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Understanding clinical ethics situations: a co-created repertoire of practices

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Abstract

Background Understanding moral problems in clinical settings is central to clinical ethics consultation practice. Although this process may seem straightforward, it is in fact complex, multifaceted, and ongoing throughout consultations. Oftentimes the moral aspects of a situation will be articulated vaguely by those involved based on feelings of uneasiness and discomfort. Thus, clinical ethicists play a key role in helping to characterize these tensions in more formal and explicit terms using references to values and principles. The clinical ethics consultation literature points to the importance of this task and to some recommended practices in this process, such as those referenced in ASBH's Core Competencies. However, there is a sizable gap between these practice guidelines and the actual methods, skills, and creativity deployed by clinical ethicists to accomplish this task.

Methods In this paper, we report a co-creative effort to lay out practices for understanding moral problems and structure them into a repertoire of practices. We followed a co-creative process involving semi-structured interviews with 20 practicing clinical ethicists as well as an iterative process involving drafting the repertoire and revising it during meetings and in manuscript form.

Results The final repertoire structure and content includes: (1) elements considered to discern the moral nature of the problem; (2) actions and approaches taken to discern the moral nature of the problem; (3) elements considered in preparation for addressing the problem; (4) actions and approaches taken in preparation for addressing the problem; (5) modulating factors, and challenges and limits.

Conclusion We hope this work helps further ground the value of co-creative work in clinical ethics while also offering practical resources to support ongoing improvement of understanding moral problems in clinical ethics.

Keywords Clinical ethics, Moral problem understanding, Co-creative research, Pragmatism, Living ethics

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Background

Understanding moral problems experienced in clinical settings is central to clinical ethics consultation practice [1, 2].[1] Indeed, clinical ethics is often defined in terms of its ability to address ethical issues within clinical practice. It has been developed, according to pioneers of clinical ethics, partly to remedy or improve other approaches, such as principlism, which have been criticized as paying insufficient attention to the nuances of clinical realities [5, 6]. Most clinical ethics methods emphasize the importance of inductively understanding the situation at hand as one of the first steps in a consultation process, while others (e.g., casuistry [7, 8] clinical pragmatism [9–11]) regard this as inescapable. The American Society for Bioethics and Humanities (ASBH) Core Competencies for Healthcare Ethics Consultants (including the third edition currently in preparation) states that the identification of the nature of the conflict or value uncertainty is a primary chief goal of the consultation [12]. The current revised Core Competencies also indicates, based on the "Ethics Facilitation Model" it adopts, that first steps in a clinical ethics consultation are (1) to "identify, clarify, and analyze specific ethical questions, concerns, dilemmas, or conflicts pertinent to the given situation" and (2) to "gather relevant background information by examining medical records and other documents such as professional practice guidelines and policy statements, codes of ethics, books, and journal articles" [12 p.2–3] It also recommends adopting "open, inquisitive communication" to grasp the situation from the perspectives of the parties involved. [12p.3] However, despite the widely agreed upon importance granted to understanding situations, there is limited practical guidance articulating meaningful steps as well as practices to consider, while attempting to accomplish this task [13].

Although this process may seem straightforward, it is in fact complex, multifaceted, and ongoing throughout consultations. Oftentimes the moral aspects of a situation will be articulated vaguely by those involved based on feelings of uneasiness and discomfort [14–16]. Thus, clinical ethicists play a key role in helping to characterize these tensions in more formal and explicit terms using references to values and principles [1]. Another complicating factor is that morality falls within the domain of values and interests, which can be very personal. Moral values and interests touch upon what people strive for and commit deeply to in ways that reflect their identities and integrity [17]. Thus, identifying and naming moral problems often means discussing what is intrinsically valuable and of priority to people. This tends to implicate sensitive matters which can be difficult to expose and discuss openly, and they may constitute a threat to a person's identity or sense of personal or professional integrity [18, 19]. Accordingly, the sensitive nature of moral situations implies that not all relevant information will be readily and easily communicated and made accessible to clinical ethicists. Nonetheless, understanding what is at stake, for whom, why, where, and when, and so forth, will be consequential for the eventual discussions about how to find a resolution to the situation. The clinical ethics consultation literature points to the importance of this task and to some recommended practices in this process, such as those referenced in ASBH's Core Competencies [1, 12] However, there is a sizable gap between these practice guidelines and the actual methods, skills, and creativity deployed by clinical ethicists to accomplish this task. Furthermore, this gap hinders ethicists' ability to explicitly adopt, teach clinical ethics practices, evaluate them, refer to them between colleagues, as well as to investigate them openly and critically.

To help bridge clinical ethics methods and practice guidelines and actual practices of clinical ethicists in wide-ranging settings, we embarked as a collective of researchers and clinical ethicists on a participatory co-creative process to develop a repertoire of practices for moral problem understanding. This co-creative process was premised on several basic theoretical assumptions aligned with forms of pragmatist ethics [11, 20, 21]. These include the assumptions that: (1) practicing clinical ethicists have developed effective ways of accomplishing this task which are worth bringing to the literature (i.e., practices embed knowledge); (2) context shapes possibilities and the pattern of practices such that practice settings matter; and (3) collating insights and practices from a wide-ranging body of clinical ethicists – notably through a participatory and co-creative process – could be a motivating and illuminating way of building a repertoire that provides a broader vision of possible practices (see Supplementary online material 1 regarding the connections of this project to pragmatism). These assumptions imply that pooling practices together could be more meaningful, constructive, and useful than attempting to standardize them. This is particularly the case where health care settings vary considerably in a country such as Canada where ten provincial and three territorial

[1] In this paper, following various authors, we distinguish between human morality and ethics [3, 4]. As a theoretical and practical discipline, ethics takes as its object of investigation the domain of moral experience and of moral behavior (morality). Whereas values are implicitly and explicitly part of everyday behaviors and attitudes such that there is a moral component to everything human beings do, ethics comes in when certain behaviors or attitudes are problematized in the form of moral issues, moral problems, and moral concerns (see Racine 2025, pages 102–105, for a typology of moral matters) [4]. We recognize that distinguishing between a more implicit and habitual domain of behavior (morality) and the exercise of critical reflection and consciousness attention to its various aspects (ethics) is not clear cut. However, the distinction has the merit of distinguishing these two essential phenomena for their own sake and integrity. Indeed, there are for example, on the one hand, moral problems and moral distress, and, on the other hand, there are ethics processes, ethics methods, and ethicists deployed to address these kinds of moral matters.

healthcare systems along with federal programs that fund and support delivery of Indigenous health care services co-exist independently. Accordingly, what is possible and meaningful in one context and one situation may not be in others. This broader vision may help improve the work of clinical ethicists by enabling them to learn what others do as well as support ethicists and ethicists-in-training in understanding moral problems.

In this paper, we report on the process and the results of building an initial repertoire of practices employed to understand clinical ethics situations. This repertoire of practices is intended to serve as a resource designed to inform and enhance ethics consultation practices – a tool which clinical ethicists are invited to draw from, while considering their own experiences and specific context. The repertoire is meant to serve as a reflexive and practice-improvement tool, i.e., as a window into the plurality of clinical ethics consultation practices to help support experimentation, reflection, and the professional development of individual clinical ethicists or clinical ethics services. Developing an authoritative guideline was rejected by our group, which expressed concerns that such a tool would instill a sense of constraint and standardization that we were not equipped to produce, and not intending to develop, since standardization can reduce sensitivity to the wide range of practical and institutional contexts for clinical ethics. Moreover, no single tool is going to be particularly useful for every ethics consultation because the nature of the issues is wide-ranging. Thus, we aimed to generate a useful but non-binding repertoire of practices as a potential strategy to assemble and organize practices.

The process and results reported in this paper are part of a broader collaborative project with clinical ethicists across Canada which aims to develop advanced methods for accomplishing three specific tasks commonly identified in the literature: understanding moral problems, facilitating moral discussions, and evaluating moral outcomes [1]. This paper specifically focuses on the process of co-creating a repertoire of practices as a tool to support the first task of clinical ethicists or clinical ethics services, i.e., identifying and understanding of moral problems. It follows a prior literature review and will lead to the use of the repertoire to launch a prospective participatory trial [13].

Methods

An iterative, co-creative and participatory process was adopted to gather experiential knowledge in the form of practices from a collective of clinical ethicists, distill them into a repertoire, and validate the inclusion of identified practices [22, 23]. Iterative – sometimes called spiral or corkscrew processes in pragmatist terminology [24] – designate models of learning and knowledge development which embody iteration and progressive enrichment via a back-and-forth between experience and conceptualization [25]. There is both a linear and circular movement entailed in the spiral or corkscrew metaphors, suggesting a process of growth and deepening of knowledge from one iteration to the next. However, given that knowledge development is not necessarily a linear and predictable process, these models acknowledge an interplay between the actual grounded experience triggering the research inquiry process and the conceptualization of the problem and generation of solutions.[2] Fig. 1 provides an overview of the key steps in the co-creative development process as well as prior and subsequent actions (dotted lines in Fig. 1). Several distinctive steps and

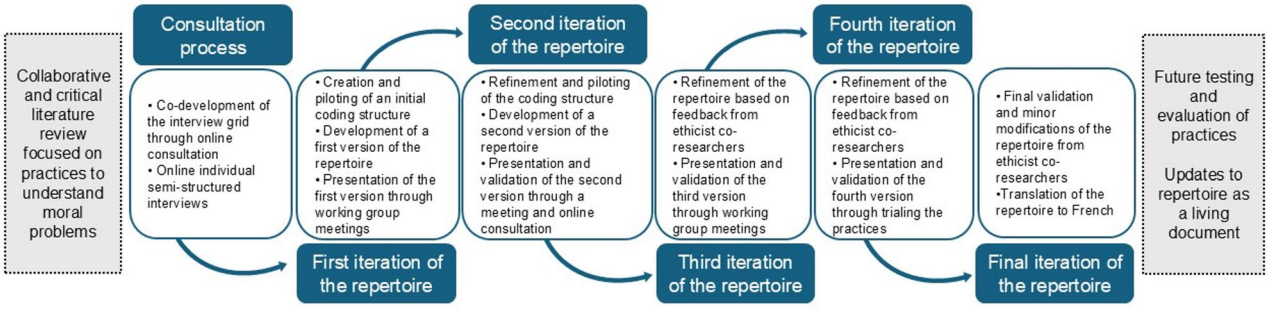

Fig. 1 Overview of the co-creative development process of the repertoire of practices

[2] These models are now used in various fields [26] but their origins can be traced to various historical contributions [27]. For example, David Kolb's theory of experiential learning model is one of the pioneering approaches in experiential epistemologies [28]. However, it was preceded by John Dewey's more elaborate concepts of reflective thought and action [29], as well as Kurt Lewin's pioneering participatory action research work in psychology [30, 31]. These contributions paved the way for the more explicit exploration of iterative participatory and creative processes in bioethics research following contemporary accounts of the synergetic enrichment between theory and experience [32] aligned with pragmatist ethics and its appeals to imagination and experimentation [4, 20, 21].

methods were used to support this development; they are detailed below.

