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What is the right thing to do? The constitutive role of organizational ethical frameworks in collective ethical sensemaking

Abstract

In the complex realm of ethical decision-making, organizations are increasingly developing comprehensive ethical frameworks as guides. These frameworks prescribe ethical principles and decision-making processes to steer organizational actors toward addressing the elusive question of 'what is the right thing to do?' in specific situations. However, the interplay between these prescriptive frameworks and collective processes of ethical sensemaking remains under-explored. Based on an extensive qualitative study within publicly-funded healthcare organizations, we examine how organizational actors, confronted with the challenge of making exceptional funding decisions, enact an organizational ethical framework. Our findings reveal the manifold ways through which such a framework both streamlines ethical sensemaking and induces new and unexpected interpretive challenges. These challenges generate ethical equivocality, which decision makers seek to reduce through particular sensegiving interventions, and, on occasion, through problematizing the abstract principles prescribed by the framework, based on what is intuitively felt right *in situ*. We contribute to the literature by developing a conceptual model of three distinct modes in which organizational actors enact the prescriptions of an ethical framework. Our paper sheds new light on the unintended consequences of using organizational ethical frameworks in real-world ethical deliberations.

Introduction

The "excruciating difficulty" (Bauman, 1993: 248) of making ethical decisions in organizations with multiple stakeholders and contradictory ethical demands, has recently attracted significant academic and practitioner interest (Scherer and Palazzo, 2007; Palazzo and Scherer, 2006). Government agencies, such as funding and certification bodies, organ transplantation and allocation agencies, as well as private sector organizations, attempt to reconcile competing ethical demands by systematizing their decision making processes, often under pressures of transparency (Bromley and Powell, 2012) and pragmatic (e.g., resource-related) constraints (Elster, 1992; Bertsimas et al., 2013; Bertsimas et al., 2012). Facebook, for example, faced with pressures to protect free speech *and* fight disinformation, has established a bundle of ethical policies ("Community Standards") and an independent panel ("Oversight Board") to moderate what user-generated content can legitimately circulate through its platform (The Guardian; The New York Times)[1]. Yet, despite the proliferation of organizational ethical frameworks, we know little about how such frameworks, designed to help decision makers reconcile competing ethical demands, are used in practice.

The literature on ethical sensemaking provides a useful theoretical lens for studying how ethical decision making (hereinafter referred to as "EDM") unfolds in natural organizational settings (Fatien Diochon and Nizet, 2019; Reinecke and Ansari, 2015; Parmar, 2014; Sonenshein, 2009; Sonenshein, 2007). Ethical sensemaking refers to the interpretative work organizational actors undertake as they search for "the 'right' way to act in a particular situation" (Parmar 2014: 1107). An ethical sensemaking perspective sheds light on the ways organizational actors "construct ethical issues out of social stimuli in the environment" (Sonenshein, 2007: 1026) and cope with equivocality, i.e., "the existence of

[1] https://www.theguardian.com/news/2017/may/21/revealed-facebook-internal-rulebook-sex-terrorism-violence, https://www.nytimes.com/2021/05/05/technology/What-Is-the-Facebook-Oversight-Board.html

several, simultaneous interpretations", in ethically challenging situations (Weick, 1979:4; see also Weick, 2001: 9-10&251; Schildt et al., 2020: 242). Engaged in ethical sensemaking, individuals in organizations rely on their intuitions and emotions (Fatien Diochon and Nizet, 2019) to resolve ethical dilemmas *in situ* (Sonenshein, 2007).

Organizations, however, are not mere collections of individuals whose ethical sensemaking efforts are aggregated. Rather, individuals in organizations are expected to discuss and collectively decide ethical issues, increasingly guided by formal, prescriptive organizational ethical frameworks (Ben Khaled and Gond, 2020; Gehman et al., 2013). While prior research has noted the rise of such frameworks, there is currently a gap in scholarly understanding concerning *how* they affect processes of collective ethical sensemaking. We aim to fill this gap in the present paper by exploring the question: How do organizational actors enact a prescriptive organizational ethical framework when they collectively engage *in situ*, in ethical sensemaking?

To address this question, we conducted an in-depth study of decision-making groups ('panels') in three English public health authorities that regularly received individual requests (called 'Individual Funding Requests' - hereafter, "IFRs") to fund exceptional treatments that were not typically funded by the National Health Service (NHS). These authorities shared a detailed organizational ethical framework to guide the decision making of dedicated IFR expert panels. The framework clarified organizational moral preferences at an abstract level, stipulating criteria and procedures panels should use when making relevant decisions. Studying IFR decision making provided us with an ideal opportunity to observe *how* a prescriptive organizational ethical framework, intended to guide collective ethical sensemaking, is put into action on the ground.

Our findings illustrate the diverse ways in which an organizational ethical framework is enacted within processes of collective ethical sensemaking, and the tensions that emerge.

Specifically, we found that while in many cases actors applied the ethical framework's prescriptions unproblematically, in other cases such prescriptions became the central object of ethical sensemaking and were effortfully applied. Furthermore, in a few cases, the framework was problematized by ethical sensemakers who used common sense and their moral intuitions to make a decision. The framework and its normative apparatus therefore played an active and central role in the collective decision-making process, albeit not always visible. Building on our findings, we theorize three different modes—absorbed, deliberate, and critical coping—in which organizational actors engage prescriptive ethical frameworks as "equipment" used in practical sensemaking activities (Dreyfus, 1991). We advance the existing literature by showing that organizational ethical frameworks are not merely tools to aid decision-making but become integral to situated processes of collective sensemaking.

The paper is organized as follows. First, we review relevant literature on ethical sensemaking. We then outline our methods before reporting and analyzing our empirical findings, drawing upon narratives that help illustrate the diverse ways in which our actors collectively engage with and enact the organizational ethical framework within their ethical sensemaking. Finally, we discuss further our empirical and theoretical contributions.

Theoretical Background

Early studies of EDM adopt a rationalist perspective, viewing ethics as "an objective feature of reality" (Parmar, 2014: 1108). From a rationalist perspective, EDM is conceptualized as a cognitive process, driven by logic and rational reasoning (Moore and Gino, 2015; Hannah et al., 2011; Schwartz, 2016; De Cremer and Moore, 2020; Fatien Diochon and Nizet, 2019; Tenbrunsel and Smith-Crowe, 2008). In organizational contexts that stipulate explicit ethical rules or codes (Treviño et al., 2014), decision makers are thought to be already "morally aware", in applying explicit moral reasoning, i.e., "conscious, language-based thinking"

(Haidt, 2001: 816) about ethics, appraising the alternatives, and choosing "the most ethically appropriate course of action" (Schwartz, 2016: 767).

