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Article abstract

Clinical ethics is widely recognised as an essential contribution to the quality of health and psychosocial service delivery. However, the lack of a common understanding of ethics within teams and insufficient organisational support often limits its optimal integration into the workplace. To address this problem, the clinical ethics committee of a rehabilitation centre developed a new clinical ethics framework based on a theoretical model and conducted a pre-implementation evaluation by interviewing future users. The study estimated the acceptability and initial adoption of the new clinical ethics framework. The quantitative results of the study indicated a high level of acceptability for the definitions, tools and supporting strategies, with the exception of the definition of the concept of ethical issues. The qualitative results showed that the future users perceived positively the attributes of the new framework, such as its benefits and its compatibility with their professional concerns. In addition, they appreciated the fact that the framework was easy to understand and could potentially be applied in daily practice. The suggestions provided by future users also helped to improve the content of the clinical ethics framework. Finally, all the results will be useful for the planification of its eventual implementation.

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Developing a New Clinical Ethics Framework for Rehab: A Pre-Implementation Evaluation from the Perspective of Future Users

Line Leblanc[a], Sophie Ménard[b], Christophe Maïano[c], Louis Perron[d], Catherine Baril[e], Nicole Ouellette-Hughes[f]

Résumé
L'éthique clinique est largement reconnue pour sa contribution essentielle à la qualité de la dispensation des services de santé et psychosociaux. Cependant, l'absence d'une compréhension commune de l'éthique au sein des équipes et un soutien organisationnel insuffisant limitent souvent son intégration optimale en milieu de travail. Pour répondre à ce problème, le comité d'éthique clinique d'un centre de réadaptation a élaboré un nouveau cadre d'éthique clinique en se référant à un modèle théorique et a procédé à une évaluation préalable à son implantation en interrogeant les futurs utilisateurs. L'étude a permis d'estimer l'acceptabilité et l'adoption initiale du nouveau cadre d'éthique clinique. Les résultats quantitatifs de l'étude ont indiqué un pourcentage élevé d'acceptabilité à l'égard des définitions, des outils et des stratégies de soutien, à l'exception de la définition du concept d'enjeu éthique. Pour ce qui est des résultats qualitatifs, les futurs utilisateurs ont perçu positivement les attributs du nouveau cadre, tels que ses avantages et sa compatibilité avec leurs préoccupations professionnelles. En outre, ils ont apprécié le fait que le cadre soit facile à comprendre et qu'il puisse potentiellement s'appliquer dans la pratique quotidienne. Les suggestions fournies par les futurs utilisateurs ont également permis d'améliorer le contenu du cadre d'éthique clinique. Finalement, l'ensemble des résultats seront utiles pour planifier son éventuelle implantation.

Mots-clés
cadre d'éthique clinique, équipes de réadaptation, modèle éthique, évaluation de la pré implantation, adoption de l'innovation

Abstract
Clinical ethics is widely recognised as an essential contribution to the quality of health and psychosocial service delivery. However, the lack of a common understanding of ethics within teams and insufficient organisational support often limits its optimal integration into the workplace. To address this problem, the clinical ethics committee of a rehabilitation centre developed a new clinical ethics framework based on a theoretical model and conducted a pre-implementation evaluation by interviewing future users. The study estimated the acceptability and initial adoption of the new clinical ethics framework. The quantitative results of the study indicated a high level of acceptability for the definitions, tools and supporting strategies, with the exception of the definition of the concept of ethical issues. The qualitative results showed that the future users perceived positively the attributes of the new framework, such as its benefits and its compatibility with their professional concerns. In addition, they appreciated the fact that the framework was easy to understand and could potentially be applied in daily practice. The suggestions provided by future users also helped to improve the content of the clinical ethics framework. Finally, all the results will be useful for the planification of its eventual implementation.

Keywords
clinical ethics framework, rehabilitation teams, ethics model, pre-implementation evaluation, adoption of innovation

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INTRODUCTION

Clinical ethics is an essential dimension of health care service delivery to manage ethical issues and dilemmas that regularly arise across various situations (1-2). However, ethical aspects of health care are complex and depend on multiple factors, such as a professional's ethical training (3-4), patient considerations, and organizational and societal constraints (5). Thus, clinical ethics practice requires not only individual competencies but also organizational support (6-7). Moreover, when clinical ethics issues and dilemmas are insufficiently addressed, health care teams may experience malaise that they cannot identify or manage effectively (8). For these reasons, clinical ethics must be a governance priority (9-10), not only for its contribution to enhancing the quality of health care service delivery (11), but also for preventing ethical malpractice and, in so doing, respecting the obligation to do no harm (12).

