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Communicative and organizational aspects of clinical ethics support

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ABSTRACT

Studies show that healthcare professionals need inter-professional clinical ethics support (CES) in order to communicate and reflect on ethically difficult care situations that they experience in their clinical practice. Internationally, various CES interventions have been performed, but the communication processes and organisation of these interventions are rarely described in detail. The aim of this study was to explore communicative and organisational conditions of a CES intervention with the intention of promoting inter-professional communication about ethically difficult care situations. Eight audio- and video-recorded inter-professional CES sessions, inspired by Habermas’ theory of communicative actions, were conducted. The observations were transcribed, sorted, and analysed using concept- and data-driven content analysis methods. The findings show three approaches to promoting communicative agreement, which include the CES facilitators’ and participants’ approaches to promoting a permissive communication, extended views, and mutual understanding. The CES sessions had organizational aspects for facilitating communicative agreement with both a given structure and openness for variation. The dynamic structure of the organization, promoted both safety and stability as well as a creativity and responsiveness, which in turn opened up for a free and dynamic inter-professional dialogue concerning ethically difficult care situations. The findings constitute a step towards a theory-based CES method inspired by Habermas’ theory of communicative action. Further research is needed in order to fully develop the method and obtain increased knowledge about how to promote an inter-professional dialogue about ethically difficult situations.

KEYWORDS

Clinical ethics support; inter-professional communication; care ethics; ethically difficult situations; healthcare professionals

Background

Ethically difficult care situations are a part of everyday healthcare practice, and may concern decisions, care and treatment in relations to patients, relatives (Hermsen & van der Donk, 2009), other professionals (Jiménez-Herrera & Axelsson, 2014), and organizations (Cohen & Erickson, 2006) or legal regulations (Kälvenmark, Höglund, Hansson, Westerholm, & Arnetz, 2004). An ethically difficult situation can be defined as a situation in which values, interests, and principles are in conflict with each other and in which there are obstacles to determining the best solution for how to act (Sarvimäki & Stenbock-Hult, 2008, p. 173). Healthcare organizations are complex and involve professionals with different areas of responsibility, codes of ethics and moral perspectives on patient care (Jameton, 2013). The professionals are also influenced by their own personal values (Fahr, 2010). In ethically difficult situations, registered nurses (RNs) have described feelings of uncertainty, powerlessness, (Rasoal, Kihlgren, James, & Svantesson, 2015) and frustration (Sorlie, Kihlgren, & Kihlgren, 2005). Physicians have described feelings of uncertainty and the burden of sole responsibility (Cohen & Erickson, 2006). RNs and physicians have been found to feel uncertain and alone in similar ethically difficult situations, but they have difficulties communicating across the professional boundaries (Grönlund, Dahlqvist, & Söderberg, 2011; Grönlund, Söderberg, Zingmark, Sandlund, & Dahlqvist, 2015). Edwards, McClement, and Read (2013) showed that healthcare professionals can help each other to address and act upon the issues at stake by communicating the ethically difficult situations with co-workers. Other studies stress the importance for healthcare professionals to systematically reflect on moral issues in organized forms so as to make the various perspectives and interpretations transparent (Pedersen, Akre, & Forde, 2009), to promote good care in concordance with patients’ needs (Dauwese, Abma, Molewijk, & Widdershoven, 2013), and to further prevent moral distress among the professionals (Sillén, Svantesson, Kjellström, Sidenvall, & Christensson, 2011).