However, a closer look at how EDM is enacted on the ground (Sonenshein, 2009; Sonenshein, 2007) suggests that organizational actors behave more like "ethical sensemakers" and "mapmakers in front of a puzzling terrain," rather than "codebreakers" (Fatien Diochon and Nizet, 2019: 465) trying to solve a pre-existing ethical puzzle, as mainstream rationalist views on EDM tend to assume. Ethical decision makers do not simply respond to objective issues of pre-determined "moral intensity" (Jones, 1991; Barnett, 2001; Rest, 1986), nor do they make ethical judgments by following the stepwise rules of rational reasoning (Haidt and Björklund, 2008; Greene and Haidt, 2002; Haidt, 2001). Rather, they engage in sensemaking, defined as a process of "creating intersubjective meaning through cycles of interpretation and action, and thereby enacting a more ordered environment from which further cues can be drawn" (Maitlis and Christianson, 2014: 67). Ethical sensemaking is triggered by equivocality – i.e. "the existence of several, simultaneous interpretations" (Weick, 1995: 4) - which is a common aspect of organizational situations and is "especially salient for moral problems given moral pluralism" (Sonenshein, 2007: 1024). This means that multiple and competing moral rules or norms may be plausible, and individuals may have difficulty deciding which rules or norms should be given priority. In the process of ethical sensemaking, organizational actors "pull from several vocabularies" (Palazzo et al., 2012: 326) concerning the notions of right and wrong and rely on their intuitions and emotions to reduce equivocality. In doing so, actors convert raw experience "into an intelligible world" (Weick, 2001: 9) and develop a plausible account of what is ethical.

While sensemaking is fundamentally a "social process" (Maitlis, 2005: 21), prior ethical sensemaking studies have focused primarily at the individual level (Sandberg and Tsoukas, 2020). Sonenshein (2007), for example, conceptualizes ethical sensemaking in

organizations as a three-phase process undertaken by individuals. First, individuals proceed through issue construction, i.e., noticing and framing the ethical aspects of a situation. Second, they make instantaneous "intuitive judgments" (Sonenshein 2007:1031), shaped by spontaneous gut feelings and other affect-laden reactions. Finally, they rationalize their intuitive judgments through *post-hoc* moral reasoning—they search "for arguments that will support an already-made judgment" (Haidt, 2001: 818). While this and other models (see Palazzo et al., 2012) allow for "social anchors" (i.e., interlocutors testing each other's interpretations) and intersubjective "representations" (Sonenshein, 2007: 1030) to influence individual sensemaking, they fall short of exploring the inherently "iterative and ongoing social and relational process" (Parmar, 2014: 1102) of collective ethical sensemaking in organizations.

A relatively recent study, nonetheless, provides some useful insights. Reinecke and Ansari (2015) empirically examined the dialogical processes of ethical sensemaking in their ethnography of Fairness International—a not-for-profit organization that has made the "pledge to set fair prices" (2015: 867) for agricultural products. Guided by procedures for ensuring multi-stakeholder participation and consensual decision making, participants engaged in deliberative dialogue concerning "what is ethical" (Reinecke and Ansari, 2015: 884) to negotiate fair prices for those affected (especially farmers). Collective ethical sensemaking, this study shows, can be fraught with difficulties in reaching consensus. Reinecke and Ansari (2015) observed that deliberators took different ethical stances on what a fair price was, revealing "disagreements over which norms and values are at stake or should be given priority" (2015: 869). The authors identified several sensemaking processes through which ethical equivocality was tamed and showed how the subjective and divergent interpretations of fairness were reconciled to reach "ethical truces" (2015: 883), i.e., consensus that was forged out of conflicting ethical stances. In this case, collective ethical sensemaking involved using

technical methodologies, making references to generalized representations (the "average" producer) in dialogical exchange, and, on a few occasions, taking thorny issues out of the agenda as well as arguing for special treatment.

A critical appraisal of the literature

While the literature on ethical sensemaking has grown substantially in recent years, our understanding of how organizational ethical frameworks affect collective processes of ethical sensemaking needs to improve. In particular, prior studies tend to assume that the prescribed moral reasoning of ethical frameworks is invoked *ex post facto* to merely justify intuitive individual positions: "in practice, people may judge through their 'gut' feelings and narrow subjective stances, even if couching their arguments under the veil of objective reasoning" (Reinecke and Ansari, 2015: 882; see also Sonenshein 2007). In a laudable effort to "mov[e] beyond rationalist conceptions of ethics" (Parmar 2014: 1105), the extant literature has, however, downplayed the role of "rational tools" (Cabantous and Gond, 2011) in EDM processes. Yet, ethical frameworks can play a guiding role, deriving from their normative prescriptions, when organizational actors come together to make ethical decisions in practice. Thus, one study found an organizationally stipulated ethics code to "actively intervene in situations, contributing to the enactment of normative realities" (Gehman et al., 2013: 104) over time. This study suggests that organizational ethical frameworks may affect situated sensemaking processes in a more consequential way than previously assumed. Further research is therefore needed to empirically explore and theorize *how* the prescriptions of an ethical framework may play an active guiding role in collective processes of ethical sensemaking in organizations.

A few studies provide some initial insights that may guide such research. Sonenshein (2007), for instance, notes that "figuring out what [a framework's] standards mean, along with their application [in particular situations], is often […] so difficult" (2007: 1025), alluding to

distinct sensemaking challenges when actors enact the prescriptions of an ethical framework in particular cases. Quite how such sensemaking challenges emerge and are addressed, however, remains under-explored. In addition, Dane and Sonenshein (2015: 78) observe that "it is one thing to understand [organizational] moral values; it is quite another to put those values into practice when making decisions." They convincingly argue that organizational actors develop "a nuanced understanding" (2015: 78) and "ethical expertise" of how to apply the moral values inscribed in an organizational ethical framework to specific situations. In other words, organizational ethical frameworks do not apply themselves: they are applied *in situ* by organizational actors who have developed ethical expertise. As studies of expertise show (Dreyfus, 2014; Dreyfus and Dreyfus, 2005; Dreyfus and Dreyfus, 1991), it is important to explore how people skillfully use tools (in our case, organizational ethical frameworks) in their work.

Building upon and extending these insights, we propose to view and empirically examine organizational ethical frameworks as practical "equipment" (Dreyfus, 2014; Dreyfus, 1991; Dreyfus and Dreyfus, 1991; Sandberg and Tsoukas, 2020) that is invariably implicated in organizational actors' ethical sensemaking practices. This means exploring not only when the prescriptions of an ethical framework become visible and/or are explicitly invoked in practice, for example, to justify a decision, but also when they play a less visible but still guiding role. In particular, an ethical framework may "disappear" (Dreyfus, 1991: 64) as a guide for EDM when organizational actors skillfully use it, having developed some form of "ethical expertise" (Dane and Sonenshein, 2015) that allows them to spontaneously, non-deliberately, and routinely make ethical sense of particular situations. Insofar as this happens, organizational actors can be said to perform ethical sensemaking through an "absorbed coping" mode (Sandberg and Tsoukas, 2020: 2). In other words, experienced ethical sensemakers may skillfully follow the moral guidance of an ethical framework without paying focal attention to

the framework and engaging it as an object with certain properties; the ethical framework just shows up as "transparent", readily available, practical equipment *for* putting the organization's moral values in practice (Dane and Sonenshein, 2015). Yet, in "breakdown" situations (Dreyfus, 1991), namely when problems arise, sensemakers may switch from an absorbed to a "deliberate coping" mode of sensemaking whereby the framework becomes "more explicitly manifest or focal" (Yanow and Tsoukas, 2009: 1352) in their sensemaking efforts. In such cases, the ethical framework becomes conspicuous, having distinct properties, which organizational actors focus on and discuss *in situ*. Thus, conceiving of organizational ethical frameworks as equipment is promising as it reveals how they can play a more or less visible, yet consequential, role in a variety of situations.

