THE 6-STEP MODEL FOR ETHICAL REFLECTION

in the health and care services

THE NORWEGIAN ETHICS PROJECT

KS

UNIVERSITAS OSLOENSIS MDCCCXI

CONTENTS

FOREWORD

The Association of Local and Regional Authorities (KS) supports the ongoing work of the local authorities to ensure a consistently high standard of ethics. This is essential in order to gain the trust of the population, and indispensable in sectors such as the health and care services. The objectives of raising the level of ethical competence include supporting key values such as fairness, self-determination and beneficence. The systematic work with ethics conducted by the health and care services is intended to reassure users that these services are committed to safeguarding their dignity and privacy.

The initiative entitled *Samarbeid om etisk kompetanseheving* (Working together to raise ethical competence) at KS was launched in 2007, since when it has supported the local authorities in their work to raise the level of competence in the field of ethics. It is a nationwide initiative designed to support authorities at regional and local level through the medium of regional ethics counsellors. The client for the Ethics Initiative is the Norwegian Ministry of Health and Care Services, and the initiative is run by KS. The project is unique in a global context, in that Norway is the only country in the world where state, local authorities and professional organisations have joined forces on a comprehensive, long-term, practice-centric programme focused on ethics in the contexts of quality and

professional development. The results of years of working closely with the local authorities and other professional environments suggest that ethical reflection reinforces the contribution that staff can make in assisting the health and care services to identify new and improved solutions, enhances the professional awareness of employees, and helps the trusts to work systematically with attitude-promoting initiatives.

Systematic ethical reflection in the services translates into an improvement in quality close to the users. Feedback from managers and employees indicates that it is meaningful to work with ethical reflection in close proximity to practice. They state that they feel better equipped to tackle working days that are often beset with challenges, both professional and inter-personal.

Over the years, the Ethics Initiative has resulted in the development of multiple methods and tools in consultation with the local authorities. The guidebook you are now reading is a new tool designed to support the local work with ethics in the services. The consensus in ethics reflection groups is that none of us is an expert who has all the answers. Everyone has something to learn, everyone has something to contribute – and in many cases, good questions are just as important as the answers.

KS wishes all local authorities every success in their work with systematic ethical reflection. Focusing on important, fundamental values in an everyday context benefits us all: employers, employees and service recipients alike.

Best regards,
Lasse Hansen (sign)
CEO of the Association of Local and Regional Authorities (KS)

INTRODUCTION

This booklet, *Guide to the 6-step model for ethical reflection*, is intended to provide employees and managers with a brief but solid presentation of a knowledge-based method that can be applied in the context of user-centric ethical challenges.

Everyone wants services of a high ethical standard, and this is conditional upon continuous work with values when encountering new challenges and demanding situations. Managers and employees relate that practice-centric conversations about values and ethical challenges make a significant contribution to this.

The evaluation report *Ethical reflection and value awareness. Significance for quality, well-being, and interaction*[1] revealed that both managers and employees in the health and care services are of

1 Prepared by Professor Rudi Kirkhaug of the University of Tromsø, autumn 2018. The report is available (in Norwegian) online at: https://www.ks.no/contentassets/e0a7fb15701d4bf895ba6be77b83a277/evalueringsrapport_sek_jan2019.pdf

the unanimous opinion that systematic ethical reflection is crucial to the quality of the services. The benefits of ethical reflection include enhanced quality, improved patient safety, better interaction with relatives, confidence and openness to the skills of others.

Systematic ethical reflection helps ensure that employees have the skills to identify, reflect on and deal with demanding ethical challenges in everyday situations close to the users. Conversations with trusted colleagues to clarify ethical issues on an ongoing basis during the day are both important and useful. However, systematic ethical reflection goes beyond that. It has to be firmly deployed, planned, managed and, ideally, based on a solid methodology. The method chosen in each individual situation depends on the nature of the challenge and on the desired result. *What* you should do is a completely different issue to *how* you should do it. Both aspects demand attention in order to reinforce the prerequisites of the individual for making ethically good assessments in the situation, and to establish solid organisational ethics and a transparent organisation culture.

The services have, for many years, used models similar to the ones we present in this booklet, and they are interested in having a guide that enables them to devote more time to actual reflection and less to remembering the method from one situation to the next. The model is particularly useful when it is necessary to sort through a situation and identify appropriate courses of action.

The Ethical Initiative in KS has prepared this guidebook via an excellent working relationship with the Centre for Medical Ethics (CME) at the University of Oslo.

We hope you find it useful!

