

Training facilitators of Moral Case Deliberation: a successful experience with external health care professionals in the sessions and in feedback to the trainees

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Abstract

Background: Both on theoretical and on practical grounds, a program has been developed to train health care professionals as facilitators of Moral Case Deliberation (MCD). MCD is a structured inquiry of a group of health care professionals into a moral issue in a concrete case, guided by a facilitator. The program for training facilitators combines practicing in training sessions and facilitating MCD in between these sessions at the own ward. The training group consists of between 6 and 12 trainees.

Methods: To meet the request for training a group of three trainees as facilitators of MCD in a Dutch health care institution, the training was adapted. During the exercises, other health care professionals were included as external participants in the training sessions. The external participants discussed their moral dilemmas, facilitated alternately by the three trainees. Like the trainer and the co-trainees, the external participants gave feedback to the trainees. In addition the trainees received personal coaching on-the-job by a trainer in between the training sessions when they were practicing as a MCD facilitator on the ward. Both trainees and MCD participants evaluated the training in a focus group meeting directly afterwards and in an oral and written evaluation after half a year.

Results: The training sessions proved to be intensive for the trainees. Due to the uninterrupted and intensive learning process fewer training sessions were needed. After the training, the newly trained facilitators were able to facilitate MCDs on their own. The external MCD participants were positive about MCD and about the training, and helped the trainees to implement MCD in the organization. Their feedback on the quality of the trainees was in line with the feedback of the trainer and the co-trainees.

Discussion: Making use of a natural setting (with inexperienced participants in MCD) and allowing unprepared health care professionals to judge the quality of the facilitator trainees, adds a unique aspect to the evaluation of the trainees and the training program. Therefore, we recommend involving more often health care professionals as external participants during MCD training sessions and as contributors to the evaluation of the facilitators afterwards.

Key words: Moral Case Deliberation, training program for facilitators, program evaluation, feedback by health care professionals as end-users.

Introduction

Moral Case Deliberation (MCD) is a form of clinical ethics support that focuses on concrete moral problems in practice [1]. A group of health care professionals together investigates a moral question in a concrete case from their own practice, guided by a trained facilitator. Cases are diverse, ranging from whether or not to involve the family of a client in decisions about treatment to whether or not to follow an agreed arrangement concerning the care for a client when the situation seems to ask for acting otherwise. The facilitator guides the group stepwise through the joint moral inquiry which is set up as a dialogue. Compared to other forms of clinical ethics support [2], the focus is not on the moral knowledge and expertise of the facilitator, but on the moral experience of the participants and their reflections. The facilitator does not give advice, but helps the health care professionals in the group to reflect on their own values and norms and to jointly develop a better understanding of the ethical issues of the case at hand.

Although the facilitator of MCD may be a trained philosopher or ethicist, the facilitator role can be performed by a health care professional as well. Both on theoretical and on practical grounds, we deem it important to train health care professionals as facilitators of MCD. Theoretically, this fits in with the presupposition that fostering moral reflection (in the form of MCD) does not require theoretical ethics expertise. Practically, the number of ethicists available is not sufficient to answer the growing demand in health care organizations. Based on these theoretical and practical considerations, we have developed a program which aims to train health care professionals as facilitators of MCD [3]. The trainees learn to practice the role of MCD facilitator by exercising and reflecting on their experiences within training sessions and in their own team or health care institution [3, 4]. The training entails an experiential learning style, in which the trainees investigate what it means to be a good facilitator by jointly reflecting on their experiences; this fits well with the dialogical learning process within MCD itself, in which the MCD participants investigate and learn what is morally good to do. In the Netherlands, we have

trained more than 500 health care professionals as facilitators of MCD over the past ten years [3]. We have also organized training programs for facilitators in other countries, especially in Denmark, Iceland, Norway, Sweden and Switzerland (Bern).