Methods

Empirical Setting

We conducted an inductive qualitative study in three publicly funded regional health authorities (hereinafter referred to as "RHAs") in England, focusing on the process of deciding upon 'Individual Funding Requests' (hereinafter referred to as "IFRs"). IFRs were requests submitted by individual patients, usually through their doctors, for medicines or treatments that were not routinely publicly funded. Even though the total annual cost of approved requests represented a relatively low portion of an RHA's total annual budget[2], such approvals occasionally had significant implications. For example, approving a costly treatment for an exceptional case could sometimes set a precedent that could fuel demand and pose a threat to future financial planning[3]. RHAs received hundreds of requests per year.

[2] For example, the total annual budget of RHA Y (one of the three RHAs discussed in our study) was approximately £1 billion (or $1.6 billion) in 2010, and the total cost of funding IFRs was around £5 million (or $7.7 million) or 5% of the total budget.

[3] For example, during our study, RHA Y approved a request for a highly specialized treatment of Age-Related Macular Degeneration. Once this decision gained publicity, there was a 100% increase in applications for this treatment within just one year (with an approval rate of 96%).

IFR decisions had historically been receiving significant negative publicity, creating "perceptions that variations in the availability of important treatments can sometimes occur at random, rather than as the result of a clear and conscious commissioning process" (Nicholson, 2009). By way of an example, such negative publicity is reflected in frequent criticism of the so-called "postcode lottery" in accessing healthcare in England (as narrated in the BBC Documentary, Panorama). Contentious decisions continue to attract media attention and have occasionally been scrutinized by Courts (Sokol, 2011). In response to this criticism, RHAs across England took a coordinated approach to develop and put in place an overarching ethical framework for IFR decision making (Department_of_Health, 2009; NHSConfederation, 2009; Nicholson, 2009; Richards, 2008). The common ethical framework, which was published on all RHA websites, was described as "a decision-making tool to facilitate fairness and transparency" when making decisions on IFRs (NHSConfederation, 2009).

The organizational ethical framework was comprised of several elements, including a set of "ethical principles" defined as "basic truths or general laws or doctrines that are used as a basis of reasoning or a guide to action or behavior" (summarized in Table 1). These principles were operationalized in the framework in a set of tests and decision-making rules, which we have constructed graphically in Figure 1[4] and to which we will refer hereinafter as the "decision making formula." This formula made explicit how decision makers would achieve the overarching ends espoused in the framework, namely "fairness and transparency:" all claimants would be examined in the same way, and decision makers would take into consideration the interests and concerns of all stakeholders in arriving at a decision. The framework also explicitly denounced behaviors, such as intuitive judgments and appeals to emotions (e.g., sympathy), that would jeopardize this mode of examination.

[4] The visual representation in Figure 1 is meant to concisely illustrate the content of the framework's core tests and decision making rules and make them more accessible to the reader. The wording of the questions used in Figure 1 is identical to that found in the framework.

—Insert Table 1 about here—

—Insert Figure 1 about here—

Finally, the framework included formal governance structures and procedures to enable the application of its principles and decision-making formula on specific IFRs. Independent IFR panels were set up with the delegated authority (as Board sub-committees) to approve treatments in exceptional cases. These panels typically included one or two senior managers (Associate Director level), one or two public health physicians, a primary care physician or other doctor, a non-executive director, and a Chair (core IFR panel members); as well as an IFR Administrator (or Officer) and, at times, one or two pharmaceutical advisors, and librarians. Panel members were expected to engage in dialogue under the auspices of the framework's prescriptions and examine as well as weigh up the relevant evidence before arriving at a decision (decline or accept a request). All panel members had received formal ethics training organized by the Public Health Directorate of RHAs. Procedures also included strict communication protocols and requirements to make decisions at quorate meetings. There were specific IFR application forms, which prompted applications to provide relevant information and evidence. Occasionally, panel decisions were appealed and scrutinized by an independent appeals panel, and if a case went to litigation, there could be scrutiny by Courts.[5]

The three organizations we studied, RHA X, RHA Y, and RHA Z (pseudonyms), differed to some extent in size, profile, financial stability, and performance, yet they all stipulated the use of the same ethical framework by dedicated IFR panels.

Data Collection

The primary source of data was direct observation of IFR panel meetings, during which a total of 140 decisions on IFRs were made (meeting durations ranged from 2 to 3 ½ hours

[5]An example of an IFR framework and related policy can be found here: https://www.england.nhs.uk/publication/commissioning-policy-individual-funding-requests/

each—see Table 2 below). The authors, as non-participants, took detailed notes of panel member conversations, how the framework's principles and various elements were invoked, who said what, when, and the sequence of conversations (e.g., statements, questions), as well as non-verbal reactions, such as nodding. For example, we noted what information from the IFR application documentation panel members paid attention to, and which concepts they used during deliberations.

—Insert Table 2 about here—

In addition to real-time observations, we had access to all documents submitted in support of the IFR cases (usually dozens of pages per case). These documents included meeting minutes, decision outcome reports, and the full information pack provided to panel members by the IFR administrator (including application forms, records of communication, and academic papers). We also conducted semi-structured interviews with RHA panel members (N=12) and RHA internal stakeholders not directly involved in IFR decision making (e.g., senior directors and managers) (N=17). Question topics included the division of labor within the IFR panel, formal accountabilities, and how the framework was and was not used by panel members across various cases. For example, after we observed that the framework's principles did not always take center stage during panel members' deliberation, we asked for clarifications.

We also gathered national policy and organizational documents pertaining to the IFR process, including the ethical framework used across our three RHA sites and 'Terms of Reference' for the panel. We also collected other published materials, such as evaluations of IFR processes by various interest groups and media coverage of some IFR cases (see, for example, Sokol, 2011; Dyer, 2011).

Finally, we gathered data through the feedback provided by the IFR panels of RHA X, Y and Z, as well as by health policy and health law researchers, when we presented preliminary

research findings to them. For instance, such feedback included information about the specific application of the organizational ethical framework by IFR panel members.