HANDLING ETHICAL CHALLENGES IN THE HEALTHCARE SERVICE

Ethical dilemmas or *ethical challenges* inevitably arise when key considerations (norms, values) collide with one another, as well as in cases of doubt, uncertainty or disagreement about the best course of action.[2] While new ethical challenges have naturally arisen during the Covid-19 pandemic, ethical challenges have always been part and parcel of everyday clinical practice (Box 1). This guidebook is sure to prove useful in encounters with both new challenges and those with which you have more experience.

2 Magelssen, M. and Pedersen, R. (2020). Hva er «etikk» i helsetjenesten? In: Etikk i helsetjenesten, red. (What is "ethics" in the healthcare services? In: *Ethics in the healthcare service*, ed.) Magelssen, Førde, Lillemoen and Pedersen. Oslo: Gyldendal Akademisk, p. 17.

BOX 1: Common ethical challenges in the healthcare service

- Patient autonomy and decision-making competence
- Cooperation/disagreement with relatives
- Use of coercion
- Limitation of life-prolonging treatment
- Prioritisation and resource utilisation (e.g. managers' responsibility for distributing limited resources fairly)
- Duty of confidentiality and patient information
- Challenges in interaction between different services and levels

Handling ethical challenges well can be extremely important:

- in clarifying what needs to be done in a given situation – and how
- in identifying good solutions, appropriate health care options and service levels, and fair utilisation of resources
- in ensuring a good working relationship between healthcare staff in establishing good, correct participation in decision-making processes for both patients and relatives
- in assuring the quality of the healthcare services that the patient encounters
- in safeguarding the privacy and dignity of the patient.

In the following sections, we present a model for systematic ethical reflection that should prove useful in encounters with ethical challenges. We will then present two different arenas for handling such challenges in practice: ethics reflection groups and clinical ethics committees.

Model for systematic ethical reflection

A model for systematic ethical reflection can assist in "clearing up" and prioritising in demanding situations. It makes it easier to articulate the key ethical challenge(s), and to establish which values come into play. We will now present a reflection model laid out in six steps. The model is known as the "CME model" or the "6-step model", and in this booklet it has been expanded to include aspects from the Ethical Reflection Checklist stemming from the Ethics Initiative in KS.[3]

BOX 2: The reflection model

1. *What is the ethical challenge?*
2. *What are the facts of the case?*
3. *Who are the parties involved, and what are their views and interests?*
4. *Which values, principles and legislation come into play?*
5. *What are the possible courses of action?*
6. *Holistic discussion/evaluation of courses of action*

3 The CME model is named after the Centre for Medical Ethics, where the model was originally developed by Reidun Førde. The model was initially applied in clinical ethics committees, and used for the first time at *Rikshospitalet* (Oslo University Hospital) in the mid-1990s. The Norwegian abbreviation "SME" can also be taken to mean the "Systematic Model for Ethical Reflection". The model is also known as the 6-step model. See Lillemoen, L., Gjerberg, E. and Nortvedt, P. (2020). Refleksjon over klinisk-etiske dilemma. In: Etikk i helsetjenesten, red. (Reflection on the clinical-ethical dilemma. In: *Ethics in the healthcare service*, ed.) Magelssen, Førde, Lillemoen and Pedersen. Oslo: Gyldendal Akademisk, Chap. 20.

STEP 1: *What is the ethical challenge?*

Identification of the ethical challenge provides direction for the ethical reflection. There may be multiple ethical challenges in a single situation. We recommend formulating the ethical issue as a question, ideally in the "should we ...?" format. For example: Should we adopt a resolution regarding coercion? Should we move the patient to a nursing home, even though he/she may be opposed to such a move? Should we inform the parents that their child is in regular contact with the school health service?

STEP 2: *What are the facts of the case?*[4]

A precise and comprehensive basis of facts constitutes an essential starting point for the ethical discussion. It is also important to attempt to limit the presentation of facts to those that are directly relevant to the current problem.

Important facts may include:

- Medical and health-specific knowledge bases such as diagnosis, prognosis/expected progression, symptoms, current treatment and reports.
- The patient's level of function, behaviour, decision-making competence
- Housing conditions and context (where does the patient receive the services?)
- What have we done so far, with what result?

4 In some services, it will be more natural to refer to "the situation" or "the challenge", because you are in the middle of what is happening, and it would seem strange to term the residents/patients and the ethical reflection regarding them a "case", but in this document we will continue to use the word "case".

