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Research Article

Assessing Quality of Moral Deliberation: A Pilot Study Using Video-Recordings

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Abstract

Background: Clinical ethics support is an emerging field. Evaluating quality of its process and content is important but has been barely studied yet.

Objectives: To assess quality of moral deliberation by developing a coding scheme and applying it to a moral case deliberation and a regular case discussion.

Research Design: This was a pilot study using video-recorded sessions.

Participants and Research Context: The sessions took place at two teams of healthcare professionals in a Dutch forensic-psychiatric institution. At the seventh meeting both teams received the same case and moral question. One session, a moral case deliberation, was led by a trained facilitator who used a conversation method. The regular case discussion session had no facilitator and no conversation method.

Ethical Considerations: Participants were informed about the study and free to withdraw at any moment. For the video-recording, written informed consent was obtained. Video-recorded material was securely saved and only watched by researchers.

Findings: A coding scheme was developed based on an explorative literature research to operationalize good moral deliberation into three categories: 'moral focus', 'open interaction' and 'variety of argumentation'. The moral case deliberation lasted longer than the regular case discussion and involved more contributions being categorized into the coding scheme.

Discussion: Our study suggests that a case discussion with facilitator and conversation method concerns more elements of what has been operationalized as good moral deliberation than an unstructured session without facilitator. We want to emphasize that the coding scheme not solely determines quality of deliberation, as this always requires normative reflections by all researchers.

Conclusion: This first effort to assess quality of moral deliberation provides valuable insights, like the influence of the facilitator and conversation method, and contributes to future research on quality of clinical ethics support processes.

Keywords: *Moral Case Deliberation; Quality of Argumentation; Ethics Support; Video Analysis*

Abbreviations

CES: Clinical Ethics Support; MCD: Moral Case Deliberation; ECQAT: Ethics Consultation Quality Assessment Tool; RCD: Regular Case Discussion; DQI: Discourse Quality Index

Introduction

Clinical ethics support (CES) aims at supporting healthcare professionals in dealing with moral challenges in their work. This support can be provided in many ways, ranging from individual ethics consultants to moral case deliberation (MCD) [1]. As the attention for CES is growing, evaluation research becomes more important [1].

Many CES evaluation studies have focused on the experienced outcomes of and satisfaction with a CES service, as shown in the review by Haan and colleagues [2]. However, experienced outcomes and satisfaction rates are not automatically a sign of quality of CES. Quality of the content of ethics support, both regarding normative conclusions as well as deliberative processes, has not been studied extensively yet. As a consequence, few tools are available to evaluate, ensure, and improve quality of CES processes [1]. Since CES should - according to its aim - help professionals to deal with ethical issues, insight into CES quality can help to improve the service.

We found some examples of evaluation research that did focus on the quality of CES. The ethics consultation quality assessment tool (ECQAT) assesses quality of ethics consultations based on the written record of the ethics consultation [3]. The ECQAT describes several elements of an ethics consultation including 'ethical analysis', which is relevant here because it is intended to offer explanations for the decisions made in the ethics consultation process. This is assessed by looking at: 1) the articulation of arguments, stakeholders and facts; 2) the attention for ethical concerns and 3) the way of balancing arguments. The ECQAT has been used to evaluate quality in portfolios of ethics consultants [4]. However, the ECQAT does not focus on the deliberative process [5,6].

Second, a Dutch network of CES professionals (i.e. neon) had developed quality characteristics for CES services through a responsive evaluative and participatory research project [7]. The quality characteristics included implementation and competences of CES staff [7,8]. However, this network did not conceptualize quality of the deliberation process itself either.

Recently, some studies have investigated processes of moral deliberation. Grönlund and colleagues [9] observed 10 video- and audio-recorded group reflection sessions, focusing on the communication about value conflicts. They found that participants came to a shared new understanding of the situation through five phases, from shared feelings of frustration to seeing opportunities to solve the conflict. A similar approach was used by Rasoal., *et al*. [10] who analyzed audiotapes of 70 MCDS to assess what and how situations were discussed. These studies are highly interesting, however, they did not define quality of deliberation.