Various kinds of clinical ethics support (CES) have been developed to promote the possibilities for healthcare professionals to communicate and handle ethical issues (Rasoal, Skovdahl, Gifford, & Kihlgren, 2017), such as moral case deliberation (MCD) (van der Dam, Abma, Molewijk, Kardol, & Schols, 2011), ethics consultations (Fox, Myers, & Pearlman, 2007), clinical ethics committees (Pedersen et al., 2009 a), and ethical rounds (Svantesson, Anderzen-Carlsson, Thorsen, Kallenberg, & Ahlström, 2008). The various forms of CES aim to raise awareness of ethical issues (Dauwese et al., 2013), broaden perspectives (Gracia, 2003), and reflections on how to deal with moral issues (Hermsen & van der Donk, 2004, 2008, 2017).
The CES intervention described in this study was inspired by Habermas’ theory of communicative action. The theory distinguishes between success-oriented actions and communicative actions. A success-oriented action is considered to be strategic and related to social interactions in order to reach desired goals. The communicative action means to talk and listen in an understanding-oriented dialogue in order to achieve a common understanding and reach consensus for moral actions based on well-considered arguments and motives (Habermas, 1990, p. 100). A prerequisite for communicative actions is an atmosphere of equality, where all participants feel free to express themselves without any claims to power (Habermas, 1996 p 100–101, 145). The dialogue might include assumptions and ideals with arguments and counter-arguments until a common understanding is achieved (Habermas, 1996 p 100–113, 303). Although the concept of consensus is part of the theory underlying the CES intervention studied here, the intervention was focused on reaching communicative agreement regarding the ethical difficulties instead of full consensus. The intention behind using the concept of communicative agreement, in line with Benhabib (1990, p. 336) was to capture the variations of the aspects that appear in the moral dialogue and that can be accepted by all those involved in the dialogue. In this CES intervention, the healthcare professionals on one ward met to reflect on an ethically difficult situation that was current in their clinical work with guidance from facilitators from the hospital ethics committee. The purpose of the intervention was to promote a communication about ethical issues and a communicative agreement on how to understand ethical difficulties and how to act or relate in the best way for the patient. Various CES interventions have been described (Forde & Pedersen, 2011; Silén, Haglund, Hansson, & Ramklint, 2015), but there is a lack of studies that thoroughly describe the communication process. In a previous study of this CES intervention, exploring the inter-professional communication of value conflicts, the participants went through a communication process where they moved from expressions of individual frustration to a common understanding of the situation. The analysis revealed five phases; expressing feelings of frustration, sharing feelings of disempowerment and helplessness, revealing the value conflict, enhancing realistic expectations, and seeing opportunities to change the situation instead of obstacles (Grönlund, Dahlqvist, Zingmark, Sandlund, & Söderberg, 2016). The earlier study focused on the communication process, while this study focuses on the conditions that allow this process to achieve a common understanding about ethical issues among the participants. There is more to learn about the execution and organizational conditions of this theory-based CES. For further development of a CES method, it is important to increase knowledge about the communication process (Grönlund et al., 2016) and develop an understanding of the conditions that shape communicative action.

The aim of this study, therefore, was to explore the communicative and organizational conditions of a CES intervention with the intention of promoting interprofessional communication about ethically difficult care situations.

Methods

The CES session

The CES-intervention under study was inspired by Habermas theory of communicative actions, emphasizing a democratic dialogue where the participants can feel free and have equal opportunities to speak (cf. Habermas, 1996, p. 303). Healthcare professionals on one ward met eight times to reflect on ethically difficult care situations in order to reach a common understanding of the value conflict. The sessions were consistently performed on the ward in the same room, at the same time, and lasted for one hour. The CES sessions were facilitated by healthcare professionals from the ethics committee at the hospital, including one main CES facilitator (hereafter called the facilitator) and one or two assistant facilitators. They were all specially trained in healthcare ethics and experienced in facilitating CES sessions. In focus for each session were ethically difficult situations from the participants’ clinical work, chosen in advance or during the session. One participant presented a situation and the other could ask for clarification. All participants then reflected on the situation to get a common picture and bring everyone into the situation. The facilitators guided the dialogue with an expressed intention to facilitate an agreement on how to understand, handle or resolve the value conflict. It was clearly stated that all participants were free to express their points of view and should be met with respect in a democratic dialogue.

Setting

Both oral and written information about the planned CES intervention study were provided to the heads of all wards at a Swedish hospital. The criteria for inclusion was a need to process perceived ethical issues and a willingness to participate in an audio and video-recorded inter-professional CES intervention over a period of eight months. Five wards applied, and among them was a clinic specialized in long-term rehabilitation that was selected on the basis of the descriptions of their dealing with intractable ethically difficult situations as part of everyday care. Examples of situations perceived as ethically difficult were the feeling of being prevented from providing care in accordance with one’s professional knowledge and values. The patients were usually hospitalized for several months on the ward and in great need of the professional care and competence.

Participants

A total of 41 professionals, including 34 women and 7 men, agreed to participate in the CES intervention on the ward. The participants included RNs, physicians [PN], enrolled nurses [ENs], occupational therapists [OT], physiotherapists [PT], social worker SW], a psychologist [PSY] and the head of the ward. The CES sessions were open to all professionals on the ward, but the composition of participants as individuals, professions and numbers varied (between 11 and 17 at each session), depending on individual work schedules and the care situation (Table 1).
period from October 2012 to May 2013. Each CES session
organisational aspects facilitating com-
communication approaches that promoted a permissive communication by
2011 combination of concept driven and data-driven qualitative
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Table 1. Number participants from each specific profession involved in the each CES session. The professions included registered nurses [RNs], enrolled nurses [ENs], physicans [PHYS], physio-therapists [PT], occupational-therapist [OT], welfare-officers [WO], psychologist [PSY] and head of department [HD].

