What healthcare teams find ethically difficult: Captured in 70 moral case deliberations

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Abstract

Background: Ethically difficult situations are frequently encountered by healthcare professionals. Moral case deliberation is one form of clinical ethics support, which has the goal to support staff to manage ethical difficulties. However, little is known which difficult situations healthcare teams need to discuss.

Aim: To explore which kinds of ethically difficult situations interprofessional healthcare teams raise during moral case deliberation.

Research design: A series of 70 moral case deliberation sessions were audio-recorded in 10 Swedish workplaces. A descriptive, qualitative approach was applied, using thematic content analysis.

Ethical considerations: An advisory statement specifying no objections to the study was provided from an Ethical Review Board, and consent to be recorded was assumed by virtue of participation in the moral case deliberation.

Findings: Three themes emerged: powerlessness over managing difficult interactions with patients and next-of-kin, unease over unsafe and unequal care, and uncertainty over who should have power over care decisions. The powerlessness comprised feelings of insufficiency, difficulties to respond or manage patient's/next-of-kin's emotional needs or emotional outbursts and discouragement over motivating patients not taking responsibility for themselves. They could be uncertain over the patient's autonomy, who should have power over life and death, disclosing the truth or how much power next-of-kin should have.

Discussion: The findings suggest that the nature of the ethically difficult situations brought to moral case deliberations contained more relational-oriented ethics than principle-based ethics, were permeated by emotions and the uncertainties were pervaded by power aspects between stakeholders.

Conclusion: MCD can be useful in understanding the connection between ethical issues and emotions from a team perspective.

Keywords

Clinical ethics, ethically difficult situations, ethics consultation, healthcare professionals, moral case deliberation

Introduction

Ethics awareness in healthcare is growing worldwide as personnel increasingly encounter ethical issues in their everyday practice.¹⁻⁴ Ethical issues are multifaceted and are associated with difficult situations in which staff experience unease or uncertainty regarding what is right or good to do² or disagree about what should be done.^{5,6} Ethically difficult situations can be classified as behaviour, treatment or resource issues.⁷ Behavioural issues are identified in several studies as a lack of respect for patients' self-determination,⁸⁻¹⁰ integrity and confidentiality.^{9,11} They can be related to difficulties with protecting patient integrity due to lack of work space¹² or pressure from next-of-kin to disclose patient information.¹⁰ Situations where patients do not follow staff recommendations can also lead to ethical difficulties, as when patients and nurses have differences in opinion of what to do.^{9,13-15} Treatment issues in ethically difficult situations can be related to the forgoing of life-sustaining treatment^{12,16} as well as unrealistic treatment expectations communicated by relatives.^{10,17} Resource issues can be the lack of finances and personnel,^{12,13} with elder care being given low priority.³

In clinical work, ethical difficulties are described in hospitals,^{9,15,18} as well as in municipal care for older people and psychiatric care facilities.^{12,19} These issues are examined among healthcare professionals with observational studies,⁷ face-to-face interviews,¹² focus groups,¹⁵ questionnaires^{10,20} and telephone surveys.²¹ Despite this, the literature shows that healthcare personnel are not always aware of the ethical dimensions in their work, may overlook ethical issues or adjust work routines to avoid them.²² Dealing with concrete ethical difficulties requires knowledge of their complex and highly specific circumstances.²³ Therefore, supporting healthcare professionals' reflections on ethics connected to everyday practice is important.^{24,25} Initiatives have been taken to stimulate ethical reflections.²⁶⁻²⁹ The Netherlands is a forerunner where moral case deliberation (MCD) is a common form of clinical ethics support.²³ The theoretical backgrounds of MCD originate from pragmatic hermeneutic and dialogical ethics and focus on meaning-making related to a concrete issue from everyday life. Pragmatic hermeneutic ethics considers the context and contingency in relation to a situation, while dialogical ethics draws attention to the process of joint learning in order to enhance the perspectives.²³ The goal of MCD is to enhance moral reflection among staff members concerning ethical issues and thus improve the quality of patient care.^{26,28,30} A trained, external facilitator in clinical ethics assists the healthcare staff to reflect systematically on a concrete ethical issue that they encounter in their workplaces.³¹ The facilitator encourages constructive dialogue between the participants, monitors the moral dimension of the patient situation and supports the process of ethical reasoning.²⁶ They use a specific conversation method, such as the Dilemma method or the Socratic Dialogue.^{26,28}