Data Analysis

We started by creating a list of all the observed IFR decisions, cataloguing important details, such as the requested interventions, the decision outcome (IFR accepted or rejected), data on real-time discussions per request and recorded discussions. We also adopted a temporal bracketing strategy whereby we sought to detect temporal evolution in the decision making process (Langley, 2009). This initial analysis revealed the temporal structure of the process that preceded IFR panel meetings and of subsequent discussions at such meetings. For example, upon receipt of a request, the IFR administrator would quickly check with the panel Chair whether the case met the formal eligibility criteria for IFR discussion. For eligible cases, the administrator would then prepare the IFR documentation (e.g., forms, doctors' letters), which was then forwarded to panel members, who engaged in group deliberation to produce a co-authored decision.

Our analysis proceeded with several iterations in the tradition of interpretive scholarship (Feldman, 1995; Locke et al., 2008; Alvesson and Kärreman, 2007). Combining and triangulating several sources of data, all co-authors wrote up "analytical summaries" (Barley, 1990; Pettigrew, 1990) concerning how the ethical framework was used and structured the deliberation dynamics that unfolded during IFR meetings—actions and interactions among panel members, who jointly tried to make sense of IFR cases (e.g., they asked questions, such as "What are they [the IFR requestors] asking for?", "What is the medical condition?" etc.). These summaries were shared and discussed among all co-authors, each of whom also played "devil's advocate" (Rerup and Feldman, 2011). This mode of working increased the reliability and integrity of our data analysis, which proceeded as follows.

Through cross-case comparison of deliberation dynamics, we explored patterns of ethical sensemaking associated with a specific "question or concern" (Maitlis and Lawrence, 2007: 61). We identified three such processes: particularizing (associated with the question 'What is going on?'), generalizing (associated with the question 'What is this a case of?'), and gauging deservedness (associated with the question 'Does this case deserve funding?') (for more details, see Findings, below). We then "zoomed in" (Nicolini, 2009) to analyze how the framework's prescriptions—its principles, formula (Figure 1), and procedures—were enacted, that is, invoked and put into action while accomplishing these sensemaking processes. Drawing on the view of ethical frameworks as "equipment" for situated sensemaking (Dreyfus 1991; Sandberg and Tsoukas 2020), our cross-case analysis quickly unveiled the diverse ways of enacting the ethical framework's prescriptions. In most of the cases we observed, panel members appeared to enact the prescriptions unproblematically, without explicitly invoking the principles and formula, throughout the process and quickly came to a decision. In other cases, however, panel members faced challenges in applying the framework and the framework became more conspicuous in their deliberations. We explored such challenges further.

In particular, we examined how panel members intensified their discussions, when gauging deservedness, especially when applying the framework's tests (Figure 1). Through a back-and-forth process, which involved revisiting our empirical material and analytical summaries, we analyzed episodes of disagreement and explored how panel members addressed their emergent difference. By consulting the sensemaking literature, we identified several sensegiving interventions—namely, efforts of panel members to "influence the sensemaking and meaning construction of others" (Gioia and Chittipeddi, 1991: 442) and converge on a collective interpretation of 'What is the right thing to do?'. Our cross-case analysis revealed an additional pattern and mode of engagement with the framework as equipment, whereby the group critically questioned the framework's decision-making formula and sought to apply it

rather flexibly to address that question. Finally, in later stages of our analysis, we examined the tensions in relation to this flexible application of the ethical framework. To derive a more theoretically complete interpretation, we juxtaposed our findings on how such tensions were handled with the insights of the existing sensemaking literature. This enabled us to identify specific "sensebreaking" (Pratt, 2000) interventions used by some panel members with a view to reprimanding others and urging them to revise their positions.

FINDINGS

Enacting the Prescriptions of the Organizational Ethical Framework

IFR panel members enacted the framework's prescriptions in and through the collective ethical sensemaking activities of *particularizing*, *generalizing*, and *gauging deservedness* (see Table 3 for data examples of these processes).

—Insert Table 3 here —

Particularizing involved panel members examining the particular details of the case (usually referred to as the "background" or "summary"), connecting information regarding previous therapies, available treatments, procedures, and protocols followed. They also described the requestor's plight and shared personal views of the patient's needs in order to jointly create a plausible story of "What's going on here" (Weick et al., 2005: 412), i.e., who applied, why, and under what circumstances. Typically, panel members constructed initial narratives, based upon their own individual reading of the available documentation and then turned to each other to confirm their interpretations and cement the facts of the clinical case. Generalizing involved addressing the question 'What is this a case of?', where panel members would discuss, which general medical categories were most relevant to the case at hand. For example, the general type might be a particular disease or condition (morbid obesity) calling for a particular intervention (bariatric surgery). Gauging deservedness involved collectively

deliberating the merits of the case ('Does this case deserve exceptional funding?') based on the evidence as well as co-authoring and formally recording the final verdict of the group.

As shown below, the framework's role in members' ethical sensemaking processes was diverse and highly consequential across cases. What panel members 'should do' in a particular case depended, among other things, on how they enacted the framework's prescriptions throughout their deliberations. Specifically, our findings suggest that in most IFR cases we observed (N=97; "straightforward cases"), panel members enacted the framework's prescriptions in a relatively non-contentious, non-deliberate and unproblematic way. Panel members were essentially guided by the framework without having to explicitly invoke it as a guide for their collective sensemaking – the framework showed up as transparent and readily available "equipment" (Dreyfus, 2014). In other cases (N=32; "complex cases"), however, panel members exercised deliberate collective effort to enact the framework's prescriptions, engaging in an ethical sensemaking process, which appeared as a "deliberate coping" mode: the framework took center stage in panel members' conversations and became a conspicuous object in a more intensified sensemaking process– they continually referred to it, examined it, and developed more complex interpretations of what its guidance meant. Finally, in a few cases we observed (N=11; "outlier cases"), panel members switched to what we call a "critical coping" mode. They problematized the framework in relation to the particular case at hand through taking a more critical stance toward its guidance and adapting it flexibly to the circumstances. Yet, the outcome of such problematization was up for grabs.

"Straightforward" cases: enacting the framework's prescriptions unproblematically

In, what participants referred to as, "straightforward" IFR cases, the framework's formula was skillfully applied and unproblematically enacted. This occurred, for example, where the evidence of clinical effectiveness was available and unambiguous, and panel

members swiftly reached a consensus on whether a patient was exceptional or not (see Table 4 for more examples). The low ethical equivocality that panel members experienced in such cases meant they spent little time in particularizing and generalizing discussions. Moreover, straightforward cases enabled panel members to train themselves in the use of the framework: to familiarize themselves with its language, principles, and rules and, thus, develop their ethical expertise.

In one example of a straightforward case, the IFR panel of RHA Z examined the case of Patient A—a middle-aged man who requested approval of acupuncture treatment for lower back pain. The requested treatment (acupuncture) was not novel—everyone on the panel, including non-clinical members, was aware of it. The panel received a pack of documents about the case a week before the meeting, including the letter from the patient's primary care doctor, a copy of the National Clinical Guidelines, the completed IFR form and the results of a literature search on "acupuncture for lower back pain" conducted by the panel librarian. The patient's doctor asserted in writing that funding should be approved in the light of the (then) available National Clinical Guidelines. According to the Guidelines, patients diagnosed with lower back pain should be offered:

> "One of the following treatment options, taking into account the patient's preference: an exercise program, a course of manual therapy including manipulation, or a course of acupuncture (more details on each below). Consider offering another of these options if the chosen treatment does not result in satisfactory improvement of acupuncture needling, up to a maximum of 10 sessions over a period of up to 12 weeks."