Hence, quality of CES is assessed in different ways and we lack an explicit conceptualization of quality of deliberation and an evaluation tool to asses this concept [1,11]. What does quality exactly mean in this context? What should we focus on when assessing a deliberation for its quality? These questions are not easy to answer as CES is offered in various ways and for a variety of goals [8]. Yet, the need for insights into and eligible tools to assess quality of CES processes has been expressed often [5-7]. A first necessary and modest step could be to conceptualize quality of deliberation within CES. We therefore performed a pilot study with the purpose to build up experiences with assessing quality of deliberation, to learn both about the methodology to observe, assess and analyze quality as well as the resulting quality impressions when comparing two different types of case discussion.

Aim of the Study

The aim of this study was twofold: 1) to develop a coding scheme to assess quality of moral deliberation and 2) to apply this coding scheme to a regular case discussion and an MCD.

Methods

To allow for a structured observation and analysis of the deliberative process, we developed a coding scheme, similar to general observation and analysis approaches in qualitative research methodology. The coding scheme was firstly developed based on a theoretical assessment of 'good deliberation'. Secondly, we applied the coding scheme to two sessions of case discussions: A moral case deliberation (MCD), and a regular case discussion. MCD is a group conversation with the aim to reflect on a moral case from practice, guided by a facilitator. The facilitator used the conversation method of Bauduin and Kanne to structure the meeting ([12,13]; see table 1). The other session had no facilitator or method, participants were only instructed to take the predetermined time to discuss a case. We video-taped the two sessions in which both groups used the same case (Presented on paper).

Context

This study was part of a larger mcd implementation project [14,15] in a forensic-psychiatric institution. Two wards were involved: Healthcare professionals working with inpatients with autism spectrum disorders (From now on referred to as the MCD-group) and healthcare professionals working with inpatients with personality disorders (Who participated in the regular case discussion, from now on referred to as the RCD-group). Both teams consisted of approximately 15 professionals, including sociotherapists, psychologists and managers. Teams had similar compositions, similar daily routines and were confronted with similar ethical challenges, so the sessions were well comparable.

Both groups participated in MCDS and regular case discussions for seven times, which lasted 10-60 minutes and were all video-recorded (Figure 1). In the first and second session, both groups were invited to discuss cases brought up by themselves, without a facilitator or a conversation method. This was done to gain baseline insight into how discussions would proceed spontaneously. In both sessions, it was observed that participants often switched topics of conversation and did not extensively focus on only one specific patient case. The organization of the next five sessions was different for both groups. In the MCD-group, five MCDS were organized, facilitated by a trained facilitator who used a specific method (See table 1, [12]). To focus on one case and to structure the conversation. The RCD-group still reflected in every session on a case without a facilitator and conversation method. This group was chosen as RCD-group because the ward is situated outside the forensic-psychiatric clinic so it was less likely that they would be influenced by colleagues from the MCD-group inside the clinic.

1	What is the moral dilemma?
2	Who are the direct stakeholders?
3	Do I need more information to make my decision responsibly?
4	Which arguments can be brought forward?
5	What is my conclusion?

