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PART A

Methodology in Empirical Ethics
Chapter 2

REFLECTIVE EQUILIBRIUM AND EMPIRICAL DATA: THIRD PERSON MORAL EXPERIENCES IN EMPIRICAL MEDICAL ETHICS

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ABSTRACT

In ethics, the use of empirical data has become more and more popular, leading to a distinct form of applied ethics, namely empirical ethics. This ‘empirical turn’ is especially visible in bioethics. There are various ways of combining empirical research and ethical reflection. In this chapter we discuss the use of empirical data in a special form of Reflective Equilibrium (RE), namely the Network Model with Third Person Moral Experiences. In this model, the empirical data consist of the moral experiences of people in a practice. Although inclusion of these moral experiences in this specific model of RE can be well defended, their use in the application of the model still raises important questions. What precisely are moral experiences? How to determine relevance of experiences, in other words: should there be a selection of the moral experiences that are eventually used in the RE? How much weight should the empirical data have in the RE? And the key question: can the use of RE by empirical ethicists really produce answers to practical moral questions?

In this chapter we start to answer the above questions by giving examples taken from our research project on understanding the norm of informed consent in the field of pediatric oncology. We especially emphasize that incorporation of empirical data in a network model can reduce the risk of self-justification and bias and can increase the credibility of the RE reached.
INTRODUCTION: BIOETHICS, EMPIRICAL RESEARCH, REFLECTIVE EQUILIBRIUM

In ethics, the use of empirical data has become more and more popular, leading to a distinct form of applied ethics, namely empirical ethics. Especially in bioethics, this ‘empirical turn’ is visible (Borry et al 2005). Empirical ethics is a broad category, grasping different interpretations of integrating ethics and empirical research. There is, however, one basic assumption in all sorts of empirical ethics: the study of people’s actual moral beliefs, intuitions, behaviour and reasoning in a practice yields information that is meaningful for ethics (Borry et al 2004). It denies the structural incompatibility of empirical and normative approaches, and believes in their fundamental complementarity. It is an answer to the critique of bioethics for being too abstract, too general, too dogmatic, as well as too far removed from clinical reality, insensitive to the peculiarities of specific situations.

In this chapter, we wish to discuss the use of empirical data in a method of ethical reflection in which coherence is central: Reflective Equilibrium.

Reflective Equilibrium (RE) was first (thoroughly) defined in the works of John Rawls (Rawls 1971). In contrast to other approaches in ethics on evaluating and justifying moral judgments, the RE approach allows an a priori equal status or weight to the various data used, like (background) theories, principles and considered moral judgments (and, in our form of the RE, empirical data; we’ll come to that). The RE approach liberates us in this way from the idea that we have to approach a moral question either ‘from theory’ or ‘from practice’. It tries to facilitate a real dialogue between theory and practice by not assigning a preferential status to either of them. Considerations on different levels of abstraction have an equal status at the start of the reflection. Rawls himself wrote: ‘(…) its justification is a matter of mutual support of many considerations, of everything fitting together into one coherent view’ (Rawls 1971, p21). Stated otherwise:

‘A reflective equilibrium process pays attention to our moral and non-moral beliefs at various reflective levels (particular intuitions, moral principles, abstract theories), and ‘tests’ various parts of our belief system by revising and refining beliefs at all levels. In a process of mutual adjustment, we seek coherence among the widest possible sets of beliefs (...)’ (Van der Burg and Van Willigenburg 1998, p1)

Coherence is achieved by interaction between the different elements in RE. This interaction can have an effect on all these elements. Thus, some elements need to be altered or

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1 Because our research field is bioethics, we will mainly talk about this field.
removed, others kept. The equilibrium reached is also a dynamic one; it can change due to new elements in the reasoning process. In RE the reasoning is normally done by one individual, whom we will call: ‘the thinker’.