Collaborative and critical literature review on practices to understand moral problems

The team is composed of an executive team and clinical and organizational ethicist co-researchers (abridged to "ethicists" and "clinical ethicists" in this paper). The executive team is composed of a project director (ER), a research coordinator (BD) and two research assistants (IF) and (GS-B) who organize meetings, develop draft study tools, undertake data gathering, data analysis, and draft manuscript writing. Co-researcher clinical ethicists participated in meetings and data gathering by sharing their experiences via various methods described below. They provided feedback on draft study materials and commented on, and revised, draft manuscripts. Together, the executive team and co-researcher clinical ethicists form the research team, and this team met as a plenary working group or in three distinct small groups. Participating co-researcher clinical ethicists were recruited via several targeted efforts: general announcements distributed through the Canadian Bioethics Society (e.g., at events and through its newsletter), targeted invitations to colleagues suspected of having interest in the topic, and snowball recruitment based on recommendations of recruited co-researchers. Recruitment aimed at creating one French-speaking group for Québec and francophone Canada (n = 6), a second group combining Atlantic Canada (e.g., Nova Scotia, New Brunswick, Newfoundland, Prince Edward Island) and the province of Ontario (n = 9, with a tenth colleague needing to leaving during the project), and a third group comprised of colleagues from the Western Canadian provinces (Manitoba, Saskatchewan, Alberta, British Columbia) (n = 6) to facilitate engagement in light of time-zone issues and geographical proximity. These groups included the clinical ethicist co-researchers and the research staff who supported and organized group meetings. Two forms of group meetings occurred: small group meetings and a larger forum meeting. The small group meetings were organized as distinct sessions of the three groups while the forum meetings involved the three groups meeting as a full assembly of co-researchers. All meetings took place online using the Zoom platform for practical reasons (e.g., convenience, costs). In preparation for the current repertoire development project, this group of researchers and clinical ethicists conducted a prior critical literature review of strategies used to understand moral problems, highlighting the strengths and gaps in existing models and practices [13]. This review documented important gaps, including the lack of precision and clarity about concrete practices and approaches to understanding moral problems. To gain an experience-based understanding of the practices employed by ethicists and ultimately to develop a repertoire of these practices, we engaged in a consultation process with the co-researcher ethicists through semi-structured interviews.

Consultation process with collaborating ethicists

In preparation for gathering data on practices used to understand moral problems, an interview grid was co-developed with collaborating ethicists. A draft of the grid was first generated by the executive team based on highlights of the prior literature review as well as salient points (e.g., context, power dynamics) which surfaced in the group discussions supporting the critical analysis of the literature [13]. Ethicists engaged with the draft through online consultation and the feedback received prompted revisions to: (1) better reflect the highly collaborative nature of ethicists' work, as the draft initially focused too heavily on aspects related to individual, personal, practices; (2) further explore the nature of the involvement of ethicists in consultations, given the variety of situations and contextual factors that affect both their participation in consultations and ability to provide help through consultations; and (3) incorporate aspects related to the consultation processes whilst remaining open-ended about which processes are used. This reflects the variety of practices alluded to by our group and the significant differences in the ways these processes are described through various methods noted in the literature. The resulting initial interview grid focused on five themes which were selected based on our group's prior critical review of the literature on clinical ethics consultation methods. Several key aspects of ethicists' work were identified as having a significant impact on understanding moral problems practices. These included: (1) the processes through which ethicists receive and handle requests; (2) the methods they use for moral problem comprehension, including how they are used and in what clinical context; (3) the broader (e.g., institutional, social) contexts in which consultations occur; (4) aspects of trust and relationships between ethicists/ethics services and the people they support; and (5) ethicists' positionality (position within the health care organization and within the broader socio-cultural and political context) and reflexivity.

Semi-structured interviews were conducted with 20 of the 22 collaborating ethicists, either in English or French, via Zoom. Each interview, typically lasting around 60 min, was audio-recorded and transcribed using the online AI transcription tool Sonix. The interview grid was piloted during the first seven interviews and subsequently amended based on collected preliminary data. Feedback from ethicist co-researchers on the interview grid and its initial piloting led to two main adjustments. First, the grid was modified to focus more closely on the

project's target, namely clinical ethics consultations. This involved better discriminating which nuances were relevant to practices such as those pertaining to: (1) the influences of organizational ethics issues and legal dimensions on *clinical* ethics issues; (2) the kinds of tasks and problems different ethicists and ethics services qualify as the domain of *ethics* support (e.g., clarifying whether providing moral distress debriefing counts as ethics support); and (3) which kinds of clinical ethics services and processes count as *consultations*, thereby, leading to a focus on the more ethically-complex and less legalistic or deontological (professional ethics) cases which can be handled by other services or committees (e.g., Legal Service, Human Resources, Occupational Health and Safety, Patient Relations, Organizational Development/Learning, DEI (diversity, equity, and inclusion) Office, Indigenous Patient Navigator, Spiritual Care, Quality and Risk). Second, the grid was modified to better capture the practices of ethicists. This initially proved difficult because, as many ethicists noted, separating their work into two distinct steps, that of understanding the moral problem and then addressing/responding to it, did not reflect the structure or process of their actual practice. In response, the interview grid was amended to provide more leeway in the ways consultation processes could be described, and follow-up questions were added specifically to explore their iterative nature. The executive team also struggled with distinguishing desirable practices for understanding moral problems from practices made necessary or preferable owing to contextual factors (e.g., the ethics service's institutional arrangements). The interview grid was thus adjusted to incorporate the contextual elements that had a direct and relevant impact on what constituted the best practices for ethics work (see Supplementary online material 2). The final version included 8 open-ended questions (see Table 1).

First iteration of the repertoire of practices

To gain a comprehensive understanding of this interview content and lay the groundwork for developing a first iteration of the repertoire of practices, members of the executive team read and coded the interview transcripts using Microsoft Word) following precepts of qualitative content analysis such as familiarization with data and developing an initial coding structure as described by Forman and Damschroder [33]. This preliminary analysis of data, conducted by GS-B and revised by ER , was exploratory and sought to generate an initial coding structure that would guide further analysis in light of subsequent feedback from all authors. This preliminary analysis was guided by the search for practices and their modulating factors. This resulted in a tentative first iteration of the repertoire of practices focused on actions, considerations, motivations, and contexts associated with understanding moral problems. This initial version of the repertoire of practices was presented to ethicists for feedback during small working group meetings (Fig. 1, first iteration of the repertoire). An important observation was that the preliminary repertoire lacked sufficient details to act as a tool that would support ethicists in understanding moral problems. Additionally, the preliminary coding structure proved challenging to apply in practice, as it was difficult to differentiate between what is done, how it is done, and the contextual factors influencing the process of understanding moral problems.

Second iteration of the repertoire of practices

These observations led to the development of a second version of the repertoire of practices based on a refined coding structure developed by BD, IF, GS-B, and ER , which shifted the focus toward the elements and actions carried out by ethicists in understanding moral problems, as well as the factors and challenges that influence this process (see Fig. 1, second iteration of the repertoire). This revised coding structure, comprising six categories (see Table 2 for an overview and definitions), was applied to the entire data set by three members of the executive team (BD, IF, and GS-B, successively) to validate and refine the coding iteratively. Coding was performed using the data analysis software MAXQDA. The process involved identifying, coding, and summarizing practices using the software's comment feature to facilitate subsequent data analysis. The practices coded and summarized under each category were extracted from the software

Table 1 Interview grid[a]

Q1: Can you describe in general terms how ethics consultation requests reach you (e.g., email, phone call, in-person visit at your office), and what you do with these requests afterwards?
Q2: When someone initially contacts you, what do you pay attention to and/or keep in mind to inform your initial assessment of the situation?
Q3: What does the usual structure of the consultation process look like, and what factors may change it?
Q4: Do you use a typology to characterize cases? Where does this typology come from? If you don't use one, why?
Q5: Are there times when your approach to the consultation is not working, and what cues you in? What do you do in those cases?
Q6: What are the practices you find useful to judge whether you understand a request and/or the ethical issue at hand?
Q7: Are there relational and/or institutional factors that help or hinder your ability to characterize ethical issues?
Q8: Is there anything about your practice/approach to moral characterization that we haven't covered and that you would like to discuss?