Normally, a training group consists of 6 to 12 trainees. This number ensures that every trainee can practice during the training session, can receive feedback from other trainees and the trainer, and that the trainees together can reflect on what it means to be a good facilitator. Practicing in a group of 6 to 12 participants is also in line with the later situation at the workplace, where MCD groups have about the same size. In 2014, we were asked to train three members of an Ethics Committee (EC) of a care institution for people with an intellectual disability to become facilitator of MCD. Based on earlier evaluation of studies of MCD in long-term care institutions [5–8], they expected that setting up MCD in the teams on the ward would support caregivers in dealing with moral issues in their work. This request for training posed a problem because the group of three trainees was too small to practice during the training sessions. Therefore, we decided to form a larger group, not only existing of the three trainees, but also including other health care professionals as MCD participants within the training sessions. These professionals did not have the intention to become facilitator of MCD, but were interested in taking part in MCDs. First, we will briefly describe the regular design of the training, and explain how the training program was adapted. Second, we will present the results of an evaluation study of the adjusted training program. Third, we will discuss the results and conclude with some recommendations.

The regular and the adapted training design

Before we present the new design of the training, we will describe the regular design. The aim of the training is to educate trainees as facilitators of MCD (i.e., in a group where there is enough trust between the participants to engage in a dialogue), using a structured method, such as the “Dilemma method” [9, 10]. Another requirement for MCD facilitators is that they develop a Socratic attitude of questioning, i.e., being able to ask open and in-depth questions stimulating reflection [11], in order to foster a dialogue and deepen the moral inquiry into the concrete moral question at hand. A key feature of the regular training design for health care professionals in order to become MCD facilitators is learning through experience and by reflecting upon that experience. This implies that practical experiences are the source of knowledge and (theoretical or conceptual) knowledge and skills are always connected to and embedded within the experience [10]. Therefore trainees have to practice the role of the facilitator, within the training sessions, and in between by practicing MCDs

in their own team or health care institution. Within the training session the trainees practice the role of the facilitator by exercising MCD together with the group of co-trainees. One of the trainees introduces a case in which he or she felt moral uncertainty; this trainee functions as the “case-owner” during the MCD. In the MCD, each step of the Dilemma method is facilitated by one trainee and the next step is then facilitated by another trainee. In this way, every trainee gets the chance to facilitate a part of the MCD while at the same time he or she functions as regular MCD participant (when another trainee facilitates another step). After each step the participants reflect on the performance. The personal learning goals of the trainee are the starting point of this reflection. In addition, the trainer gives her/his reflections and feedback; quite often through reflective questions. In this way, the feedback creates possibilities for a moral inquiry into what it means to be a good facilitator in the specific situation. In between the training sessions, trainees practice the role of facilitator by organizing and facilitating a MCD in their own team or health care institution. In those exercises at the shop floor, they act in a buddy system: one trainee is facilitator and the other trainee is observing the facilitator. The self-reflection of the facilitator and the observation of the observer (i.e., the buddy) are guided through two almost equal questionnaires: a self-reflection questionnaire and an observation questionnaire. These questionnaires have been developed in order to specifically indicate the expected behavior of the MCD facilitator within each step of the MCD. The questionnaires are also input for a shared reflection process directly after the MCD sessions (in which both the trainees learn) and in the training sessions afterwards with the trainer and the other trainees. It also gives the trainer some idea about how the exercises went and to which degree the trainee develops her or his competencies as a MCD facilitator.

Furthermore, within the regular training, there are several moments in which the training itself is being evaluated: after each training session the specific training session is shortly being evaluated orally. Halfway and at the end of the training a more extensive and structured evaluation takes place orally. Finally, some weeks after the training, all candidates receive a detailed web-based evaluation questionnaire (partly based on earlier research [4]).