Table 1: *MCD Method of Bauduin (2009).*

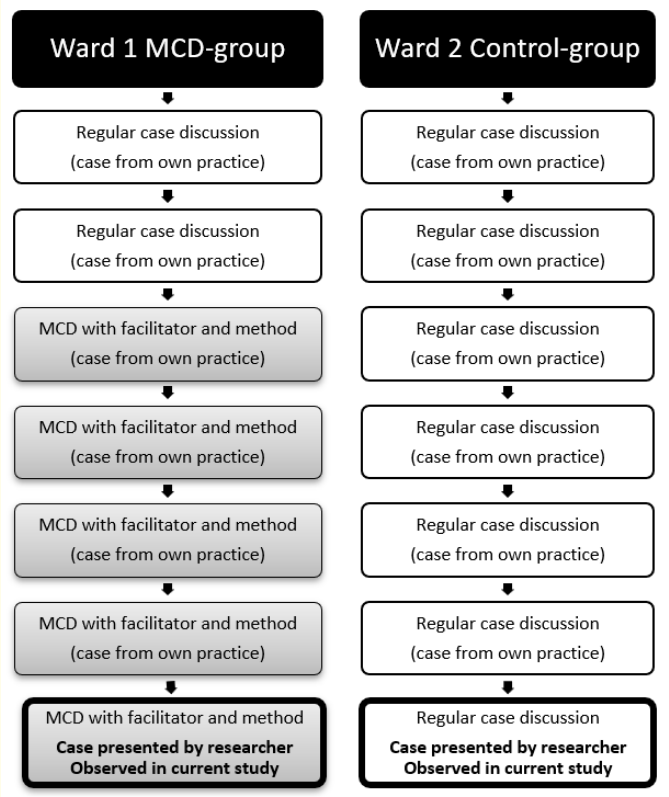

Figure 1: *Overview of video-recorded sessions.*

In the seventh session, the same case and moral question were presented to both groups to allow for a comparison between the deliberations. The video-recording did no longer form a threshold for participants to express their views as they got used to the presence of the camera [16]. Therefore, the video-tapes of this seventh session from both groups were used in this study.

Case

The MCD-group and the RCD-group were thus confronted with the same patient case in the video-recorded sessions used in this study. The case was fictional, but based on actual situations from another ward within the institution. Some essential elements were adjusted on privacy grounds before presenting it (on paper) to the groups.

The case concerned a 44 year old male inpatient with a personality disorder. He had been convicted of the rape of young women whom he did not know personally and he was involuntarily admitted to the forensic-psychiatric clinic eight years ago. During those years, he stayed at a closed setting and received forced treatment. In forensic psychiatry, treatment is aimed at resocialization and returning in society. The likelihood of violence being repeated is predicted during admission with risk assessment tools. Patients who show improvement and a reduced risk for repetition can get permission of the ministry of security and justice to leave on absence. this goes step-by-step: firstly securely escorted, then escorted and in later stages also unescorted.

The patient in this case had shown detrimental behavior (i.e. violating the rules) during admission but had also been motivated to re-socialize. He was now cooperating well in treatment for 1.5 year and was allowed to go on unescorted leave. Since three months, he was in a relationship with a woman from outside the clinic. He met her through an online dating site, and they had already met in real life as well. The woman had an eight-year-old son and a history of difficult relationships with men.

Patient and woman now asked to make use of the visitors bedroom within the institution, with her son, because they both wanted to grow in their relationship and the patient wanted to develop his role as a father. This visitors' bedroom consists of a living room and two separate bedrooms. Using the visitors' bedroom would imply a large extent of privacy during night and morning: patient and relatives will be locked up without being observed, and will be disturbed only during specific checks or when they ask for it themselves.

The two teams had to decide if they grant this request to use the visitors' bedroom with the woman and the child.

Data analysis

The videos of both sessions were watched by two observers (JDS and HJ) and every verbal expression of participants was scored according to the coding scheme that was being developed (Table 2). Contributions of the facilitator (In the MCD-group) were also scored with a remark that these came from the facilitator. Furthermore, observers noted which stakeholders and possible solutions were mentioned. The observers tried to come to consensus about the scoring of all expressions.

Next, scores of both coders were integrated into a definitive categorization that was discussed with other authors until final agreement was reached.

Ethical considerations

The healthcare professionals were informed about the aim and methods of the study and that sessions would be video-recorded. They were free to withdraw from the study at any time without the necessity to give reasons for it. They gave their written informed consent for video-recording. The video-recordings were saved securely under lock and key within the institution, not-accessible for others. The videos were only watched by the research team.

Results

In this section, we firstly described the development of the coding scheme. Secondly, we described the results of applying the coding scheme to the two case discussion sessions.

Development of coding scheme

Since there is no consensus about what constitutes quality of moral deliberation, we first needed to conceptualize 'good moral deliberation'. This inherently involves normative presuppositions about what good moral deliberation entails, which should be stated explicitly [11]. Next, we operationalized 'good moral deliberation' by defining essential and observable elements, which formed the coding scheme.