The panel's discussion unfolded as follows.

> *Marianne* [public health consultant] opens the discussion: "It [the recently published systematic review] clearly shows that there is no evidence of clinical effectiveness. Acupuncture does not work for lower back pain."
> *Andrew* [pharmaceutical advisor] adds: "that's my reading, too."
> Everyone in the group nods.
> *Matt* [IFR chair], approvingly says. "I am hearing that the panel should turn it down. Let's just be a bit careful with the wording. We should not highlight that the National Guidelines are outdated."

> *Marianne* adds: “I am more than happy to face the public and explain our reasons for this decision [to decline]. There is just no evidence of clinical effectiveness!”.

The decision was recorded as follows: “Although the Panel recognizes the National Guidelines that recommend acupuncture for lower back pain, the panel were directed to the literature search which includes systematic reviews which show no evidence that acupuncture works for lower back pain. There is clinical evidence to suggest that this treatment is not clinically effective.”

Drawing on the situational cues of the case (e.g., clinical condition, criteria matching condition to suitable treatments, etc.), the panel members swiftly figured out that the patient was eligible according to National Clinical Guidelines (the IFR appeared to pass the policy test, see Figure 1). However, as one member articulated the overt failure of the case to stand the “clinical effectiveness test” (Test 4, see Figure 1), panel members quickly reached a unanimous decision to decline the request—most of them nodded approvingly without invoking the framework’s criteria during their deliberation. Having “internalized” the framework, as one member put it, they skillfully enacted it without much need for dialogic deliberation. They did what was clear to all needed to be done.

—Insert Table 4 here —

“Complex cases”: enacting the framework’s prescriptions effortfully

In what panel members often described “complex” cases, they made the framework’s decision-making formula conspicuous in their deliberations and put additional effort to apply it *in situ.* As it was ambiguous what the framework’s guidance meant in relation to such cases, panel members faced interpretative challenges, and disagreements often broke out that had to be addressed.

In one example of a complex case, RHA Y examined the case of Patient B—a 14-year-old boy that requested, through his primary care physician, funding for an expensive drug

licensed for an unusual metabolic disease, Phenylketonuria ("PKU")[6]. The newly licensed drug was described as "the first pharmaceutical treatment available for the treatment of PKU" (excerpt from a formal report used at the IFR meeting). The panel received the application file which included several supporting documents (e.g., emails; letters from parents, doctors, dieticians, a psychologists, schoolteachers, full-text academic papers published in top biomedical journals (e.g., Sanford and Keating, 2009) and scientific reports).

In this case, particularizing and generalizing were effortful. While members agreed on the need to generalize, in order to uphold the organization's abstract ethical principles (exclusive focus on clinical benefit, see Table 1), they disagreed on how to do so. Specifically, one panel member remarked that "the request is motivated by a behavioral issue" (i.e., it is a case that falls under a general class of behavioral cases) and drew the panel's attention away from the other particularities of the case. By framing the case as "behavioral", and therefore non-clinical, according to the framework's principles (to examine requestors' clinical needs *only*) the case should not be discussed as IFR. Conversely, other panel members noted the uncommon *clinical* needs of the patient, which raised an ethical issue for the organization and called for the careful application of the framework's formula.

Perplexed by the clinical characteristics of this case, panel members decided to apply the framework's tests to organize their deliberation, which unfolded as follows:

> *John* [Chair] addressed everyone: "What do we think about [evidence of] clinical effectiveness?"
> *Caroline* [public health consultant] worryingly said: "Moderate."
> *Pat* [pharmaceutical advisor] strongly interjected: "There is no evidence! The case is not about PKU, but about malnutrition. […] It is also quite clear that there is no evidence of organic damage. Also, they didn't submit any new evidence, only some letters from the father and the doctor."

[6] According to a formal report used during panel discussion: "PKU is a rare metabolic disease resulting in raised blood phenylalanine levels, which can reach neurotoxic concentrations. The condition is characterized by poor neurocognitive and neuromotor development with subsequent impairment of intelligence and social functioning. Management is by dietary restriction of phenylalanine. […] This requires almost complete elimination of protein-rich foods from diet with the substitution of specially prepared dietary supplements. It is widely acknowledged that the dietary supplements required are considered by patients to be of low palatability."

Barbara [senior manager] immediately reacted: "We've got something here! The patient is losing weight (pointing to some evidence from the application file). Beware that we have a responsibility for all the needs of the patient. […] After all, we are in the business of meeting needs."
Caroline: "There is some evidence that the drug works. While the existing treatment [already funded by RHA Y] works, there is some evidence that if you respond to the drug, your malnutrition improves." She then alluded to a formal appraisal report on the drug, which suggested that "young children and adolescents might be one subgroup that will benefit more from treatment than the general population as their neurocognitive ability is still considered sensitive to the effects of Phe (phenylalanine) at a time when academic achievement is crucial and when dietary management begins to falter."
Nick [associate manager]: "But, we don't have evidence the drug addresses psychological problems."
Pat: "He's malnourished because he [the patient] is refusing to eat! He's made a decision not to eat! He needs psychological support. [Reading an excerpt from a report circulated during the meeting]: 'it is perhaps optimistic to expect that a patient, who cannot comply with dietary restrictions, is able to comply with a daily medication regimen'."
John tried to summarize the debate so far: "We received no *new* evidence of clinical effectiveness."

In gauging deservedness, panel members strove to be fair by conforming to the framework's procedural requirement to apply the tests, step-by-step, and reserving judgment until they had collectively examined the evidence. In debating clinical effectiveness (test 4, Figure 1), the panel shared their readings of the available evidence and discussed whether and to what extent the requested drug could improve the individual requestor's health. However, disagreements over the evidence became salient, for example, with Barbara and Caroline convinced that there was a strong causal connection between the improvement of Patient A's health and the use of the requested drug, though Pat apparently disagreed. Panel efforts were further complicated when attention was turned to the exceptionality test (test 3, Figure 1), as prescribed by the ethical framework.

John [IFR chair]: "We need to check the evidence for exceptionality. Does this patient have an exceptional ability to benefit?"
Caroline [public health consultant] said, worryingly: "We don't know. But he [the patient] does have unusual needs. The dietician was very clear. She was very happy to support it [approving of the request]. This is about quality of life."