[a]Only main questions are featured; sub-questions and follow-up questions are not reflected above

Table 2 Coding structure for the second iteration of the repertoire of practices

Categories (codes)		Definition
Elements considered (to)…	…Discern the moral nature of the problem	Any element considered during the process of understanding moral problems to help discern the moral nature of the problem
Actions and approaches taken (to)…		Actions and approaches taken during the process of understanding moral problems to help discern the moral nature of the problem
Elements considered (in)…	…Preparation for addressing the problem	Any element considered during the process of understanding moral problems in preparation for addressing the problem
Actions and approaches taken (in)…		Actions and approaches taken during the process of understanding moral problems in preparation for addressing the problem
Modulating factors		Factors that influence the process or practices related to understanding moral problems
Challenges and limits		Challenges and limits that influence the process or practices related to understanding moral problems

and subsequently grouped into relevant subcategories of practices (e.g., groups of elements considered, or groups of actions employed). This process resulted in a second iteration of the repertoire of practices, which was presented to the entire group of ethicists for feedback during a meeting where they were invited to review and comment on the repertoire. A copy of the repertoire was also shared with ethicist co-researchers via email following a meeting held to validate the fine-grained content of the repertoire and allow direct modifications and suggestions. All meetings were recorded and made available to those who were absent so that they could benefit from the discussion and use this to inform any feedback or additional insights. The executive team compiled all the comments and suggested modifications. Overall, the repertoire was judged to be much improved in terms of practicality and clarity. However, some practices were identified as missing, and limitations of the visual presentation of the work were noted. Throughout the co-development process, everyone was encouraged to identify practices they would see as unfit for inclusion.

Fourth iteration of the repertoire of practices and draft manuscript

Following the small group meetings of clinical ethicist co-researchers, the executive team revised both the repertoire and the current manuscript (at this stage incorporating draft background, discussion, and conclusion sections), for a fourth time (see Fig. 1). The feedback was incorporated into the repertoire. The introduction, discussion, and conclusion sections of the manuscript were written. Both documents were shared with ethicist co-researchers via email to make a final round of comprehensive modifications.

Fifth and final iteration and approval of the repertoire of practices and manuscript

The feedback from the shared fourth iteration was incorporated into both documents. The documents were then sent to ethicist co-researchers for a final time, to validate the revisions and approve their participation in the manuscript (see Fig. 1). All signing co-authors approved these documents. The resulting final repertoire (see Supplementary online material 3) is shared as an editable, open-source, Microsoft Word document to allow all individual ethicists and clinical ethics services to use, reuse, modify, and supplement the repertoire for their own needs, in keeping with the spirit of a tool. A French language version of the repertoire is available upon request.

Future testing and evaluation of practices

As part of the ongoing collaborative larger project, the proposed repertoire will serve as a basis for the subsequent development of tailored individual action plans to be implemented by a subgroup of ethicists in a participatory trial. The participating ethicists will be organized in peer groups to share the strategies they will deploy to improve certain aspects of their practice. They will be supported by ongoing peer meetings and opportunities to exchange insights. This phase will culminate in a participatory reporting and evaluation process.

Results

Presentation of the repertoire of practices

The repertoire, containing the full list of practices, can be accessed as a supplementary document (see Supplementary online material 3). It is structured in accordance with the categories used for coding identified in Table 2 (i.e., practices to discern the moral nature of the problem; practices to prepare for addressing the problem; modulating factors; challenges and limits) (see Fig. 2). The practices described in the text may not be in the same order as the tables and the repertoire since some practices were combined within a sentence to demonstrate similarities, differences, or simply to enhance readability. There are also some overlaps in the relevant practices that apply to different sub-tasks. The general nature of practices reported deserves clarification. They are both wonts which are (sometimes/often/always) enacted as well as actions which are considered to be desirable. The repertoire is thus a compilation of what are considered to be helpful or promising practices rooted in experience-grounded

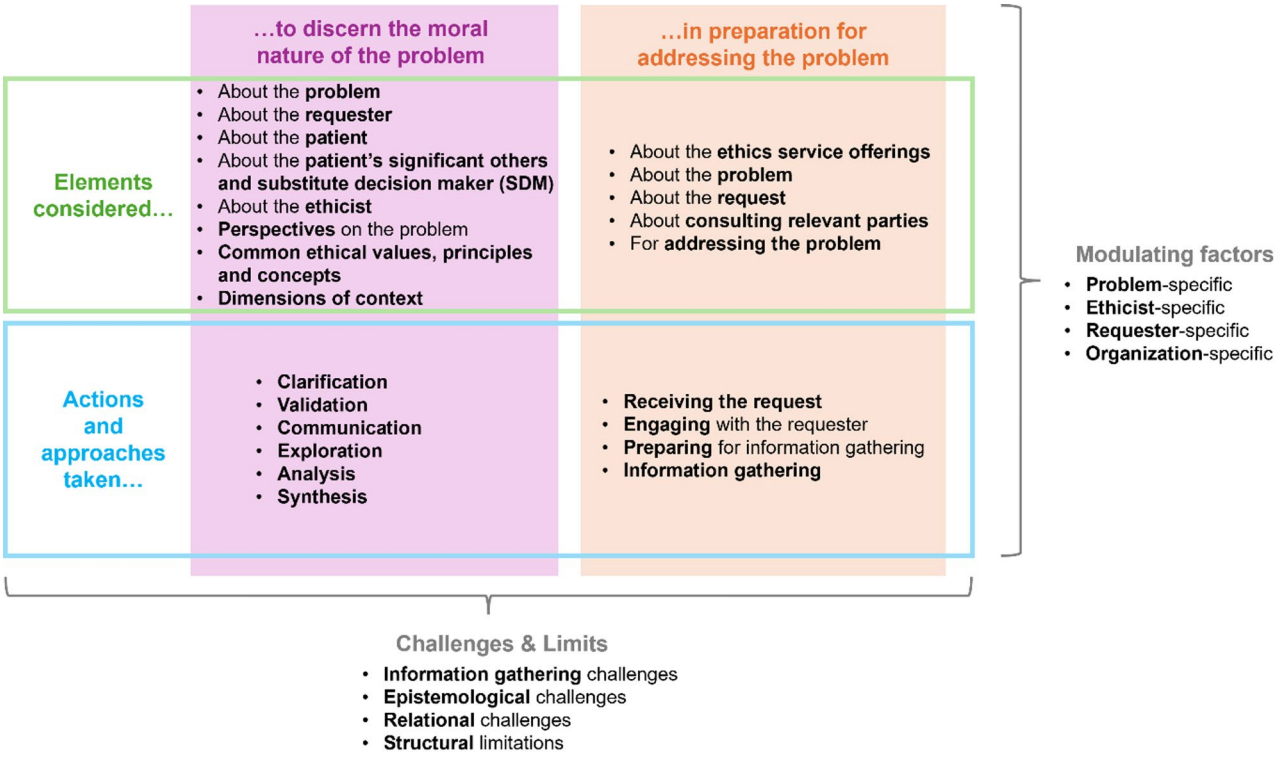

Fig. 2 Overview of the repertoire of practices in a visual format

aspirations, in line with ancient accounts of practical knowledge as phronesis [34, 35] and its contemporary pragmatist account as deliberative wisdom [4]. In keeping with these accounts of practical knowledge, determining whether and to which extent a practice is appropriate is a matter of practical judgment. No two clinical settings are the same; no two clinical ethicists are the same; and no two situations are exactly the same. All this variability calls upon clinical ethicists to exercise practical judgment and creativity in how they calibrate any promising practice. For example, practices related to "information gathering" may sound like more information is always better, but these practices need to be deployed with circumspection since there are situations were pursuing these will be inappropriate or will run counter to other goals.

Elements considered to discern the moral nature of the problem

This first category consists of eight groups of practices. These are used to discern the moral nature of a problem, aiming to understand what makes the situation a moral problem, and elicit the various elements to include or to bear in mind while engaging in this exercise of discernment (see Table 3).

About the problem

Categorizing problems can be a useful first step in understanding a situation. Common issues, such as determining the scope or applicability of a substitute decision-maker's (SDM) decision-making authority relative to treatment, end-of-life care, capacity to consent to treatment, risky discharge planning, and the best interests of a patient, can quickly be identified and help to determine the subsequent steps. However, such categories should be used with caution as they can hinder the understanding of the situation by framing the issue prematurely and too narrowly. The facts germane to a case are another essential component. They include medical facts and facts about, among others, the timeline/trajectory of care, prior discussions, who is involved in the situation, and who is and could be affected by the proposed decisions. Special attention is sometimes given to the role of clinical facts in the consultation as they help clarify aspects of the situation, but they also can distract from the moral dimensions of the problem. Disagreements between relevant parties[3] about the facts of a case can be a clue to understanding the nature of the moral problem.

The choice of words used by relevant parties, non-verbal communication, barriers to communication, and the

[3] The term "relevant parties" describes all potential individuals and/or groups that are to be considered in understanding a moral problem and/or are actively involved in the problem, including such persons as the requester, care team, significant others (when relevant). The term "stakeholder" has generated unease among some co-researchers due to its colonial connotations, specifically owing to its association with regard to the rights of Indigenous communities. For this reason, we elected to use the expression "relevant parties".

