Morisprudence: a theoretical framework for studying the relationship linking moral case deliberation, organisational learning and quality improvement

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ABSTRACT

There is a claim that clinical ethics support services (CESS) improve healthcare quality within healthcare organisations. However, there is lack of strong evidence supporting this claim. Rather, the current focus is on the quality of CESS themselves or on individual learning outcomes. In response, this article proposes a theoretical framework leading to empirical hypotheses that describe the relationship between a specific type of CESS, moral case deliberation and the quality of care at the organisational level. We combine insights from the literature on CESS, organisational learning and quality improvement and argue that moral case deliberation causes healthcare professionals to acquire practical wisdom. At the organisational level, where improving quality is a continuous and collective endeavour, this practical wisdom can be aggregated into morisprudence, which is an ongoing formulation of moral judgements across cases encountered within the organisation. Focusing on the development of morisprudence enables refined scrutinisation of CESS-related quality claims.

INTRODUCTION

Within the literature on clinical ethics support services (CESS), it is increasingly fashionable to advance a *quality claim* that CESS are vehicles for healthcare organisations to improve quality. This quality claim is attached to a range of CESS approaches, such as moral case deliberation, clinical ethics committees and clinical ethics consultation.[1–10] Providing evidence for the quality claim is important because the potential for quality improvement provides a solid legitimacy for healthcare organisations to invest time and effort in forms of CESS.[11–13]

Our initial position is that this quality claim, while not necessarily false, is based on thin evidence. One of the principles of quality improvement is to focus on healthcare provision at the organisational rather than the individual level. The goal of quality improvement is to raise the entire healthcare quality curve within the organisation.[14 15] CESS evaluation research has, however, mainly focused on the quality of CESS provision itself,[9 15–18] the quality improvement in a single case where CESS were provided,[16] or on individual outcome variables rather than organisational outcomes.[5 9 12 19–25] Admittedly, these research endeavours have led to theoretical rationales for how CESS benefit individual learning and how they provide quality in *single-patient cases*. However, the subsequent step by which CESS lead from individual learning to healthcare quality improvement at the level of a collective of healthcare professionals and potentially healthcare organisations remains undertheorised. This is problematic if researchers, practitioners and healthcare managers want to evaluate the claim that CESS increase the capacity of an organisation to deliver quality across the board—across cases. This gap stands in the way of much-needed methodological rigour through which quality claims may be scrutinised and also impedes theoretical progress within the field.

In order to narrow our scope, we focus on the potential of one specific type of CESS—moral case deliberation—as a means to instigate quality improvement. Moral case deliberation involves a joint reflection by healthcare professionals on a moral question from their practice. Professionals reflect on and reach a decision about an ethical issue themselves instead of putting a case before a fixed clinical ethics committee. The deliberation is, however, facilitated by a trained ethicist who will structure the moral reasoning during the deliberation using a conversational method that distinguishes steps within the deliberation, such as clarifying the moral issue, laying bare the facts of the case, arguing for or against possible actions, and reaching a conclusion.[26] The ethicist also attempts to ensure that, during moral case deliberation, all participants are treated as equals and have the opportunity to participate.

The current article aimed to advance a theoretical framework that provides empirically assessible hypotheses that describe the relationship between moral case deliberation and care quality at the organisational level, by which we mean a group of healthcare professionals who coordinate quality care provision within a healthcare department, such as an intensive care unit (ICU). The main question of this study is whether and, if so, how moral case deliberation leads to organisational learning and, subsequently, quality improvement. We attempt to answer this question by integrating insights from the literature on quality improvement and organisational learning into the CESS evaluation literature while building on a basic theoretical model (figure 1). This is a novel approach since there has so far been only a limited exchange between these fields of study.[27]

This article next explains how studying quality improvement at the organisational level differs from studying quality provision as an activity of

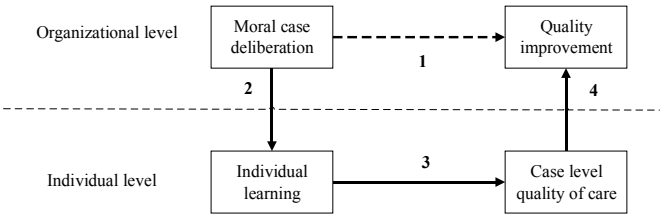

Figure 1 Conceptual model describing quality improvement, achieved through moral case deliberation, and the relationship between organisational learning and individual learning.

individual healthcare professionals in single cases. Following this and accepting that organisational learning depends on the subprocess of individual learning,[28 29] we discuss what *individual* healthcare professionals learn from moral case deliberation. Figure 1 represents the overall process. It shows that the claimed relationship, that CESS are vehicles for healthcare organisations to improve quality generally accepted ('1', the dotted arrow), actually works through mechanisms '2', '3' and '4'. We then address the main question: how does this aggregate at the organisational level?

QUALITY IMPROVEMENT AT THE ORGANISATIONAL LEVEL

Healthcare professionals may seek moral case deliberation when they are faced with moral problems in individual patient cases to which there is no obvious best moral response, that is, where various values and considerations are at stake.[10 20 26 30] The question of what quality of care actually is in such cases often, either explicitly or implicitly, underlies these moral problems. As such, what is generally required is a moral judgement about what generates the best quality for a patient in a particular situation. Moral case deliberation is intended to arrive at such a moral judgement by giving structure to the moral reasoning process. It is in this sense that moral case deliberation may be seen as an 'intervention' aimed at improving the quality of care in single cases. We will return to the issue of how to define the quality of care within this process later.

As we have already noted, the current literature is mostly preoccupied with single cases where CESS led to improved quality[17] or with the effect of CESS on the behaviour of individual healthcare professionals.[20 21] As such, these studies address mechanisms 2 and 3 in figure 1. From an organisational perspective, these mechanisms are subprocesses of organisational learning. However, to infer quality at the organisational level, we need to focus on mechanism 4, where these subprocesses contribute to organisational learning and quality improvement at the multiple-patient level.

At the organisational level, improving the quality of care is not, in the first place, about improving the care quality for a single patient at a single moment. Quality improvement at this level is the combined, and continuously ongoing, efforts of everyone involved in the care process to make changes that will lead to better patient outcomes.[31 32] Active engagement of professionals is widely seen as a prerequisite for quality improvement in an organisational setting.[32] The quality improvement literature describes three features that need to be taken into account when studying the effect of possible quality enhancers (such as moral case deliberation) on quality itself: probability, continuousness and collectiveness.