We assumed that a group deliberation that 1) is focused on the moral elements of the case, 2) consists of open interaction and 3) shows variety in argumentation represents a relatively higher quality of moral deliberation than a deliberation that lacks or only contains few of these elements.

Firstly, to make the deliberation a moral deliberation, it should not only concern legal and practical aspects, but also refer to values, norms, principles, virtues, etc. Secondly, the importance of open interaction is emphasized frequently in papers about MCD [2,13]. Open interaction means that participants engage in a critical interaction and are open for various viewpoints and arguments. In MCD, participants are involved in a dialogue about their own perspective and that of others. Through this interaction, they learn to become sensi-

tive to all perspectives and enrich their own understanding of the moral case at hand. Thirdly, within a deliberation, experiences and perspectives are exchanged and through this, participants might gain a joint understanding of the situation [13]. According to Rudnick [17], a 'fruitful dialogue' enables 'the attempt of each party to understand the arguments and needs of the other parties so that they can persuade, be persuaded, improve on arguments on all sides or decide on disagreement'. Therefore, a good group deliberation should consist of open and critical interaction and a variety of arguments reflecting the exchange of perspectives, experiences and justifications. Our assumption is inspired by the theoretical background of MCD, namely pragmatic hermeneutics and dialogical ethics [17,18]. In short, pragmatic hermeneutics states that situations are always interpreted from one's own perspective and perspectives can be changed through experiences and dialogue [18]. Dialogical ethics presupposes that there is no external source to determine whether a conclusion is right, but that the conclusion should be established through a constructive group discussion, in which participants are open to and confronted with each other's perspectives and arguments and jointly arrive at a conclusion [17]. Both theories emphasize openness to other's perspectives and, hence, explain our elements of open interaction and variety in argumentation.

In order to operationalize the three elements, we were inspired by some coding schemes which were developed for analyzing moral and political reasoning [19-21]. Firstly, Keefer and Ashley [19] developed a systematic analysis of moral reasoning among students and ethicists, consisting of seven 'components': to identify the: 1) moral issue; 2) relevant knowledge and facts; whether 3) resolutions and 4) moral justifications are offered; and if 5) alternative scenarios; 6) moral consequences and 7) alternative resolutions are considered. These components can show the moral focus (our first element) and determine if a critical and open interaction has taken place about relevant knowledge and possible resolutions (our second element). Therefore, we integrated these components into our scheme. Another source was the discourse quality index (DQI), including criteria to qualify a political speech [20]. Although a speech is different than a group deliberation, the criteria to assess the degree of 'respect' in a political speech are relevant: respect for groups and "respect toward counterarguments […] raised by opponents" [21]. We assumed that in an open dialogue, people should respect and acknowledge other perspectives and counterarguments.

We will now describe our translation of the three elements into observable categories, which form the coding scheme as presented in table 2.

Element	Category	Subcategories
Moral focus	1. Moral elements	All moral aspects that pass by (i.e. a value, norm, principle or anything qualified as 'right' or 'wrong' that refers to the case)
Critical Engagement	2. Clarification	a Moral Issue b Own contribution c Contribution other person d Identifying consensus e Identifying disagreement f Summarizing/structuring the discussion
	3. Knowledge	a Questions b Answers c Facts
	4. Critical interaction	a Question-asking about a contribution b Elaboration c Disagreement d Conceding e Refining a position in response to others f Pointing at missing element in other's contribution
Variety of argumentation	5. Justification	All arguments, including reference to stakeholders
	6. Alternatives	a Alternative scenarios b Alternative resolutions

Table 2: *Coding scheme for assessing quality of deliberation.*

Moral focus

The moral focus of a deliberation can be assessed in the first element 'Moral focus', category 'moral elements' (no. 1) and the second element Critical Engagement, in the subcategory 'Moral issue' (no. 2a) (Table 2). The category 'Moral elements' (no. 1) involves the collection of values, norms, principles or anything qualified as 'right' or 'wrong' that refers to the case (e.g. 'autonomy of the patient'). The subcategory 'Moral Issue' refers to statements that (try to) define the moral dilemma.