In Sweden, MCD (often referred to as ethics rounds or ethical reflection) are practised in some healthcare settings³²⁻³⁵ A few training courses for facilitators have been offered by the Dutch ethicist Bert Molewijk,²³ but unlike in the The Netherlands, no systemic training specifically for leading MCDs has been offered and there is no consensus of how MCDs should be conducted. A large project was therefore initiated to explore the content of the Swedish MCDs that were led by facilitators who had not received any specific MCD training. Systematic training and employment of professional ethicists require resources, and it is therefore of interest to explore MCDs given by both those educated in clinical ethics and those with general knowledge of ethics through practice. The overall goal of the project is to gain an understanding of the content from different perspectives and thereby detect core components of Swedish MCDs. Simultaneous investigations in Europe are attempting to understand this complex psycho-social multicomponent intervention that may also shed light on MCD outcomes.³⁶ Knowledge of the nature of the ethical issues healthcare personnel actually discuss is needed. Only one Dutch study describes ethical issues raised during MCD, and they were descriptions of ethically difficult situations the participants experienced *before* the MCDs.²⁴ The issues concerned residents' behaviour, divergent perspectives on good care and organisational context. To our knowledge, no study has described which actual ethically difficult situations are raised during MCD.

In summary, there is a need to further understand the ethical difficulties experienced in everyday clinical practice, the difficulties healthcare teams share and the content of MCD. Thus, this study aims to explore which kinds of ethically difficult situations interprofessional healthcare teams raise during MCD.

Method

Design

This study had a qualitative approach with an inductive, descriptive design.³⁷

Settings and participants

A total of five hospitals and two community care settings that had employed MCD facilitators were recruited. The inclusion criteria were workplaces where management and a majority of the staff communicated an interest to participate in MCD, which had no earlier experiences of MCD and had a guarantee of allotted time for participation from management. Included in the 10 workplaces were hospitals with the clinical specialties of dialysis, internal medicine and geriatrics, and community care settings that included rehabilitation and short-term care (Table 1). Staff members were invited to participate at information meetings and with letters.

The external facilitators who led the MCDs had various professional backgrounds: philosophers, chaplains, nurses and physicians. The only instruction given to them was to encourage dialogue about ethically difficult situations of concrete patient situations from the participants' clinical practice. A definition of an ethically difficult situation was given to the facilitators and the participants prior to the start of MCD: *situations in which you experience unease or uncertainty of what is right or good to do or are in disagreement about what should be done*. Participating staff (n = 687) included various professional backgrounds. The number of times they participated varied (see Table 1).

Data collection

A series of eight MCDs were held once a month at each workplace and lasted for 60 or 90 min. The sessions were audio-recorded, which the facilitators were responsible for (Table 1). In total, there were 70 MCDs recorded, and there were 10 internal dropouts due to cancelled meetings or technical problems with the recording. The audio recording of each session was transcribed by an experienced research secretary.

Analysis

The analysis process was inspired by thematic analysis.³⁸ The patterns of meaning which emerged as a result of reading the MCD transcripts were coded in several steps. Chronological analyses of 38 MCDs were performed by the first author (D.R.). First, a familiarisation with the data was conducted by reading and re-reading all of the transcripts. Second, the text was marked containing extracts that were only relevant to the research aim, and their key features were noted. Third, the codes were examined for each transcript and compared with each other. Fourth, the codes were sorted and merged based on similarities and differences into subthemes. These results were then deliberated during several processes among the co-authors and during seminars. During the last seminar, it was decided to expand the analysis from 38 and include all of the audio-recorded MCDs (n = 70), in order to enrich the result. The last author (M.S.) continued the thematic coding on the additional MCDs with help from the software NVivo10.³⁹ Subthemes from the previous analysis were compared with the new subthemes, and finally, themes were generated by M.S. with co-assessment from the other authors.

Table 1. Setting and MCD participants.