Probability

Within quality improvement, quality initiatives are assumed to only contribute to the *probability* that care will become better.[14] For instance, within moral case deliberation, healthcare professionals often address a single, morally complex patient case. While moral case deliberation may lead to healthcare professionals providing better service quality in one case, it may not do so in other cases: sometimes the effect is substantiated, while at other times (for all sorts of reasons) there is either no effect or the quality improved but due to other factors than moral case deliberation. As such, there is an epistemological *problem of attribution* when studying quality improvement: the relationship between a quality improvement initiative and the resultant quality is not perfectly known. One cannot be certain that a given set of processes resulted in one or more specified outcomes.[14] This means that there is a risk of superstitious learning, whereby an organisation (or individuals within the organisation) falsely connects the quality improvement effort to an increase in quality.[33] The same risk is present in studies of the relationship between moral case deliberation and quality improvement. Moral case deliberation can be about 'extreme' cases where the odds of quality improvement are either extremely high or extremely low. The threshold of case deliberations needed for organisational learning may thus be very low, depending on the case at hand and how it relates to other morally challenging cases encountered within the organisation.[34] It is also possible that one encounters deviant cases where all the beneficial circumstances for learning effects were in place but none of the expected effects resulted, or vice versa, learning occurred but was completely unexpected. As such, inferring quality claims on the basis of a *single case* of moral case deliberation is naïve, given the risk of overestimating or underestimating the effect of moral case deliberation on quality. What is needed, methodologically, is a cross-case design that compares multiple cases of moral case deliberation within the same organisation.

Continuousness

For organisations, quality improvement is a continuous effort which should involve constant evaluation and adjustment of healthcare activities, policies, protocols, etc.[35–37] Improvements usually follow from cyclically revising care processes on the basis of information that these processes themselves produce such as through plan–do–study–act cycles.[35] The continuous character of organisational learning contrasts with learning that is more ephemeral, where learning effects are temporary. From an organisational perspective, ephemeral learning is especially ineffective when important knowledge, insights or skills are not retained at the organisational level and have to be constantly relearned. Moral case deliberation practices could be an example of this phenomenon since empirical studies have shown that healthcare professionals report improved insight and greater awareness of ethically difficult situations during moral case deliberation, but also that they did not experience such changes in their later daily work.[13 20] This suggests that moral case deliberation may only lead to a peak in the quality of care provision for a single patient and that care reverts to prepeak levels once the moral issue in the specific case has been addressed. Across somewhat similar cases (ie, a homogeneous set of cases, as discussed later), this would amount to a loss of learning effects. Figure 2 depicts this theoretical idea graphically, where each moral case deliberation *n* leads to a peak in quality during or immediately after the deliberation, but the quality of care then reverts to predeliberation levels. Research has supported the hypothesis that, in general, increasing the time between iterations of an activity will

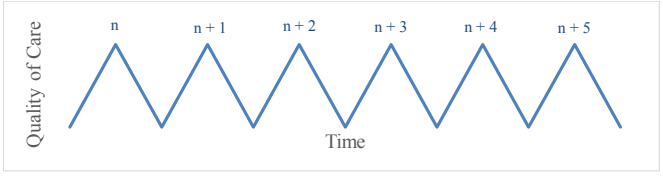

Figure 2 Simple graphical depiction of ephemeral learning.

be associated with loss of learning effects.[38] In our own ICU, we therefore attempt to organise moral case deliberation once per month.

Collectiveness

An inherent aspect of organisational learning is its collective character, by which we mean that it is a social process which benefits the group's performance.[28 39 40] This does not mean, however, that organisational learning should be conceived of as a single process performed by the entire organisation in a uniform fashion.[40] Quality improvement efforts are initiated or performed by groups of individuals. With moral case deliberation, organisational learning may happen through, as Lipshitz and Popper have described it, 'an assemblage of loosely coupled sub-processes in which different organisational units […] engage in different fashions and at different levels of intensity'.[40] Participants in a single moral case deliberation are often a small subset of all healthcare professionals within an organisation. In our ICU, moral case deliberations on average involve 10–20 healthcare professionals out of a population of over 300. If a moral case deliberation involves a unique subset of healthcare professionals each time, and if the conclusions of the deliberation are not dispersed throughout the organisation, the effect on quality will reflect figure 2. Additionally, there are healthcare professionals that are not, or to a lesser degree, interested in participating in moral case deliberation. Moreover, a substantial amount of healthcare professionals, such as residents, flow in and out of the workplace. While organisational learning does not depend on the special knowledge or unique characteristics of specific individuals,[40] there has to be at least some subset of actively engaged individuals to address the moral problems in their work together.[32] Additionally, these individuals need to be given the chance to improve practice through moral case deliberation, for if a few actively engaged individuals have hardly any impact on the organisational level at all, this may also lead to frustration and moral distress.[26]

With the inflow and outflow of healthcare professionals in hospital departments, and thus a constant flux of knowledge and insights, to provide constant quality, let alone increase the provided quality over time, organisations need an 'organisational memory'. The knowledge, insights or skills acquired during subprocesses of quality improvement (of which a single moral case deliberation is an example) should be transferred and become embedded in the workplace culture, in collective repositories or in organisational protocols.[33–35 37 41]

Implications for studying quality improvements through moral case deliberation

These features require that we view each single moral case deliberation as a subprocess of a larger, continuous learning process when studying quality improvement at the organisational level. Further, we need to acknowledge that, in some instances, moral case deliberations can have a large impact on organisational learning, while in other instances, there is little impact.

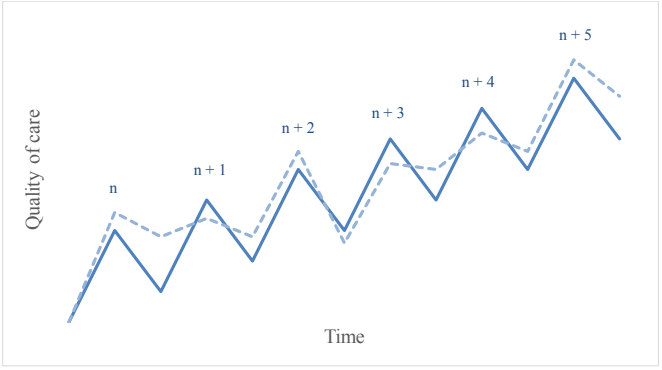

Figure 3 Graphical depiction of the effect of organisational learning, through moral case deliberation, on quality of care.