Table 3 Elements considered to discern the moral nature of the problem

Elements considered to discern the moral nature of the problem	
About the problem	
• The facts	• Potential biases and knowledge gaps in understanding the problem
• Potential misunderstandings about the facts	• Aspects of the problem that determine how to apply the values
• The people affected by the problem	• The type of problem according to a specific typology or framework, shared or particular to the individual gathering information about the problem
• The harms/implications of the problem	
• The feelings associated with the problem	
• Why the problem is important	• Disagreements between patients* and caregivers or between patients and team members on end of life, consent, best interests, etc.
• The central concern in the problem	
• The values at stake and in tension	• Distinctions between values conflict, values uncertainty, and values constraints
• Sources of uncertainty about the problem	
• Issues that may affect understanding of the problem	
• The specific characteristics of the problem	
• The words used by the relevant parties to describe the problem	
About the requester	
• Who is the requester	• Aspects of the problem that cause the requester confusion or distress
• The concern(s) of the requester	• What the requester considers to be the problem
• The requester's expectations for the outcome	• The extent of the problem according to/for the requester
• The words used by the requester to describe the problem	• The requester's position/positionality
• Previous steps/measures taken to address the problem	
About the patient	
• Their wishes	• Their experiences with the healthcare system
• Their preferences	• Their interactions with the interdisciplinary healthcare team
• Their values as related to the problem identified	• Their insurance status (whether they are uninsured – this may impact the type of care they can/will receive)
• Their cultural or religious beliefs and backgrounds	• Their level of understanding and decisional capacity
• Their diagnosis	• Their care trajectory
• Their prognosis	• How they perceive their care trajectory
• Their socio-demographic characteristics	• What informs their perspective
• Their position/positionality	• Any parts of the patient's story that do not appear on the medical chart but are salient to the understanding of the ethical concern
• Their significant others (families and friends – including found family and extended kin networks)	
• The issues they face	
About the patient's significant others and substitute decision maker (SDM)	
• Their relationship with the patient	• Their ability to determine the patient's best interest
• Their relationship to the patient's significant others	• Their experiences with the healthcare system
• Their understanding of the patient's wishes, preferences, and values	• Their interactions with the healthcare team or administration
• Their perception of the patient's best interest	• The difficulties they face in supporting the patient or acting as SDM
	• What informs their perspectives
About the ethicist	
• Their relationships with others involved in the request	
• Related moral problems to which they have previously been exposed	
• Their previous experience and professional/disciplinary background	
Perspectives on the problem	
• Of the patient	• Diverging perspectives
• Of the patient's significant others or representative	• Perspectives that should be considered
• Of members of the healthcare team	• Represented perspectives
• Of other ethicists	• Missing perspectives (e.g., perspectives of relevant communities or sub-communities such as the patient's religious or cultural group)
• Of members of the ethics committee (if applicable)	
• Consensual perspectives or areas of consensus	

Table 3 (continued)

Elements considered to discern the moral nature of the problem	
Common ethical values, principles, and concepts	
• Autonomy • Beneficence • Best interests • Equity • Quality of life	• Respect • Harm reduction • Non-maleficence • Justice • Safety • Trust • Transparency • Solidarity • Relationships • Principles and values in tension
Dimensions of context that affect the understanding of the moral problem	
• Clinical • Cultural • Legal o Relevant healthcare legislation and concepts o Legal aspects that could affect the trust of the clinical team o Human rights o Legal and deontological (professional) norms** • Organizational o Relevant guidelines, policies, and practices • Psychosocial • Structural/Systemic o How forms of discrimination (e.g., ableism, ageism, classism, racism, sexism) shape the problem and understanding of the problem	• Relational o Power dynamics between affected or relevant parties o The relationship between the patient, the patient's significant others, and the healthcare team o How the healthcare team reacts to/ perceives the patient's behavior o The complex interpersonal dynamics within the healthcare team o The complex interpersonal dynamics between the patient and their significant others o The complex interpersonal dynamics between the patient's significant others o Relationships that relevant parties might be trying to preserve by not saying things o The posture adopted by the ethicist in relation to the relevant parties o The extent to which the therapeutic relationship is undermined/ broken

*The term patient may include the patient, the patient's representative, and/or the substitute decision maker

**Deontological norms here refer to professional deontological codes and codes of ethics

feelings relevant parties associate with a situation can point to moral problems. The values and ethical principles at stake and in tension can aid in identifying what is believed to be the central problem. Potential conflicts between the demands and obligations of various professionals, patients, and others with standing in a case as well as institutional orientations can cause or exacerbate moral problems. Acknowledging and noticing potential biases and knowledge gaps of relevant parties (and ethicists) can help parties to identify and appreciate otherwise hidden aspects of the moral problem.

About the requester

Upon receiving a consultation request, elements about the requester, such as who the requester is, what steps they have taken to deal with the problem, and the words they use to describe the situation (including coded language, such as adjectives describing the patient or their significant others, or the use of medical terminology) can be elicited. Other pertinent elements are identifying what the requester considers to be the moral problem and its significance along with their concerns, expectations, positionality, and any sources of confusion and/or distress. For example, for some in our group, this means that as soon as a consultation request is received, a call is made to the requester to find out where they are coming from, their role, and the situation they are facing. It is important to fully understand the situation, including the requester's perception of the situation, their distress, their questions, and how they express the moral issue, as well as their expectations toward the clinical ethicist or the ethics team. This is particularly important to fully understand the situation, but also eventually to respond to needs.

About the patient

The patient's wishes, values, and preferences for the type of care received, their quality of life after treatment, capacity for understanding, diagnosis and prognosis, and their likely trajectory of care are all key elements that may be considered in the comprehension process. Similarly, their perspectives on the situation can provide valuable information on the moral issue at hand – perspectives shaped by, for instance, their own trajectory of care, values, cultural and religious beliefs, socioeconomic and demographic background, and relevant experiences including any prior engagement with the healthcare system. To gather this information, patients and/or their

significant others (e.g., families and friends) can be consulted directly, or the clinical staff and other individuals involved (e.g., social workers, spiritual care providers, or the legal service) can be approached to provide additional insight.

About the patient's significant others and Substitute Decision Maker (SDM)

The patient's significant others and SDM can play an instrumental role in understanding the situation, particularly in cases where substitute decision-making is appropriate. Their perspectives and interpretations of patients' preferences for the plan of care are vital when patients have not provided adequate or relevant information about their values and preferences through advance care planning documents. Advance care planning documents may provide a care team's best, or sole, insights into the patient's best interests, their experiences with the healthcare system and professionals, their relationship to the patient's significant others (if relevant), and what might inform these perspectives.

About the ethicist

The identity of the ethicist (most notably, the ways in which various aspects of one's identity intersect) such as ethics training, related experience, disciplinary background, cultural background, and spoken language can shape how facts and accounts are interpreted and the practices that are prioritized. The practice of the ethicists therefore calls for ongoing reflexivity. If the ethicist has previous relationships with those involved in the current request, being attuned to the nature of these relationships can inform and shape the process of comprehension. For example, this can take the form of constantly engaging in self-reflection, and challenging ourselves in practicing to think about our identities (especially if we hold identities that mostly relate to power). Reflexivity and awareness about one's identity and position are a constant practice. They are a way of working and being together. They require ongoing scrutiny, vulnerability, and willingness to step into spaces with humility. This allows for real connection, seeing humanity in others, and allowing for others to be vulnerable and feel safer.

Perspectives on the problem

The perspectives of the patient and their significant others, as well as less closely involved individuals, such as the members of the wider care team, can help the ethicist attain a more holistic understanding. In complex cases, the perspectives of fellow ethicists and clinician colleagues, e.g., those on an ethics committee or in an ethics department, can be valuable as their various experiences and types of expertise may shed light on missed details or offer a different view of the situation. The interplay of different perspectives can both be the source of the moral problem and provide cues as to its nature. There may be consensus or diverging perspectives, and attention can be paid to which perspectives are represented, missing (such as certain communities that the patient and/or close relations are a part of), which are necessary, and which are tangential to an adequate understanding of the problem.

Common ethical values, principles, and concepts

Several values, principles, and concepts may apply to a situation, including but not limited to autonomy and patient wishes, best interests of the patient, equity, quality of life (especially as the patient understands it), respect, harm reduction, non-maleficence (do no harm), justice, safety, trust, solidarity, transparency and relationships. The potential tensions between these principles and concepts (and others) – as well as between different interpretations of the same principle – can influence which moral issues will arise, how these issues are perceived, and the kind of consultation required.

Dimensions of context that affect the understanding of the moral problem

Moral problems can be shaped by a variety of broader dimensions: clinical, cultural, legal (e.g., legislation and jurisprudence, standards of practice, or legal opinions), organizational (e.g., relevant policies and procedures), psychosocial (linkage between the beliefs of individuals and social factors), relational (e.g., power dynamics, complex interpersonal dynamics, reactions and perceptions between different healthcare professionals, the state of the therapeutic relationship, relationships that the patients, their significant others or clinical team members might be trying to preserve), and structural (e.g., systemic racism, sexism, ableism, classism). For example, a good question to ask ourselves is not whether or not systemic oppression is playing a role, but ask HOW are systemic factors at play? Who stands to benefit from this decision? Who will bear the ultimate consequences, especially the harms? Who has more to lose? Who is impacted by a decision that may be missing from the decision-making process?

Actions and approaches taken to discern the moral nature of the problem

This category is comprised of action-oriented practices ethicists may engage in when partaking in moral problem comprehension (see Fig. 2). It is separated into 6 sets of practices (see Table 4). The spirit guiding these practices is charitable: the moral nature of problems is deciphered throughout the process of moral comprehension. Given that most consultations are triggered by requests for help (they are not reliant on the clinical ethicist's initial perception of the moral problem and their account of

Table 4 Actions and approaches taken to discern the moral nature of the problem

Actions and approaches taken to discern the moral nature of the problem
Clarification
• Being careful not to assume understanding. Clarifying… o The facts o How relevant parties perceive/describe the problem o Any jargon or coded language (e.g., "difficult patient") used by relevant parties o What relevant parties are most concerned about o Any elements lacking clarity • Paying attention to any clarifications provided by relevant parties
Validation
• Validating and refining the understanding of the problem with… o The requester o The healthcare team o The patient or patient's significant others (including the patient's SDM) o Other ethicists or members of the ethics committee, attending to the ethical considerations they raise o Other departments or services within the organization (e.g., Legal Service, Human Resources, DEI (diversity, equity, and inclusion) committee, Patient Relations, Social Work, Indigenous Patient Navigator, Clinical Support, etc.) o Literature on the subject o The patient's medical chart or alternatively, choosing not to consult the chart to avoid being unduly influenced by what has or has not been recorded in the chart or to preserve patient privacy • Taking a step back, taking the time, and taking the necessary steps to ensure a good understanding of the problem
Communication
• Adopting an active listening mode • Dialoguing with relevant parties rather than relying on a list of formal questions • Letting the requester freely describe their perspective of the problem and how they feel about it • Encouraging the requester to take a thoughtful and measured approach to the problem, balancing reflection with the urgency of action as required • Asking questions in a way that helps relevant parties reframe their own perspectives and explore underlying reasons related to the problem • Using an accessible ethics vocabulary • Nurturing and maintaining a non-hierarchical environment where relevant parties feel comfortable sharing their perspectives and dialoguing • Directing attention and discussion towards the patient's wishes, best interests, perspective, and needs to get a more accurate understanding of the problem
Exploration
• Exploring with the requester/relevant parties… o Values or norms related to the problem o The initial discomfort prompting the request o Moral considerations o The perceived moral conflict
Analysis
• Determining the most appropriate ethical method/approach for understanding the problem • Considering potential implicit biases • Ensuring that the facts are well understood • Noting aspects of the problem that are under-addressed and should be addressed • Making sure that the perspectives of all relevant parties have been heard and considered • Reflecting on why the problem has been referred to the ethics service • Being open to the possibility that the problem may be quite different from what was originally described or anticipated • Looking for normative issues that have been raised • Paying attention to non-verbal cues when communicating with relevant parties • Paying attention to, recognizing, and reflecting on one's position in relation to the reported problem (e.g., privileges, role, implicit biases, identity, relationship to territory) • Being vigilant in approaching sensitive problems or those likely to attract legal or media involvement • Using intuition as an experienced ethicist to bring out hidden or unspoken issues/sub-issues • Considering a plurality of ethical methods/approaches in understanding the problem to consider it from multiple angles
Synthesis
• Articulating the various elements in writing • Reframing/reformulating the problem in ethical terms • Identifying the ethical question(s) at the heart of the matter • Synthesizing the information gathered in the form of an emerging narrative

ethics), this process is ideally undertaken in dialogue with those who are part of the situation without imposing an overly rigid and pre-existing idea of what the nature of the domain of ethically relevant concerns is or should be.