To optimize clinical ethics practice in the workplace, health care organizations must strengthen the synergy between health care teams and their institutional clinical ethics committees (13). The mandate of clinical ethics committees should include multiple roles, namely prevention, education, and consultation (14-15). These three roles must be applied proactively (10), and their link with the quality of health care service delivery should be highlighted (9). To realize this mandate, Accreditation Canada, an organization dedicated to ensuring the quality of service-delivery, recommends that clinical ethics committees

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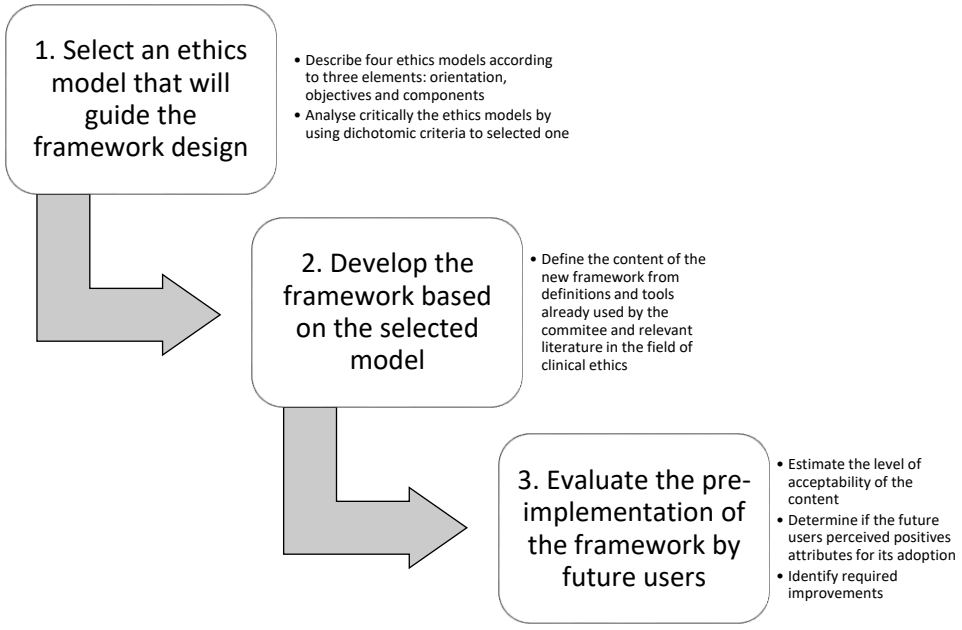
provide a clear clinical ethics framework. Furthermore, this framework should be based on a relevant ethics model to orient and organize their content (8), compared to a framework that simply summarizes an organization's internal documents. The orientation, objectives and components of the model should help develop an organization's shared vision of ethics and reinforce professional capacities to identify and clarify ethical malaises, dilemmas, and issues. However, selecting the most relevant model can be challenging in a context where several ethics models could serve to design such a framework. While it is pertinent to look at many theoretical models, and even detailed frameworks from other organizations, it is necessary to adapt these to local contexts. Furthermore, engaging in co-construction and validation with local institutional members can ensure that the resulting framework best meets the needs of health care teams while building a shared sense of ownership and trust in the new framework.

In 2013, the clinical ethics committee from the Pavillon du Parc rehabilitation centre for developmental disabilities began developing a new clinical ethics framework. In 2015, they conducted a pre-implementation evaluative study of this framework. The purpose of this article is to present the steps involved in developing the framework and report on the results of our evaluative study from the perspective of future users. The clinical ethics committee followed three key steps with their respective objectives. First, they selected one of four ethics models to guide the design of the new framework by analyzing each model's orientation, objectives, and components with dichotomic criteria (concrete/abstract, simple/complex, clinical/organizational). Second, the committee defined the content of the new framework using their ethical definitions and tools, and by conducting a review of the relevant literature in clinical ethics. It is important to note that these models provide general principles but are insufficient by themselves to be operational for developing a clinical ethics framework. Third, the committee evaluated the pre-implementation phase of the new framework to examine its acceptability, initial adoption, and required improvements via a questionnaire completed by future users (Figure 1).