We theorise that if moral case deliberation is to lead to higher quality care at the organisational level, we should be looking for a process that creates the pattern depicted graphically by the solid line in figure 3. This shape reflects the probable, continuous and collective character of organisational learning. The line represents the quality of care within an organisation. Each *n* represents an instance of moral case deliberation. The overall upward trend indicates that, somehow, knowledge or insights about quality of care are retained and carried over from one moral case deliberation to the next. The peaks and troughs reflect that, after each moral case deliberation, some knowledge or insights may be lost, for instance, because it flows out of the organisation as a consequence of personnel turnover or because knowledge and insights are not efficiently or effectively dispersed. Peaks and troughs can vary in magnitude (as reflected in the example depicted by the broken line). This illustrates probableness: moral case deliberation does not invariably lead to the same quality outcomes. Where possible, studies that wish to assess quality should therefore analyse the entire upward process, not just the subprocesses at each *n*. Studying single deliberations, such as at $n+1$, risks concluding that moral case deliberations have no effect on quality (since there is no increase from *n* to $n+1$ on the broken line), while studying cases such as at $n+2$ may erroneously lead to an overestimation of quality effects (due to the sharp increase from $n+1$ to $n+2$). To avoid such errors, a theoretical framework is required that can analyse how a series of moral case deliberations can get us from the quality level at *n* to that at $n+5$.

We have now outlined the general nature of the process for which we want to develop a theoretical framework. However, we have also noted several important notions that still need to be addressed. First, we have yet to define what takes place in the subprocesses of organisational learning at each *n* in figure 3. We therefore now need to address the question as to in *what way* a single moral case deliberation may cause a quality improvement.

MORAL CASE DELIBERATION AND QUALITY OF CARE

What is the mechanism through which moral case deliberation can increase the likelihood of a quality improvement? To answer this question, we need to first address the issue of what quality of care actually means. There are two general approaches to understanding quality of care. The first equates quality of care with a set of relatively focused outcome metrics, such as the 'effectiveness', 'safety', 'timeliness' or 'people-centredness' of healthcare.[42] This approach views quality as a measurable property. For instance, operationalisations of the metrics effectiveness or

safety of healthcare include, respectively, 30-day readmission rates or adverse event rates.[43]

The value and validity of many of these quality metrics have recently been questioned.[44 45] They have been deemed reductionist, and many of the measures are seen as partial indicators of quality at best.[46 47] This criticism has inspired a second approach to studying quality of care. We can label the proponents of this approach 'quality pluralists'. They argue that 'quality' varies according to the context and the perspectives of the people involved. Quality provision is thus pluralistic and dynamic: what is 'good' quality fluctuates across cases.[47] For instance, the degree to which effectiveness of care is a sign of good quality depends on the context. At the same time, it is not always possible to simultaneously realise all quality outcomes in a single case. This implies that, sometimes, one has to forgo one value (eg, 'person-centredness') to realise another (eg, safety).

This quality pluralism approach seems useful when considering the relationship between moral case deliberation and quality improvement. After all, as mentioned earlier, healthcare professionals often request a moral case deliberation where it is unclear or even disputed what the quality of care is under given circumstances. However, if we adopt the idea of quality pluralism, we are faced with a problem when studying any intervention aimed at quality improvement since 'improvement' presumes some sort of growth along a variable of interest. The upward slope in figure 3 reflects this notion. For instance, a quality improvement may assume that healthcare provision can be made 'safer'. One can implement a safety intervention and assess whether postintervention healthcare is safer than it was before the intervention.

However, according to the quality pluralists, optimising the quality of care in morally complex cases requires different responses by professionals in each new case. This requires a sophisticated degree of moral reasoning in which healthcare professionals are finely attuned to the facts and contexts of each morally complex case. The quality pluralists argue, after all, that to achieve quality care, healthcare professionals constantly need to respond to new situations in ways that benefit the specifics of the patient case, sometimes prioritising one value and sometimes another. This creates problems of case comparability. If each new case of quality provision requires a different response, and we have no uniform measure of quality, how can we decisively say that there has been an improvement—that, as a result of moral case deliberation, quality has improved across apparently non-comparable cases? It seems that quality pluralism does not fit well with the assumptions behind figure 3.

MORAL CASE DELIBERATION AND INDIVIDUAL LEARNING: PRACTICAL WISDOM

This mismatch between figure 3 and quality pluralism can be addressed by focusing on what individual healthcare professionals who participate in moral case deliberations *learn*. Moral case deliberation has been credited with helping healthcare professionals grasp the range of meanings that quality of care can have within a single case.[10 20 26 30] If each new moral problem requires different responses from healthcare professionals in order to optimise the quality of care, then they need skills that help them determine the best response in any unique and morally complex case that arises in practice. What is needed is, first, a keen awareness of similarities and differences between cases, the varying contexts and the perspectives involved, and, second, a way of knowing how to act in these contexts. This keen awareness, together with the capacity for knowing what to do in new circumstances, has been labelled *clinical judgement* in medicine and *practical wisdom* in (neo-)Aristotelian ethics.[48 49]

Formally, clinical judgement is defined as the application of knowledge of evidence-based medicine—understood within the framework of a physician's previous experiences with similar patient cases—to novel patient cases with new circumstances in clinical practice.[48 49] It mainly manifests itself at the process level of healthcare, during activities such as diagnosis and prognosis, treatment decision making and in the provision of care. It is often seen as a manifestation of practical wisdom in the narrow sense: it is practical wisdom applied to the realm of medicine. Pellegrino has defined practical wisdom broadly as 'the capacity for deliberation, judgement and discernment in difficult moral situations'.[50] Schwartz and Sharpe define it as 'the ability to perceive the situation, to have the appropriate feelings or desires about it, to deliberate about what was appropriate in these circumstances, and to act'.[51]

Within ethics, the casuists argue that our moral reasoning is a function of practical wisdom. Casuistry is a strand of ethics that argues that, when confronted with a morally complex case, we base our response on our experience with previous, more or less similar, morally complex cases.[52–54] This happens, initially, through recognition of certain paradigmatic features of a previous case in a new case. For instance, when ICU physicians are confronted with the question of whether to continue treatment of a critically ill patient, there are several paradigmatic considerations on which to base any moral judgement in such cases: what quality of life is acceptable to the patient? what quality of life can the patient be expected to enjoy after receiving the treatment? what is the chance that the treatment is effective? what are the benefits of the treatment and what harm could it do? The answers to these questions result from comparisons with other cases: the expected quality of life for a patient is inferred from what is known about broadly similar cases.