Clarification

Taking care not to assume understanding or that a moral problem is actually at stake can be a useful practice. First steps might involve clarifying the facts, capturing how relevant parties describe and perceive the problem, attending to any jargon or coded language (e.g., "difficult patient", corporate-speak) in order to uncover possible underlying meanings in a specific choice of words, discerning what the relevant parties are most concerned about, and questioning any other elements that may lack precision. The clarifications provided by interested parties can often reveal unstated priorities, pressing concerns, values, and more. For instance, although the first step is to contact the requester to fully understand the situation, in some more complex cases, formal discussions with the parties most directly involved in the case can reveal other important aspects of the problem at hand. Legal or organizational issues can distract from the patient's best interests in favor of, for example, the need for control by certain stakeholders or the fear of a legal action. It is therefore important – in our experience – to create a space where everyone feels comfortable sharing their view of the moral problem to reach a shared understanding.

Validation

Discerning the moral nature of the problem (if the problem is best accounted for as a moral problem)[4] also involves validating and refining understanding and this can be done with various affected parties. These can include the requester, care team, the patient (including whether to consult the patient's medical chart), or the patient's significant others (including the patient's SDM), other departments or services of the organization and the literature on the subject. Engaging in validation with ethicist peers, and being receptive to the ethical considerations they raise, can be helpful when the issues are more complex to discern. Most notably, there can be value in taking the time to confirm that a good understanding of the case has been gained by checking in with more experienced or trusted parties. For example, this can take the form (depending on the circumstances) of a debrief with other ethicists or colleagues or supportive services (e.g., Legal Service, Human Resources, DEI committee).

[4] Human morality is at stake in much everything human beings do, but not every problematic situation is predominantly a moral problem. Problems can be chiefly clinical or legal in nature although problems are probably rarely if ever purely of a single type.

Communication

Adopting an engaged listening mode and being cognizant of one's own biases can help in discerning the moral nature of the problem. Useful practices include engaging in dialogue with the relevant parties and giving them space to freely communicate pertinent information and feelings related to the situation. Encouraging relevant parties to take a thoughtful and measured approach, while keeping in mind the interplay of the real and perceived urgency of the situation, is a particularly important practice, especially when aiding the requester in determining whether to reflect first or to act on a situation. Asking questions in ways that help to reframe perspectives aids in uncovering underlying reasons and promoting reflection. Promoting and nurturing a dialogue-friendly and non-hierarchical environment to generate comfort and the freedom to share perspectives is imperative. This can be done by using accessible ethics vocabulary, avoiding academic or other complex jargon, and by directing the discussion towards the patient's wishes, interests, perspectives, and needs. This is particularly important when laypersons are involved in the discussion. For example, when entering a difficult conversation, one practical approach is to begin by explicitly naming the role of the ethicist and its limits, and then inviting the patient/family to share what feels most important to them before any clinical framing is offered. This can take the form of a statement such as: "Before we get into the medical details, I want to make sure we start with what matters most to you. Can you share what is the most important thing we need to know so we can support you?" This small shift helps re-center the patient's priorities, reduces hierarchical tone, and opens space for shared decision-making, and gives an opportunity for the family to share their views and values so they guide the discussion.

Exploration

Another practice to discern the moral nature of the problem is exploring the more complex and sensitive factors, such as the values, principles, and norms related to the problem, as well as its moral considerations and potential conflicts, real and perceived. Additionally, delving into the initial discomfort the affected parties experience which originally prompted the request, at times related to the complexity, sensitivity, and interrelated dynamics of the problem, can help ethicists in furthering understanding.

Analysis

Assessing the normative issues raised, highlighting under-addressed aspects of the problem, and identifying possible implicit biases in understanding the problem are some actions undertaken to set up for ethical analysis (e.g., what approaches might be most relevant to use in

analyzing the problem/issue at hand). Reflecting on why the problem has been referred to ethics, and particularly what created a need to contact ethics rather than other services for resolution of this issue, can be a useful practice. Remaining open to the possibility that the problem may be quite different from what was originally anticipated or described, keeping an eye out for normative and other cues can also be helpful. Reflecting on one's position, especially as an ethicist can uncover how particular experiences, worldviews, and more – such as one's own privileged status – can have an impact on moral problem comprehension.

Synthesis

Synthesizing one's understanding of the problem by writing down the diverse elements related to the problem, reformulating the problem in ethical terms, identifying the ethical questions at the heart of the matter, and summarizing the information gathered in the form of an emerging story can help in discerning the moral nature of the problem and preparing for subsequent stages of the consultation process. For example, this can take the form of summarizing the situation, then the ethics question, the options discussed, and then establishing next steps and ensuring the latter align with the expectations of others involved since sometimes some may not like or agree with the outcome, but this needs to be done for transparency and procedural justice.

Elements considered in preparation for addressing the problem

The following section outlines elements that may be considered by ethicists in preparing to address the problem (see Fig. 2). Notably, these elements are not intended to prompt direct engagement with the problem but rather serve as considerations to equip ethicists to address it at a later stage. They are grouped into 5 sections (see Table 5).

About the ethics service offerings

Ethics services offer varying kinds of support, including education, moral distress debriefings, informal consultations, and formal or structured clinical ethics or organizational ethics consultations. The services offered by the ethics service can be considered at the outset of a consultation to ensure their compatibility with the needs, expectations, and motivations of the requester. Having insufficient domain-specific ethics expertise and experience with a problem can be a challenge for an ethics service or ethics consultant. Additionally, the potential benefit of including other services and resources in the consultation (e.g., those provided by social workers or spiritual care providers, or a legal team) can be ascertained. The ethics service's institutional and administrative arrangements (e.g., on-site ethics services, ethics committees assigned to a region, university-based bioethics programs providing consultation services) may also influence the choice of practices relevant to addressing the problem.

About the problem

There is an important distinction to be made between the request and the actual moral problem; the former happens at a single event in time, whilst the latter extends through time. The duration of the problem (both how long the situation has been in existence, and anticipating how much time will be required to address it), and whether previous requests have been made about this problem can be relevant cues guiding the process of handling the current request. The complexity of the problem will need to be ascertained, which depends on factors such as if there are differing perspectives within the clinical team, for an ethicist to determine how or if to proceed (whether an ethics committee would be helpful to address the problem, for example). Whether the problem needs to be dealt quickly for medical, legal, or reputational reasons (e.g., if the story threatens to spread in the media) or because of a "moral urgency" (e.g., when the requester is experiencing significant moral distress without there being a medical urgency) may influence how quickly the problem will be dealt with, as well as its sensitivity. Broadly, it can be important to question what form of ethics support would constitute the best response to the problem (e.g., how many meetings, specific consultations, or general education sessions).

About the request

Because it is often the starting point of the consultation process, careful attention is often paid to the request itself: its origin and format (e.g., filed via an intake form, an email or phone call, an in-person meeting, a staff meeting to which the ethicist is invited), the people involved or mentioned in the request, and the kind and completeness of the information initially provided, as well as any expectations articulated with respect to the outcome of the problem. Potential and observed power dynamics between the relevant parties, different services involved (e.g., Legal Service), and the institution's leadership (e.g., management or executive officials) are other elements that ethicists can be attentive to.

About consulting relevant parties

Determining who should be consulted (e.g., whether to speak with the patient or consult the patient's chart) and how to consult them are other elements that can be considered by ethicists preparing to address the problem. For instance, seeking advice from an ethics committee or ethics colleagues may be beneficial for working through highly complex cases. Circumstances will determine

Table 5 Elements considered in preparation for addressing the problem

Elements considered in preparation for addressing the problem

About the ethics service offerings

- The need for a formal or informal process/consultation
- Whether the problem relates to clinical or organizational ethics (or some hybrid)
- The role and possible contribution of the ethicist
- Other services/departments consulted
- The ethicist that is best placed to deal with the problem depending on…
  - o Availability
  - o Expertise
  - o Position in relation to the problem
- The requester's experience with the ethics service and relevant perceptions of the ethics service
- The requester's needs, expectations and motivations
- Resources/services to be included in the process
- Compatibility of the request with the services offered, current capacity, and the mandate of the ethics service, or with another service in the healthcare setting

About the problem

- Sensitivity/media coverage/public perception
- History (if there are previous requests)
- Institutional issues or constraints that may affect addressing the problem
- Level of urgency
  - o Whether the problem needs to be dealt with quickly for medical, legal, or publicity reasons, or because of the distress it generates within the clinical team
- Duration/extension in time, i.e., both how long the situation has existed and how much time it is anticipated will be required to resolve it
- Complexity, depending notably on…
  - o Whether there are differing perspectives on the problem between members of the clinical team
  - o The ethicist's ability to anticipate how the ethics committee (if applicable) would view and address the problem
  - o Who the requester invites to the consultation
  - o The number of perspectives involved
- Relation to other known problems in the healthcare setting (e.g., is this a recurring theme?)
- What form of ethics support will be most effective to address the concern (e.g., Is it best addressed by a consultation about a specific case or a more general education session related to the topic but not the particular case? Is a series of consultations needed, or a single meeting?)