> *Pat* [pharmaceutical advisor] confidently interjected: "This is not exceptional. [reading loudly the recommendations of a widely esteemed Medicines Advisory Group] 'There is no evidence to support the existence of any costs that can be offset against the cost of this drug. […] It is entirely additive to existing therapy.' I cannot find any evidence that this patient deserves more than what we already pay for his standard treatment. I cannot see why he is different from other PKU patients."
> *John* [*IFR chair*] hesitantly summarizes: "It seems that the view of the panel is that there is little evidence of exceptionality. […] Are we all comfortable [to decline the case]? We need to be really careful about how we minute this. There seems to be interest by the press."

While panel members largely agreed on the abstract meaning of exceptionality (i.e., the formal definition included in the framework), their discussions revealed different interpretations of how it applied to the case at hand, generating ethical equivocality. For example, Barbara was unsure about the exceptionality of the case, Caroline found "some" supportive evidence for exceptionality, and Pat was convinced that there was "no evidence." Panel members' conclusions on the correct application of the same ethical rule—the exceptionality test—varied, preventing a consensus judgment.

To overcome these challenges, panel members engaged in two kinds of sensegiving interventions: (a) mobilizing authoritative texts and (b) invoking the voice of the 'impartial spectator' (further examples from our data are shown in Table 5). Mobilizing authoritative texts involved verbally citing the written recommendations of an esteemed expert group or the conclusions of peer-reviewed and published academic papers, such as papers reporting on the findings of Randomized Controlled Trials—the 'gold standard' of biomedical research (Luce et al., 2010). This created "argumentative pressure" (McMahon, 2009: 107) on other members to either revise their positions or respond through a better argument, a more authoritative account, which others could agree on.

—Insert Table 5 here —

In this case, for example, Pat mobilized authoritative scientific papers and expert reports to lend credibility to, and improve the coherence of, his earlier argument ("There is no

evidence!"), resulting in panel members with differing views not persisting with their arguments. In effect, they were swayed by Pat's argumentation move of "ventriloquating" (Bakhtin, 1986) letting the evidence speak as if it had an autonomous and fully objective voice. Mobilizing authoritative texts enabled panel members to converge on a single authoritative interpretation of the evidence and construct an unambiguous account for whether the case passed the framework's 'clinical effectiveness test'.

In a few cases, the use of this discursive intervention significantly prolonged the deliberative process. For example, in a case discussed at RHA Z, a new drug had been requested "to aid stem cell collection prior to transplant". Caroline (the public health consultant) was confused about the abstract of the paper published in the prestigious *Journal of Clinical Oncology* and asked the librarian to provide the full paper. Pat (pharmaceutical advisor), who had originally mobilized the text to convince others that there was no evidence of effectiveness, dovetailed with Caroline: "It doesn't make sense! The article contradicts itself! We need to read the full-text article, and if it doesn't make sense, we have to contact the authors." In this case, the decision was made only after the full-text of this authoritative paper was examined to determine whether the drug requested was clinically effective.

In addition to mobilizing authoritative texts, panel members invoked the voice of the "impartial spectator" (Smith, 1761; Broadie, 2006; Williams, 2006) to resolve interpretative differences regarding the evidence of exceptionality (test 3, see Figure 1). The impartial spectator was not a particular individual they had in mind, but an abstract, unspecified individual, often referred to as "someone else",— in Bahktin's terms, the "indefinite unconcretized other" (1986: 95). The reference to "someone else" was to hypothetical other "quiet groups of patients", "groups of patients who don't have the ability to write" (interview excerpt with RHA Y IFR chair) or the taxpayers at large, who, if they had faced the same case would have drawn the same conclusion. The Chair, and occasionally other panel members, for

example, would often ask whether they should be "spend[ing] that money on someone else", alluding to the needs of other abstract individuals drawn from the population at large and encouraging the group to appreciate the meaning of exceptionality (see Table 5 for other examples). Such invocation during deliberations was a recurrent theme in our data (see Table 5). For example, in the case of Patient B, the "others" included any potential PKU claimant, whose needs had to be taken into account if aggregate utility (total health) was to be maximized fairly, as per the exceptionality definition included in the organizational ethical framework.

Through mobilizing authoritative texts and invoking the impartial spectator, panel members overcame their interpretative differences to conclude their deliberations. The equivocality they experienced was incrementally reduced until it allowed all participants to align behind a decision. The resulting decision had enacted the framework's prescriptions as it had been obtained through collective deliberation (as per the framework's principle of rational deliberation see Table 1), through following the prescribed procedural sequence, and through applying the decision-making formula. Interestingly, the challenges that the panel had experienced when enacting those prescriptions, and the undecidability that had plagued their discussion, were largely glossed over when co-authoring a collective judgment in writing. In the case of Patient B, for instance, they recorded their verdict in an unambiguous fashion:

> "This case is unusual in that the panel was being asked to approve the funding of the drug not for its primary purpose (PKU) but to help control the patient's behavioral difficulties and resulting malnutrition. We accept the necessity of considering the patient as a whole, but there is no evidence to support the use of [the requested drug] in this way. There is an effective well established alternative therapy which is maintaining this patient's primary current therapy. The RHA's responsibility is to meet the needs, not wants of its entire population.

"Outlier" cases: Problematizing the framework's prescriptions

In a few cases, which panel members referred to as "outlier" or "rare", we observed panel members' problematizing the rigid adherence to the decision making formula. They

critically questioned the formula and made ethical judgments on the basis of what intuitively 'felt right'. However, this was an open-ended process, fraught with distinct difficulties.

In one example of an outlier case, RHA Z examined the IFR request by Patient C. The request was for IFN Gamma Therapy for Neutrophil disorder. Patient C was a young female who had been diagnosed with leukaemia in childhood, which went into remission. There was also a note on the prevalence was 1< in 10,000 and that "treatment cannot be stopped." The discussion unfolded as follows:

> *Eric [IFR chair]*: "Doctors are still uncertain of the diagnosis!"
> *Judith* [public health consultant] said, worryingly: "we can't stop the γ-INF! The hospital is still funding the treatment. It is expensive to be in ITU for two weeks!"
> *Andrew [pharmaceutical advisor] looks at the evidence*: "There is only one randomized control trial (RCT) reported. The therapy may be effective in adults; there are no National Guidelines available for the specific case and the Scottish Health authority also has no position on the topic at present…"
> Everyone in the room is visibly reticent. The request is extremely rare and urgent. Yet it would be impossible to source authoritative evidence to pass the test of clinical effectiveness.
> *Judith* [public health consultant] breaks the silence as if speaking on behalf of everyone else: "What are the chances of having another one?!"
> The panel decided to approve the request and recorded their decision as follows: "This is IFR due to Rarity of condition. There is no other reasonably substitutable treatment. There is limited evidence of clinical effectiveness, as this is extremely rare. There is an RCT which shows that treatment to be effective. This is also a cost effective use of NHS resources."