Both clinical judgement in the narrow sense and practical wisdom in the broad sense amount to a skill in pattern recognition. When confronted with morally complex cases, practically wise physicians automatically recognise that specific features within a case require them to weigh values or principles that have accompanied these features in other cases. For instance, a physician may realise that the combination of the harm done by the treatment and the patient's specific comorbidities may lead to a post-treatment quality of life that is unacceptable to the patient; that is, the fact that these comorbidities are present strongly suggests adhering to the principle of non-maleficence. Conversely, if these comorbidities were not present and much less harm was involved in the treatment, this would strongly downplay the importance of considering the principle of non-maleficence. How much emphasis one puts on a principle such as the benefit of the treatment, which one might take as reflecting the expected quality of life post treatment, may differ according to the patient's age. One might feel, for example, that, given the harm involved, a certain ICU treatment may not benefit a very old patient as much as it would a very young patient. Another example concerns respecting a patient's autonomy. As a general guiding principle, this could be given far greater weight with patients who have very strong opinions about treatment than with patients who inform their physicians that they completely trust their expertise.

PRACTICAL WISDOM AND CROSS-CASE MORAL REASONING

The relatively simple examples previously mentioned illustrate that moral considerations within a case are not simply dependent

on applying a principle to a case, but on the constellation of facts surrounding a case that promote certain principles and/or values over others.[53] The casuists conceive moral reasoning as determining how the facts and details of a case bear on the moral considerations at play in that case. We become more skilled at differentiating the important moral considerations from the less important ones in any particular case through the experiencing of many cases.[48 55]

Consequently, pattern recognition will, in time, take place almost automatically.[56] This is because pattern recognition incites what the casuists have called *analogical reasoning*: when a healthcare professional recognises that a pattern in a novel moral case is to a degree analogous to that in a previous moral case, this will lead to the conclusion that the moral response in the novel case requires that the same principles and/or values that were at stake in the previous case be addressed.[52–54] The more fine-tuned a professional's cognitive and perceptual machinery becomes to patterns in cases, the more automatically they will recognise the moral considerations at stake and how to respond in the particular case. This is important because, in medicine, the situations in which moral consideration is required often need to be addressed promptly.[57]

Cases, however, differ in complexity as well as in the principles and values at stake. Casuists place the complexity of a case, relative to another case, on a paradigmatic–peripheral continuum.[53 54 58] Paradigmatic cases are relatively unproblematic ones in which we are able to quickly recognise all the relevant facts and deduce what would be the best moral response to a problem. Such cases invoke moral considerations that almost certainly point us towards one course of action: the action that will bring about good quality care. Peripheral cases, on the other hand, are cases where the quality of care is disputed.[54] This can take the form of a true dilemma, such as when there are, at the same time, plausible reasons to both continue a treatment and stop it. We would expect that it will generally be in such cases that healthcare professionals request moral case deliberation and where organisational know-how on how to achieve quality care in a novel and complex case will be acquired.

Further, we would also expect that, at the same time, pattern recognition will manifest itself more easily in healthcare practices when there are more obvious likenesses across moral problems. Therefore, to the notion of paradigmatic and peripheral cases, we add that the overall case composition, and thus professionals' moral experience, can be either homogenous or heterogenous.[34] If healthcare professionals are regularly confronted with only variations on the same moral problem, they will more likely recognise 'sameness' across these cases and more likely be able to place these cases in the same category. For instance, clinical geneticists and gynaecologists often cooperate around the issue of deciding whether to perform prenatal screening and diagnostics and, in some cases, whether it would be right to grant a request to terminate a pregnancy in light of the potential suffering of the child, the parents or both. This an example of a clinical practice that is confronted with a highly similar cross-case composition. Such practitioners are regularly confronted with the same type of question (ie, weighing the potential future suffering of a child or parents against the child's right to life), while the circumstances change to some extent (eg, there is a different hereditary disease to consider, or a difference in the parents' capacity to care for their child). We can say that, within such a healthcare practice, moral experience is highly homogenous and that the professionals' learning curve will develop along a history or a 'string' of highly similar cases. The amount of moral case deliberations needed for organisational learning to take place might also consequently be low, as it will be likely that collective awareness about the repetitive moral issues and the morally best responses will quickly arise.

Conversely, there can also be practices in which cases are rarely if ever alike. ICU professionals, for instance, are confronted with a great variety of people, problems and diseases which cause highly heterogeneous moral experience and will therefore be much less likely to find that the moral issues in their practice are variations on the same paradigmatic core; that is, ICU practice contains great cross-case *heterogeneity*. Examples include whether and when to continue or stop treatment of a patient, whether and when to resuscitate a patient, the right way in which to engage with families having different standpoints or values, or what is the right care for patients who are unable to participate in medical decisions, including patients who are in a coma and psychologically impaired suicidal patients. In such a practice, pattern recognition will develop along multiple 'strings' of cases. This increases the likelihood that there will be more time between moral case deliberations on the same subject which more easily leads to loss of learning effects. Thus, the threshold of activities for organisational learning to take place is much higher.

We can now outline a learning curve for the subprocess of individual learning whereby a healthcare professional, over time, accumulates know-how on how to recognise and form judgements about moral cases that arise in practice. This learning curve is compatible with both the idea of quality *improvement* and quality pluralism. It is a skill that improves in the process of encountering additional peripheral cases. These peripheral cases will in time become paradigmatic cases once the healthcare professionals learn to automatically adopt the best moral responses to such cases.