Institutions	Workplaces/specialties	Audio-recorded MCD sessions	
University hospital	Peritoneal dialysis unit	8	
	Dialysis unit	8	
	Medical reception	4	
General hospital	Medical assessment unit	7	
Community hospital	Internal medicine ward	8	
	Dialysis unit	7	
	Geriatric cardiology ward	6	
Community care	Geriatric palliative ward	8	
	Rehabilitation	8	
	Short-term care ward	6	
<i>Total: 5</i>	<i>10</i>	<i>70</i>	

Professions	Number of participants ^a	% representation in the MCDs	Mean participants in each MCD (range)
Nurses	400	98	6 (1–18)
Assistant nurses	144	66	2 (1–8)
Physicians	44	50	0.6 (0–2)
Nurse managers	33	43	0.5 (0–1)
Social worker	12	17	0.2 (0–1)
Occupational therapists	12	16	0.2 (0–2)
Physiotherapists	11	16	0.2 (0–1)
Others ^b	31	58	0.4 (0–2)
Total	687		9/4- 24

MCD: moral case deliberation.

^aThe number of participants from each profession, which implies that persons could participate several times.

^bMedical secretary, ward administrator, accountant, counsellor, biomedical analyst and chiroprapist.

Ethical considerations

An advisory statement specifying no objections to the study was provided by the Swedish Regional Ethical Review Board of Uppsala (dnr 2012/34). Consent to be recorded was assumed by virtue of participation in the MCD sessions. At each MCD session, the facilitator encouraged the participants to use pseudonyms for the patients/residents to protect their integrity.

Results

In most of the MCDs, the discussions concerned a specific ethically difficult situation about a current patient. Three themes emerged: powerlessness over managing difficult interactions with patients and next-of-kin, unease over unsafe and unequal care, and uncertainty over who should have power over care decisions (Table 2).

Powerlessness over managing difficult interactions with patients and next-of-kin

The staff raised issues connected with feelings of powerlessness when not being able to manage situations. The descriptions were accompanied by emotional expressions of powerlessness and descriptions of work

Table 2. Ethically difficult situations raised during MCDs.

Themes	Subthemes	Raised in MCDs
Powerlessness over managing difficult interactions with patients and next-of-kin	Feelings of insufficiency in responding to patients' and next-of-kin's emotional needs	14
	Difficulty to manage patients' and next-of-kin's emotional outbursts	10
	Discouragement over motivating patients not taking responsibility for their own health	8
Unease over unsafe and unequal care	Unease over discharging patients to unsafe conditions	9
	Unease over unjust care due to social status and behaviour	8
	Unease over physician's improper treatment of patients	5
Uncertainty over who should have power over care decisions	Who should decide over life and death?	5
	When should the patient's autonomy not be respected?	21
	When is it right to withhold or disclose the truth for patients and next-of-kin?	9
	How much power should next-of-kin have over care?	11

MCD: moral case deliberation.

stress. The ethically difficult situations concerned feelings of insufficiency in responding to patients' and next-of-kin's needs, difficulty managing patients' and next-of-kin's emotional outbursts and discouragement over patients not taking responsibility for their own health.

Feelings of insufficiency in responding to patients' and next-of-kin's emotional needs. Insufficiency and stress were expressed over not being able to provide good care to an anxious patient in need. They perceived an inability to fulfil patients' needs to talk about sorrows or support dying patients. It was perceived especially difficult to support patients and next-of-kin who disagreed about the care or were in denial of a pending death. Furthermore, some staff described that patients could have generated false hopes, did not want to talk about death or they felt there was insufficient time or an incompetence to reach them. Exhaustion was felt when dementia patients were constantly calling for their attention. The staff understood this could be a form of expression and a call for help, but felt powerless in how to handle it:

That we cannot give him what he wants is the basis of it all. No, he [the patient] can never be satisfied. No, he is insatiable. He would like to have someone there the whole time. He rings continually.

It was also difficult to meet patients who were acting impatiently while waiting to be informed of care and treatment decisions. Insufficiency to show empathy could be experienced due to time constraints or a bad conscience over feeling tired and a lack of involvement with suicidal patients.