When reviewing facts, it often becomes clear that some relevant facts are missing. It is important to articulate the information we should also have had. The process of establishing additional facts can also be one of the courses of action (Step 5).

STEP 3: *Who are the parties involved, and what are their views and interests?*

This step of the reflection process aids us in viewing the case from additional perspectives. It is therefore useful to ensure that as many of the parties affected as possible can participate in the reflection and present their views themselves. In an ethical reflection process it is important also to include the views of those people who are not physically present, for example healthcare personnel who are familiar with the patient. If you are not aware of the views of the parties affected, you must take care not to assume their perceptions. It is occasionally also relevant to mention indirectly affected parties, such as society in general or other patients.

The person leading the ethical reflection can ask the parties for their views, as well as their emotions and experiences in the context of the case. What is at stake for the parties affected? This step is designed to identify both *views* and *interests*, given that a person's interests can sometimes be different to those he/she consciously expresses. One example could be a patient with a diminished capacity to make decisions who wishes to stay living at home, while others believe this to be irresponsible. In this case, there may be a clear difference between the person's views (i.e. the desire to remain living at home) and his/her best interests (which could be to move into a nursing home). At the same time, the greatest care must always be taken when claiming that a person does not know what is best for himself/herself, and that we, as professionals or relatives, know better.

STEP 4: *What values, principles and laws come into play?*

A value is an asset in people's lives, or something that is important to us in living good, meaningful lives either as individuals or as part of a community. Examples of values include life and health, truth and trust. In many cases, it can be beneficial to identify values by linking them to the parties affected; for example: "In this situation, what is important *to the patient*?" and "In this situation, what is important *to you as a nurse/doctor/physiotherapist*?"

In an ethical reflection we can also refer to four key principles of healthcare ethics:

- *Respect for the patient's autonomy* – which entails an obligation to be mindful of the patient's right to self-determination and/or co-determination.
- *Beneficence* – which means that healthcare personnel have an obligation to do good for the patient, through providing healthcare that is useful and by preventing harm.
- *Do no harm* – which means that healthcare personnel have an obligation to avoid subjecting the patient to injury and suffering.
- *Fairness* – which means that healthcare personnel have an obligation to treat similar cases similarly, and to be mindful of resource consumption and distribution.

When we articulate values and principles, they should also be linked specifically to the ethical question. Which values and/or principles are likely to be in conflict, and in what way?

It is also important to articulate *hidden values*. These are values that have an influence on the choices we make, but which we may not be aware of ourselves. In many cases, this can be a matter of our innate

attitudes or prejudices which complicate our capacity to make good decisions.

This step also focuses on the laws and guidelines that are relevant to the ethical challenge. It is rare for laws and guidelines to constitute a "ready reckoner" regarding the right thing to do, but they do delimit the scope for moral and professional estimation.

STEP 5: *What are the possible courses of action?*

An ethical discussion will often lead to a number of new courses of action and intermediate solutions. In this step, it can be useful to hold a brainstorming session about possible courses of action, without applying critical evaluation. The necessary evaluation takes place in the next step.

STEP 6: *Holistic discussion/evaluation of courses of action.*

The objective of the holistic evaluation is to weight the different courses of action. What are the pros and cons of the different options, and which one(s) is/are best founded, taking everything into account? Here, it is relevant to attempt to link different courses of action to the affected parties' views of the case, and to specific values, principles and laws. One way to do this is to ask how the affected parties' views, as well as the applicable values and laws, align with the different courses of action. At the end of the reflection process, it is important to clarify who holds the responsibility for following up on what was determined during the reflection. What should be done, and by whom?

Example of use of the reflection model

Here, we illustrate how the reflection model can be applied in practice.

Kristine (85) has been suffering from gradually worsening dementia for several several years, and two years ago she suffered a stroke. This resulted in her being moved to a nursing home, because her husband (88) – who suffers from complaints including heart failure – was no longer able to take responsibility for her. Kristine's condition has improved after the stroke, and she is now able to move around the ward with a walker. However, she still finds it hard to express herself orally. The progression of her dementia has clouded her perception of time and place, although she can still recognise both her husband and her two daughters. Moreover, she always appears happy and satisfied, and gives the impression of enjoying being on the nursing ward. Her relations with her family are good, and she receives visits almost daily.

Kristine catches pneumonia, which is treated with antibiotics. The treatment seems to be working, but she is listless and remains bed-bound for a few weeks after the end of the course of antibiotics. However, she has now begun to squeeze her mouth shut when she is offered food and drink. The situation is discussed at a pre-rounds meeting. The doctor understands her condition as a whole, in that she is approaching the end of her life, and her resistance to eating and drinking is related to this. The doctor does not want her to be given intravenous fluids or nourishment. The treatment measures should shift towards palliative care.