**VARIED OF RE-METHODS – THE NETWORK MODEL WITH THIRD PERSON EXPERIENCES**

There are various versions of the RE approach, each differing in the nature and amount of the elements used.\(^2\) Certain types of consideration are deliberately included or excluded, depending on the goal of the reasoning process.\(^3\) This pragmatic (and of course reasoned) selectivity in the light of specific purposes is also a response to the danger of all-inclusiveness, which could make a RE method unworkable.

We will not discuss all RE versions here. We will only talk about the version we use in our research project on understanding the norm of informed consent in the field of pediatric oncology. In the remainder of this chapter, we will give examples taken from this research project to illustrate how we use RE to give answers to our research questions. The RE version we use is an adjusted form of the ‘Network Model’, first introduced by Van Willigenburg and Heeger (1989). They formulated an equilibrium which consists of considered moral judgments (they called it ‘intuitions’), applicable moral principles and the morally relevant facts of a case. Considered moral judgments are defined here as judgments containing specific ideas and particular situations. This form of RE is particularly useful if one uses RE for justifying a specific course of action in an individual case, as, in order to judge a situation, we must distinguish between the morally salient features of that situation. It is important to notice that in this model facts are not regarded as merely passive objects to which moral judgments or principles have to be applied, but as factors in the equilibrium process itself. There is a genuine interplay between facts, principles and moral judgments (intuitions).

We used The Network Model, but with two adjustments. First, we added background theories (on the moral status of a child and on developmental psychology) to the RE.\(^4\) This was done because these theories provide the normative background of the principles used. Without background theories, the focus would be exclusively on the individual case (as in the Network Model), instead of on developing a (modest) theory which is

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\(^2\) For an overview of the various versions, see: Van der Burg and Van Willigenburg 1998, p12-17.
\(^3\) This goal can be establishing a (modest) moral theory, selecting moral principles or deciding a specific moral problem.
\(^4\) Van der Burg called this Network Model, supplemented with background theories, the wide or extended Network Model. See: Van der Burg 1991.
Reflective equilibrium and empirical data

Applicable in a concrete field of ethical considerations and judgments, like Pediatrics.\(^5\) Furthermore, their prescriptive or performative nature makes background theories particularly fit to correct for the tendency towards moral conservatism, as Norman Daniels (1979) suggests. Second and the topic of this chapter, the moral experiences\(^6\) of others than ‘the thinker’ were integrated in the Network Model. This means that the experiences with a case or practice in the relevant moral community – collected by empirical research – are brought into the RE process. A basic assumption of this suggestion is the idea that the experiences people have in a practice\(^7\) are potentially morally relevant. The judgments and behaviors of these people give us unique insights in the practice at hand and should be taken into account in ethical reflection (Van Delden 1993, 1999\(^8\)). The experiences are used in order to enrich the deliberation of ‘the thinker’ with the norms and practical wisdom of the field. The deliberation process remains that of the ‘thinker’, not necessarily of all the individual people in the practice. But because of the resemblance of the justification process in RE to the day-to-day moral reasoning within the moral community, the judgment reached will be more readily accepted and acted upon in practice (Van Willigenburg and Heeger 1989, p61).

To sum up our approach: the dialogue between theory and practice will consist of going back and forth between information stemming from practice (morally relevant facts and moral experiences of people in the practice) and from theory (principles and background theories). Figure 2 shows the different elements of our ‘Network Model with Third Person Moral Experiences’ in a model.

The idea that empirical research on moral views is relevant to reflective equilibrium methods has been suggested by various authors (Van der Burg and Van Willigenburg 1998, p.15). But applying RE this way in empirical bioethics also raises questions and criticism. What precisely are moral experiences? How to select the moral experiences that are eventually used in the RE? How much weight should the empirical data be given in the RE? And the key question: can the use of RE by empirical ethicists really produce answers to practical moral questions?

In this chapter we will address the reasons for including empirical data, and we will try to give an answer to the above questions and to criticism. As mentioned earlier, we

\(^5\) Although we aim at a modest theory, we still talk about concrete cases. With ‘concrete’ we mean that we do elaborate on real persons in real situations. We do not hold a theoretical debate, but we deal with specific situations in which decisions have to be made that affect real people.