Figure 1: Steps in the development and evaluation of the new framework



Description of the models according to three elements: orientation, objectives, and components

The ethics committee's first step was to select an ethics model that could serve as a foundation for orienting and structuring the design of a new clinical ethics framework. The committee consulted the literature to identify relevant ethics models and then described them according to three specific elements: *orientation*, *objectives*, and *components*. A review of the recent literature found that these elements were common characteristics in the design of clinical ethics frameworks (16). The committee retained ethics models that provided information on those three elements, addressed clinical ethics in general rather than focusing on a specific area (e.g., decision-making in ethical dilemmas), and were related to clinical practices. Following this approach, the committee identified four models that could potentially guide the design of the new framework, and described them according to the three elements:

Orientation and objectives. Each of the following models adopts a different perspective: the Prilleltensky model (12) focuses on social participation in ethics development, the Weinberg model (17) on ethical malpractice, the Reiter-Theil model (11) on best clinical practices, and the Young model (18) on the development of ethical thinking. For the objectives, the Prilleltensky and Weinberg models focus on harm prevention, the Reiter-Theil model on the quality of clinical practice, and the Young model on universal ethics.

Components. All models offer three components, excluding the Young model, which proposes five. Ethical discourse is present in 3 of the 4 ethical models. The Prilleltensky model adds two other components to ethical discourse: ethical action and ethical support. In line with its orientation to clinical practice, the Reiter-Theil model adds two more components, evidence-based knowledge and skills. In addition to ethical discourse, Weinberg proposes paradox and complexity, which refer to the contradictory and restrained nature of clinical practice and could explain its focus on ethical malpractice. In other words, despite good intentions, it is possible to cause harm in the context of service delivery. The components proposed by the Young model refers to principles that guide decisions and actions by considering clinical, organizational and societal contexts.

Critical analysis of the models based on dichotomous criteria

The committee completed a critical analysis of the four identified models to choose the most relevant for the framework design using three dichotomic criteria: simple or complex, concrete or abstract, and clinical or organizational. The model selected by the committee had to meet the first dimension of each criterion: simple, concrete, and clinical. These criteria came from an article in the field of implementation science that also sought to compare theoretical models (19). The advantages of these criteria remain that there are a manageable number, and they are mutually exclusive. Additionally, since it is a framework that responds to an educational mandate, it should be simple to understand and apply. Furthermore, the framework should also be applicable to rehab teams in a clinical context rather than an organizational one. After the analysis, the committee did not select the Young model because of its broad scope and how it related more to larger contexts. More specifically, while the idea that ethics has implications at several levels (i.e., patients, clinicians, and institutions) is very interesting, designing a framework from a list of values with such a broad scope makes the exercise far more difficult. Also, the Weinberg model seemed too complex and abstract to guide the development of the framework; however, the assumption that clinical practice has risks of harm despite good intentions is important. For the Reiter-Theil model, the idea that ethics is linked to the application of best practices is also important. Still, it is necessary to address the concepts of ethics more concretely in a framework. The Prilleltensky model, however, met the criteria the most favourably and each of its three components were concrete and easy to understand and it is the one that best integrates the important elements compared to other models. Moreover, the ethics committee appreciated that this model was oriented toward clinical practice and harm prevention while also considering the context in which health care teams apply ethics (ethical support). Ultimately, the committee selected the Prilleltensky model to guide the new clinical ethics framework design. Table 1 presents the four identified ethics models and the results of the critical analysis.

Table 1: Critical Analysis of Four Clinical Ethics Models

Step 1: Summary of each model	Orientation	Objectives	Components	Step 2: Results of the critical analysis		
				Simple or complex	Concrete or abstract	Clinical or organizational
Prilleltensky et al. (1996)	Social participation	Prevent harm and promote common discourse	1. Ethical discourse 2. Ethical action 3. Ethical support	Simple	Concrete	Clinical
Weinberg (2005)	Ethical malpractice	Prevent harm	1. Ethical discourse 2. Paradox 3. Complexity	Complex	Abstract	Clinical
Reiter-Theil et al. (2011)	Ethical and clinical guidelines	Help maintain and improve quality of care	1. Evidence-based knowledge 2. Skills 3. Ethical discourse	Complex	Abstract	Clinical
Young (2016)	Broader principles than clinical, growth of ethical thinking	Help build universal ethics	1. System 2. Science 3. Law 4. Evaluation procedures 5. Symptom/ performance	Complex	Abstract	Clinical and organizational

Development of the new framework content

The clinical ethics committee designed the new framework based on the Prilleltensky model and its detailed components: 1) *ethical discourse* – definitions of ethics, principles, issues, and dilemmas; 2) *ethical action* – actual ethics and ideal ethics; and 3) *ethical support* – resources and information processes. The committee then defined the content of the new framework by using their ethical definitions and tools, followed by a review of the relevant literature. The following section details the content of the new framework and shows how Prilleltensky's model was used to design the subsequent framework development.