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Data collection

Eight CES sessions were audio- and video-recorded during a period from October 2012 to May 2013. Each CES session lasted for approximately one hour. Two video cameras were used in order to get two viewpoints with extended opportunities to collect information about the non-verbal communication that occurred during each session. The video cameras were fixed on tripods in order to reduce the risk of disturbing the ethical discussions (cf. Heath & Hindmarsh, 2011, p. 38–41). The first author acted as an observer, with the primary task of handling the equipment and making sure that the sessions were properly audio- and video-recorded. Due to technical failure, only visual data from one video camera was collected in two of the CES sessions.

Data analysis

The audio- and video-recorded observations were analysed with a combination of concept driven and data-driven qualitative content analysis (cf. Schreyer p 80–91) by using Transana, which is a computer-based tool for sorting and processing qualitative audio- and video-recorded data (cf. Antonsson, Åström, Lundström, & Granheim, 2013; Dempster & Woods, 2011; Mavrou et al., 2007). Transana allows simultaneous transcription, sorting, and processing of video-recorded observations containing both verbal and visual data. First, all data from the eight CES sessions were imported into Transana. The material was then viewed and listened to in chronological order to gain a sense of each CES session and of the whole intervention process in relation to the research question. Reflective notes were made during and directly after the video observations to further capture various non-verbal expressions outside the camera lens, such as, gestures, sighs, or latecomers entrance. The audio recorded verbal content was then transcribed into text. The two concepts of organizational conditions and communicative conditions, introduced in the aim, were used as the basis for the concept driven analysis. For the analysis, the concepts were formulated as questions. How is the CES intervention organized and structured? How are the communicative conditions and the communicative action on ethical issues promoted? All audio, visual and transcribed data were then sorted in line with the identified concepts, divided into sequences according to the accomplishment of the communication and coded. The sequences constituted various parts of the observed communication, therefore parts of the same sequence could fit into more than one concept (cf. Heath & Hindmarsh, 2011, p. 68–69). The coded sequences within each concept were then sorted and analysed, by using a data-driven strategy, according to patterns of similarities and differences in the communication. During the analysis categories were formulated (cf. Schreier, 2012, p. 84–90) and further sorted under two headings based on the concept driven analysis. Finally, the video-recorded observations were re-viewed and confirmed in relation to the resulting categories.

Ethical considerations

The study is part of a larger project and has been undertaken in accordance with the Helsinki Declaration (2013) and approved by the Ethics Committee of the Medical Faculty at Umeå University (Dnr 2012–338-31M). After being informed verbally and in writing about the study, that the CES sessions would be audio- and video-recorded, and that they had the right to withdraw without any explanation, the participants signed an informed consent form. There was a risk that audio- and video-recording the CES session could be perceived as threatening the participants’ privacy. However, the participants were informed that their confidentiality would be ensured. The video-recorded data and transcriptions are saved in a secure external drive.

Results

The observations of the communicative and organizational conditions for the CES intervention resulted in five categories. Three of the categories were sorted under the heading “Approaches to reach a communicative agreement” The approaches that facilitated an interprofessional dialogue to reach communicative agreement were: promoting permissive communication, promoting extended views and promoting a mutual understanding. Two of the categories were sorted under the heading “Organisational aspects facilitating communicative agreement”. The organisational aspects that enabled communicative actions to reach communicative agreement were: promoting safety and stability and promoting creativity and responsiveness among the participants.

Approaches to reach communicative agreement

Approaches to reaching communicative agreement constituted the facilitators’ and participants’ communicative actions to promote a permissive communication, extended views and a mutual understanding. The approaches were situation related, attuned to the atmosphere, confirming and challenging, and directed towards communicative agreement. A common thread constituted the facilitators responsiveness and active listening. Each approach is described below.

Promoting a permissive communication

For the most part, the facilitators and participants maintained an approach that promoted a permissive communication by expressing engagement, listening, and sharing their own experiences. The video observations showed that the facilitators adopted an active listening position by directing themselves to the person speaking, leaning forward, nodding, and
using probes such as “please tell us more”. By adopting a listening approach, the facilitators not only became attentive to the events in the group, but also showed an interest and engagement in the participants’ stories. The participants were listened to and taken seriously, which seemed to build a sense of trust. In the observations, the facilitator invited the participants to participate in the communicative action with open or specific questions, such as “Please can you tell me?” or “What do you experience as difficult?” By allowing pauses, the participants were allocated time for reflection. The observations show that the participants allowed each other to speak out freely. Some participants spoke more than others, and sometimes they interrupted each other. When an important topic was disrupted, the facilitator returned to it and picked it up later when suitable. The following sequence concerned the experience of receiving a negative critique.