\(^6\) When elaborating on the input of persons other than the ‘thinker’, we talk about experiences rather than intuitions or considered moral judgments. This is to distinguish them from the judgments of the ‘thinker’. In the paragraph on moral experiences we will come back to this preference.

\(^7\) We use MacIntyre’s definition of ‘practice’: ‘a practice is a coherent and complex form of socially established cooperative human activity’ (MacIntyre 1984, p.187)

\(^8\) Van Delden used the considered judgments of practitioners in the medical field in RE to construct a set of guidelines on do-not-resuscitate decisions.
will illustrate this by giving examples taken from our research project on understanding the norm of informed consent in the field of pediatric oncology. The examples are to be found throughout the text, but in separate textboxes. Our aim is to show how empirical information can practically be incorporated in a network model.

Let us also mention what we are not going to do. Our focus will be entirely on the use of empirical data in the RE process. We will not discuss other (also fundamental) elements of the RE, like principles or background theories. Neither will we discuss criticism on these elements or on coherentism as justifying principle. This has been done elsewhere and falls beyond the scope of this chapter.9

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MORAL EXPERIENCES

In Rawls’ RE the considered judgments are only those of the ‘thinker’. In our use of RE we also include the judgments of people acting in the studied practice, namely the pediatric oncology ward. For this purpose, we have added some notions from the empirical ethical approach used in phenomenology to the standard use of RE. Instead of using concepts like considered judgment or intuitions concerning the people in the field, we use the term moral experience. This is to emphasize the importance of the conscious events that make up an individual life and the events that make up the conscious past of a community. Phenomenologically speaking, moral experiences show the normative structure of the historical social reality in which they take place. In this, we follow Richard Zaner and his interest in ‘narratives’ (Zaner 1988). With the use of moral experiences, we want to emphasize the notion that moral life is rooted in the context in which it is lived. Every encounter is interpreted in terms of acquired understandings, shaped by previous experiences and the prevailing cultural system.

In epistemology, the central role of perceptual experience in grounding knowledge and justification is widely recognized. In ethical theory literature, there is not much attention given to the moral counterpart of this perceptual experience. Robert Audi attempts to fill the gap. According to him, moral experiences are the basis of knowledge or justified belief regarding one’s moral obligations. He attributes a significant epistemic (evidential) role to moral experience in grounding knowledge and justified belief of both singular moral judgments and general moral principles. On the difference between intuitions and moral experience he says:

‘(...) far from reducing to a keen awareness of intuited propositions, moral experience may be a ground of such intuitions in the first place. We may intuitively judge that a deed is wrong because our experience of it is one of moral revulsion; the intuition may be a product, not a cause, of the revulsion.’ (Audi 1998, p360)

And on considered moral judgments as formulated by John Rawls:

‘(...) one kind of intuitive moral judgment – a kind that for intuitionists and other moral theorists plays an epistemically basic role in ethics – is often not only a cognitive appraisal but also a response to a moral experience.’ (p362)

10 With this view we commit ourselves to a social basis for morality, instead of a psychological one.
Chapter 2

Audi moreover states that the practice of moral judgment epistemically depends on moral experience (p362).

Moral experience is also connected with another concept of pre-logical knowing: ‘tacit knowledge’. This concept, introduced by Michael Polanyi (1967), comprises a range of conceptual and sensory information and images that can be brought to bear into an attempt to make sense of something. Tacit knowledge can be understood to be culturally embedded knowledge (including regional culture, organizational culture or social culture) and is difficult to share with people not embedded in that culture. It involves learning and skills in a way that cannot solely be prescribed or written down. The knowledge of how to ride a bike is an example: one cannot learn to ride a bike by reading a textbook; it takes personal experimentation and practice to gain the necessary skills, as well as a valuation of cultural norms. Much experience of a personal and normative character in medical practice resembles forms of tacit knowledge.