Thus, interpersonal moral reasoning during a moral case deliberation may cause individual healthcare professionals to, subsequently, automatically formulate individual quality judgements. This notion leads to a remark on a long-standing debate within moral psychology between rationalists and intuitionists. Rationalists argue that moral judgement is the outcome of a process of deliberate moral reasoning about the values and principles at stake in a moral problem.[59] In other words, moral reasoning precedes moral judgement. Intuitionists claim otherwise: they argue that moral judgement stems from intuition and emotions, thus that moral reasoning only plays a role after private judgements have been formed. Moral reasons are 'confabulated': arguments about values and principles are provided *after* a judgement has already been made.[60]

It may seem as though we have described a learning curve in which healthcare professionals learn to formulate intuitive quality judgements regarding individual cases after repeatedly participating in a rationalist process of moral reasoning about such cases. However, if this was the case, it would suggest that practical wisdom is a matter of intuition more than of applying well-reasoned moral principles. It further implies that moral case deliberation incites intuitive decision making, rather than processes of rational thought, in healthcare professionals. Rather, as Horgan and Timmons have argued, although one might respond to moral problems in a manner which is automatic and *may seem* intuitive, the response actually conforms to values and principles that have been embraced as a result of rational moral reasoning.[59] During such responses, we are said to possess such values or principles 'morphologically'. Horgan and Timmons explain:

When a principle or norm is possessed morphologically, one can say that its manner of operation is procedural – in virtue of possessing the principle in this manner, an individual is disposed to form moral judgements that non-accidentally conform to the principle. Moral judgements are thus formed 'automatically' and spontaneously in virtue of the individual's persisting psychological structure as a morally competent individual.[59]

MORISPRUDENCE

We now return to learning on the organisational level. We have argued that organisational learning depends on the subprocesses of individual learning, but also that it has a different nature than individual learning: the aim of organisational learning is directed at increasing the probability of quality provision. As such, inferring strict causal links between a single moral case deliberation and a single instance of quality improvement is a lot less obvious. Moreover, the organisational learning process (such as for an ICU) is characterised by continuousness adjustment at the collective level.

As argued previously, individual learning from moral case deliberations can be characterised as a growth in practical wisdom whereby individuals become more aware of likenesses and differences between moral problems that arise in their practice. We argue that, if healthcare professionals repeatedly go through the process of deliberating together about moral problems that arise in their practice, this will create a form of collective practical wisdom at the organisational level. Elsewhere, the practical wisdom at this level has been called 'morisprudence'. Morisprudence has been defined as a 'repertory of paradigmatic cases'[61] and as an ongoing report of morally significant likenesses and differences across cases.[61 62] It can best be characterised as an organisational memory through which anyone in the organisation can track how moral problems have historically been addressed within the organisation; that is, it is a track record of nuances and shifts within the ongoing discussion about what individual healthcare professionals within the organisation collectively believe to be quality care across a variety of cases.

Figure 4 depicts how morisprudence comes about. It depends on the process through which healthcare individuals continuously and collectively discuss moral problems within their practice. Rationally structured deliberations concerning novel cases lead to the discovery of likenesses (patterns) and differences across cases through a process of analogical reasoning. This, in turn, will lead to the formulation of a moral judgement through careful comparison and consideration of what quality care is in the case at hand. The content of this judgement depends on the facts and the context of the case and is therefore consistent with quality pluralism. Having formulated this judgement, healthcare professionals may then act on it with the goal of realising quality care in that single case. However, the process does not stop there: after a quality improvement has taken place in that individual case, a more complex variation of a similar moral problem may arise in practice and provoke new debates about quality provision. We can label this the morisprudential mechanism of moral case deliberation: new, peripheral cases continuously force healthcare professionals to reconfigure their ideas about quality care, resulting in a growing taxonomy that tracks which categories of moral problems invoke which kinds of moral considerations.[52 53]

We now proceed to formulate several hypotheses which theorise the relationship between moral case deliberation, organisational learning and quality improvement. We call our main hypothesis the morisprudential hypothesis. We also identify additional empirical phenomena that specify under which conditions the morisprudential hypothesis applies. We call these additional hypotheses the explicitness hypothesis, the morphological hypothesis and the cross-case homogeneity hypothesis.

Morisprudential hypothesis

The preceding discussion leads us to formulate a basic hypothesis about the way in which morisprudence leads to quality improvement in organisations. This hypothesis has two components: first, if cases are frequently discussed within an organisation, it will become more likely that a novel moral problem directly provokes reference to one or more cases within the shared collection of cases. Second, as the possibility for analogies between novel cases and cases within the shared collection becomes greater, the organisation's capacity for formulating a moral response that fulfils the requirement of quality provision in novel cases grows.

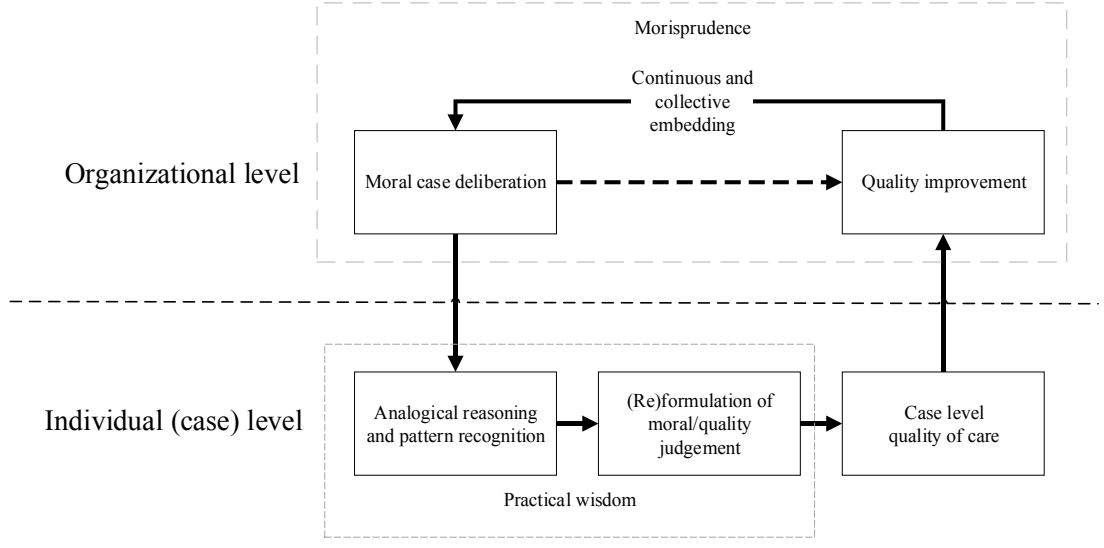

Figure 4 Conceptual model describing quality improvement from moral case deliberation as a relationship between organisational learning and individual learning.