- EN if I were to do something wrong, I would absolutely want to know it in a pedagogic way, so that you don’t just throw it in your face ... but I think no one wants to be criticized.
- RN 1: I think most of us want to know if we do something wrong, but I have difficulties taking criticism. I know it is very important, but there is a risk that I will think about it for a long time afterwards.
- RN 2: It is because I do not get criticism so often, and when it happens it is like a slap in the face.....
- RN 1: [changes track] I think.... we often talk over the patient’s head....
- Facilitator: Often, we have to make each other attentive to such routines.....But [turns back to RN:1] - how are we going to do that without making you so shocked?
- RN 1: Oh, [turns to the EN] I just feel that you must convey it in a pedagogical way and generalize....'

The facilitators shared their own professional and personal experiences, which appeared to have a releasing effect on some of the participants. They dared to share not only experiences, but also vulnerabilities and shortcomings. The observations showed a lot of laughter among the participants and facilitators. With this releasing approach, the participants seemed to reach beyond each other’s superficial facades, which appeared to equalize the power relationship between them.

Promoting extended views

In the observations, an approach to promote extended views seemed to follow from the communicative action by sharing of insights, experiences, listening, and validating each other’s statements. The facilitators asked each participant to tell their experience of the ethically difficult situation, and various perspectives on the situation were expressed. When the facilitator asked the participants to formulate the value conflict, they first replied with silence. The facilitator supported the participants in formulating the value conflict and they started to communicate the value conflict by telling stories from their clinical experience.

They talked about conflicting situations, the tension between negative consequences, the risk of violation of the patient’s autonomy, and troubled relations. The following example concerns a patient on long-term rehabilitation after a massive trauma. Due to the injuries his cognitive and physical capacities were very limited. The staff were therefor giving restrictions about TV and gaming in order to make him maintain the rehabilitation.

- PN: …my feeling is that to every other patient, we assign as much autonomy as possible ... but now it is just the opposite. ....
- OT: …We know that he [the patient] has prerequisites to manage an independent life. It would be an incredible defeat if he would have to move into the nursing home.

Now and then during the communicative action, the facilitators summarized with repetitions and follow-up questions, such as “How can you understand this?” or “What is the conflict?” By using such an approach, directed to the whole group or to a specific participant, further reflections of the situation were promoted, sometimes at a later point of time. The recurrent and reflecting dialogue, with the possibility to re-evaluate one’s arguments, opened up for extended views which showed to be an important step towards a communicative agreement.

The following sequence shows a dialogue concerning how to understand a patient’s relative who had been critical of the rehabilitation process.

- EN 1: I was there when she said that she [the patient] had less than 30 minutes of exercise, got so angry and ran out....
- SW: Why?
- EN 1: Because there were only 30 minutes of exercise ...
- PT: …She thinks the only exercise is physical therapy.
- EN 2: It is not so easy for her [the patient] either ... if she [the relative] is forcing her and...
- F: How can you understand this situation? Do you have any explanation?
- EN 3: I think she [the relative] is very frustrated, has a lot of anguish and cannot handle it.

The facilitators intervened in the dialogue only when needed, for instance by making sure everyone had the chance to speak or facilitate the progress of the dialogue. The participants shared experiences, opinions, and factual knowledge from their personal and professional points of view. Various perspectives were revealed, and these opened up space for recognition of others’ points of view. The combination of the facilitator’s active listening approach, reflecting questions and sharing theoretically-based information, such as, health care ethics, medical issues or human behaviour seemed to promote the communicative action towards extended views. The facilitators sometimes connected the situations with theoretical and practical information, related to the situation, in an everyday language. The theoretical knowledge paved the way for alternative thought patterns and seemed to stimulate the participants to reflect on various levels.
F 2: when I listen to what you say…. if he has, what you may call a paranoid personality, he might have difficulties in trusting in other people… it is common that persons with a paranoid personality… withdraw and avoid others as much as they can, because things may go wrong…. so my first thought is….. are you playing in the same arena when you discuss goals and plans?

RN: One maybe should think as he [the name of L 2] said. I’m thinking… what are we asking from him? Do we ask too much?

While some of the participants made use of theory and others viewpoints by reflecting on and re-evaluating their own points of view, others continued the communication from their practical experience. In the following communication sequence the participants communicated how to relate to a patient who was in a need for rehabilitation. The patient had a reverse circadian and was too tired to cooperate in his rehabilitation. The dialogue was moving between a practical and reflective level. The facilitators showed to confirm the varying levels in the dialogue.