In the framework, the committee's proposed definition of ethics was "a reflection which aims to determine the best way to act, considering the constraints relating to determined situations" (20, p.1). For the ethical principles, the ethics committee retained

autonomy, beneficence, non-maleficence, and justice (21) because of their universal and multidisciplinary scope (22). However, this does not exclude other values involved in ethically challenging situations. The ethics committee selected Saint-Arnaud's (23, p.2) definition of an ethical issue, "an object of theoretical discussion which is aroused by the advancement of scientific knowledge or changes in practices that could lead to value conflicts." Finally, the committee proposed the following definition of an ethical dilemma: when actions lead to positive and negative consequences, forcing a painful choice (24-25).

Regarding ethical action, the committee selected two tools for supporting the practice of ethics, one relating to ethical reflection and the other to ethical deliberation. They chose the reflective tool developed by Van Hoose and Kottler (26) because it prompts health care teams to reflect on their ethical conduct. This tool includes questions relating to the circumstances that can justify the non-application of ethical values, such as truth, professional competences, and deontological standards. The committee also selected the ethical deliberation grid, developed by Legault (25), because its steps are logical and effectively described. This tool comprises four steps: analysis of the situation and the consequences of the decision, clarification of values, making a reasonable decision, and dialogue related to the decision that is taken.

The section on ethical support included resources (e.g., regular discussions, a form to access the clinical ethics committee) and information processes (e.g., an internal website for employees, training) that highlighted the proactive role of the clinical ethics committee and reiterated the organization's ethical responsibility (27). Because the Prilleltensky model emphasizes social participation and dialogue, it would align with evaluating the acceptability and initial adoption by future users, as opposed to the method of validation used by experts in other studies (28).

EVALUATION OF THE PRE-IMPLEMENTATION OF THE CLINICAL ETHICS FRAMEWORK

Methodology

The participants evaluated pre-implementation of the framework by completing a questionnaire designed by the ethics committee. The focus on pre-implementation aimed to promote dialogue within the organization and is also compatible with the educative mandate of the clinical ethics committee. This type of evaluation established the level of acceptability of the content of the clinical ethics framework and the initial adoption by documenting its attributes as understood by future users. More specifically, Yes or No questions were used and sometimes prioritized a single statement to measure the acceptability of the framework content (quantitative data); and the comments section was analyzed to explore attributes of the framework and suggestions for its improvement (qualitative data). The quantitative data were centred on acceptability, as it is the first measure of implementing a new practice (29). The qualitative analysis was useful for exploring attributes, including advantages, compatibility, and complexity, which are recognized to predict the adoption of new practices (30).

Recruitment and procedure

A purposive sample was used to recruit staff members from the Pavillon du Parc rehabilitation centre for developmental disabilities to complete a questionnaire, and oriented recruitment toward rehabilitation teams and their members (n = 22), including managers, professionals, and administrative staff. Participants (n = 241) completed the questionnaire during a team meeting in the presence of the ethics committee. The questionnaire, which lasted 20 to 30 minutes, was designed to estimate the percentage or level of acceptability of the new framework content, deepen understanding of the perceived attributes, and enrich the entire clinical ethics framework. Those who did not wish to participate were free to withdraw from the meeting. This approach was part of an improvement process aimed at ensuring that the clinical ethics framework responded to the needs of rehabilitation teams. Permission was obtained from the rehabilitation centre's research ethics board to use secondary data because, in the context of the improvement process, the data were collected by the rehabilitation centre and not by the researchers.

Measuring instrument

The questionnaire created by the clinical ethics committee had 16 questions in total based on the three components: *ethical discourse* (n = 11), *ethical action* (n = 3), and *ethical support* (n = 2). Acceptability was measured using Yes or No questions, although the participants could justify their answers by adding comments. For questions in the ethical support section, participants had to prioritize a single statement among several but could freely add other options. Also collected were socio-demographic data to describe the participants in the study.