Let’s now turn to the situation in which we were asked by the health care organization to train three employees as MCD facilitators. To create the necessary practical experience for these three trainees in the training sessions, as described above, the training program had to be redesigned. Eight employees of the organization, with different backgrounds and from various departments, were recruited for participating in the MCD sessions within the training. In this way these employees created possibilities for the trainees to practice their role of facilitator of MCD. The eight employees formed

a group of so-called “external participants” and only participated in the training sessions during the actual MCD exercise in which the three trainees alternately facilitated the MCD. In this design, feedback with tips and advice was also given by the external participants: thus they were “co-trainer” for the facilitator-trainees even though they were not aware of the training goals and the related literature on MCD facilitation. Tips were practical, like the use of name tags and making good use of the flip-over, that is writing clearly and using adequate terms, reflecting what is being said by the participants during the session. Advice entailed remarks about the process, i.e., ensuring the active commitment of all the participants instead of just one or two, or taking time and slowing down in order to foster group reflection on moral issues. This feedback was in line with the fundamental ideas behind MCD (not known to the external participants) and implied practical additions, rather than fundamental adjustments.

Next to adding external participants, the training program was adjusted by adding a specific didactical tool: “coaching on-the-job”. This element was added to the program in order to give the trainees extra feedback during the phase of practicing at the ward, because the training program, consisting of four sessions, was relatively short. During the exercises of MCD in between the training sessions, which the three trainees organized and facilitated in different teams on the ward, one of the trainers was present to give support and feedback before, during and after the MCD exercise. This also provided additional insight in the functioning of the trainee since it was no longer a training context but a real-life situation. As in the regular design, one of the other trainees also was present (a “buddy”). The trainer discussed individual learning goals of the trainee before and gave feedback (together with the observer trainee) after the MCD session. The trainee also received a written feedback report from both the trainer and the co-trainee. For these reports the above-mentioned observation questionnaire was used. This implied that the feedback was given in a fixed template for a systematic observation and reflection on the role of the MCD facilitator, with added tips and advice. Each trainee received three times a coaching on-the-job with personal feedback and evaluation of the MCD session from the trainer and a co-trainee.

Implementation and results in practice

The training with the adapted design was applied in four sessions of four hours each during six months. Each session started with a discussion on the literature that had been studied and questions by the trainer and the three trainees. After a short break, the external participants joined the session and the MCD was carried out in the manner described above. In the first two

training sessions the trainees received feedback on their performance immediately after their turn (i.e., when they facilitated a specific step of the Dilemma method). This is also done in regular trainings. However, this meant that the MCD session on a specific case stopped because of these feedback-rounds and the external participants reported that this interrupted the dialogue too much. Therefore it was decided to wait with the feedback until the whole MCD exercise was over.

Coaching on-the-job for the trainees was organized ten times. At the end of the training program, two of the trainees qualified as facilitator for MCD. The third trainee had attended the four training sessions and had received coaching on-the-job twice, but decided for personal reasons not to start practicing as a MCD facilitator.

The training was evaluated on two different occasions. The first evaluation took place at the end of the last training session with the three trainees and seven of the eight external participants. A half year later, a follow-up training session was organized with the two qualified facilitators and six of the original external participants. At the end of this session, the training was again evaluated, both orally and by means of a written questionnaire. The external participants indicated that they had been aware of the training situation as primarily an exercise for the trainees. Nevertheless, they also indicated that the sessions had been very valuable for them. One participant expressed this as follows: *“Each time when I left here, I felt more energy!”* As a consequence of their participation in the MCDs in the training sessions, they dealt differently with ethical issues. One participant said: *“In a difficult situation, I am now more inclined to define who is involved, this gives me more peace.”* Another participant remarked: *“Because I now know where my discomfort comes from, I can accept more that sometimes there are no ‘good’ or concrete solutions.”* The external participants mentioned that, especially in the beginning of the training, the process was rather slow (*“It was a pity that we could not always do all the steps [of the method], because of too little time”*), or not clear (*“Sometimes it was difficult to know what we were doing, that confused my thinking and concentration at that moment”*). Finally, the external participants mentioned that it was difficult to continue keeping up the new reflective attitude outside of the MCDs. One participant said: *“It is hard to keep it going, both for myself and in my team: although the team was really excited at first, I now hear ‘no time for a MCD’.”* Another participant added that change is a process which requires a long-term investment.