In this and other outlier cases, panel members tried to enact the framework's prescriptions, when gauging deservedness. In the case of Patient C, following the framework's formula meant that panel members should decline the request: while the case was rare (passed test 2, Figure 1), the evidence of clinical effectiveness was lacking (failed test 4, Figure 1). Contrary to other more straightforward cases, however, they felt that sticking to the framework's formula would mean making a decision that would be wrong. Based on their intuitive moral sense, panel members critically questioned whether rigidly adhering to the framework was the right thing to do. Moreover, Judith (public health consultant) drew people's

attention to the "chances of receiving another one". Her point was that if the panel chose to fund this request, the risk of having to apply the same decision to a similar case in the future was very low. Panel members decided to approve the IFR.

In another outlier case concerning an expensive drug for eye treatment (Avastin®), panel members noted that there was "currently no good evidence available." If they had strictly followed the decision-making formula, they would have had to reject the request. Yet panel members focused their attention to the strong likelihood (as indicated by clinician letters) that "the patient will go blind if no treatment is given," which felt outright to be wrong; they chose to approve it. Yet, even though panel members had problematized some of the framework's core prescriptions, they still invoked the framework's language during their deliberations to arrive at the decision. For example, they still referred to the "lack of evidence of clinical effectiveness" whilst noting that "there is some biological plausibility and contextual evidence of stabilization." They also justified the approval by flexibly adapting the exceptionality principle, as follows: "This is a very exceptional case as blunt trauma to both eyes is unusual. If the patient goes blind, the cost for the population to support a blind person would be higher than the cost of funding the drug" (Chair summarizing the discussion). The use of the framework's language, therefore, allowed the panel to adjust the decision-making formula to the circumstances, rather than dismiss it outright.

However, problematization was an open-ended process. When the discussion about a particular case kicked off, some panel members remained narrowly focused on how to address the specific question of the decision-making formula (e.g., the clinical effectiveness test, see Figure 1). For these members to join others in questioning the framework's premises, they had to be nudged, through sensegiving, to take note of the possibility that by sticking to the formula might lead to an inhumane decision. One sensegiving intervention used on such occasions was *stressing sympathy and common humanity*. For example, in one rare case concerning a laser

treatment to eliminate serious facial hairs, there was weak evidence of clinical effectiveness. Some panel members were starting to argue for a 'No'. A panel member nudged them to critically question the 'No': "I feel sorry for this person. I think we would be very stingy if we said 'No'. The requested procedure is quite inexpensive. In this case, funding would really make a lot of difference. Meanwhile, the cost of special devices to eliminate facial hairs over the years would exceed the cost of the laser procedure." Her critical voice helped other panel members see the need to prioritize sympathy with the requestor at the expense of rigidly applying the framework. Consequently, they agreed to approve the request.

Another sensegiving intervention was to *highlight the inadequacy of the framework's moral guidance*. For example, in a rare IFR case (a request for "Stereotactic Radiosurgery for Brain Mets"), a panel member at RHA Y openly urged panel members who argued for a 'No', to change their minds using the following argument:

> "It just doesn't feel right that because she [the patient] got radiotherapy first she cannot get brain surgery (radiosurgery) now [...] I think it's harsh to apply policy with a cost-effective solution available. We can't be in a situation where we are so rule-bound and just walk away!" (from field notes)

That member highlighted the inadequacy of the framework's formula to navigate the decision making process: rigid adherence to the framework felt counter-intuitive and would yield a suboptimal ethical outcome, thereby convincing others to approve the request.

Thus, in contrast to complex cases, where the prescriptions of the framework were effortfully enacted, in outlier cases, they were often problematized. Further examples are shown in Table 6.

—Insert Table 6 here—

At times, however, the outcome of problematizing the framework was to eventually reinforce, rather than weaken its authoritativeness, following disagreements over the appropriateness of intuitive responses to the case at hand. Specifically, some panel members were particularly mindful of the framework's explicit denunciation of intuitive judgments and

the so-called "rule of rescue," i.e., the impulsive urge to use any available "resources [to] 'rescu[e]' identifiable individuals who are in imminent danger" (Sheehan, 2007: 352)[7]. When disagreements emerged over the expression of sympathy and the need to problematize the framework, the adherents to the framework used sensebreaking interventions, i.e., discursive moves prompting others to "re-consider the sense that they have already made [and] to question their underlying assumptions" (Maitlis and Christianson, 2014: 69).

Specifically, in some outlier cases where such tensions emerged, we observed the recurrent use of 'reprimands' and 'reminders' as ways to urge participants to *not* critically questions the framework's prescriptions but put more effort into enacting them rigorously (see Table 7 for examples). Reminders would rhetorically support reprimands. In particular, in response to intuition-based statements, such as "I have a feeling that it's a 'Yes'" and "The patient's doctor has written a very eloquent letter, I feel it's a 'Yes'", the Chair (who often acted as the spokesperson of the framework) or other members would respond with a reprimand ("we mustn't give procedure on the basis of the eloquence of the letter") and a reminder ("let's go back to the criteria"). For instance, in RHA Z, the panel examined a request for an expensive drug license while the patient had been in intensive care and "in imminent risk of death". Some panel members immediately argued for a 'Yes'. Yet, others reprimanded them in a patronizing tone: "You bring emotion to the table!" reminding them that "This group is about fact and evidence!", that "we are supposed to be rational" and that "we should ask the question 'Should we spend that money on someone else?' The rule of rescue does not apply here." The reprimands and reminders made the authoritative normative voice of the framework (the "rule of rescue does not apply here") present in the discussion. Thus, reprimands and reminders reinforced a discursive loop: while reminders enhanced the

[7] The rule-of-rescue was explicitly censured in the framework as follows: "To give in to the impulse to 'do something' can result in inconsistent and unfair decision-making because agreed principles and policies are set aside *in order to meet the needs of the decision maker* (i.e., to feel good, avoid feeling bad, avoid unpleasantness or reduce risk)" (italics in the original text of the framework).

visibility of the organization's ethical prescriptions and updated the group's understanding of how those prescriptions should be applied (i.e., by striving to be dispassionate moral reasoners), reprimands disrupted panel members' unreflective reliance on their intuitive selves.

—Insert Table 7 here —

For some group members, however, accepting the framework's injunction to behave dispassionately and suppress personal feelings under all circumstances was an ongoing personal struggle. One panel member in RHA Z (a GP doctor) resigned, as she felt that the panel was procedurally "too rigid" (in her words) and fixated on principles, and as a result, unjustifiably rejected many requests from patients in need of exceptional treatment. Another member (the Chair of RHA Y) felt that the strict adherence to procedures (e.g., sourcing and carefully analyzing all the relevant scientific literature) at the expense of problematizing the framework often meant delaying decisions and prolonging the individual requestor's suffering and agony. These panel members were torn between what they saw as diverging ways of 'being ethical', even though others reminded them that they ought to behave in accordance with the framework's prescriptions.

Discussion

Under growing "accountability pressures" (Schildt et al., 2020: 255) to reconcile the competing ethical demands of diverse stakeholders (Palazzo and Scherer, 2006; Reinecke et al., 2017), organizations are increasingly developing prescriptive ethical frameworks as guides to ethical decision making. Yet our understanding of how such frameworks are mobilized in practice within organizations has been limited. Drawing together our findings, we depict, in Figure 2, a model of how a prescriptive organizational ethical framework is enacted in practice and unveil its multifaceted guiding role in collective ethical sensemaking processes.