Difficulty to manage patients' and next-of-kin's emotional outbursts. Exhaustion was expressed over how to handle demanding and angry patients and next-of-kin. The requests from patients could be for a single room or specific food, but because the patients were using a demanding tone it was felt harder to fulfil their needs. A feeling of frustration was experienced due to a lack of solidarity in the management of these situations. Some played the 'good' nurse and fulfilled the requests, while others took a harder stand and tried to set boundaries. Difficult outbursts occurred with dementia patients, for example, during personal hygiene care or if they were hindered from running around naked. Outbursts from other emotionally unstable patients included accusing staff of lying or threatening them or other patients when they did not get their way:

Sometimes she [the patient] gives up her cigarettes and sometimes not. I think it depends a little bit on how she feels. And on how violated she maybe feels. [...] It is a difficult balance [...] partly because she is threatening and then because it is awful to have to nag and get into the conflict that happens many times a day. It saps your energy.

Staff described next-of-kin outbursts as aggressive when they complained of neglect and threatened to report them. In some cases, personnel became involuntarily involved in conflicts between patients and next-of-kin and also between next-of-kin. These could be old conflicts or disagreements over future care. The staff had difficulties handling this.

Discouragement over motivating patients not taking responsibility for their own health. There were experiences of discouragement over patients they perceived as irresponsible or not complying with staff recommendations. It could involve disagreements between patients and staff over the best course of action. The staff could feel frustrated over patients who did not follow previously agreed care plans:

... she [the patient] was told to lose five kilograms in order to get a kidney. And instead of losing she went up fifteen. [...] However one tries to give different alternatives like starting group exercise or going outside and walking or anything else, and no matter what you've said, nothing gets through ... It can be a little frustrating. [...] And the whole time excuses why she can't walk or exercise and why she has eaten the wrong thing and so on

Unease over unsafe and unequal care

In the second theme, the staff were in disagreement about what should be done in order to provide safe and equal care to all patients. The staff felt unease over discharging patients to unsafe conditions and over unjust care due to social status and behaviour. In a few MCDs, staff expressed powerlessness over physicians' improper treatment.

Unease over discharging patients to unsafe conditions. Regarding patients' social situations, the staff felt unease discharging a patient to uncertain home situations or transferring dying patients to nursing homes. This involved patients who had been offered too little home care or none at all and those that seemed to have unsafe home situations due to problematic relatives:

I know that she [the patient] cannot remain and stay with us [at the hospital], but it feels so unethical to send her home when you know, to what? She won't be able to manage her medicines. An apartment she says she doesn't live in. Where she says social services has left a child that she should take care of. No, it doesn't feel good.

Unease over unjust care due to social status and behaviour. Ethically difficult situations concerned giving care equally to all. Staff experienced that powerful, friendlier and demanding patients got more attention than others and this was expressed as unease and distressing among staff. Influential patients with high social status, such as physicians, were felt to receive more attention by physicians than patients with low social status, such as addicts:

... the question is if this had been someone else. Had it been a doctor or some politician or whatever, then she [the patient] would not have laid there and waited and gotten worse.

In a few MCDs, the staff had questioned themselves when, for example, they had given the more open and friendlier patients more attention than the quiet ones. The staff felt unease over feeling pressured to give demanding patients more time:

...one feels that she [the patient] demands so much time. But we have actually other patients and they have needs too. That there is so much effort put into them and then all the others have to wait on the side. It really doesn't feel right

Unease over physician's improper treatment of patients. In MCDs without physician participation, staff brought up situations where they experienced the physicians' behaviour as uncaring, such as when they exposed patients or gave bad news like a cancer diagnosis in front of other patients. Improper treatment was also experienced when they witnessed something they considered questionable or the physician neglected the nurses' alarms in emergency situations:

But that the doctors didn't acknowledge what we had said to them and that he [the patient] and his wife... were rather frightened and nervous considering the condition he was in. He felt that we didn't do anything for him, he became a bit frustrated. He had been promised someone would come at 8:00am but no one came, finally at 1:00pm a day later someone does come and does something, and then they see that it is something very serious... many of the personnel that had taken care of him felt powerless. We had told about everything we had seen but no doctor would listen to what we had observed.