About the request

- Origin
- Format (e.g., email, telephone, in-person)
- Previous steps/measures taken
- Sufficiency of information provided in the request
- Persons involved/mentioned (e.g., whether the request comes from or concerns a person of power within the organization)
- Their expectations for the outcome
- Expectations of the requester (e.g., do they expect support / recommendation in a 10-minute phone call, or are they receptive to more comprehensive involvement?)

About consulting relevant parties

- Who should be consulted
  - o Whether or not to speak with the patient or consult the patient's chart
  - o Whether or not to consult the patient's significant others or SDM
  - o Whether or not to consult other members of the ethics committee/service
- How to consult interested or affected parties
  - o The safest and most effective ways of gathering information
  - o Whether an interdisciplinary consultation is appropriate
  - o Whether a videoconference consultation is appropriate
  - o Whether the tool of communication (e.g., e-mail vs. phone) used will relay the same information
  - o The best way to involve/consult another ethicist

For addressing the problem

- Alternatives and potential compromises
- Relevant legal and policy considerations to help clarify potential options
- Who is the legally or organizationally authorized decision-maker
- Possible options to address the concern and their justifications…
  - o That take into account relevant parties' perspectives and values, their strengths, and their weaknesses
  - o The most extreme, radical, or opposing options
  - o The options that best fit the facts
  - o The most ethically justifiable options
  - o Legal options and potential ethical options beyond the law
  - o Options preferred by organizational leaders (e.g., Risk, Legal, Public Affairs, Senior Management)
- Relevant cultural and religious considerations to help clarify potential options
- Processes for resolving moral problems to which the ethicist has previously been exposed
- The need to unravel certain complex interpersonal dynamics within the clinical team beforehand
- Whether the patient's level of capacity has been already assessed or should be
- Which ethical approach/method the relevant parties and/or the ethicist are most likely to resonate with

whether an interdisciplinary meeting or separate meetings are more appropriate and whether a videoconference or in-person meeting is preferable. Additional reflection may be needed to determine the most appropriate or most effective methods for gathering information (e.g., who is consulted and when, the words used by various parties, how information is shared) and who should be part of the consultation process.

For addressing the problem

Several elements can be considered to help create circumstances conducive to addressing the problem (e.g., exploring which options best fit the facts, identifying options within and at the margins of legal limits, the most extreme options, possible options within institutional structures) and their justifications to ensure a deep understanding of the problem. Assessing the need to unravel certain complex interpersonal dynamics within the clinical team or among the patient's significant others can help identify the next steps.

Actions and approaches taken to prepare for addressing the problem

Various actions and/or approaches can be deployed to prepare to address moral problems. These are not actions taken to directly deal with the problem but help to set the stage. These were divided into 4 groups of practices (see Table 6).

Receiving the request

The consultation process usually begins with the reception of a request, no matter how informal, and may involve various channels (e.g., email, phone, informal conversation, online form, invitation to consult, formal procedure, triage by administrative assistant) depending on the clinical environment, clinical ethics service procedures, and other contextual work-related factors. These various channels bring different aspects to the foreground in terms of the type of information gathered, the follow-up needed, accessibility of the request process, and the sensitivity and ease of understanding the problem. Therefore, one of the first steps for the ethicist is often receiving, reading, and interpreting the request. It is advantageous to be flexible when triaging requests, whenever possible, depending on the ethics service's mandate, and to set a low threshold for consultations (e.g., low threshold for categorizing whether a consultation involves a sufficient amount of moral content to be considered appropriate) to promote the accessibility and usability of the service.

Engaging with the requester

A second group of actions relates to engaging with the requester. Practices such as inviting the requester to describe the problem freely, asking them to summarize or clarify areas of uncertainty or confusion, and exploring various aspects of the case (needs, urgency or discomfort about the situation, perception of next steps, who is affected, who and how to consult) can help ethicists in preparing to address the problem. Clarifying the mandate of the ethicist and ethics service, particularly to avoid confusion about the role, the actions, and support that can be offered can also be helpful.

Preparing the information gathering

Preparing for information gathering can take the form of inviting relevant parties to share their perspectives and obtaining agreement or consent from those involved (patient, substitute decision-maker, if the patient is incapable, care team). Setting up a meeting to address organizational issues with those affected or interested may be relevant depending on the context. Additionally, depending on the situation, feasibility, and local norms, obtaining the patient's consent to consult their medical records may be necessary and informing physicians and managers or directors of services (for organizational ethics consults) recommended. A portion of the work done at this stage involves encouraging participation – as many do not understand the role and utility of ethics services – as well as creating a space where those who are asked to contribute feel valued (particularly by attempting to counter any hierarchical tendencies within the group).

Information gathering

This pertains to the actual act of information gathering. This can include practices such as reviewing the medical chart of a patient to identify relevant healthcare professionals involved in the case or to gain a deeper understanding of the issue. Depending on the particular situation, it can also be pertinent not to consult the medical chart in order to maintain neutrality, respect patients' privacy, and to avoid being unduly influenced by the healthcare professional's view on the situation). As for how to gather information about the problem, ethicists may choose to consult the individuals involved in the problem (i.e., the patient, the care team, the patient's significant others, the unit manager) individually or in groups. While consulting the care team as a group can be useful to gain an interdisciplinary understanding, individual meetings with some sub-set of interested parties may sometimes be more advisable as some parties may not be willing to share their perspective in group settings, especially when it involves a hierarchical workplace or complex patient dynamics. Additionally, information about the patient can be obtained via the care team rather than by meeting the patient directly when preferable or necessary. For instance, some ethicists who serve as external consultants might not have the opportunity to meet with

Table 6 Actions and approaches taken to prepare for addressing the problem

Actions and approaches taken to prepare for addressing the problem
Receiving the request
• Receiving, reading, and interpreting the request… o By telephone o By e-mail o Via an online form o Through informal conversations o Through an invitation to a consultation o Through formal consultations o Following the internal triage process • Consulting other members of the ethics service or redirecting the requester if it is not clear whether the problem falls within the mandate of the ethics service • Being flexible when triaging requests • Noting any timelines associated with the request
Engaging with the requester
• Letting the requester freely describe the problem and express their needs • Asking the requester to summarize/clarify the problem • Exploring… o Their needs and expectations o Their sense of urgency/discomfort o Their perception of the next steps o Who is affected by the problem o Who to consult as part of the process o How to consult them (e.g., contact details, consultation procedures) • Clarifying the role of the ethicist and the mandate of the ethics service
Preparing for information gathering
• Approaching/inviting relevant parties to share their perspectives o Clarifying the role of the ethicist and the mandate of the ethics service o Explaining the benefits of a consultation to encourage participation • Obtaining the agreement of the care team and the patient to meet with the patient and/or their significant others as appropriate, or proceeding without such agreement • Informing the most responsible physician and/or the relevant parties of the consultation request if possible/relevant while being as open and transparent as possible about the request for ethics support • When possible, obtaining the patient's consent to consult their medical records • Setting up a meeting with those who are affected by or interested in the problem in the context of organizational issues
Information gathering
• Reviewing the patient's medical chart to identify relevant healthcare professionals and gain a deeper understanding of the issue, or alternatively, choosing not to consult the chart to avoid being unduly influenced by what has or has not been recorded in the chart or to respect their privacy • Consulting the individuals involved in the problem (e.g., the patient, the care team, the patient's significant others, the unit manager) individually or in groups to gather information about the problem o Gathering information about the patient via the care team rather than directly from the patient when preferable or necessary o Consulting the care team as a group, if possible, to gain an interdisciplinary understanding o Consulting informally, or individually, relevant parties who may be reluctant to share their perspectives in an open meeting o Avoiding gathering information on aspects of the problem that are not essential to the ethical question or concern o Encouraging in-person (when possible and applicable) consultations to facilitate trust-building interaction with relevant parties o Adapting the consultation process to the availability and context of relevant parties • Consulting relevant departments or services within the organization to better understand other dimensions of the problem • Documenting relevant information for the patient's care journey or for the team in the patient's chart, in an email, or in the form of a report

the patients, or some might fear that doing so may harm the trust-based relationship with the care team. Moreover, in consulting relevant parties, there is often great value in in-person one-on-one interactions, a willingness to adapt to the relevant party's needs, and in avoiding non-pertinent information to maintain privacy. Another identified practice is consulting relevant departments to further a more holistic understanding of the situation.

Modulating Factors

There are several factors that have an impact on the process of understanding moral problems. They vary in scope and specificity, ranging from problem-specific factors to more systemic considerations, such as various aspects of wider organization that shape information-gathering efforts (see Table 7).

Problem-specific

Although moral problems superficially can appear to be similar, they all have their particularities. The large variability of the problems that are reported to ethics services, their uniqueness, and the time required to respond to them, may influence the practices used by ethicists to understand them, including the people met, the number of consultations required, and the linearity of the process. In addition, there needs to be a balance between the specificity of the situation (is there a morally relevant difference in this case that would justify different treatment?) with considerations of fairness (would I do this for another patient/have I done this before for another patient?).

Ethicist-specific

Factors related to ethicists themselves, i.e., their educational backgrounds and professional training, their previous experiences in the field, their interests and values, their ability to access support from colleagues, their positionality, their skills, and the differences in interpretation of divergent norms may influence the practices used by ethicists to understand moral problems. These factors contribute to the particular methods chosen to aid in understanding, the problems that will be perceived as complex, the level of attention required to understand the problem, the speed and ease of understanding certain problems (especially when the problems are nuanced and complex), and more.