Quantitative and qualitative data analysis

The quantitative data on acceptability were analyzed by calculating the percentage of responses to the Yes or No questions. An 80% approval was considered a consensus, and the Wald chi-square test estimated confidence intervals of the 'Yes' responses. A Z-score (with a continuity correction) was obtained based on the binomial distribution relative to a proportion of 0.80 approval.

The qualitative data were analyzed to deepen understanding of the acceptability rate and improve the new clinical ethics framework, following the Miles, Huberman, and Saldaña method (31): a) collected the data from the answers to the open questions, permitting the justification of the content's acceptability; b) condensed the data using a coding grid based on the diffusion of innovation theory (30), proposing three attributes: relative advantages, compatibility (i.e., with values, needs, and experiences), and complexity; c) displayed the data in matrices ordinated by attributes; d) proposed and verified conclusions with an intercoder agreement technique. To ensure the integrity of the analysis, two researchers on the team (LL, SM) coded

the comments about the justification of the Yes or No questions and performed a detailed comparison of their respective codes. Each dissonant passage and any coding disagreements were discussed, the definition of the codes revised as needed, and a common understanding of the material established. This approach made it possible to standardize the analysis techniques of coders and thus enhance the inter-rater reliability (32). Participant suggestions were also analyzed to help inform and make recommendations for improving the clinical ethics framework.

RESULTS

A total of 241 future users evaluated the clinical ethics framework. They were predominantly women (77.6%), had an average age of 41 years, and worked an average of 11 years in a rehabilitation centre for developmental disabilities. The majority of participants were health care professionals in the field of psychosocial interventions (74.7%), with some administrative employees (12%) and managers (9.5%). More than half (61.7%) had a university education (37.3% undergraduate studies, 17.8% graduate studies, and 6.6% a certificate), while 26.2% had a college diploma and 10.4% a high school diploma. The most frequently mentioned fields of study were psychoeducation (22.8%), social work (14.5%), special education (14.1%), and administration (6.6%).

Acceptability of the content of the clinical ethics framework

Table 2 presents the level (percentage) of acceptability according to ethical discourse and ethical action. Regarding ethical discourse, the results indicated that participants validated three of the four definitions proposed in the framework: ethics, principles, and dilemmas. There was no consensus on the definition of ethical issues, indicated by the confidence interval for this question being below 80%. Regarding ethical action, the two tools presented (i.e., ethical reflection and deliberation) obtained a high percentage of acceptability.

Table 2: Wald Chi-Square Test for Ethical Discourse and Ethical Action

	Yes		95% Confidence Interval		No		P value
Ethical discourse	n	%	Higher	Lower	n	%	
Ethics	218	94.37	97.33	91.41	13	5.63	<0.05
Ethical principles	232	97.48	99.46	95.51	6	2.52	<0.05
Ethical issues	168	77.42	82.95	71.89	49	22.58	NS
Ethical dilemmas	206	90.35	94.16	86.54	22	9.65	<0.05
Ethical action							
Ethical reflection tool	221	93.25	96.43	90.07	16	6.75	<0.05
Ethical deliberation tool	228	97.02	99.18	94.86	7	2.98	<0.05

Table 3 presents the level (percentage) of acceptability regarding ethical support (i.e., resources and information processes). The acceptability of ethical support was estimated by asking participants to prioritize, among several options, the resources and information processes that seemed most relevant to them. The two resources that obtained the highest percentages were “the regular integration of discussions relating to ethics during team meetings” and “access to an ethics consultation request form.” The least often prioritized resources were those aimed to “include a point specifically concerning ethics during clinical supervision meetings.” For the information processes, the measures with the highest percentages were related to activities that meet the needs of staff. In contrast, the least prioritized measures involved an ethics audit system to measure the targeted goals.