Uncertainty over who should have power over care decisions

The personnel felt there were several power aspects that influenced good care, and they sometimes felt uncertain as to what was the right or good action. The situations were interpreted to be dealing with four questions: Who should decide over life and death? When should the patient's autonomy not be respected? How much power should next-of-kin have over care? When is it right to withhold or disclose the truth for patients and next-of-kin?

Who should decide over life and death? The question of is it right to save a patient's life against their will was an ethically difficult situation that arose. One example was an older patient who was admitted due to a medicine overdose following a suicide attempt. On the ward he refused treatment, which raised an ethical conflict between the value of treatment of the self-induced condition and respecting autonomy:

... who is one to decide, also what gives us [the Staff] the right to decide that he has to continue living even though he absolutely doesn't want to. [...] it was as I understand it, rather well thought out. It wasn't just something impulsive or acute that happened, but something well thought out

Personnel from community care had felt uncertain as to whether it was right not to perform cardiopulmonary resuscitation (CPR) in the absence of a do-not-resuscitate (DNR) order. For one patient, the community care personnel knew a DNR order had existed when the patient was in the hospital, but at the community care facility there were no guidelines for resuscitation. At the same time, they felt some ambivalence with their feelings due to their unease and expressed uncertainty regarding the meaningfulness of CPR on frail older patients:

... but a concern can very well be that one [referring to staff] sometimes feels this type of uncertainty, because if there is no decision that there should not be CPR, so actually then that's what's valid. [...] where is the line drawn then, at 75 years with multiple illnesses or 85 years with multiple illnesses? Who don't we throw ourselves on and start CPR?

When should the patient's autonomy not be respected? A major issue was the concern of when it was right to go against the patient's wishes. The questions concerned whether it was right to use coercion when staff were convinced of good medical outcomes and whether to respect the patient's decisions when staff doubted whether the decisions were good.

In situations of coercion, the patients had protested against medical treatments, procedures and care, such as, the insertion of urinary catheters or enteral feeding tubes and rehabilitation. The staffs were convinced that the treatment was good for the patient, but they were uncertain of the rightness of the actions. One dementia patient refused to swallow antibiotic pills, and there were questions as to whether it was right to circumvent the treatment through intravenous administration, which entailed two staff members holding the patient by force. In these situations, the staff felt they were harming the patient more than helping.

The staff perceived the patients at times to be at different levels of competency: competent, moments of clarity and incompetent:

To respect his [the patients'] decision when he perhaps didn't understand what it was he was deciding on.

Instead of rehabilitation, a 100-year-old patient who had a hip repaired following a fracture wanted to return directly home. Staff felt there was an ethical conflict respecting her wishes because they knew that without rehabilitation the home care service would not be able to care for her.

When is it right to withhold or disclose the truth for patients and next-of-kin? The staff expressed their struggle to maintain confidentiality, and the question arose, when is it right to breach confidentiality if the consequences seem good. Staff felt it was difficult to withhold information about patients when other patients showed concern for them. There were situations that the staff perceived as cultural or religious issues: when the family claimed to know the particulars and the staff perceived them as wanting to take control over the patient, and the patient did not want them to know. It also happened that patients prohibited the staff from revealing any information to next-of-kin because of bad relationships:

One understands them [the family], but at the same time you don't want to go against his [the patient's] wishes

Some of the MCD discussions concerned the question of whether it is right to withhold certain information to prevent anxiety. There were also situations when staff felt they were infringing on patients' right to information. For a patient just diagnosed with lung cancer, the nurses questioned the rightness of the physician on call directing the nurses not to divulge the information until the ordinary physician returned in several days. They felt they would be left in an ethical dilemma if the family asked them and they could not disclose the truth.