OT 1: how many chances and how much resources shall we give [him] when it still does not work?
OT 2: We could let him know how things will work out [for him] if he doesn’t cooperate [in the rehabilitation].
SW: No I don’t think that is a good idea
PN: …one shall seize the opportunity and [support him to] break bad habits when he is in a positive mood. Thus not to punish him when he is in a negative mood...
RN: hm but then he has to to be awaken...
OT: he needs to be on the track and have a will because if he doesn’t want to [participate] it will not work...
PN: but I believe we have to make a change and make use of our frustration in a constructive way...

Promoting a mutual understanding

The observations show that the facilitators’ approach to promoting a mutual understanding were to make use of the participants’ stories for further reflections. By allocating enough time for reflections, the participants were able to interpret and reinterpret the value conflict at their own pace. The facilitators supported the participants on the way by repeatedly asking questions about how one can act, relate, or respond. The observations show that the facilitators’ approach encouraged the participants to use their own stories to stimulate further reflections.

-F: You find it easier to meet her. Could you give us some advice [turns to the EN]?
-EN: What for me personally makes the difference is that I’ve grown up with such a family and I can see my mother in this....

During the sessions, the participants said things to suggest that they alternated between extended views, found proposals for action, or remained frustrated. They seemed to go through a process where new knowledge and new perspectives successively changed the way they interpreted and understood the problem. The transition for this change, however, was individual, and it looked as if some participants needed more time to reflect over the various aspects that were communicated.

The following sequence shows how the expert promotes an alternative way to encounter an ethical difficult care situation.

Expert: You have no power instrument because the addicts build up a defense. It is about to reach him by the sense.. and have a dialogue in private

RN: Yes I think one have to open up for a dialogue, explain that we are present for him if he needs our support.....

The facilitators empowered the variations of expressions by allocating time for thorough reflections. One way to promote a mutual understanding was to return to the same problem both within and between the sessions. The following sequence shows a participant expressing alternative perspectives regarding the patient’s situation, but the dialogue took a new path. Hence, later on, another participant returned to the subject of concern.

-EN: He told [the other patients] at dinner yesterday that there is no AA [Alcoholics Anonymous] for pill [addicts].
-F 3: But there is.
-Expert: Then in fact they are NA [anonymous drug abusers] meetings. It works if one visits AA meetings as well, but for drugs it is NA.
-PT: I have thought about what you said earlier [points to the EN] about talking with others. When he went to eat, he seemed to enjoy talking with other people than just professionals.
-EN: He also talked about abstinence.
-F 3: Would it be valuable for him to talk with another abuser sitting in a wheelchair?
-RN: Yes, I have to think about it and do some research... It would be good for him to meet someone with similar problems.

The observations show that the participants wished to raise the same case during several CES sessions. The facilitators kept a responsive approach to this, and allowed the same case to be in focus until a common understanding was reached, and this gave opportunities for further reflections between the sessions. Having sufficient time for the participants to understand the value conflict seemed to prepare them for a commonly changed picture of the situation. Some participants expressed alternative ways of handling the situation.

EN 1: She the [relative] is openly aggressive, one can see when she comes [how angry she is]... she [the patient] becomes grouchy to her and then it is our fault
EN 2: I feel angry because we all... do what we can to make it better for her [the patient]
Next session:
F: How can you understand this situation?
PT: I think she [the relative] is very frustrated and she has a terrible anguish to handle....
EN 1: She [the relative] said that she came [to this unit] so she [the patient] could get rid of the respirator so it is a great frustration [for her]
The facilitators highlighted these proposals with repeated conclusions as reminders, which seemed to encourage the participants to discuss these alternative ways further. Hence, they finally approved the repeated proposals for actions and arrived at a communicative agreement.

**Organisational aspects facilitating communicative agreement**

The CES organization was found to consist of both a constant or given structure and of flexibility with openness for variation. Such an integration created a stable yet dynamic organization that paved the way for recognition among the participants, and appeared to promote safety and stability. The integration of constancy and flexibility also promoted a free and lively dialogue, which seemed to promote creativity and responsiveness in the communication process about ethically difficult care situations.