Morisprudence can function either weakly or strongly, depending on two conditions. These conditions not only influence the likelihood of moral case deliberation leading to quality improvement but also have consequences for the way in which one can empirically evaluate the quality claim. The first condition is the organisational capacity for making morisprudence explicitness, which depends on professionals' active engagement and organisational commitment. The second condition is the extent of cross-case homogeneity within the moral problems that arise within an organisation's practice.

Explicitness hypothesis

It is questionable that morisprudence will automatically be embedded in the workplace culture or organisational protocols.[33 35 37 41] This will happen automatically. Moral judgements formed during moral case deliberation are often put directly into action. Documentation of lessons for organisational change may be limited (eg, the outcome of a deliberation may be documented in a patient's electronic health records). Professionals who care for a patient about whom there has been moral case deliberation, but who did not attend, will have to take note of the outcome of moral case deliberation through the patients' records or, otherwise, interpersonally. However, knowing the outcome of a moral reasoning process does not provide information about how that outcome came about and will thus tell professionals little about underlying moral considerations.

An important condition for the collective gain of moral knowledge is therefore the capacity of the organisation to make moral knowledge and insights explicit. Active engagement of professionals, as well as organisational commitment, is a prerequisite for this capacity.[31 32] Morisprudence can be either something that an organisation consciously attempts to build, so that it can function as an explicit source of reference, or it can remain tacit, where it will become part of the workplace culture. If explicit, morisprudence could be in the form of a digital library that healthcare professionals can consult to read about the deliberations and solutions of colleagues concerning past moral problems. Additionally, ethicists may be asked to present or report to members of the organisations and management, once in a while, the cases which have been deliberated about and the moral considerations that prevailed in those cases. We hypothesise that if morisprudence is explicit in this way, the likelihood that moral case deliberation will lead to quality improvement will be substantial. We call this the explicitness hypothesis. If conducting empirical research, a quality claim can fairly easily be assessed if organisations keep such an explicit repository of moral reasoning in past cases. Such an explicit repository directly provides the data, including at the organisational level of analysis, needed to study the type of process depicted in figure 4.

At the same time, explicit morisprudence poses a risk. It should be distinguished from the jurisprudence function in the legal sphere. In common law systems, for reasons of consistency and predictability of the law, jurisprudence operates on the doctrine of *stare decisis* (precedence), meaning that decisions in legal cases require the same decision to be made in later analogous cases. Within the system of jurisprudence, previous decisions thus have great 'gravitational force'.[63] Conversely, moral reasoning operates on the principle of autonomous judgement: in solving moral problems, healthcare professionals are not required to conform to the previous judgement of others.[63] As such, morisprudence will only suggest the direction in which a moral response should be sought. It provides heuristics and suggests which moral considerations would naturally play a role within novel cases that arise in practice. This process allows the relatively effective, sophisticated and rationalistically structured moral reasoning that is required to navigate quality pluralism. It facilitates an organisational memory and a rational, and thus non-intuitive, approach that may morphologically affect the organisation's culture when it comes to moral problem solving.

Morphological hypothesis

However, if morisprudence remains tacit, the morisprudential mechanism may still be at work, be it less pronounced. In this case, we hypothesise that healthcare professionals possess tacit morisprudence morphologically as described previously.[59] This is the morphological hypothesis. It holds that by virtue of possessing morisprudence morphologically, healthcare professionals will be disposed to form moral judgements that intentionally conform to the organisational morisprudence repertoire. Its assessment must necessarily start at the individual level of analysis. This hypothesis can only be assessed through a combination of directly observing a string of moral case deliberations (and providing an ethnography of the development of moral reasoning regarding care quality across these cases) and conducting interviews with participants and non-participants of moral case deliberations. Such interviews would need to inquire into the functioning of their moral reasoning concerning the quality of care across cases, suggesting that researchers would need to adopt a strategy of serial interviewing.

Additionally, we expect that, if morisprudence remains tacit, the likelihood that moral case deliberation will lead to quality improvement will be substantially lower. It is, after all, much less likely that tacit knowledge, which is not kept centrally but dispersed and morphologically kept within all the individual healthcare professionals' minds, will incite moral reasoning that invokes clear connections between novel cases and the taxonomy of cases. This likelihood could well be even lower in practices that have a high turnover of personnel as tacit knowledge can be lost. While on the plus side, new colleagues may have a novel innovative take on a moral issue.

Cross-case homogeneity hypothesis

The second condition that influences the likelihood that moral case deliberation will lead to improved quality is the degree of homogeneity of moral experience that arises within an organisation's practice. This, one could argue, is something that an organisation has no control over. Earlier, we have argued that a healthcare practice in which moral problems with the same composition regularly reoccur will more easily see a growth in pattern recognition on the individual level of analysis. The same is true for morisprudence at the organisational level, which leads us to infer the cross-case homogeneity hypothesis: if there is considerable cross-case homogeneity, moral case deliberations will more easily and more quickly lead to quality improvement. This recognition seems less likely in practices where moral problems are highly heterogenous. This also implies that an empirical assessment of quality claims in practices with a highly heterogeneous moral problems will be significantly more difficult. In situations with severe heterogeneity, it is much less likely that one will encounter a string of cases along which one can identify an ongoing, developing moral reasoning process regarding quality provision.

There is, however, also again a risk to a high degree of cross-case homogeneity: it may result in a sort of moral laziness, a situation in which healthcare professionals all too quickly assume that a novel case is exactly like a previous case and that ethical reflection is not needed. Moreover, frequently deliberating about cases that are highly alike may cause fatigue and possibly

cynicism about the value of moral case deliberation. Cross-case homogeneity will thus accelerate internalisation of morisprudence, whereas too much homogeneity can at the same time hamper moral reasoning processes.