Table 3: Percentage of Acceptability Regarding Ethical Support

Resources	n	%
Regularly integrate discussions relating to ethics	108	44.8
Have access to a support request form	64	26.6
Give an ethical support role to specialists in clinical activities	42	17.4
Include a point on the agenda specifically concerning ethics during clinical supervision meetings	22	9.1
Other	3	1.2
Missing data	2	0.8
Total	***241***	***100***
Information processes		
Organize activities that meet staff needs	72	29.9
Create places to discuss ethics and receive training	50	20.7
Use the intranet to learn about ethics and ask questions	36	14.9
Identify groups within the establishment and their respective roles in bringing ethics to daily life	28	11.6
Offer an annual workshop on ethics	25	10.4
Have an annual action plan	17	7.1
Establish an ethics audit system to measure the targeted goals	8	3.3
Missing data	5	2.1
Total	***241***	***100***

Perceived attributes by futures users of the clinical ethics framework

The comments about the justification of the Yes or No questions were coded for the sections 'ethical discourse' and 'ethical action' to estimate if future users positively perceived the three attributes (i.e., relative advantages, compatibility, and complexity) predicting the adoption of a new practice (30). Due to the limited number of comments for the ethical support section, it was impossible to qualitatively analyze the data. The exhaustive list of items, and the choice to prioritize only one, could explain the low number of comments.

Ethical discourse: definitions

Regarding the relative advantage, the analysis of the comments allowed for a deeper understanding of the acceptability of the definitions of ethics, principles, issues, and dilemmas. For example, participants highlighted two advantages related to the definition of ethics: the common understanding of ethics in the organization and a greater ability to distinguish personal, professional, and institutional values that can guide ethical reflection and action. The universal nature of the principles was also perceived as an advantage, as well as the balance between patient care and autonomy. The participants also pointed out that both the definitions of ethical issues and ethical dilemmas presented a potential to positively introduce a legitimate interest in larger ethical issues in practice, compared to dilemmas that require immediate decision-making.

For compatibility with values, needs, and experiences, participants mentioned that the definition of ethics corresponded well with the values of beneficence (i.e., remaining focused on welfare and rights) and non-maleficence (i.e., the desire to avoid causing harm). Moreover, the terms mentioned in the definition of ethics corresponded to everyday professional reality, including adopting ethical behaviour while facing individual, clinical, and organizational constraints. They also agreed with the meaning given to ethical issues, namely that clinical and societal evolution implies constant adjustments. The definition of dilemma was compatible with the concern that clinical decisions must be appropriate and justified, but this process is difficult.

For the complexity of the proposed definitions, participants highlighted the clarity of the definitions of the principles of autonomy, beneficence, non-maleficence, and justice. However, for several people, the definition of ethical issues proposed in the framework was difficult to understand and apply. Table 4 presents the results of the analysis of the perceptions of adoption attributes regarding the proposed definitions.

Table 4: Perceptions of Adoption Attributes Regarding Proposed Definitions

Definitions	Relative advantage	Compatibility	Complexity
Ethics	• common vision and understanding • coherence and strengthening of institutional values • distance from its values	• compatible with importance of 'reflection' and 'doing well' • considers the uniqueness of each person • need to rethink ways of doing things to improve	• clear, concise • easy to understand • applies to everyone
Principles	• decision and action guided by principles that apply to all • emphasizes care and patient autonomy	• compatible with the desire to avoid causing harm • remain focused on the welfare and rights of clients • meet professional obligations in a well-functioning organization	• easy to understand and apply • comprehensive • simple vocabulary
Issues	• distinction between issues and dilemma legitimizes reflection about broader ethics discussion	• compatible with the idea that clinical practice and society are constantly evolving and require adjustment	• definitions appeared complex for several persons, but for others, the main elements were there
Dilemma	• recognize the dilemma and be aware of the consequences of this type of situation	• compatible with the idea that decisions must be appropriate and justified • consequences of actions should be assessed • difficult to make choices considering divergent needs	• clear, simple • concrete

Ethical action: tools

The participants positively perceived the three attributes of the two proposed tools (i.e., ethical reflection and ethical deliberation). The two tools can remind us of the importance of questioning our ethical decisions and behaviours. The reflection tool is relevant because it promotes asking questions regularly and systematically and is consistent with the profound values of the quality of services and non-maleficence. However, participants recognized that ethical reflection is a complex process. The questions in the reflection tool represent workplace situations and correspond with their professional experiences. The tool for ethical deliberation has the advantage of framing the discussion via logical steps, allowing a person to make a better-informed decision. This step-by-step progression makes the process of ethical deliberation easier and more understandable. Table 5 presents the results of the analysis of the perceptions of adoption attributes regarding the proposed tools.