Requester-specific

Factors related to the requester, such as their positionality, their expectations of the process and outcomes and how much time and interest they have in engaging with the ethics service can also influence the practices used by ethicists to understand moral problems.

Table 7 Modulating factors

Modulating factors
Problem-specific
• The large variability of the problems that are reported
• The uniqueness of each problem
• Time required to respond
➢ Those factors influence notably the people met, the number of consultations, and the linearity of the process
Ethicist-specific
• Education and training
• Previous experience as an ethicist and/or healthcare professional
• Interests
• Values
• Ability to access support and experience from colleagues either within the organization or through communities of practice, etc.
• Positionality
• Differences about interpretations of divergent norms
➢ Those factors influence the methods chosen to understand moral problems, the problems that will be perceived as complex, the level of attention to certain elements of the problem, the amount of information gathered to understand the problem, and the speed/ease of understanding the nuance/complexity of certain problems
Requester-specific
• Their expectations
• How much time/interest they have in engaging with the ethics service (e.g., do they want a recommendation after a 20-minute phone call)
Organization specific
• The availability of administrative support in the triage of requests
• The degree of freedom permitted in the use of ethics methods/approaches
• The mandate of the ethics department and the organization, and how much control the ethicist has over the mandate of the service
• Power dynamics within the ethics service and organization, notably relationships of mutual trust and respect between the ethics service and the organization and/or its leadership
• Structure, policies and location of the organization
• Differences between organizational policy and any applicable professional standards
➢ Those factors influence the types of problems reported and dealt with by the ethics service, the types of methods chosen to understand moral problems, and the people consulted

Organization-specific

Factors related to the organization itself can also influence the practices used by ethicists to understand moral problems and how they will be addressed. For instance, some ethics services have an administrative assistant capable of triaging requests, which can influence next steps. Additionally, the mandate and priorities of the ethics service can undermine the degree of freedom ethicists have in choosing specific consultation methods. Moreover, power dynamics and relationships between the ethics service and the organization/leadership, the structure, policies, and location of the organization, as well as differences between organizational policies and any applicable professionnal standards may influence the types of problems reported and dealt with by the ethics service, as well as the people consulted.

Challenges and limits

A sizable portion of ethicists' work related to understanding cases involves dealing with the challenges and limitations that can influence this task. These are separated into 4 sections below (see Table 8).

Information gathering challenges

Information gathering challenges can undermine the process of understanding moral problems. For instance, there can be insufficient information on requests (e.g., in the intake form or initial email) or partial information leading to misunderstanding of the problem. Additionally, back and forth communication through emails, and limited time can hinder the process of gathering information. Relatedly, the hybrid nature of healthcare, particularly working from home, can determine the possible and preferred methods of gathering information. Repetition of the same piece of information by the same or different relevant parties can also lead to a false sense of understanding by the ethicist and/or relevant parties. Moreover, issues of consent about sharing or discussing patient's personal health information can restrict information gathering and complicate understanding. Therefore, due to the complexity and extent of some problems, a significant challenge can be collecting the *right* information amongst a mass of less relevant information.

Epistemological challenges

Other challenges relate directly to the process of understanding. For instance, discerning the organizational dimension of moral problems, which are often less visible or tangible, can be difficult when such dimensions are relevant to the situation. In that same vein, the lack of access to the patient (or their representative) and power dynamics between them and the care team (as well as the dynamics within the care team) can hinder, even obscure, the ability to gather and understand the patient's perspective. The clinical dimension of a situation, and/or the legal formulations used to describe it, can distract the relevant parties from appreciating the moral dimension of the problem. Similarly, pinpointing the moral nature of the problem, especially when intimately linked to context, and categorizing the moral problems with sufficient objectivity (e.g., in complex problems which typically involve several actors) can be difficult as this may be a reflection of the ethicist's experience or perspective more than the problem itself. Finally, an ethicist's prior experience with similar cases can result in over- or under- confidence in their understanding of the situation, focusing on the similarities rather than the differences. Additionally, the requester (in most cases a member of the care team) may impose restrictions on the kind of help or advice they want and the format and modalities of the consultation (e.g., limiting the interaction to curbside consultations), thereby limiting the ethicist's ability to achieve a holistic understanding of the situation.

Relational challenges

Relational challenges can also undermine the process of understanding moral problems. For instance, relevant parties can have a limited grasp of the ethics service, the kind of support it offers, and the nature of an ethics consultation which may lead to difficulty in maintaining confidence in the consultation process. Moreover, sometimes patients' SDMs or significant others may mistrust the healthcare system and the ethics process. Similarly, relevant parties (i.e., the patient, their significant others, or the care team) do not always recognize the existence of a moral problem, may refuse to be engaged, or will allocate too little time for the consultations to be fruitful. Another recurrent issue is when the healthcare team is not in favor of the ethicist meeting directly with patients. Additionally, maintaining the role of mediator can pose challenges when trying to validate the perspectives of different relevant parties. Sustaining a good collaboration with the legal team can be tricky due to possible tensions between the recommendations of the legal service and the ethics service. Finally, when an issue arises with people in positions of power in the organization (e.g., senior leaders or institutional officials), more time, caution, and sensitivity is required to gain trust and access to people and information. Power dynamics and political realities within an institution can cause an ethicist to have to "play the game" to pursue a favorable outcome, potentially distorting and influencing any related interaction and comprehension.

Structural limitations

Structural challenges can also undermine the process of understanding moral problems. For instance, there is an

Table 8 Challenges and limits

Challenges and limits	
Information gathering challenges	
• Insufficient information in requests, making it difficult to fully understand the problem • E-mail exchanges can slow down information gathering, leading to frequent back and forth with relevant parties • Limited time to gather all necessary information before meeting relevant parties • Repetition of information can give a false impression of full understanding • Time and availability constraints make it difficult to organize meetings with all relevant parties	• Potentially infinite amount of information to collect on the problem • Hybrid nature of the healthcare environment – e.g., people working from home with computers and cell phones, people on site, impacts types of information gathering that are possible or preferred • The patient or their substitute decision-maker consent or refusal of consent to discuss personal health information impacts who is involved
Epistemological challenges	
• Difficulty in discerning the organizational dimension of moral problems • Complexity of taking into account the patient's perspective and power issues with the care team, especially when the ethicist does not meet the patient directly • Coded language can obscure and hinder understanding of moral problems • Difficulty in pinpointing the moral nature of the problem, especially when it is intimately linked to the context • Legal formulations of problems can restrict moral understanding by focusing solely on legal aspects	• The clinical dimension of the problem often distracts relevant parties from the moral nature of the problem • Difficulty in objectively categorizing moral problems (e.g., "complex problems") • The ethicist's previous experiences can lead to over-confidence or a lack of confidence in understanding problems • Less holistic understanding of the problem when requests take the form of informal consultations and when the need is to help people move forward • The requester's choices may limit the possibility of meeting other relevant parties in order to obtain a complete understanding of the problem
Relational challenges	
• Relevant parties do not always appreciate the relevance of the process of understanding • Difficulty interacting directly with patients, especially when the healthcare team is not amenable to this approach • Clinicians do not always attend ethics consultations, or sometimes allocate too little time for them • Difficulty in consulting patient's significant others, who may be mistrustful of the healthcare system and of the ethics process • Challenge of validating the perspectives of all relevant parties while acting as a mediator • Challenge of maintaining the dynamics of the ethics consultation when many relevant parties are involved • Time and care are required to gain trust and interact with people in positions of power from the organization	• Relevant parties do not always wish to involve the ethicist/ethics committee in the consultation process • Difficulty in maintaining commitment from all relevant parties throughout the process • Clinicians do not always recognize the existence of an moral problem, or sometimes refuse to be consulted • Maintaining a good collaboration with the legal team is sometimes tricky due to possible tensions between the recommendations of the legal counsel service and those of the ethics service • Differing views on the respect of privacy • Potential conflicts of interest for the ethicist such as maintaining good relationships with the care team vs. taking an approach others might dislike • Power dynamics and institutional politics may distort or influence the nature of engagement • Family members may not want the clinical team to be informed of their concern(s)
Structural limitations	
• Risk of unduly restricting what counts as a moral problem and what does not • The mandate of the ethics service is often limited to understanding specific problems, without the possibility of fully engaging with the clinical situation as a whole • The small size of ethicists' teams/professional community limits their ability to validate their understanding of moral problems with each other • Ethicists serving a large geographical area remotely can be hindered in grasping the problem and the process of understanding	• The legislation restricts who is considered an interested/affected party • The mandate of the ethics service does not include enforcement/compliance/professional practice • Time constraints and pressures can be a barrier to good processes and outcomes • Financial barriers to more ethically defensible outcomes are also common (e.g., discharge destinations may be suboptimal, rehabilitation care in community may be too costly, medications or home care may be unaffordable to many patients)

inherent risk of unduly restricting what counts and what does not count as a moral problem. The mandate of the ethics service can thus limit it to understanding only the specific problem for which it is consulted, obfuscating the broader context of the situation that influenced the problem. In some cases, the small size of ethics teams (as well as the ethicist professional community) that serve a large geographical area remotely can hinder the ability to validate understanding with one another, and the process of holistic understanding. In terms of the broader structure, policies and laws can restrict who can be considered an affected party and the mandate of ethics services does not include jurisdiction over standards of professional practice and rarely gives them the ability to provide binding recommendations. Similarly, time constraints and pressures can present obstacles to good practices, processes, and outcomes. Finally, there can be financial barriers which limit the enactment of the most ethically defensible outcomes, such as cost of rehabilitation or homecare.