During the day, her daughters come to visit and the nurse has a conversation with them about the situation. One of the daughters,

who is a nurse herself, thinks that they should start intravenous fluids and nourishment. She claims that failing to do so will shorten her mother's life, referring to such a course of action as "passive euthanasia". Her younger sister, however, thinks that what is most important is to keep her mother as comfortable as possible during the time she has left. She also mentions that their father understands and accepts that the end is near. The elder sister becomes extremely upset over this.

STEP 1: *What is the ethical challenge?*

The situation described here involves a clinical decision being challenged by one of the relatives. We can formulate the issue as a "Should we ...?" question: *Should we take into account the daughter's request for intravenous treatment?*

STEP 2: *Facts of the case*

The intention here is to identify the relevant factual information, not to present everything we know about the patient. In this case, it will be important to state the changes that have taken place, both as regards the patient's medical condition and what she is expressing through her body language and behaviour. It will also be natural to present a brief description of the relatives' reactions, given that they form the basis for the reflection, even though this is examined in more detail in the next step.

STEP 3: *Parties affected*

The parties affected have their own opinions and interests, but they may also be affected on an emotional and existential level. We should therefore not focus this step exclusively on the different

parties' views of the case, but seek to establish what, in a broader sense, is at stake for the individuals involved.
Kristine herself is in a vulnerable situation and unable to express her own wishes and needs clearly and unambiguously. She is in the hands of her helpers and dependent on our capacity to interpret her signals and treat her with respect and dignity during the final phase of her life. It is our interpretation, in combination with the medical facts, that forms the basis for the choices we make on her behalf.

It is likely that in the immediate future, the *relatives* will be obliged to accompany their loved one during the last days of her life. This is a situation that can stir up a variety of emotions. And in this case, the relatives take extremely different approaches to the situation. Like her father, the younger daughter seems to understand and accept that her mother's life is coming to an end. She also seems to trust the evaluations performed at the nursing home. The elder daughter, in contrast, shows little confidence in the decision, and has her own opinion regarding her mother's treatment. As she is also a nurse herself, she may well believe that her opinion should carry more weight.

The role of the staff is to be there for both the patient and the relatives. The staff need to follow a process in which everyone feels that their needs and wishes have been accommodated as far as possible. The staff adhere to the clinical evaluations put forward by the doctor. What makes this situation demanding is having to deal with the conflict between the clinical evaluations and the elder daughter's wishes.

The doctor is responsible for the clinical decision, but is not directly involved in the conflict described. She is nevertheless affected because it is her decision that is being challenged. The doctor is

dependent on the care personnel providing her with reliable information about both the clinical situation and the relatives' reaction to the process going forward.

STEP 4: *What values, principles and laws come into play?*

The four principles of healthcare ethics will often encompass significant values that are brought into play. Therefore, it is a good idea to start by reviewing these principles. In the context of the *principle of autonomy* we cannot ignore the patient's refusal to eat. Forcing food into her would violate her autonomy, as would administering nutrition intravenously. *Do no harm* and *beneficence* centre on making sure not to subject the patient to unnecessary or prolonged suffering. It is natural for patients who are on their deathbed to refuse to eat and drink, while their relatives view the provision of food and drink to be an expression of basic human care. The principle of fairness is less applicable and not as challenged in this situation.

As examples of other values that may be brought into the argument, we could mention *consideration* and *compassion*. These values apply not only to how we treat the patient, but also – and to just as great an extent – to the attitudes with which we interact with the relatives, especially the daughter who is challenging our professionalism.

Under the header of "Values", we should also discuss the *"hidden values"*, i.e. conditions that may unconsciously affect the choices we make. In order to explore this aspect, we can ask "What would be simplest for me, personally? What would I want to avoid? What is my 'gut feeling'?" and so on. It may be a matter of the impulse to avoid conflict by backing down; in contrast, it may result in our feeling

irritated and indignant, and therefore not open to dialogue. In this specific situation, it would be natural to explore the emotions and reactions that are triggered in us when the daughter, who is a nurse herself, speaks so forcibly against the professional evaluation that was conducted jointly with the doctor. This may trigger irritation, in that we may feel diminished or degraded. However, it is also possible to envisage situations where the staff may feel submissive to a relative with strong opinions, professional skill and a forceful personality.