Open interaction

Next, we assessed how to operationalize open interaction. In our coding scheme (Table 2), open interaction is represented by the element of 'Critical Engagement', in the second and third categories 'Clarification' (no. 2) and 'Knowledge' (no. 3), based on the schemes described before. The category 'Clarification' relates to all statements that aim to clarify the discussion, including the moral question at stake, one's own contribution or that of someone else or a summary of what has been said [19]. The category of 'Knowledge' concerns the facts of the case [20]. This reflects the openness and curiosity of participants to learn more about the case by asking questions. Furthermore, disagreement is assessed here by a fourth category 'Critical Interaction' (no. 4), which relates to asking questions, expressing disagreement about each other's statements, elaborating on what others have said or pointing out that another's position needs elaboration [21]. Question-asking might represent an open attitude of participants towards the other participants and the moral case. This is crucial for the dialogue: "one both acknowledges that the perspective of the other is different from one's own, and is interested in bridging the gap between the two" [18]. Furthermore, asking questions is necessary to confront one another with different perspectives and to investigate presuppositions about the case. Next, disagreement and the freedom to disagree are seen as important elements of deliberation in literature about ethics reflection [18]. Thus, open interaction is reflected in a questioning attitude of participants and the extent of disagreement, but only if these refer to respecting and exchanging perspectives.

Variety of argumentation

Thirdly, variety of argumentation refers to the range of viewpoints and resolutions [18]. Do participants consider all relevant perspectives? Do they mention various alternatives and conclusions to the case? In our coding scheme (Table 2), variety of arguments within the deliberation is represented in the fifth category 'Justifications' and includes all arguments of participants, with reference to a perspective (e.g. the patient). The sixth category 'Alternatives' also represents this element, identifying whether participants propose a resolution or suggest that if certain aspects of the case had been different, a different resolution might (not) be viable [19,20]. By this, variation in arguments, the number of perspectives and (alternative) resolutions can be assessed.

To summarize, our coding scheme consists of three elements that represent six categories with subcategories. The deliberation to be analyzed with the coding scheme can be video or audio material and has to be observed by at least two coders to enhance reliability. Contributions of participants should be coded into one or more subcategories; in other words, a citation could be placed in two subcategories at the same time.

We want to stress here that our coding scheme is not a tool that solely provides an answer to the question 'is this a high-quality deliberation?'. This answer always requires an additional normative evaluation by all researchers before making final conclusions regarding the quality of deliberation.

Applying the coding scheme: The two sessions of case discussion

The session with the MCD-group lasted 1 hour and 23 minutes and involved 6 participants: 3 women and 3 men, of whom 5 sociotherapists and 1 psychologist. They were between 25 - 55 years old. The RCD-group consisted of 11 participants: 8 men and 3 women, of

which 7 socio-therapists, 3 psychologists and 1 unit coordinator. They were in the age of 35 - 55. The session with the RCD-group lasted (as planned) 60 minutes, but after 11 minutes, participants finished their discussion about the presented case, agreed on the conclusion and started talking about other cases and issues, with no clear link to the presented case. This also happened during previous sessions, both in this group as well as in the MCD-group during previous regular case discussions (See figure 1), in which the actual case discussion ended on average after 10 minutes. The length of this session is therefore not an exception. The coding of the session of the RCD-group is done for the discussion about the case, so the first 11 minutes. As a consequence, the number of total statements is lower than the MCD-group (See table 3).

	MCD-group	Control-group
Category	**Number of statements (of facilitator)**	**Number of statements**
1. Clarification		
1a Moral Issue	8 (3)	1
1b Own contribution	3	1
1c Contribution other person	8 (6)	1
1d Identifying consensus	4 (2)	3
1e Identifying disagreement	-	-
1f Summarizing/structuring the discussion	33 (33)	5
2. Knowledge		
2a Questions	8	10
2b Answers	3 (1)	6
2c Facts	7	4
3. Critical Interaction		
3a Question-asking about a contribution	27 (20)	4
3b Elaboration	9	5
3c Disagreement	2	4
3d Conceding	2	-
3e Refining a position in response to others	1	-
3f Pointing at missing element in other contribution	1 (1)	-
4. Justification	113	13
5. Alternatives		
5a Alternative scenarios	11 (3)	1
5b Alternative resolutions	3	4
6. Moral Elements	25 (9)	8
Statements without categorization	3	0
Statements assigned to >1 category	35 (13)	10