**Acquiring the moral experiences of people in a practice**

In our study we try to grasp the moral experiences of children, parents and physicians on treatment and research decisions in a pediatric oncology practice and the role of informed consent. We based our study on a qualitative design with in-depth semi-structured interviews with patients (age 8-18 years), their parents and physicians. As our study aimed to explore views, motives and practices, a qualitative interview design seemed most appropriate. The interview topics that structured the interviews were formulated after examining the relevant literature and after preliminary observational studies had been performed. All the families and physicians were interviewed by MdV, who kept a reflexive diary to record contextual details of the interviews and her reflections on the research process. The moral experiences thus obtained expressed the internal norms of the physicians on decision making and gained insight in the problems children and parents faced during the decision making process.

**WHY USE EMPIRICAL DATA TO FIND ANSWERS TO PRACTICAL MORAL QUESTIONS?**

One cannot answer a practical moral question unless one knows the facts. Therefore, the need for ‘fact-finding’ by empirical research seems evident. As indicated earlier, in our model, the data about the practice (the moral experiences of third persons involved in a practice) have a special position. They are not merely the object about which statements are formulated, but they themselves can have an input into the process of formulating arguments.
Reflective equilibrium and empirical data

There are good reasons for including empirical data in RE, and thus using them as independent input. First, it acknowledges the fact that every practice (in our case the medical practice) contains in itself special characteristics that should be involved in ethical reasoning. It brings ethics closer to beliefs that play a role in daily life. Second, it enriches moral reasoning because it illuminates relevant aspects of the case or solutions that one wouldn't have thought of when starting from theory. Moreover, moral experiences reflect the internal norms, the practical wisdom and the subtle, context-driven paths that practitioners follow when specifying abstract principles in concrete cases; and therefore they constitute a good deal of the internal norms and wisdom included in moral reasoning. Empirical research opens large sources of relevant expertise and thus generates potentially important information on the normative structure of reasoning and acting. Outside a practice it is difficult, if not impossible, to grasp these sources. Third, the chance of implementing the outcome of moral reasoning is increased when it is better applicable to the particularities of a practice. Fourth, it enhances moral thinking by taking into account the difficulties and problems that a certain moral dilemma poses in practice. Hereby we want to stress the importance of elaborating on the difficulties and problems encountered by patients, not only by medical workers. The target groups of patients and their relatives have been neglected for a long time in the professionally oriented ethics discussions in health care. Patients and their relatives have at best been considered as topics of theoretical or problem-oriented medical ethics, but not real partners in ethical discourse. Focus on patients broadens the scope and therefore the credibility of the equilibrium reached. Reiter-Theil calls this: ‘Interest Groups-Related Medical Ethics’ (Reiter-Theil 2004). Related to this fourth reason is the final reason to include empirical data in the RE (especially third-person experiences): one reduces the risk of self-justification and bias by the ‘thinker’. The risk of self-justification is one of the main weaknesses of the RE model: coherence is not a sufficient guarantee for credibility or moral truth. As in legal practice and theory, facts and norms need to be combined in a search for truth. By including third-person experiences, one reduces the risk of self-justification in two ways: since the experiences of many are brought into the RE process, there is a good chance of getting a pluralistic view on the matter at hand. Furthermore, minority positions can also gain attention in the process of reasoning.

When addressing the problem of credibility and self-justification, we will have to explore more specifically the considered moral judgments of the ‘thinker’.

11 For these reasons, see also: Van Delden JJM and Van Thiel GJMW 1998; Van Delden et al 2005, p45.
CONSIDERED MORAL JUDGMENTS AND CREDIBILITY

In every form of RE, considered moral judgments of the ‘thinker’ (sometimes called: intuitions)\(^{12}\) play an important role. They are the foundation stones of the equilibrium.

Rawls (1971) takes considered judgments to be judgments in which our ‘moral capacities are most likely to be displayed without distortion because they are given under conditions favorable for deliberation and judgment in general.’ The judgments are moral convictions that the ‘thinker’ has and that tells him which goods, situations and acts are \((prima facie)\) good or bad. The judgments are well considered in the sense that they are not the result of an impulse or emotional reaction. They are made under conditions conducive to avoiding errors of judgment and therefore the holder of the judgment is relatively confident.