**Promoting safety and stability**

The participants seemed to appreciate the clear layout of the sessions. They became familiar with the way the sessions were organised, and used to the recurrent procedure. The constant and given structure of the CES sessions appeared to be important for promoting safety and stability. All sessions included the pattern of an introduction, a reminder of the status of the issue or a presentation of a new ethically difficult situation, an open dialogue, and concluding remarks. The facilitator introduced every session by welcoming all the participants and briefly explaining the rules for the CES session. The rules concerned a request to keep a respectful attitude to each other, feel safe to talk, search for possibilities, and avoid getting caught up in obstacles. The facilitator continued by asking the participants to talk about any ethically difficult situation that they were struggling with at the moment. If the participants expressed a wish to draft a situation that had been communicated in a previous session, the facilitator concluded what was communicated previously and asked the participants to explain how the situation had progressed. If the participants expressed a wish to draft a new situation, the facilitator addressed a specific person or to whole group and asked whether someone would like talk about the situation. While one of the participants explained the situation of concern, the facilitator listened actively. The facilitator asked the participants whether they all knew about the situation, whether someone needed more information, and if this was what everyone wanted to communicate about. After confirmatory expressions from the participants, the facilitator informed the participants about the working process.

F: we are going to work in three steps. You can say what you think about the problem. We will dig down to the problem in order to understand what the [situation] actually is about, and then we will search proposals for actions.

In order to clarify various perspectives of the ethically difficult situation, the facilitator turned to each participant, one by one, and asked them to say how they experienced the situation. Those participants who expressed a wish to pass were met with respect. By asking each participant to express their experience, the facilitator allocated talk space even to those participants who had difficulties in articulating or expressing themselves. The facilitator confirmed these participants by showing an active listening approach and follow-up questions.

EN: [talking about an ethically difficult situation] … that obstructs all possibilities for the patient to rehabilitate and complicates our work …. How can we handle this?

F: Do you all know about this situation? .. Even you? [turns to the physicians]. Does anyone have a question … to get a clearer explanation? [shaking one’s head and -yes]. … Is it okey to discuss this? [paus, -nodding and yes]. Well now, I want to hear from you all [directing the arm as: one by one in turn] what you think about this situation and your experience. You may pass, if you wish to.

OT: Yes, I can say how I experience the situation. From the beginning, she showed all her thorns, then it got better and .. now it is bad again. One avoids going there…

F: What do you think is difficult?

OT: [Thought pause]…..One wants to be sufficient…

During the sessions, the leaders facilitated communicative action by repeatedly asking follow-up questions and summarizing the essence of what had been communicated. At the end of each session, the leader made a summary of issues of concern, communicative agreements for action strategies, and concluding remarks.

F: What you have just talked about is that one cannot force him [the patient] to make a change but rather try to make him engaged by himself… to rather have a close collaboration with him and that one of you will talk with him… in a way that makes him feel that you care for him…

The given structure with its constancy seemed to provide stable, safe, and familiar surroundings serving as a condition for expressing individual frustrations, sharing frustrations, and revealing value conflicts. The participants showed to be safe enough to express their emotions and they helped each other to find alternative ways to handle the situation.

EN: We are more or less susceptible to her [the relatives] hints… I have a rucksack in life that makes me very badly affected….I become completely resigned and think: how I shall respond to this…

F: …how can you respond …? …

PT: Most often It works, if you haven’t been so badly affected and lost your self confidence… if you just keep calm and feel your dignity you can make it.

Finally, the facilitator asked whether everyone who wished had been heard, whether anyone felt harassed or uneasy, and expressed gratitude for their contribution to the participants.
Promoting creativity and responsiveness

Although the CES-sessions were organised with a given structure, and a recurrent procedure, there was also a flexibility with openness for variation. The flexibility was mainly facilitator-driven and depended on the specific situations, issues of concern and the stages in the communication process. This flexibility and openness to variation seemed to bring energy to the dialogue and further promote creativity and responsiveness. By sharing their own point of view and asking questions that gave directions to a change of thought pattern the facilitators promoted further reflections.

RN: She does not want to speak with anyone but she rather [shows aggressions].... She, of course, feels very bad....
PT: ...... I think we must set limits [to her] without to becoming defensive but it is not easy when you get sworn at
F: How can you respond in a respectful way.... and resist being upset?
EN: We have to respond clearly to her..

The facilitator’s posed questions in different ways but the core were calling for a self-reflection and concerned for instance; What do you experience as a problem in this? How does this make you feel? How can you understand their behaviour? How do you handle this? How can you relate to [them]. By responding to the participants with respect and confirmation, the facilitators expressed a sense of trust that promoted spontaneous expressions of experiences and emotions.