Table 3: *Coding scheme with scores of both sessions.*

Content and conclusion

In order to understand the scores about quality of deliberation, some details about the content and conclusion of both sessions is helpful. During the case discussion in the RCD-group, one participant mentioned that there was a rule that states that patients may only use the visitor's bedroom after a relationship of one year, so that it was clear that the request to use the visitor's room should not be granted in this case. Although this rule did not actually exist in the institution, other participants did not doubt the rule and agreed with him, which contributed to a soon end of the deliberation. In the MCD-group, participants also jointly concluded that they would not yet grant the request of the client, since the relationship was too vulnerable yet and they did not want to risk harming any stakeholder. They wanted to support the client in order to build his relationship with the woman in order to eventually get permission in future to use the visitor's bedroom. In summary, both groups came to the same conclusion about the moral case, but after different considerations.

Moral focus

The category 'moral elements' (indicating moral focus of the deliberation, see table 2 and 3) included the most statements when looking at both sessions separately, compared to other categories. In the MCD-group, a larger variety of moral elements passed by than in the RCD-group. We further assigned 8 and 1 statements to the subcategory 'identify moral issue' in the MCD-group and RCD-group respectively. At the start of the deliberation with the MCD-group, participants and facilitator explicitly articulated the moral issue. In short, the moral focus seemed to be more apparent in the MCD-group than in the RCD-group.

Open interaction

Open interaction can be assessed with the categories Clarification, Knowledge and Critical Interaction (Table 2 and 3). In the MCD-group, many statements in these categories came from the facilitator: especially the Clarification-subcategories 'summarizing/structuring the discussion' and 'question-asking about a contribution': 33 (100%) and 20 (74%) respectively. The statements in the RCD-group did not refer often to these categories. However, the RCD-group provided a higher number of statements in the knowledge-category, as many questions were asked about unknown facts and practical consequences of the case. In this group, more statements were categorized as 'disagreement' than in the MCD-group. Therefore, regarding the open interaction of both sessions, the facilitator contributed to more clarification and open interaction than was achieved in the RCD-group, but the RCD-group contained more explicit disagreement and question-asking about knowledge, which might also indicate open interaction.

Variety of argumentation

Variety of argumentation in the deliberation is characterized by the considered perspectives, resolutions and justifications. The session of the MCD-group contained 113 statements in the category 'Justifications', versus 13 statements from the RCD-group. The MCD-group considered more perspectives, like the child, other patients and the biological father, and more values, like empathy and fathers' love (See table 4). Thus, in this group, a higher variety of justifications, perspectives and values was brought in than in the RCD-group. This was especially done during step 4 of the conversation method (See table 1).

When looking at the justifications, those in the MCD-group included the risk for the safety of all involved, maintaining peace at the ward, protecting woman and child, protecting the patient, avoiding stress and not doing harm to all involved. Especially the potential risk for the safety of woman, child and all involved was mentioned many times. In the RCD-group, the principle that the institution had a rule that would not grant the request was leading in the arguments. However, also the potential consequences for the safety for woman and child were mentioned. In addition, the MCD-group considered more alternative scenarios and resolutions than the RCD-group (14 versus 5) (Table 3). In summary, the MCD-group considered a larger variety in perspectives, values, justifications and alternatives than the RCD-group.

MCD-group	Control-group
Perspectives: • The healthcare professional • The institution • The patient • The woman • The child • Other patients • The biological father	**Perspectives**: • The healthcare professional • The institution • The patient • The woman
Values: • Good care • Fairness • Developing the relationship • Autonomy • Safety • Fathers love • Treatment • Sexuality • Trust • Participating in society • Empathy • Caring for woman and child	**Values**: • Good care • Fairness • Developing the relationship • Autonomy • Safety • The health of the patient • The importance of being well informed.