During the oral evaluation the trainees indicated that they had experienced the training as intense. They also mentioned that, neither during the training sessions nor during the coaching on-the-job, did they act as participant in the deliberation, so they could give full atten-

tion to the facilitating and the process of deliberation. This was considered advantageous for the learning process but there was also a drawback. One of the qualified facilitators observed that just sitting back was not possible: *“There was more pressure behind it: I always had to perform!”*

Discussion

The experiences in the adapted training showed positive results. Four training sessions in half a year, together with four times coaching on-the-job per trainee, proved to be enough to learn to facilitate MCD. At the end of the training, the two trainees who completed the training were able to organize and facilitate MCDs on their wards.

The formation of a training group with external participants made it possible to facilitate a training program for only three trainees. To optimize the learning environment for the trainees and maximize their learning process, the training group was the same during all training sessions. The trainees reported that they felt confident enough to act as a facilitator in the training group. However, they also indicated that they had a feeling of “being observed” during the MCDs in the training sessions. The uncertainty of the trainees may have been caused by their relative lack of facilitator experience but also by the way in which feedback was given by the trainer, the co-trainees and the external participants. In the first two training sessions, feedback was given after each turn of one of the trainees (i.e., usually trainees performed one step of the Dilemma method). Because this appeared to be disruptive for the dialogue, at the third training session it was decided to give feedback at the end of the MCD. The external participants, still present after the MCD, joined in this last part of the training session and, like the trainer and the other trainees, gave their views on the way in which the dialogue had been facilitated. Feedback by the external participants had not been discussed beforehand and was not expected. Because of their participation in the feedback procedure, the external participants became quite involved in the implementation of MCD in the organization as well (instead of merely “consuming” MCD). The feedback and reactions of the trainer and those of the external participants did not differ that much. Based on these experiences, we recommend organizing a separate meeting with the group of external participants together with the trainer and the trainees before the actual training starts. This would create the opportunity to better inform the external participants and to agree upon the purposes and the course of the events in the training sessions. In this preparatory meeting the contribution of the external participants can be further clarified and discussed.

At the end of the training, the trainees reported that they experienced the training as intense. However, the

number of training sessions and the time frame were limited. Compared to the regular training program, this training design might have been more intense for the trainees due to the uninterrupted practicing during all the training sessions and also in between, either as a facilitator or as an observer. An advantage of the adjusted design is that trainees do not have to switch from being a MCD participant to the role of facilitator and back to a MCD participant again. Another advantage is that with a small number of trainees, trainees have the opportunity to take more turns as a facilitator than is the case in groups with more trainees.

A disadvantage of training a small number of trainees is the limited opportunity to learn from each other. There is less exchange of experiences and trainees experience less diversity in style of facilitation compared to a larger training group. Meetings and peer sessions with trained facilitators from other health care organizations are therefore more necessary, compared to trained facilitators in a regular training program.

Finally, the external participants who contributed to the success of the training program all valued their participation. They became familiar with MCD in a more thorough fashion and with more inside information than in usual MCD meetings because they were present when the objective and the performance of the different steps of the method were discussed between the trainer and the trainees. This made it possible for the certified MCD facilitators to engage these well-informed external participants as ambassadors during the later process of implementation of MCD in the organization.