CONCLUDING REMARKS

The developed theoretical framework aimed to generate empirically assessible hypotheses that can be used to adequately scrutinise the relationship between moral case deliberation and care quality at the level of organisational learning. Previously, we have formulated several: the morisprudential hypothesis, the explicitness hypothesis, the morphological hypothesis and the homogeneity hypothesis. This framework was born out of the critique that, within the field of CESS, it is becoming commonplace to postulate, with little empirical evidence, that CESS lead to sustained improvements in the quality of care. The question driving this framework was therefore how this actually works: how do CESS lead to organisational learning and subsequently to quality improvement? We specifically focused on the potential of moral case deliberation to result in quality improvements. We argued that, at the level of individual learning, the moral reasoning process which takes place during moral case deliberations can enhance healthcare professionals' practical wisdom.

At the organisational level, where quality improvement is a continuous and collective endeavour, a collective form of practical wisdom can take shape in the form of morisprudence, amounting to an ongoing repertoire of moral judgements across cases encountered within the organisation. We have argued that, if one wants to know whether CESS genuinely contribute to higher quality care, we should adopt a longitudinal methodology and focus on the way in which strings of repeated moral case deliberations leads to morisprudence, organisational learning and ultimately quality improvement. Additionally, one should be wary about which attributes of a practice are studied since the way in which organisational learning takes place varies according to the degree of cross-case homogeneity within the encountered moral problems, to the personnel turnover, as well as to the explicitness of the moral taxonomies. Consequently, the effect of CESS on quality improvement will vary, depending on the context.

There is a limitation to our approach. We have solely focused on moral case deliberation. This framework may not be applicable to a range of other CESS models, such as clinical ethics consultancy. Contexts in which moral issues are put before a fixed ethics committee, however, may develop morisprudence because the fixed professionals that are part of such committees may more easily build up organisational memory. Researchers may want to comment on applicability of this framework to a range of CESS models.

Empirical work could test our hypotheses by tracking a series of moral case deliberations in a set amount of time in two contexts that differ with regard to the frequency by which moral case deliberations are organised, the explicitness of morisprudence as well as the homogeneity of moral experience. The first step would be to compare two healthcare practices that are alike on two of these dimensions but differ with regard to one of them. In formulating our hypotheses, we have attempted to provide a bedrock on which the field can systematically study the relationship between CESS and quality of care.

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REFERENCES

1 Abma TA, Molewijk B, Widdershoven GAM. Good care in ongoing dialogue. improving the quality of care through moral deliberation and responsive evaluation. *Health Care Anal* 2009;17(3):217–35.
2 Bahus MK, Førde R. Discussing end-of-life decisions in a clinical ethics Committee: an interview study of Norwegian doctors' experience. *HEC Forum* 2016;28(3):261–72.
3 Crico C, Sanchini V, Casali PG, *et al*. Evaluating the effectiveness of clinical ethics committees: a systematic review. *Med Health Care Philos* 2021;24(1):135–51.
4 de Boer JC, van Blijderveen G, van Dijk G, *et al*. Implementing structured, multiprofessional medical ethical decision-making in a neonatal intensive care unit. *J Med Ethics* 2012;38(10):596–601.
5 Magelssen M, Gjerberg E, Lillemoen L, *et al*. Ethics support in community care makes a difference for practice. *Nurs Ethics* 2018;25(2):165–73.
6 Molewijk B, Hem MH, Pedersen R. Dealing with ethical challenges: a focus group study with professionals in mental health care. *BMC Med Ethics* 2015;16(1):1–12.
7 Seekles W, Widdershoven G, Robben P, *et al*. Evaluation of moral case deliberation at the Dutch health care Inspectorate: a pilot study. *BMC Med Ethics* 2016;17(1):31.
8 Svantesson M, Karlsson J, Boitte P, *et al*. Outcomes of Moral Case Deliberation - the development of an evaluation instrument for clinical ethics support (the Euro-MCD). *BMC Med Ethics* 2014;15(1):1–2.
9 van der Dam S, Schols JMGA, Kardol TJM, *et al*. The discovery of deliberation. from ambiguity to appreciation through the learning process of doing moral case deliberation in Dutch elderly care. *Soc Sci Med* 2013;83:125–32.
10 Weidema FC, Molewijk BAC, Kamsteeg F, *et al*. Aims and harvest of moral case deliberation. *Nurs Ethics* 2013;20(6):617–31.
11 Fletcher JC, Siegler M. What are the goals of ethics consultation? a consensus statement. *J Clin Ethics* 1996;7(2):122–6.
12 Schmitz D, Groß D, Frierson C, *et al*. Ethics rounds: affecting ethics quality at all organisational levels. *J Med Ethics* 2018;44(12):805–9.
13 Silén M, Ramklint M, Hansson MG, *et al*. Ethics rounds: an appreciated form of ethics support. *Nurs Ethics* 2016;23(2):203–13.
14 Donabedian A. *An introduction to quality assurance in health care*. Oxford University Press: Oxford, 2003.
15 Varkey P, Reller MK, Resar RK. Basics of quality improvement in health care. *Mayo Clin Proc* 2007;82(6):735–9.
16 Inguaggiato G, Metselaar S, Molewijk B, *et al*. How moral case deliberation supports good clinical decision making. *AMA J Ethics* 2019;21(10):913–9.
17 Svantesson M, Silén M, James I. It's not all about moral Reasoning: understanding the content of moral case deliberation. *Nurs Ethics* 2018;25(2):212–29.
18 Haltaufderheide J, Nadolny S, Vollmann J, *et al*. Framework for evaluation research on clinical ethical case interventions: the role of ethics consultants. *J Med Ethics* 2021. doi:10.1136/medethics-2020-107129. [Epub ahead of print: 18 May 2021].
19 de Snoo-Trimp J, Widdershoven G, Svantesson M, *et al*. What outcomes do Dutch healthcare professionals perceive as important before participation in moral case deliberation? *Bioethics* 2017;31(4):246–57.
20 De Snoo-Trimp JC, Molewijk AC, Svantesson M. Field-testing the Euro-MCD instrument: important outcomes according to participants before and after moral case deliberation. *HEC Forum* 2020.
21 Svantesson M, de Snoo-Trimp JC, Ursin G, *et al*. Important outcomes of moral case deliberation: a Euro-MCD field survey of healthcare professionals' priorities. *J Med Ethics* 2019;45(9):608–16.
22 Finder SG, Bartlett VL. Discovering what matters: interrogating clinician responses to ethics consultation. *Bioethics* 2017;31(4):267–76.
23 Molewijk B, Van Zadelhoff E, Lendemeijer B. Implementing moral case deliberation in Dutch health care: improving moral competency of professionals and the quality of care. *Bioethica Forum* 2008;1(1):57–64.
24 Gaudine A, Thorne L, LeFort SM, *et al*. Evolution of hospital clinical ethics committees in Canada. *J Med Ethics* 2010;36(3):132–7.
25 Jansen MA, Schlapbach LJ, Irving H. Evaluation of a paediatric clinical ethics service. *J Paediatr Child Health* 2018;54(11):1199–205.
26 Haan MM, van Gurp JLP, Naber SM, *et al*. Impact of moral case deliberation in healthcare settings: a literature review. *BMC Med Ethics* 2018;19(1):85.
27 Schildmann J, Nadolny S, Haltaufderheide J, *et al*. Do we understand the intervention? what complex intervention research can teach us for the evaluation of clinical ethics support services (CESS). *BMC Med Ethics* 2019;20(1):1–12.