How much power should next-of-kin have over care? The staff felt that the presence of next-of-kin could impede patient care and the question arose whether the next-of-kin should influence symptom alleviation. The staff expressed concern that the patients' autonomy was diminished as a result of the assertions made by next-of-kin. The conflicts centred on who had the determinable right to know what was good for incompetent patients. For one patient in pain, the staff perceived pain relief as necessary, but the next-of-kin resisted due to the side-effect of drowsiness. There were situations when staff felt powerless – unable to protest against the decisions made by the family in agreement with the physician regarding treatment and procedures, but without the patient's involvement. The staff asked themselves whether it was right to force treatment on a patient due to the assertions of next-of-kin:

And then she [the daughter] complained that the father had lost weight because we did not give him any food. Even though he [the patient] could not eat, could not swallow. [...] we [Staff] tried to feed him and we even

tried with different types of food preparations [...] I think that all this with the food is really difficult. I like to feed people but I don't like to force myself on someone just because a daughter wants it. I can really suffer with the patient

Discussion

The ethically difficult situations brought up by the participants in the MCDs comprised powerlessness over managing difficult interactions with patients and next-of-kin, unease over unsafe and unequal care, and uncertainty over who should have power over care decisions. The findings suggest that the nature of these situations reflected the ethical issues of everyday ethics,²⁵ contained more relational-oriented ethics than principle-based ethics, were permeated by emotions and the relationships were pervaded by power aspects.

First, the ethical issues of everyday ethics²⁵ have been captured in the MCDs, which seem close to the context of everyday clinical practice and seemed to emanate foremost from nurses and assistant nurses. The theme powerlessness over managing difficult interactions with patients and next-of-kin resembles the theme 'Resident's behaviour' where situations are provided by participants in a questionnaire *before* participating in the MCD, which is reported in a Dutch MCD study²⁴ as well as in others.^{5,9} The disagreement and divergent perspectives among professionals reported in the Dutch and other studies^{6,33,40–43} did not appear in our study. This is probably due to different data-collection methods. Our study captured ethical issues that were raised together as a team during MCDs, not what individuals perceived as ethical issues. This could also explain why the previously stated core ethical issue in healthcare of overtreatment of dying patients¹⁶ was not prominent in this study. There were indeed decision-making issues about CPR, but they were mostly raised in community care workplaces where physicians were not a part of the team. An interpretation of this could be that the participants did not dare to raise professional disagreements when the key stakeholder was present. This is also supported by the subtheme 'Unease over physician's improper treatment of patients' raised during MCDs lacking physician presence. A dialogue of different perspectives and conflicts of interest among different team members is a challenge that the facilitator should encourage and support.

Second, a number of the issues that the participants brought to the MCDs did not have a normative question of how one should act, that is, principle-based ethics. Many issues seemed more like relational-oriented ethics. We interpreted relational-oriented ethics as emanating from the theories of ethics of care,⁴⁴ ethics of proximity^{45,46} and virtue-ethics.⁴⁷ The focus is more on the relationship with the vulnerable patient and the larger context of his or her life, the interpersonal connectedness⁴⁴ and the mutual interdependence, rather than on the moment of the decision-making alone and that the right action⁴⁸ might not be defined as an ethical issue from the perspective of principle-based ethics.¹¹ One reason for categorising these issues as ethical is that in addition to receiving the definition of an ethically difficult situation prior to the MCDs, the participants were allowed to define what they interpreted an ethically difficult situation to be. Other authors have taken the opposite point of view with the interpretation that healthcare professionals do not know when an issue is an ethical issue.⁴⁹ *Nota bene*, these situations are what the participants *brought* to the MCDs; the scope of this study was not to study how these issues might have evolved during the MCDs. This will be published elsewhere.

Third, the situations brought to the MCDs in this study seemed to be permeated by burdensome feelings of powerlessness and unease. The situations reflected the difficulties the staff had balancing the emotional needs of the patients/next-of-kin with their own emotional needs. In ethics of care, it is ethically relevant how we meet the needs of others as well as our own.⁴⁴ According to Carol Gilligan,⁵⁰ emotions play an important role in morality; since persons are enmeshed in a web of relationships, the factor of emotions has to be taken into account in the experience of a moral problem. When an impartial perspective is expected,

emotions can enable us to grasp a situation that may not be immediately available from a principle-based perspective.⁵¹ According to Molewijk et al.,³⁰ emotions are an integral part of virtue-ethics and can be informative for the MCD dialogue, that is, giving information on which normative thoughts accompany the emotions. MCDs could therefore be a useful tool to integrate moral reasoning and emotions³⁰ in order to get under the surface and understand interactions with patients, next-of-kin and other personnel. This can enhance moral sensitiveness, which is an important virtue. Here, the facilitator of MCD has an important role to promote an atmosphere in which the participants dare to express their thoughts in order to deliberate difficult emotions. The feeling of powerlessness has also previously been reported as a sign of moral distress.⁵² We detected that several of the MCDs contained psycho-social reflection, such as a focus on the staff's own emotional situation, which will also be published elsewhere. One beneficial outcome of MCDs might be emotional relief, but if this dominates, the MCD will take the form of psycho-social supervision instead of ethical reflection. An important role of the facilitator may be to balance the psycho-social and ethical components of MCD.