In our study, the considered moral judgments of the ‘thinker’ are the judgments of the primary researcher (MdV). For us, these judgments function as a basic assumption, a practical (in the sense that it refers to a specific practice, namely pediatric oncology) hypothesis. The practical hypothesis originates from (initial) theoretical deliberation about known facts of the practice, applicable principles and known norms within the practice. After the deliberation, the ‘thinker’ reaches some sort of ‘hypothetical equilibrium’. In our research, the data used to formulate the hypothetical equilibrium were obtained by a literature search and observations in the (outward) pediatric oncology clinic. From these data we formed a theoretical framework, from which eventually an empirical study could be developed into decision-making in pediatrics, the various moral experiences of the actors involved and the weight of parental authority and child assent.

One of the hypotheses of our research was formulated as follows:

Considering that:
- The ethical ideal of respect for all persons supports respect for the developing autonomy of children and adolescents in decisions about their participation in research.
- In pediatric oncology, almost every treatment is combined with research, ranging from evaluations of the current treatment protocols to randomized clinical trials; and
- For this research, Dutch law requires the informed consent of children above the age of 12, as well as parental permission.

\(^{12}\) In most literature on RE, the terms considered judgments and moral intuitions are used synonymously. Some authors want to separate the two terms. See for instance: Van Willigenburg 1991.
The hypothetical equilibrium could be:

‘Children aged 12 years and older should always be fully informed about research and give independent consent before entering a trial’

This hypothetical equilibrium is the starting point for reaching a new, reflective, equilibrium, which is based on the dialogue between information stemming from practice (morally relevant facts and moral experiences of people in a practice) and from theory (principles and background theories).

In our study, facts about the pediatric oncology practice are for example that discussions regarding diagnosis and treatment almost always include dialogue about participation in research, ranging from evaluations of the current treatment protocols to randomized clinical trials. This makes it difficult for physicians, parents and children, to determine whether research or clinical issues are at hand (for example when talking about goals and risks) and makes obtaining informed consent for the research a difficult task. Moreover, in pediatric oncology, the complex treatment- and research-related decisions arise against a background of acute, serious medical illness and extraordinary psychological and emotional strain. Then, treatment and research protocols, because of their complex scientific structure, are difficult for laymen to understand. And finally, decisions about research participation often need to be made within hours or days. Still, a remarkable proportion of children with cancer – about 70% - participate in a trial during their illness.

Important principles in pediatric research include: respect for autonomy (obtaining both parental permission and the child’s assent for research purposes is promoted), beneficence (can research be good for the child / in its best interests?) and non-maleficence (do we harm a child by letting it participate in research, or do we harm it when it cannot participate?).

We want to emphasize the ‘deliberative’ starting point of the RE process, because no ‘thinker’ enters an equilibrium process with a tabula rasa. His judgments are based on certain premises. Often, especially in bioethics, there is a great deal of activism in this starting point, in the sense that bioethical research presupposes that there exists some kind of moral wrongdoing in practice, and one accordingly strives to change the practice into something one believes to be good. To improve the transparency of the process of RE and to prevent self-justification, it is important to show one’s premises. The con-
sidered judgment, or: hypothetical equilibrium of the researcher is formed out of these premises and the known facts and norms of the practice. As has been said, it’s the starting point for the subsequent RE process.

The subjective character and therefore the credibility of considered judgments are often questioned. Many authors note that nothing prevents one’s considered judgments from expressing only the arbitrary commitments and sentiments of a prejudiced viewpoint (Van der Burg and Van Willigenburg 1998, p8). With our interpretation of a judgment as a hypothetical equilibrium we at least try to be transparent about what elements or premises constitute this first judgment. Furthermore, judgments can alter during the RE process. In this way, the RE process itself can function as a filter, which can separate reliable from unreliable judgments. The process of weighing and balancing judgments, principles and background theories can let us identify judgments that are apparently wrong or prejudiced. Reasoning in RE means precisely this: the consideration of judgments in the light of principles and theories (Van Delden et al 2005, p44).