28 Argyris C, Schön D. *Organisational learning II: theory, method, and practice. reading: Addison-Wesley publishing company*, 1996.
29 Coleman JS. *Foundations of social theory*. Cambridge MA: The Belknap Press of Harvard University Press, 1994.
30 Hartman L, Metselaar S, Widdershoven G, *et al*. Developing a 'moral compass tool' based on moral case deliberations: A pragmatic hermeneutic approach to clinical ethics. *Bioethics* 2019;33(9):1012–21.
31 Batalden PB, Davidoff F. What is "quality improvement" and how can it transform healthcare? *BMJ Qual Saf* 2007;16(1):2–3.
32 Davies H, Powell A, Rushmer R. Why don't clinicians engage with quality improvement? *J Health Serv Res Policy* 2007;12(3):129–30.
33 Levitt B, March JG. Organizational learning. *Annu Rev Sociol* 1988;14(1):319–38.
34 Nguyen T, Cai CX. Value-enhancing learning from Industry-wide diversification experience. *Brit J Manage* 2016;27(2):323–37.
35 Deming WE. *Out of the crisis. quality, productivity and competitive position*. Cambridge: Cambridge University Press, 1992.
36 Knudsen SV, Laursen HVB, Johnsen SP, *et al*. Can quality improvement improve the quality of care? A systematic review of reported effects and methodological rigor in plan-do-study-act projects. *BMC Health Serv Res* 2019;19(1):683.
37 Taylor MJ, McNicholas C, Nicolay C, *et al*. Systematic review of the application of the plan-do-study-act method to improve quality in healthcare. *BMJ Qual Saf* 2014;23(4):290–8.
38 Desai V, Madsen P. Take your time? how activity timing affects organizational learning and performance outcomes. *Organization Science* 2021.
39 McNicholas C, Lennox L, Woodcock T, *et al*. Evolving quality improvement support strategies to improve Plan-Do-Study-Act cycle fidelity: a retrospective mixed-methods study. *BMJ Qual Saf* 2019;28(5):356–65.
40 Lipshitz R, Popper M. Organizational learning in a hospital. *J Appl Behav Sci* 2000;36(3):345–61.
41 Argote L. Organizational learning research: past, present and future. *Management Learning* 2011;42(4):439–46.
42 Campbell SM, Roland MO, Buetow SA. Defining quality of care. *Soc Sci Med* 2000;51(11):1611–25.
43 Brook RH, McGlynn EA, Cleary PD. Quality of health care. Part 2: measuring quality of care. *N Engl J Med* 1996;335(13):966–70.
44 Berwick DM. Era 3 for medicine and health care. *JAMA* 2016;315(13):1329–30.
45 Zegers M, Veenstra GL, Gerritsen G, *et al*. Perceived burden due to registrations for quality monitoring and improvement in hospitals: a mixed methods study. *Int J Health Policy Manag* 2020.
46 Cribb A, Entwistle V, Mitchell P. What does 'quality' add? Towards an ethics of healthcare improvement. *J Med Ethics* 2020;46(2):118–22.
47 Koksma J-J, Kremer JAM. Beyond the quality illusion: the learning era. *Acad Med* 2019;94(2):166–9.
48 Kaldjian LC. Teaching practical wisdom in medicine through clinical judgement, goals of care, and ethical Reasoning. *J Med Ethics* 2010;36(9):558–62.
49 Pellegrino ED, Thomasma DC. *The virtues in medical practice*. Oxford University Press: Oxford, 1993.
50 Pellegrino ED, Professionalism PED. Professionalism, profession and the virtues of the good physician. *Mt Sinai J Med* 2002;69(6):378–84.
51 Schwartz B, Sharpe K. *Practical wisdom: the right way to the right thing*. New York: Riverhead Books, 2010.
52 Arras JD. Getting down to cases: the revival of casuistry in bioethics. *J Med Philos* 1991;16(1):29–51.
53 Jonsen AR, Toulmin S. *The abuse of Casuistry. A history of moral Reasoning*. Berkeley: University of California Press, 1989.
54 Strong C. Specified principlism: what is it, and does it really resolve cases better than casuistry? *J Med Philos* 2000;25(3):323–41.
55 Conroy M, Malik AY, Hale C, *et al*. Using practical wisdom to facilitate ethical decision-making: a major empirical study of phronesis in the decision narratives of doctors. *BMC Med Ethics* 2021;22(1):1–13.
56 Kristjánsson K, Fowers B, Darnell C. Phronesis (practical wisdom) as a type of contextual integrative thinking. *Review of General Psychology* 2019:1–19.
57 Schwartz B. Practical wisdom and organizations. *Research in Organizational Behavior* 2011;31(4):3–23.
58 Tremblay PR. The new Casuistry. *Georgetown Journal of Legal Ethics* 1999;12(3):489–542.
59 Horgan T, Timmons M. Morphological Rationalism and the psychology of moral judgment. *Ethic Theory Moral Prac* 2007;10(3):279–95.
60 Haidt J. The emotional dog and its rational tail: a social intuitionist approach to moral judgment. *Psychol Rev* 2001;108(4):814–34.
61 Toulmin S. The case for cosmic prudence. *Tennessee Law Review* 1988;56(1):29–42.
62 Jonsen AR. Casuistry and clinical ethics. *Theor Med* 1986;7(1):65–74.
63 Goldman AH. The force of precedent in legal, moral, and empirical Reasoning. *Synthese* 1987;71(3):323–46.