Discussion

Understanding clinical ethics situations in depth and in ways that pay heed to the multifaceted nature of these situations is a crucial first step in clinical ethics consultation processes [1]. However, despite statements about its importance and its central place in some influential theories and methods (e.g., casuistry) [7], there is still a gap between the concrete practices clinical ethicists use to understand moral problems and the specification of various methods [13]. To help fill this gap, build community around sharing, and, eventually, improve practices, we assembled a group of Canadian clinical ethicists to survey the practices they employ to undertake this task. Inspired by pragmatism [11, 20, 21] and deliberative wisdom theory [4], this was done following a participatory and co-creative process where clinical ethicists acted as co-researchers and co-creators of a repertoire of practices. This process – based on various methods (e.g., semi-structured interviews, working group meetings, participatory writing) – allowed for the identification of practices used to understand moral problems and allowed us to structure them in ways that attend to the realities of the terrain and of the multifaceted work of clinical ethicists. As an outcome, research results documenting practices for understanding problems were generated, as well as a practical companion English/French repertoire of practices (see online material). This repertoire offers an accessible format for practical uses (e.g., consultation by individual clinical ethicists and ethics services, and training and knowledge sharing use). Here we comment on the strengths and limitations of these results and outcomes while keeping in mind existing complementary literature. We focus on discussing the strengths and weaknesses of the process of co-development rather than the specifics of proposed practices since these are not proposed as binding practices; they are meant to be adopted by individual ethicists in accordance with their professional judgment and obligations.

The value of participatory co-creative research on clinical ethics practices

This project followed a participatory co-creative process where insights from a broad and diverse group of clinical ethicists were successfully collected and mobilized [22]. Although a repertoire could have been generated through other methods (e.g., by a survey of individual clinical ethicists, ethics services, or an expert group mandated by a professional society) and may have yielded similar benefits in terms of filling a knowledge gap, the participatory nature of this process proved valuable in many respects. Engaging colleagues as co-researchers in the research process allowed to open up the study because we challenged one another to reflect on our practices and their significance as we engaged in both description and dialogue. For example, members of the group not only offered the information or data that research participants could provide, but they also shared holistic user perspectives on how the knowledge generated and assembled in the repertoire can be used. For instance, the early iterations of the repertoire were not satisfactory, and the involvement of a large group helped in structuring and analyzing the material in ways that brought the repertoire closer to clinical ethics practice. Thus, the participatory process allowed for iteration and maturation in a way that a survey or one-time discussion, even with validation of transcripts, would not. It also provided the opportunity to iterate one's own contribution over time (to provide more depth or nuance in light of further reflection) notably considering others' contributions.

In addition to increasing usability, which is a known benefit of participatory research [36], the ongoing discussions and collaborative work constituted a learning and knowledge exchange process via which those involved are exposed to new information on practices as well as discussions about their limitations. This work helps build capacity and engagement of clinical ethicists in research. The term "multi-scope" could describe the repertoire and the process of generating such a tool because it offered participants opportunities to see clinical ethics consultation practices through the eyes of colleagues. By approaching the practice from multiple vantage points, the group was able to access extensive views of the practice which helped to identify overlooked aspects. This kind of awareness and broadening of horizons prompts critical reflection that can help participants better justify what they do. The sense of community being built while working together on the pooling of knowledge and insights also

had another benefit, i.e., to help everyone become more motivated to use and share the repertoire to improve practices and experiment with new ways of doing things. This readily lends itself to subsequent steps in the broader project within which this repertoire is embedded.

Beyond the study itself – since occasions are rare for groups of ethicists to work together via interinstitutional collaborations – this work paves the way for greater consolidation of work relationships between colleagues across the Canadian clinical ethics community and it reflects one of the main strengths of participatory research [23]. The study allowed for the learning of diverse processes and practices occurring in various jurisdictions and clinical settings as well as the reflective processes taking place. In sum, our experience confirms some of the key strengths attributed to participatory research in the specific context of clinical ethics; that is, it can foster the development of knowledge and tools which are better adapted to work practices [22, 37]. Our experience encourages greater attention to the use of participatory and co-creative methodologies and methods in clinical ethics and bioethics, fields that have much to learn from other domains that have already made headway in this direction [20, 38].

The limitations of participatory co-creative research on clinical ethics practices

Participatory and co-creative work is generally recognized as time consuming and methodologically challenging since it requires much empirical ethics work in addition to creating and maintaining room for participation and changes throughout the research process [38, 39]. Furthermore, participation is an aspiration which helps drive research but is also rarely, if ever, fully achievable because of various practical constraints such as research resources, availability of people involved, etc. In fact, participatory co-creation is partly a methodological aspiration and should perhaps be recognized as such to avoid undue criticisms focused on outcomes since the progress made in breaking down barriers is perhaps a more meaningful measure of success than what participation accomplishes. More specifically, with respect to the development of a repertoire of practices, the work undertaken has important limitations which are worth naming and reflecting on. For example, given the collegial and collaborative pooling of practices, the repertoire is descriptive rather than evaluative or normative. In line with the pragmatist philosophy guiding the project, the mind frame guiding the development of the repertoire was to remain open to various styles of clinical ethics practice and to the relative usefulness of practices in different contexts [21, 40]. An impetus to standardize practices would be contrary to this goal given the many obstacles to standardizing practices across various contexts of practices and situations which – even if handled by the same clinical ethicists – could eventually be dealt with differently based on the nature of the situation at hand. For example, consider the simple practice of "Obtaining the agreement of the care team and the patient to meet with the patient and/or their significant others as appropriate, or proceeding without such agreement" (Table 6) as an expected or standard practice. As some participants noted, the choice not to obtain the agreement of the patient so might be defensible if: (1) a clinical team needed an opportunity to discuss their ethical struggles with the situation rather than an occasion for making a decision that affects the course of a patient's treatment, and (2) it would be unlikely that the patient/SDM would find out about the consult, and (3) it would likely harm an already-strained relationship between the patient/SDM and the care team if the patient/SDM were informed about the consult, and (4) the case were to be discussed without including identifying information or a chart review of a particular patient. These are illustrative reasons, they are not exhaustive or prescriptive.

To assess the relevance of the practice of informing the patient/SDM and seeking their agreement, a clinical ethicist needs to understand why the practice is chosen and if it is appropriate, given the particulars of the situation. If, for example, the patient/SDM was not informed because the ethicist simply did not think they needed to know, or because of a culture of secrecy within the organization, then we might find the choice of that practice problematic. Accordingly, to provide room for professional judgment and contextual sensitivity, there is no single or unified philosophy guiding the use of the repertoire. It is not a normative or binding tool, but a repository of relevant and meaningful practices from which individuals can pull from. This was purposefully done to avoid discussing some of the deeper philosophical commitments that guide each individual clinical ethicist and on which agreement would likely be difficult and unproductive to pursue. The subsequent testing of the repertoire will also reflect this open stance with respect to underlying philosophical commitments and clinical ethics approaches and theories. Relatedly, the practices included in the repertoire have not been evaluated or tested. However, the group agreed that anyone strongly disagreeing with a given practice could present arguments to veto a given practice.

This repertoire was derived from interviews and consultations on the practices of 22 ethicists working across the various provinces in Canada. Although this is a sizeable group given the relatively small number of practicing ethicists in Canada, the repertoire cannot be considered final and is not meant to be an exhaustive set of practices, nor does it portray the nuances of how others across Canada might practice. The recognition of this incompleteness and fallibility is consistent with

pragmatism [21]. Likewise, the repertoire does not provide detailed procedural instructions since the testing of the repertoire, and the development of such strategies is the object of further participatory work. Participating co-researchers will be supported in developing their own action plans to put into practice this repertoire. This flexible and open-ended approach is grounded in the nature of a participatory and co-creative methodology as well as pragmatist theory underlying this project (see Supplementary online material 1) which both emphasize the contextual sensitivity of professional practices. Accordingly, forthcoming research will delve deeper into enactment procedures. However, this will be done in a way that supports the professional autonomy of clinical ethicists and their judgment in determining what works and why in their own practice setting. We hope that this collegial and open-ended approach will deliver results that show the strengths of working on professional development from a bottom-up and collaborative approach. Our desire to make the repertoire adaptable and a usable tool (in addition to the ethical rationale of the open science movement) led us to offer a free open-source form of the repertoire for further adaptation, modification, and use [41]. Finally, our work and larger discussions also made us aware that the visual presentation of the repertoire with the use of geometric shapes, boxes, line may induce a sense of simplicity ("Cartesianism"), possible rigidity and analytic clarity which does not correspond to real-world practice. Nonetheless, we maintain that identifying practices, and various aspects of the tasks involved in understanding cases, can serve as a steppingstone for improving practices despite the fact that practices tied to contexts are more fluid than what a repertoire could fully convey and portray.

Conclusion

Understanding moral problems is a key aspect of, and motivation for, clinical ethics consultation and is identified as such in several influential clinical ethics methods such as casuistry and clinical pragmatism [7, 10]. However, this crucial component remains rather vaguely described without details on more precise practices at stake. As a collective of collaborating researchers and clinical ethicists, we pulled from our experience to identify current practices and structure them into a repertoire which can be used to teach clinical ethics practice and be consulted by practicing clinical ethicists. It is also shared in a format which allows users to borrow freely from and edit the repertoire so that it can be a living and working document for groups and individuals. Future work of this collaborative group will involve trialing the repertoire prospectively and tackling other significant aspects of clinical ethics consultation processes to further specify and understand them.

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

Supplementary Material 3.

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Authors' contributions

ER, G S-B, and BD made substantial contributions to the conception of the work; G S-B, BD, IF, and ER made substantial contributions to the acquisition and analysis of the data; ER, IF, G S-B, and BD made substantial contributions to the draft manuscript; all other co-authors made contributions to the acquisition to the data, the interpretation of the data, and revised the manuscript.

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Data availability

We do not have research ethics permission to share the data (the transcripts of the interviews and meetings) which could easily identify participants. Any concerns regarding this matter can be formulated to Dr. Eric Racine, eric.racine@ircm.qc.ca.

Declarations

Ethics approval and consent to participate

The study was approved by the Research Ethics committee of the Institut de recherches cliniques de Montréal [approval number 2023 – 1217]. All participants gave informed consent prior to data collection. The project was carried out in compliance with the Helsinki Declaration and other applicable Canadian regulations and research ethics guidelines.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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