Michael DePaul proposed a similar solution. He called it: a radical conception of RE (DePaul 1993,p40). In DePaul’s view, the considered moral judgments at the beginning of the reasoning process can differ substantially from the judgements which eventually end up in equilibrium with principles and theories. Initial beliefs or judgments may start the process of reflection, but they will in no sense determine the direction of the reflective process. His method may lead to ‘a very great shift in moral view’ of the researcher, which he called ‘conversion’ (p40-42). Typically, a person can acquire the ability to make relevant discriminations in judging and arguing only after a considerable amount of experience and training. Philosophical deliberations along the lines of the RE method should not only be thought of as affecting our beliefs and arguments, but should also be expected to cause ‘changes in a person’s judgmental faculties, so that these faculties no longer function in the same way, yielding the same beliefs and theories, as they previously did’ (p211). The radical conception of RE may therefore demand the expansion of one’s range of experiences, for example ‘real-life’ experiences through submersion in a certain practice, or by listening to voices in the practice. Of course: selecting the experiences and the views that people express in this practice, remains difficult. There is a significant risk that (in order to ‘prove’ the hypothesis of the ‘thinker’) certain experiences are left out and others are emphasized. It is therefore very important that the ‘thinker’ describes the reasons for including and excluding experiences. Of course, reflection on background and tenability of moral experiences is always necessary, before we can use it

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13 The question of how to reconcile the perspective of a particular person on a subject with an objective view on the same subject is a fundamental issue in ethics, knowledge theory and theories on the relation of mind to the physical world. For an introduction, see: Nagel 1986.
Reflective equilibrium and empirical data

As an insight in practice. But eventually, the process of reasoning towards an equilibrium should culminate in that reflection. As soon as experiences are further examined, the RE process has started. This means that in the RE process itself, experiences are selected as tenable or not. This selection should be transparent and documented in a descriptive qualitative approach.14

When philosophical deliberations that lead to an equilibrium can guarantee that some (seemingly wrong) judgments are abandoned by the researcher during the process, then the problem of restricted credibility of moral judgments at the start of the process is reduced. As long as radical changes in someone’s judgments (and, according to DePaul, judgmental faculties) are possible, there is less danger of systematically wrong judgments in an equilibrium. It is remarkable, that in bioethics, various researchers describe a ‘conversion’, especially when confronted with empirical data (e.g. The 1999a, 1999b).

Using moral experiences to reach RE

The moral experiences relevant to the above mentioned hypothetical equilibrium were as follows: almost every physician stated that full informed consent from adolescents ≥ 12 years, although required by Dutch Law, is difficult to achieve. In discussing treatment as well as research, physicians relied on proxy consent and their ideas on how to protect the best interests of the child. They acted in this way because in their opinion a child (even aged 12 or older) is not capable of deciding, especially in a stressful situation. Furthermore, they themselves conformed to the research protocol. And, since they had proxy consent from parents, a positive IRB-review15 and their own investigator integrity, they felt confident that the research project protected the children from harm. Parents and children found it difficult to distinguish research from treatment and were preoccupied with survival, not with research participation. Children often felt comfortable that their parents made the decisions about research issues. Parents found it difficult to refuse research participation because they were afraid to offend the physician that had to save their child.

These internal norms, problems and views were subsequently included in moral reasoning using RE. We asked ourselves whether the internal norms of the physicians were compatible with the ‘theoretical’ norms expressed in the hypothetical equilibrium. Furthermore, we deliberated on the views of parents and children and on how to integrate them in a coherent way. In other words: we readjusted the hypothetical equilibrium into