Fourth, the uncertainties over who should have power over care decisions mostly resembled traditional principle-based ethics. The uncertainties were pervaded by power aspects as the staff described situations when they felt that the patient was over-treated against their will and the patients' autonomy was overruled. The staff also raised questions over how much power next-of-kin should have over the care and when was it right to withhold information from patients and next-of-kin. Power is often interpreted in terms of coercion and domination,⁵³ or it can be seen as a matter of authority and control or influence vis-a-vis other persons.

The staff can choose to have power 'to' or power 'over'. Power 'to' here is to treat someone against their will and to help someone using the staff's competence when they believe it leads to something good, such as with the insertion of needed catheters or the encounter with the person with dementia who refused to swallow antibiotic pills. The staff were convinced that the treatment was good for the patients, but they were uncertain of the rightness of the actions, which is a positive kind of power because it was done with good intention.⁵³ Power 'over' is a negative kind of power, that is, to make decisions for somebody without involving the person. The staff in this study seemed to feel that the physicians and relatives had power over the care; they felt that they knew what the patient wanted, but decisions were made without involving the patient. They also showed an awareness of their power; healthcare professionals have power over patients, and with power follows responsibility and obligations.⁵⁴ Responsibility for a patient implies completing the tasks assigned to the staff in a given situation, where they have obligations to provide good care.⁵⁵ Responsibility has ethical as well as human aspects. When the responsibility involves another person, it also has a moral one⁴⁶ which could be the reason to why the staff needed to reflect over these situations in the MCD.

Strengths and limitations

The strengths of this study are the rich and numerous descriptions of ethically difficult situations connected to authentic cases raised by interprofessional teams. Our study complements the knowledge from previous studies that report mostly on individual experiences through questionnaires or interviews.^{10,12,20} This study complements a previous Dutch MCD study that focused on nursing homes and psychiatric wards by providing a wider perspective from different specialities in hospitals as well as from community care.^{24,56}

There are some limitations to this study. First, there were difficulties understanding the audio recording in some MCDs when several participants were talking simultaneously, and this may have led to the loss of important data. Second, there was a lack of participating physicians in the MCDs. Physicians seemed to have problems prioritising the MCDs, but in all, there were more physicians attending the MCDs than expected. Third, it was difficult to identify which professionals raised the ethical issues. This had been easier if videotaping had been used. However, in some MCDs when it was possible to identify the professionals, the issues seemed to come mostly from nurses or assistant nurses. The original design of

the study was to use videotaping, but it was rejected by the first workplaces which actually allowed us to include many more MCDs. Fourth, the topics of the MCDs might seem too negative as they focused on difficult cases and not on ‘good cases’, such as value-based ethics, which participants also can learn from. However, since difficult emotions seemed to be the force for participating in MCD, we think an important part of MCD is emotional relief.

In this study, professionals working in both acute care and care for older people shared many ethically difficult situations, but ethical problems raised in other specialities might differ. Unfortunately, surgical workplaces did not express an interest for MCDs.

Conclusion and implications

The ethically difficult situations described in this study are what the participants *brought* to the MCDs, and the scope of this study was not to study how these issues might have evolved during the MCDs. The ethically difficult situations appeared to be connected foremost to emotionally burdensome relations with patients and next-of-kin, where relational-oriented ethics seemed to play a more important role than the traditional principle-based ethics.

MCD can be useful in understanding the connection between ethical issues and emotions from a team perspective.

An important role of the facilitator may be to balance the psycho-social and ethical components of the difficult situations. This could be an area for future research that examines the ethically difficult situations raised during the MCD sessions and in particular the role of the facilitator.

Conflict of interest

The authors declare that there is no conflict of interest.

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