Table 5: Perceptions of Adoption Attributes Regarding Proposed Tools

	Relative advantage	Compatibility	Complexity
Reflection tool	• stimulates questioning, self-criticism, and introspection • reminder that we are constantly evolving	• questions correspond to those that participants ask themselves daily • responds to the need to reflect on achieving the best quality of services and reducing risks	• questions are concrete but not always easy to answer
Deliberation tool	• offers structure and steps to follow during ethical deliberation • guides thinking before acting • helps to take a step back in the situation	• relevance of the proposed steps • important to consider consequences before acting • responds to the need to make the best possible decision • need support to obtain dialogue	• clear, progressive, and concrete steps • easily understandable and applicable

Improvements to the clinical ethics framework

In addition to the perception of adoption attributes regarding definitions and tools, some participants made suggestions to improve the content of the clinical ethics framework and its application. Regarding the definition of ethics, participants believed one should consider situational constraints and facts when defining ethics. According to the definition of principles, it would be appropriate to better clarify the difference between the principles of non-maleficence and beneficence. Participants also noted that it would be useful to relate these principles to the organizational policies and the code of ethics and add the fundamental principle of respect for persons, which includes all the other principles. The participants also recommended that the framework propose a definition of ethical issues more closely linked to clinical practice.

Compared to ethical discourse, the ethical action section of the framework needs some guidelines to help rehabilitation teams consider the challenges of applying these tools. For example, it is challenging to put all four principles into action, thus making it difficult to act well, prevent harm, and be equitable and just. It is also necessary to have sufficient ethical support to implement and apply these tools flexibly. As such, it is important to mitigate organizational constraints that may limit action when following ethical principles. Ethical support is essential to devote adequate time for individual and team reflection, especially when faced with ethical issues and dilemmas. The appropriate use of the clinical ethics framework depends on organizational leadership, which must support rehabilitation teams to operationalize the clinical ethics framework.

DISCUSSION

The present work describes the steps for developing a new framework by a clinical ethics committee and its evaluation by future users working in a rehabilitation centre for developmental disabilities. While the results from the qualitative analysis indicated a positive perception of the attributes associated with adopting a new practice (i.e., relative advantage, compatibility, and complexity), the suggestions to improve the framework also highlighted the real-life difficulties in the application of the tools and in achieving the necessary ethical support. The acceptability percentage showed that while participants tended to accept the content proposed by the committee (i.e., definitions and tools), they did not agree on the definition of ‘ethical issues’.

Acceptability of the content proposed in the framework

The generally favourable opinions from participants about the proposed definitions for the ethical discourse section represented a starting point for a common understanding of ethics, which is necessary in an interdisciplinary context (33). However, there was no consensus on the definition of ethical issues, probably due to its more theoretical than practical perspective. A more straightforward definition could be proposed, such as “a situation where an ethical value is liable to be violated” (34, p.4) with concrete examples of issues (e.g., confidentiality, consent, guardianship, access to services) in rehab practice (35).

Participants also viewed favourably the proposed tools in the ethical action section. While access to tools to address ethical issues in the workplace is necessary and valuable, it should also be considered that their real-time application presents challenges and complexities (33). Indeed, ethics usually refers to uncertain and high-risk situations involving emotional and cognitive processes complicated by different levels of constraints (36). Tools are crucial when clinical decisions and actions are made rapidly, and ethically difficult situations occur simultaneously. The complexity of some ethical situations makes decision-making more difficult and justifies the need for support in the workplace when facing such issues and dilemmas.

The ethical support identified in the framework relates to two distinct strategies: *resources* and *information processes*. The resources prioritized by participants show how important it is that the clinical ethics committee assume all possible functions, including education, development of institutional policies on clinical ethics, and consultation of ethics-related situations without neglecting the sharing of ethical responsibilities (1). The results from a survey also indicated that health care staff need resources to guide them in facing ethical challenges, such as a clinical ethics committee and systematic ethics discussions (37). However, more informal resources such as spontaneous discussions and to access to a clinical ethics committee should not be overlooked (33). This emerging perspective in ethics can better account for sometimes spontaneous – and even impulsive – responses by health care teams to situations with ethical dimensions (36). This is an example of moving away from traditional ethics, which involves a purely sequential and rational process in a step-by-step ethics

deliberation (36). Consequently, the clinical ethics committee should be more open to questioning and re-evaluating their actions regarding ethical support in their institution (1). Moreover, the role of the clinical ethics committee must be known, as well as the modalities of access.

