issues. However, that does not fit within the scope of this article.

learned that the process of making a decision is much more complex and nuanced then often is suggested. They also realized that not the potential threat of the young man had been the decisive reason (often seen as an objective medical criterion for seclusion), but the lack of good communication with the young man, the risk estimation with respect of the female nurses during the evening shift, and the lack of any relationship with the young man because of the nurse's holidays. They also acknowledged that it is difficult to find a factual proof, both positive and negative, for deciding whether the timing of a preventive seclusion is morally justified.

The Benefits of Both Approaches in Psychiatry

The input of practical experiences and interaction of all stakeholders during the process enhanced the knowledge about coercion. In the context of a safe environment of homogeneously composed groups participants responded to each other, asked questions, redefined problems, deliberated, revealed 'blind spots' and explored new dimensions and perspectives. Participants valued each other's input, because it provided them with 'eye openers' and new insights. The dialogues not only inspired individuals, collectively participants developed a new line of thinking that has led to cultural shift in many institutions. This shift can be characterized as a transition from a control-oriented culture (with fixed problem definitions) to a negotiation culture with deliberate attention for the individual client, the family, prevention and structural evaluation of coercion [5]. It may well be the case that the central role of dialogue in the moral case deliberations and responsive evaluation process finds its reflection in the shift towards a more reflective and deliberative culture. Likewise it may well be that the hermeneutic and constructivist epistemology of responsive evaluation indirectly and inherently has become integrated in the coercion practice. For example, seclusion is no longer seen as a causal and mechanical outcome of situation A, but caregivers have begun to realize that influencing situation A before it factually becomes situation A, is a process of negotiation, a construction that may well be reframed and redefined if they are willing to engage in dialogue. More fundamentally, the emerging dialogical attitude of caregivers and other stakeholders in itself already induced a reframing of the concept of coercion.

Conclusion

Moral deliberation and responsive evaluation share the theoretical claim that good practices originate from concrete experiences through equal dialogue among stakeholders with different perspectives. The dialogical process and attitude itself is already a first important step in dealing with problematic situations and improving practice and cooperation within that practice. In both approaches social and practical learning processes in concrete circumstances play a central role. Social learning refers to learning as a social and collective process (not solely a cognitive act of the individual). This type of learning focuses not on theoretical knowledge ('know that'), associated with reason and rationality, but on practical knowledge

('know how'), associated with intuition and feeling. Practical learning results in 'local' (contextual and experiential) knowledge. This is a relevant source of knowledge because it is located within specific contexts. This is often referred to as the principle of indexicality [40]: the context of the situation is the index for the use of general rules and principles. Nussbaum [37] talks about the '*living conversation*' between rules and principles on the one hand and the particulars of the situation on the other hand. Good practitioners should be familiar with the rules and principles, but they should also recognize the particularities of the situation. Responsive evaluation and moral deliberation embody a methodology to articulate experiences and stories that provide the input for dialogues among stakeholders and help to integrate experiential knowledge and abstract rules and principles.

Moral deliberation considers practice as a source of moral wisdom: without a practice and the experiences of the stakeholders, moral knowledge (both from theory as from stakeholders) has no meaning. Responsive evaluation offers a methodology to gain a deep understanding of experiences and to share and confront experiences of stakeholders, in asymmetrical contexts [3]. Responsive evaluation provides a process-oriented methodology and heuristics for dialogues within organizational contexts marked by power unbalances, disempowered stakeholder groups and various, conflicting, interests. A combination of moral deliberation and responsive evaluation provides efficient clues for improving health care practices, both with respect to the content of morally problematic cases as with respect to the ongoing process of improving practices in complex organizations [32, 55]. The synergy between the approaches in the project seems logical, but one might ask whether it is worth the effort. It required a lot of work to engage the various institutions and stakeholders, to develop a project structure, to keep them motivated, to find (financial) support, and to keep on going after one of the phases ended. Secondly, on route the team of evaluators (with a social science background) and ethicists (with a background in philosophy) had to become acquainted with each other's intellectual training and ideas concerning practice improvement. We also note that the path towards fruitful cooperation was not laid out in advance. It is only in retrospect that we were able to reconstruct the process and design. Transdisciplinary collaborations as described in the case example are fostered when the partners have an open mind, and a tolerance for ambiguity and co-incidences. This in itself, fits well with the open-minded and dialogical attitude of both approaches, as mentioned before.

Furthermore, we should be clear that moral deliberation and responsive evaluation are not always ideal, linear processes. Sometimes, dialogue is not (yet) feasible. Conflicts of interest, asymmetrical relationships, scepticism among established or disempowered groups and sensitive topics may hinder genuine conversations among stakeholders. When a dialogical process is possible, it will not always result in mutual agreement and consensus. If, nonetheless, agreement is reached, it may prove difficult to put the conclusions into action. Moreover, those who want to practice moral deliberation and responsive evaluation processes should not expect that consensus is everlasting. On the contrary, consensus is always fragile. A responsive and open attitude fosters the handling of inevitable misunderstandings and failures. Misunderstandings and failures do not have to

make us passive. If we recognise that agreement is always partial and finite, then the same applies for misunderstandings and failures. We can be open for cases of disagreement, and prepared to learn from them. Dialogue does not prevent misunderstanding, but offers a possible way to understand and deal with misunderstanding when it occurs and to learn from mutual disagreement. This idea is shared by moral deliberation and responsive evaluation, and provides a basis for their cooperation in improving healthcare practice.

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