RN 1: It is very difficult to respond in a conflict with her... because you do not know how she will react ....
RN 2: [interrupts] ...then she got so angry and was nearly falling out of the chair
F: Oh yes....Can you imagine how all her emotions are expressed towards you? .. How can you respond to her?
OT: … it is good to hear that all this is not only directed to me
F: Yes, you are so right

The number of facilitators varied between the sessions. The observations show that in those sessions guided by one sole facilitator there were sometimes difficulties in maintaining a democratic dialogue and distributing talk space to everyone, especially when several participants became very engaged in a discussion. In sessions involving two or three facilitators, they appeared to help each other notice and highlight various aspects of experiences and emotions.

RN: She [the relative] give us sarcastic comments
F: But probably it is not directed to you
RN: she is frustrated because the slow progress [of the daughters recovery]
F3: Yes she needs help to understand that there is no use to hurry up
F: These complaints are probably not directed to you but is rather her despair....
RN: One have to understand her..

PT: It is worse [for her now] ... earlier one knew that this is a dedly disease bu now you know nothing....

The flexibility also included the facilitators’ recommendations of literature for those who wished to gain a deeper understanding of the ethical issue of concern. Experts were invited twice to discuss and give lectures when the participants expressed a need for professional and factual knowledge in order to understand the situation. One of them was an expert in substance misuse, giving a short lecture about what it means to be a person with substance misuse. The other expert was a staff strategist, giving a short lecture about the meaning of positive and negative feedback, followed by an open discussion. The lectures promoted new insights and stimulated to further reflections.

F: so what you say is that it is a great art to give a critique in a constructive way... ?
SW: Yes, I think it is important as you said [directs to the expert] that we have a messenger and a receiver, and it depends on how I as a receiver react to criticism. It does not matter how a person provides criticism if I always have to defend myself....

As the CES sessions were open for all staff members on the ward, the content of what had been communicated became open to the whole group of professionals. However, the number of participants varied, and some dropped in after the appointed time for the session, which disturbed the dialogue. Hence the facilitators and participants lost focus and sometimes forgot what they were talking about. In the analysis, both positive and negative aspects of this specific kind of flexibility were found.

Discussion

The aim of this study was to explore the communicative and organisational conditions of a CES intervention with the intention of promoting interprofessional communication and facilitating communicative agreement. Altogether this paved the way for a communication process towards communicative agreement. The combination of constancy and flexibility in the CES sessions worked as a stable cornerstone that allowed the participants to recognize the course of events, and promoted conditions for a communicative action. On the one hand, the participants were free to communicate from their own point of view according to their context. On the other hand, they were prompted by the organization to keep themselves within commonly accepted norms. This is in line with Habermas’ (1994) description of democratic structures as a continuous balance between autonomous humans’ self-governances and universal social norms. The organization of the CES sessions...
was built to promote an argumentation process and make it possible for the participants to express themselves, to determine the validity of each other’s statements, and to reveal side effects. Through the communicative action, the participants in this study ended up with a common understanding of the situation (cf. Habermas, 1990 p 67–71, 1996, p. 302) and communicative agreement for how to act. Bartholdson, Lützén, Blomgren, and Pergert (2015) showed that the argumentation process allowed the participants in their study to arrive at a common understanding of the situation and to become united. CES sessions within other contexts, including other participants and facilitators, might, however, have a different process. Hence, according to Abma, Molewijk, and Widdershoven (2009), there is always a risk of failures and disagreements in a moral discourse, but the dialogue itself provides opportunities to learn from disagreements and to deal with failures. Benhabib (1994) further developed Habermas’ theory of communicative action and emphasized the advantage of human diversity with all its various aspects and experiences in a reflexive dialogue, because it provides opportunities for the participants to develop an extended mentality (Benhabib, 1994 p 170–171, 186). The combination of constancy and flexibility in the CES sessions allowed for the variations that further promoted a permissive communication climate. The participants were invited to the dialogue as equals, but some participants took more talking space than others. The facilitators handled the uneven distribution by continuously offering talking space to the silent participants. According to Abma et al. (2009), it is important to notice and give attention to everyone because the silent participants’ statements are important for the plurality of aspects. The openness for all variation and human plurality required the facilitators to be aware of various courses of events, which might be challenging for one facilitator to manage alone. Therefore, involving two active facilitators in the CES sessions might be an advantage. In a study by Weidema, Molewijk, Widdershoven, and Abma (2012), the facilitators of CES sessions expressed a need for support and believed that a key-person from the ward would contribute to the CES and improve attendance.