Table 4: *Perspectives and values mentioned during the deliberations.*

Discussion

This study aimed to develop and apply a coding scheme to assess quality of moral deliberation in an MCD and a regular case discussion. In this part, we will reflect on our findings and the use of the coding scheme.

Reflecting on our findings

An interesting finding was the dominant contribution in the RCD-group by one participant who suggested the existence of an institutional rule that supported the conclusion, which was seemingly easily agreed upon by other participants. This may give rise to the question whether we had just 'bad luck' with this participant. We hypothesize that he would at least be questioned about this rule if he was part of the MCD-group, because mentioning a rule does not in itself justify what is morally right to do within MCD. Furthermore, within MCD, there is explicit attention for possible different viewpoints and everyone is actively involved to learn from each other's viewpoints. We believe that the process of agreeing would have been slowed down (at least) by inviting everyone to express his or her opinion. We therefore think that choosing another session as 'RCD-group' would not definitely lead to different results. The finding shows that, if no facilitation is provided and no structured method is used, it might happen that certain participants play a dominant role and that unjust grounds influence the final conclusion.

Considering the content of the deliberations, our findings indicate that the MCD-group expressed more considerations related to the core elements of our coding scheme than the RCD-group. We think this can be explained to a large extent by the conversation method, the facilitator and the difference in duration.

Firstly, it might not be surprising that the deliberation with the MCD-group had more moral focus, as the conversation method (See table 1) includes an explicit step to formulate a moral question. The finding that more facts were discussed in the RCD-group than the MCD-group is unexpected since the conversation method includes a step to consider all facts. A possible explanation for this is that talking about facts is 'more natural' or 'safer' than talking about one's own opinion or values, so perhaps for the latter a facilitator is needed.

The extensive consideration of perspectives, values, norms and justifications in the MCD-group is probably also due to a step in the conversation method that explores relevant perspectives. During this step (See table 1), The facilitator asks participants to think of all potential stakeholders' possible arguments on how to deal with the case. Still, our study shows that even without this explicit invitation, and in less time, the RCD-group did think of relevant stakeholders and their interests, mentioned justifications and engaged in critical interaction. Participants even disagreed more often openly with each other in the RCD-group than in the MCD-group, which might indicate more open interaction. However, they soon agreed on a certain rule that answered the moral question. This makes us hesitant to conclude that the RCD-group actually engaged in a form of open interaction that contributed to the quality of deliberation as operationalized by the coding scheme.

Thirdly, our study showed that the MCD session had a longer duration than the RCD session, even though they had the same time available for the discussion. The difference in duration occurred despite a higher number of participants and a greater variety of professions in the RCD-group than the MCD-group. We had expected that when more participants are involved, all with their own opinions and responsibilities, it would take more time for them to explain and exchange views in order to find a common ground. It is questionable if everyone expressed their view in the RCD-group like they did in MCD-group. Nevertheless, the difference in duration is an important and potentially confounding element in our study to keep in mind when interpreting our results.

Yet, we cautiously conclude that - Even when participants explicitly receive time to deliberate on a case-Participants conclude their discussion sooner when their discussion is not led by a facilitator or structured by a conversation method. The method and the facilitator urge the participants to use more time and look more in detail to the moral challenge at hand and to scrutinize the adherence to rules or certain reasons in general. The conversation method leads to a clear moral focus and the explicit and extensive consideration of all relevant perspectives and arguments. Next, the role of the facilitator is not only important for guiding participants through the method, but also for contributing to the moral focus, open interaction and variety of argumentations, mainly by asking many and different kind of questions.

However, it is important to note that this does not mean that the regular case discussion had no or a 'bad' quality of moral deliberation. Moreover, this session still contained many moral elements and arguments as our findings showed. This finding raises the question whether MCD actually needs large amounts of time to discuss a moral question and if it can be made more time efficient.

Reflecting on the coding scheme

Using the coding scheme was challenging. We will now describe our lessons learned and some suggestions for improving the coding scheme. Firstly, the element of open interaction was not yet clearly enough described and might even be risky, since a lot of critical interaction or a negative critical interaction might undermine the quality of deliberation. How participants interpret or experience critical interaction will also differ among participants: some might feel offended, while others might say that their presuppositions are challenged

in a pleasant way and that they learn new things due to critical interaction. Further empirical and conceptual work is required to investigate this.