For the information processes, the choices made by participants related to various modalities, including ethical discussions in clinical meetings, training opportunities, and the use of an intranet. Interestingly, participants viewed an ethics audit system to measure the targeted goals as a lower priority. This result contradicts the recommendation that health and social service institutions should emphasize ethical assessment and performance (2). It seems that those in the rehabilitation field seek to proceed incrementally, first by fostering a conceptual understanding of ethics, then focusing on its daily application, and finally, by including a process for evaluating ethical activities. This observation illustrates that competency in ethics can vary according to individuals, professions, and contexts. For that reason, ethical training should consider pedagogical characteristics aligned with the reality of the workplace, such as interactive training, relevance, and needs-based assessment (38).

Future users' perceptions of framework attributes

The qualitative analysis revealed that future users positively perceived the attributes (i.e., advantage, compatibility, complexity) associated with adopting a new practice for ethical discourse and ethical action. An important argument mentioned by the participants was that a common ethical discourse should be a critical goal for rehabilitation service providers as these discussions would be exercised in an interdisciplinary context. This perceived advantage also suggests that ethical discourse strengthens institutional coherence without negating individual or professional values. Reconciling different views on values in a team can be facilitated through a better understanding of clinical ethics (33). It would be interesting to address different ethical approaches in the framework. For example, deontology or consequentialism can lead to different interpretations of the team's decision-making process.

The analysis also showed that the proposed definitions should reflect the reality of clinical settings and be compatible with day-to-day practice. The efforts made in clinical ethics are mainly motivated by expectations of the quality and efficacy of services, and health care teams are aware that this implies individual, team, and organizational levels (39). To contribute to the well-being and rights of the clients, health care teams must also understand the concept of ethics concretely, which calls for definitions to be as simple as possible. For example, to propose a more precise definition of ethical issues, it would be helpful to add an ethical issues tool in the clinical ethics framework (10). In that sense, the ethical deliberation tool is viewed positively by helping structure the reflection process and identifying and clarifying values in practice.

Suggestions made by future users to improve the framework

The results of this study demonstrate the relevance of the Prilleltensky model in organizing the structure and content of a new clinical ethics framework. This model proposes a sequential process that makes sense for rehabilitation teams, including understanding the concepts of clinical ethics, using tools to apply them, and obtaining support in a preventive and immediate manner (12). For each of these sequences, the suggestions made by participants in the evaluative study added the necessary nuances to build a clinical ethics framework consistently while considering the needs of future users. These needs highlight the importance of clarifying ethical concepts (e.g., non-maleficence and beneficence) and considering the constraints that limit clinical ethics practice and promoting proper ethical support.

LIMITATIONS AND FUTURE RESEARCH

The pre-implementation evaluation used in the present study estimated the acceptability of the framework content proposed by the clinical ethics committee, helped clarify the attributes related to its initial adoption and collected suggestions for improving the clinical ethics framework. This new framework presents advantages and is compatible with future users' values, needs, and experiences. However, the high percentage of acceptability of the content should be considered with caution due to certain methodological limitations. First, since committee members designed the questions and were present during the completion of the questionnaire, social desirability may have influenced participants when answering the questions. Second, while participants positively perceived attributes related to adopting this new practice, it does not necessarily mean that they would be used in daily practice. Third, the questionnaire proposed prioritization of items in the ethical support section rather than a Yes or No scale, which may have resulted in fewer comments justifying their response choice. It would be advantageous in the future implementation of the framework to pay particular attention to the usefulness and feasibility of the strategies to support ethics.

The desire to integrate clinical ethics into day-to-day practice remains a challenge for rehabilitation teams. Therefore, the intention to adopt such a practice must be actively supported, mainly because organizational constraints could significantly limit the application of ethical principles. The leadership and proactive role of clinical ethics committees are required to support ethically difficult situations and promote the understanding of ethics, organize support strategies, and mitigate organizational constraints. This commitment is the key to maintaining interest in the new framework before, during, and after its implementation. The evaluative process should continue by examining the implementation of the clinical ethics framework and the extent to which this new document is shown to be useful in real clinical contexts. Developing a new framework initiated by a clinical ethics committee is a promising and high-priority first step that requires in-depth reflection on the meaning of clinical ethics and its actualization.

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