14 For the reader of empirical ethical research it can sometimes be easy to see through a biased selection. Certain respondents would be mentioned often, others never.
15 An Institutional Review Board (IRB) is a group that has been formally designated to approve, monitor, and review biomedical and behavioral research involving humans with the alleged aim to protect the rights and welfare of the subjects.
an empirical reflective equilibrium. To reach a new equilibrium, we compared the data on the moral experiences of the different actors with the existing interpretations of the principle of respect for autonomy (on which informed consent is based) and with the theories and ideals lying behind these interpretations. This can be described as follows: At first sight, it seems quite safe to rely on proxy consent and physicians’ ideas on how to protect the best interests of the child. But discussion should focus on the appropriateness, in the research setting, of this substitute for the adolescent’s consent. This model needs to be balanced in a RE with the moral weight of the principle of autonomy. We have to be aware that there is a difference between the treatment relationship and the research relationship, and that this difference remains valid in pediatric oncology. In the research relationship, the researcher seeks to advance knowledge to improve the care of future children. Any therapeutic benefit to the individual is in principle secondary to the overriding goal of obtaining new knowledge. Because of the fundamental differences between the research- and treatment-relationships, we claim that, although this is sometimes acceptable for treatment decisions, informed consent by adolescents (and their parents) in the research setting can never be ignored. Adolescents deserve a reasonable opportunity to make decisions about what happens to them within a research setting. To do so, both clinicians and researchers need to do more in explaining to adolescents the differences between experimental research and standard care. This can turn out to be a laborious task, especially in pediatric oncology, as much research is intertwined with clinical care and it may therefore be difficult to define clearly what portion of a given protocol is research rather than clinical care. But the mere fact that this intertwining is an important feature of pediatric oncology, and that treatment centres conform to research protocols, is not an excuse to omit the effort. Furthermore, one of the background theories, developmental psychology (e.g. Piaget 1965), shows that a firm lower age limit of 11 years can be set, at which children achieve the capacity for abstract thought and gain the ability to understand the risks and benefits of research. Well-crafted information materials could aid investigators in explaining to potential child research participants and their parents exactly which elements of their care are research, and therefore optional (for example additional blood samples or spinal taps). If we take informed consent (and therefore respect for patient autonomy) seriously, we have to develop an understanding of this norm that takes into account the complex setting of pediatric oncology and the limits herein of autonomous decision-making by child patients and their parents.
CONCLUSION

Different aspects can strengthen the credibility of the moral judgments of the ‘thinker’ and can make the resulting RE free of bias. All these aspects have to do with using empirical data. We think that the best answer to the question of how to identify non-biased moral judgments is that there needs to be space for a moral conversion, a radical shift in judgments, just as DePaul described. It is the duty of the ‘thinker’ to stay susceptible to various moral experiences. In our opinion, this means three things for the methodology of an empirical study. First, the ‘thinker’ needs to have gained relevant experiences in the field studied and with this experience a relevant moral sensitivity on the subject. Second, when entering a practice, the thinker should investigate the norms and facts of the studied field, and the moral experiences of the people in the practice, until a state of saturation is reached. The search and subsequent analysis of data should be transparent and documented in a descriptive qualitative approach. Moreover, the search should be described in such a way that it is repeatable. Third, we should strive for intersubjectivity. This can be done by discussing the steps taken in RE, openly and with the utmost transparency, with other researchers and by making explicit the arguments used to reach RE. It does not mean that a consensus has to be reached on the facts and judgments that will eventually be used in RE. The intersubjectivity should be based on reasonableness (Van Delden et al 2005). Other researchers should be able to understand why the ‘thinker’ selected certain judgments and facts, although they perhaps would have selected other judgments.

The RE model we embrace, The Network Model with Third Persons Experiences, gives us many opportunities to involve the context of a moral problem and therefore empirical data in ethical thinking. As long as the ‘thinker’ stays susceptible to a wide range of experiences and facts, and accepts that his own judgments can change due to the RE process (the ‘conversion’), we expect this model to work very well for problem solving in specific cases.

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16 We can learn a lot from the social sciences and their experience with the methodology of qualitative research. There is extensive literature on validity, reliability and generalizability. For an overview, see: Denzin and Lincoln 2000.
17 During our analysis, we used computer software (Kwalitan 5.0; see: Peters 2000) for multiple text management, including coding, locating, and retrieving key materials, phrases, and words.