Secondly, our coding scheme does not include space for describing actual content of sessions, since it is focused on the process. In our results section we however shortly described the conclusions of both sessions to facilitate understanding of our results concerning the process of deliberation. Future users of the coding scheme could also include a short summary of the content, but with caution, as this summary only serves as a guide for describing and interpreting the quality of the process of deliberation.

Furthermore, we did not find a good way to integrate the dominant influence of a rule in the coding scheme. However, it is important that attention is given to the way people talk during the sessions, with an eye for potential dominant arguments and the sphere of the session. We describe several times that the difference in the arguments can, as far as we are concerned, partly be explained by the time difference. But the time difference itself can possibly (also) be explained by the fact that in one group they were doing moral case deliberation where the facilitator is responsible for, among other things, delaying the thinking process.

One conceptual question remains: how do high scores reflect high quality of the process of moral deliberation? We want to stress here that the coding scheme should not and cannot be used as a 'simple' tool to score quality of deliberation. Deliberation as such is, according to us, too complex to catch in an objective instrument. Quantitative results of a scoring scheme can never form a final answer, but they are part of the overall answer about the quality of moral deliberation. We therefore suggest to use the coding scheme as an heuristic guide for coding researchers who themselves have an important role in establishing a well-considered conclusion about the quality of the moral deliberation. Any final conclusion regarding quality of deliberation should be formulated through combining observational scores from the coding scheme with impressions and reflections of the observers in an open dialogue among researchers.

Furthermore, we think that, in line with the conceptual fit of the three elements with the theoretical framework of MCD, in the end, experiences of participants determine to a great extent the experienced quality of deliberation. Scoring results give an impression about what is observed, not about how the quality of the deliberation is experienced. And as briefly mentioned before, participants might have different criteria and feelings regarding whether the for example see critical interaction as a sign of a qualitative deliberative process. This in itself does not undermine the relevance of the coding scheme, since the coding scheme offers an observational score of quality of moral deliberation. The difference between observational scores and the way participants experience quality of deliberation should be acknowledged and preferably a dialogue should take place between the researchers and participants of the sessions. Future research on the quality of deliberation could compare different epistemological approaches to and evaluations of quality of moral deliberation.

Based on our experiences with this coding scheme, we developed a new coding scheme in order to continue learning how to assess quality of deliberation within MCD [22]. We hope that both this study and the improved coding scheme will contribute to what is lacking at the moment within CES evaluation research: clarity with respect to both conceptualizing and evaluating quality of moral deliberation. The coding schemes might be relevant – with some changes – for assessing quality of deliberation within other types of CES as well.

Strengths and Limitations

Our study has several limitations. we already described the large difference in duration between both sessions, and want to add here that also the number and variety of participating professionals differed between the two groups. Next, the video-recording might have had an influence on the behaviour of participants and the facilitator, although they were already filmed six times before and we did not have the impression that they behaved differently because of the video-recording [16]. Furthermore, our study only involves two sessions about only one case; future comparative studies should include more sessions in order to see if findings can be confirmed.

Studies that record actual CES activities on video are relatively new in CES evaluation research. Strength of this pilot study is that it provides novel insights in how to assess quality of moral deliberation. Furthermore, the comparison between MCD and a regular case discussion about the same case with participants with similar professions in the same healthcare setting has not yet been done before.

Another strength of this study concerns the theoretical fit between intervention and measurement: The coding scheme that was used to compare sessions was based on the same theories as those underlying MCD.

Conclusion

This paper described a first attempt to develop a coding scheme to assess the quality of deliberation and provided insight into the use of this coding scheme by comparing two case discussion sessions. A structured and facilitated case discussion such as MCD seems to contain more moral focus, critical interaction and variety of argumentation than a regular case discussion. Lessons learned from this study can be (and have been) used to further develop the coding scheme and inform the broader debate on what quality of CES entails and how it could be observed and assessed; and on the added value of structured forms of CES like MCD. As such, our study further contributes to the emerging empirical field of evaluation of CES.

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