Laws and guidelines will include the provisions of the Patients' Rights Act with regard to consent, the right to co-determination, and the rights of immediate relatives. In addition, it is also relevant to emphasise the provisions of the Healthcare Personnel Act concerning professional liability and diligent care.

STEP 5: *What are the possible courses of action?*

Between the two extremes, which can be represented as a "yes" or "no" to a given issue, there is a whole range of intermediate solutions and measures that may contribute to a better process for the parties. It may be a question of working to establish a more fruitful dialogue, or other measures designed to generate trust and confidence. In some cases, it is also worth considering making some concessions to the relatives, such as administering fluids for a given period and then re-evaluating the situation. A "time out" of this kind is sometimes what is needed to let things fall more firmly into place for the relatives. No matter what, the decision should not be taken to administer fluids to the patient on an ongoing basis, given that we fear this may cause the patient undue suffering during her final days.

STEP 6: *Holistic discussion/evaluation of courses of action*

On the basis of what we said during Step 5, it seems evident that the discussion is unlikely to conclude with an unequivocal “yes” to the question that formulated the ethical challenge – but nor will it lead to a firm “no”. In Step 1, we ask: “Should we show consideration for ...?” In one way or another, we should absolutely show consideration for a relative who may be in an emotionally turbulent state and struggling to accept that her mother is dying. It is to be hoped that a holistic discussion will help identify an approach that encompasses consideration for both the patient and the relatives in an ethically responsible manner.

GUIDE

STEP 1: THE ETHICAL PROBLEM / QUESTION: ***Briefly describe the problem***

STEP 2: FACTS	**STEP 3: PARTIES AFFECTED**	**STEP 4: VALUES**
	Who are the **parties affected** and in what way(s) are they affected? – What is important to the different parties and what are their views of the case?	• Which **values/** come into play challenged? • Hidden values conflict of valu which values/p
WRITE DOWN FACTS *The group participants can ask questions designed to elucidate/clarify facts if necessary.* *What does the* ***knowledge basis*** *tell us?* • *How does any other specific professional knowledge affect the case? Related to, for example: function, behaviour, expected progression, symptoms, etc.* • *What has been done thus far?* **Missing facts:** *Are there any relevant facts that we have been unable to access?*	*For example: Information from the patient, relatives, employees, others?* *How do the different parties perceive the situation? – What is at stake for the individual?* *How is the person who is actually experiencing the ethical problem affected?*	*Example: 4 princip ethics:* • *Fairness,* • *The princ no harm"* • *Benefice* • *Self-dete co-determ* *Other values? The of the organisatio In the event of co values: which valu conflict, and how?* *Which hidden valu traditions, habits a assumptions) can considered likely t choices and attitu*

STEP 6: HOLISTIC EVALUATION. WHICH COURSE OF ACTION IS BEST, TA

Holistic discussion. Further: How should we deal with this, and how do we follow

n in the form of a question. Ideally start the question with "SHOULD ..."

, PRINCIPLES AND LEGISLATION		STEP 5: COURSES OF ACTION
/principles or are ? Is there any es? – Between principles?	What is stated in any **laws and regulations** that may find application?	
oles of health *ciple of "Do* *",* *nce,* *rmination/* *mination* *e core values* *n?* *nflicting* *ues are in* *?* *ues (e.g.* *and* *be* *to affect our* *des?*	• *Relevant laws and regulations; e.g. the Patients' Rights Act, the Health and Care Services Act, the Health Personnel Act, etc.* • *Service declarations, codes of ethics and conduct*	*What are the possible **courses of action**?*

An example of a form and a form for completion are available to download from:
https://www.ks.no/fagomrader/helse-og-omsorg/eldreomsorg/samarbeid-om-etisk-kompetanseheving/verktoy-og-metoder/

AKING EVERYTHING INTO ACCOUNT?

up now? Should anything be done to reduce possible harmful outcomes?

Where can I turn for help with an ethical challenge?

Healthcare personnel can use the reflection model we have described here either individually or in consultation with their colleagues. However, it generally provides a stronger result when used in a collegial community, where a trained ethics counsellor leads the discussion and the use of the model. Two types of forum for systematic ethical reflection have been established and are currently in use in many areas of the healthcare service:[5]

Ethics reflection groups

An ethics reflection group consists of a group of colleagues (ideally from different professional areas) who meet at the workplace to discuss ethical challenges they are facing – often linked to patients for whom they have a shared responsibility. These groups typically comprise 5-8 members who meet regularly, ideally setting aside 60 or 90 minutes for discussion with application of the reflection model. Patients and relatives typically do not participate in these meetings, and minutes are not necessarily taken of the discussion.