Approaches to promoting a permissive communication paved the way for a communicative action. By actively listening, the facilitators not only received and read the participant’s stories, but also supported them in reviewing and revealing their own stories. This can be seen in the light of Koskinen and Lindström (2015) who indicated that, if we narrate experiences and struggles to someone who is listening and receiving our story, we not only share the agony, but might also get to see our struggles from a different light and with new opportunities. A number of participants showed that they were comfortable and by the communicative action, they could help each other to see extended views. In line with Lipari (2009), the ethical response is about speaking and listening. To respond to one another, we first have to come close and listen because other people are always different from ourselves and impossible to completely understand. According to Koskinen and Lindström (2013), listening means inviting someone else into a community, getting to know them, and being moved by the difference of the other. Guvâ and Hylander (2012) state that by listening to the participant’s expressions and asking challenging questions the facilitators may both confirm and guide to the participants to further reflections. Rasoal, Kihlgren, and Svantesson (2017) showed in a study that, if the facilitators challenged the participants to reflect on their own perspective on the situation, then new insights were opened up. The facilitators in this study acted as role models in their responsiveness, and let the participants communicate freely without intervening more than necessary. The participants not only told their own stories, but also showed responsiveness to others’ stories. By an approach though promoting extended views, the participants could step beyond their superficial facades, come closer to each other and share various perspectives of the situation. Benhabib (1990, p. 339) states that, if we reflect together in a moral community and judge our point of view by the views of others, we might mutually change our perspectives in a way that might tie humans together. According to Habermas (1996, p. 127–130), every person has their lifeworld as a reference and this is inaccessible to others. By sharing our context of understanding, we might influence and reproduce our lifeworld structure and further reach new understandings.

By means of an approach to promote mutual understanding, the participants were allocated time and repeated discussions. Therefore, the same case was in focus for several CES sessions, which in turn also promoted further discussions between the sessions. In a study by Dauwerse, Weidema, Abma, Molewijk, and Widdershoven (2014), ethical conversations between healthcare professionals in their practical work were important complements to the organized forms of CES for developing the skills to reflect on moral issues. Benhabib (1990), p. 345) states that the continuous process of moral reasoning might pave the way for developing fair and reasonable moral judgments. Because the participants in this study were free to continue the ethical dialogue between the CES sessions, they had the opportunity to cultivate new impressions and perspectives at their own pace. The approaches to reach a communicative agreement and organisational aspects for facilitating communicative agreement in this study promoted openness to human variety and stimulated communicative action. All participants on the ward were welcome to participate in the sessions, and this flexibility was an open invitation. However, the latecomers entered the room one by one, and the dialogue was obviously disturbed. This variation demanded responsiveness by the facilitators, which might be challenging for inexperienced facilitators to manage. The facilitators in this study were all well experienced in facilitating CES sessions. Furthermore, the participants were engaged, spoke freely, and were interested in the case of concern. In another context with different group dynamics, relationships, and otherwise ethically difficult situations, the communicative action might develop differently. The question is how other CES facilitators in other contexts might manage to balance these variations. Hence, extended investigations would be an advantage in order to further develop the CES described in this study.

**Strengths and limitations**

Audio- and video-recording the sessions provided rich verbal and non-verbal data. However, the equipment might have affected some participants involvement in the dialogues at the beginning. Studies show that the presence of researchers...
and equipment might influence the participants’ behaviour, but usually the participants become used to and forget the equipment (Caldwell & Atwal, 2005; Haidet, Tate, Divirgilio-Thomas, Kolanowski, & Happ, 2009). By using an audio and video-recorder, the researchers could be present as participating observers (cf. Mays & Pope, 1995), which might have reduced the experience of being observed. Hence, the participants spontaneously joined into the conversation after a while. During the analysis process, the research team met regularly to discuss the emerging results. This study is an intervention including professionals from one ward. Therefore, further intervention studies are needed in order to obtain increased understanding of how to promote an interprofessional communication about ethnically difficult situations in various contexts.

Conclusion

The results of this study showed a base for a CES method in development, including approaches to reach a communicative agreement and organisational aspects for facilitating communicative agreement. The combination of constancy and flexibility during the CES showed to work as important conditions for a communicative action in a permissive communication climate. This combination promoted a trustful, free and dynamic dialogue that opened up for responsiveness and creativity. The facilitators’ role was important. By being responsive to the situation and making use of the varying courses of events, they maintained safety and stability and promoted a permissive communication climate. This approach further stimulated the dialogue towards extended views and mutual understanding. In this intervention, the facilitators were well experienced and they managed to facilitate the CES by making use of the given structure and openness for variation. Other contexts, and other facilitators might mean that the communication develop differently. Therefore, the findings from this intervention need to be further developed, reproduced and more clearly described in order to become a method to use in other contexts.

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References