Conclusion

In order to combine practicing and feedback learning, the program of the training facilitator of MCD was adapted to a small group of trainees. To this training group, external participants from different parts of the organization were added. The external participants experienced MCDs on cases from their own practice, while the trainees alternately led the dialogue during the training sessions. In this way, the trainees were able to practice being a facilitator and to observe the performance of their co-trainees. Because the trainees did not have to switch from being a participant in the dialogue to being a facilitator or observer, they were able to give full attention to the final target of the training, i.e., becoming a MCD facilitator. In addition, the trainees had coaching on-the-job by a trainer during four MCD exercises at the ward. For the trainees, the program was intense, but rewarding.

The training program was evaluated positively by the external participants. The end users of the training program, the health care professionals in the organization who will take part in the MCDs led by the trainees, evaluated the MCDs and the quality of the trainees as facil-

itators. Their experiences with MCD were positive, and made them into ambassadors of MCD in the organization later on. Their feedback to the trainees was congruent with that of the trainer and the co-trainees. Making use of a natural setting (with inexperienced participants in MCD) and allowing unprepared professionals to evaluate the quality of the facilitator trainees adds a unique aspect to the evaluation of the trainees and the training program. Therefore, we recommend involving more often professionals as external participants during MCD training sessions.

Conflict of interest: None to declare.

Zusammenfassung

Hintergrund: Es wurde ein theoretisch und praktisch basiertes Programm entwickelt, um Gesundheitsfachpersonen als Moderatoren («Facilitators») in ethischen Fallbesprechungen nach der Methode der Moral Case Deliberation (MCD) auszubilden. MCD ist eine strukturierte Untersuchung eines moralischen Problems durch eine Gruppe von Gesundheitsfachpersonen anhand eines konkreten Falls, geleitet von einem Facilitator. Die Ausbildung der Facilitators kombiniert ein Einüben der Methode in Übungsstunden mit ihrer Ausübung im jeweils eigenen Arbeitsbereich zwischen den Übungssitzungen. Eine Trainingsgruppe besteht aus sechs bis zwölf angehenden Facilitators.

Methode: Um einer Gruppe von nur drei angehenden Facilitators das Trainingsprogramm zu ermöglichen, wurde das Training von uns angepasst. In die Übungen wurden andere Gesundheitsfachpersonen als externe Teilnehmende einbezogen. Diese externen Gesundheitsfachpersonen diskutierten ihre moralischen Dilemmata, facilitiert jeweils durch einen der drei Facilitator-Anwärter. Wie die Trainer und Kotrainer gaben sie den auszubildenden Facilitators auch Feedback. Zusätzlich dazu erhielten die drei Auszubildenden eine persönliche Beratung in ihren jeweiligen Arbeitsumgebungen zwischen den Übungssitzungen. Sowohl die Auszubildenden als auch die externen Teilnehmenden evaluierten die Trainingstage direkt anschliessend in einer Fokusgruppe sowie ein halbes Jahr danach nochmals in mündlicher und schriftlicher Form.

Ergebnisse: Die Trainingsstunden waren für die Auszubildenden sehr intensiv. Dank des intensiven Lernprozesses ohne Unterbrechungen waren weniger Sitzungen nötig. Die drei neu ausgebildeten Facilitators waren nach dem Training in der Lage, selbst Fallbesprechungen zu moderieren. Die extern teilnehmenden Gesundheitsfachpersonen waren positiv MCD und dem Trainingsprogramm gegenüber eingestellt und halfen den Trainees bei der Implementie-

rung von MCD in ihrer Organisation. Ihre Rückmeldungen zur Qualität der Trainees entsprachen denen des Trainers und des Kotrainers.

Diskussion: Bei der Evaluation der Facilitators und deren Ausbildung leistet einen einmaligen Beitrag, dass die Auszubildenden in einem natürlichen Umfeld, mit in Bezug auf MCD unerfahrenen Gesundheitsfachpersonen, arbeiten und von diesen in ihrer Qualität beurteilt werden konnten. Deshalb empfehlen wir, öfter externe Gesundheitsfachpersonen in den Ausbildungssitzungen und auch in die anschließende Evaluation der werdenden Facilitators einzu beziehen.

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