5 In addition, you can always contact the council for professional ethics. For additional information about reflection groups and ethics committees, see Gjerberg, E., Førde, R., Lillemoen, L. and Magelssen, M. (2020). Etikkrefleksjonsgrupper og klinisk etikk-komiteer. In: *Etikk i helsetjenesten*, red. (Ethics reflection groups and clinical ethics committees. In: *Ethics in the healthcare service*, ed.) Magelssen, Førde, Lillemoen and Pedersen. Oslo: Gyldendal Akademisk, p. 233–242.

For additional information (in Norwegian) about the significance of practice-centric ethical reflection from the Ethics Initiative, as well as advice, methods and tools, visit http://www.ks.no/etisk-kompetanseheving

Ethics reflection groups have been established in many nursing homes and, to some extent, in other areas of the municipal health and care service.[6] As an employee, you are welcome to suggest to your manager that you start up an ethical reflection group in your department.

Clinical Ethics Committees

While ethics reflection groups are informal groups typically consisting of colleagues from the same department, a Clinical Ethics Committee (CEC, also known as an "Ethics Council") is a more formal body for the entire hospital/healthcare trust, or for the whole municipal health and care service, or parts of same. All healthcare trusts are obliged to have a CEC, while at present 17 local authorities in Norway have established a CEC. These committees normally comprise 8–12 members, representing multiple professions. It is also common to bring in external representatives such as experts in professional ethics and user representatives. Everyone – healthcare staff, managers, patients and relatives – can contact a CEC and request discussion of a case. CECs invite relatives and/or patients to participate in their discussions where conditions allow, and minutes are taken of the discussions. The advice provided by CECs is only a recommendation to the people responsible for the treatment, and it does not have a binding effect.[7]

6 For advice on how to set up ethics reflection groups, see Magelssen, M., Karlsen, H.M., Pedersen, R. and Lillemoen, L. (2017). *Hvordan lykkes med etikk-arbeidet?* (*How to succeed in the work with ethics?)* Sykepleien (Nursing Magazine) https://sykepleien.no/forskning/2017/10/hvordan-lykkes-med-etikkarbeidet

7 For an overview (in Norwegian) of CECs in Norway, together with the relevant contact details, see: https://www.med.uio.no/helsam/tjenester/kunnskap/etikk-helse-tjenesten/praksis/kek/

Initiatives for health and care services from the Association of Local and Regional Authorities (KS) and the Centre for Medical Ethics.

The Ethics Initiative within KS is a national programme designed to support regional and local authorities in their work to improve ethical skills. The Norwegian Ministry of Health and Care Services is the client, while KS holds responsibility for execution. The Ethics Initiative works primarily through regional ethics counsellors. These counsellors come from different educational backgrounds and have different skills, but they all have solid experience from municipal health and care services. They are seconded from their regular positions, devoting 20–40% of their working hours to the initiative. The counsellors assist the local authorities on the basis of the authorities' needs; this often takes the form of direct guidance in specific cases, courses in method, courses for managers, contributions to professional development days, etc. This input can be provided both in person at physical events or via the internet. The Ethics Initiative provides tools for ethical reflection based on the local authorities' needs and feedback. We prepare practical ethics booklets and e-learning tools, organise regional professional development days in ethics, hold monthly ethics webinars and prepare ethics calendars. The local authorities themselves contact the organisation to request support from the Ethics Initiative. Contact details are published on the website http://www.ks.no/etisk-kompetanseheving at KS.no.

The Centre for Medical Ethics (CME) at the University of Oslo cooperates with KS on ethics work for the municipal health and care service, and also has responsibility with regard to the healthcare trusts. Through teaching, guidance and research, CME seeks to enhance ethical skills and ethical awareness in the healthcare

services. CME works with coordination and professional development of the clinical ethics committees in healthcare trusts and local authorities. The work of the CME is financed by the Norwegian Directorate of Health. See https://www.med.uio.no/helsam/tjenester/kunnskap/etikk-helsetjenesten/

CME and KS work together to utilise our shared resources in the best interests of the municipal health and care services. On the basis of the research, evaluation and experience we have built up from this work over the years, we are confident that systematic use of the knowledge-based methodology we have shared with you through this guidebook will result in improved health and care services[8].

8 Relevant research and evaluations are to be found on the websites listed above.

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ROYAL NORWEGIAN MINISTRY
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