—Insert Figure 2 here—

Specifically, our model suggests that in many cases (deemed "straightforward" by decision makers), the framework's prescriptions are enacted unproblematically and ethical equivocality (Sonenshein, 2007)—ambiguity over the right thing to do—is experienced to be low (path 1in Figure 2). The framework appears as readily "available equipment" (Dreyfus, 1991) to organizational actors, unproblematically guiding their collective sensemaking processes and structuring how they think about, discuss, and grapple with the right thing to do, in a "transparent" fashion (ibid). Operating within an "absorbed coping" mode, actors are "subsidiarily aware" (Yanow and Tsoukas, 2009: 1349) of the directionality the framework provides in their ethical sensemaking; the normative language of the framework and its prescriptions are the background tools, "not the object of [their] attention" (ibid).

In "complex" cases, however, enacting the framework involves significant deliberative effort (path 2). Ethical equivocality in such cases is experienced to be high since organizational actors do not spontaneously grasp and/or agree on what the framework's prescriptions mean in relation to the particular case at hand (e.g., the evidence is debatable). They appear to switch from an absorbed coping mode of sensemaking to one that is deliberate (see also Sandberg and Tsoukas, 2020). Operating within a deliberate coping mode, the framework appears as "*un*available" (Dreyfus, 1991: 71) and "conspicuous" (ibid), rather than readily applicable. That is, actors' awareness shifts "from what had up until that point been background or subsidiary [i.e., the framework's directionality in ethical deliberations] to focal or thematic [awareness]" (Yanow and Tsoukas, 2009: 1352). As Yanow and Tsoukas (2009: 1352) note, "it is a shift from attending from the tool(s) being used, to attending to the tools themselves." To reduce equivocality and reach consensus, panel members engage in "sensegiving" (Maitlis and Christianson, 2014), such as mobilizing authoritative texts, and invoking the impartial spectator. These interventions allow them to maintain, albeit effortfully, the framework's

normative boundaries, i.e., expectations that the group's ethical deliberation should be bounded and narrowly focused on applying the framework's decision-making formula.

Finally, organizational actors may deem cases as "outlier" when ethical equivocality becomes intractable to them. Here, they sense that rigidly adhering to the framework's decision-making formula will lead to unreasonable decisions and/or potentially glaring or morally reprehensible failures (path 3). In such situations, they can neither draw unproblematically on their past experiences to spontaneously apply the framework, as in the "straightforward" cases, nor intensify their sensemaking efforts to render the framework applicable, as in the "complex" cases. They switch to what we call a "critical coping" mode; namely, they treat the ethical framework as dysfunctional, rather than authoritative, equipment for their ethical sensemaking. This happens through sensegiving interventions, such as stressing sympathy and common humanity and highlighting the framework's inadequacy. These interventions allow them to push the framework's normative boundaries and make a decision based on what intuitively feels right to them as a group (arrow 3a), whilst still embracing the framework as an important part of their normative apparatus.

Yet, not all organizational actors may agree with the problematization of the framework. Instead, they may engage in "sense*breaking"* (Pratt, 2000), such as reprimanding and reminding, to coerce other group members to apply more effort to enact framework's prescriptions. When successful, these efforts contribute to a collective switchover from a "critical" to "deliberate" coping mode of ethical sensemaking, and to a reconceptualization of the case at hand as "complex", thus bringing it within the framework's normative boundaries, rather than treating it as an "outlier" (arrow 3b).

Our study makes several theoretical contributions. First, our study advances current understanding of the substantive role prescriptive organizational ethical frameworks may play in ethical sensemaking processes. Prior studies of ethical sensemaking suggest that

organizational actors use the prescriptions articulated in an ethical framework largely as a legitimizing tool to wrap intuitive ethical judgments with a "veil" of objectivity (Reinecke and Ansari, 2015: 882). These studies view ethical frameworks as somewhat peripheral to ethical judgments, as organizational members tend to invoke a framework's moral reasoning to explain or justify their decision *post hoc* (Haidt, 2001; Sonenshein, 2007, 2009). Our study challenges this view. By conceptualizing an organizational ethical framework as "equipment," we show how it plays a *constitutive* role in collective ethical sensemaking. Our findings demonstrate that a framework's prescriptions become constitutive of actors' thinking, talking, and deliberating with one another about the ethical aspects of a case at hand (Garfinkel, 1967). The framework is integral, rather than peripheral, to the process of ethical "issue construction" (Sonenshein, 2007: 1027) — to what is noticed, where attention is focused, what the relevant ethical concepts are, how deliberation is conducted. Our findings show that the ethical equivocality of the situations organizational actors find themselves in can derive more from the challenges of applying the framework's prescriptions *in situ,* and less from the emergence of "multiple competing intuitions" (Haidt, 2001: 819) or conflicts between actors' incompatible ethical stances (Reinecke and Ansari, 2015). In essence, our study shows that organizational actors' efforts to enact a prescriptive ethical framework *in situ* are inextricably intertwined with their sensemaking efforts to address the ambiguous question of 'What is the right thing to do?'. Rather than a *post hoc* rationalization device, a prescriptive organizational ethical framework is consequentially implicated *throughout* the ethical sensemaking process by directing ethical sensemaking in particular ways and, thus, excluding, in effect, other ways of exploring that question.

Moreover, our analysis suggests that an organizational ethical framework is constitutive of the ethical sensemaking process, not only when its prescriptions are enacted and applied in practice, but also when they appear inapplicable. In particular, in categorizing a case as outlier,

ethical sensemakers problematize the framework and rely on their intuitive selves to make a final decision. Yet, as we saw in our study, they view this reliance not as a disregard for the framework's prescriptions, but as a necessary means to work around its limits, make ethical equivocality more manageable, and avoid making potentially inhumane decisions. Like Garfinkel's (1967) jurors, IFR panel members collectively made judgements based on common sense with a view to adjusting the framework's prescriptions to the circumstances at hand, rather than overriding them as inapplicable (Maynard and Manzo, 1993). For example, in such outlier cases, they remained focused on establishing "exceptionality" as per the framework's prescriptions, not by answering directly the question posed by the "exceptionality test" (see Figure 1), but by addressing a more plausible one—i.e., 'Does it feel right to treat this case as exceptional?'. Our study therefore shows that even when a prescriptive ethical framework may appear inapplicable, it remains constitutive of organizational actors' sensemaking efforts.

This insight also highlights that ethical sensemaking requires critical thinking skills that go beyond competencies for instrumentally applying ethical rules and is relevant to other settings. In many organizations, the consistent application of stringent ethical policies and rules is mandated, often with a view to eliminating possibilities of human error. Organizations often "configure" (Woolgar, 1990) the context of decision makers' work through removing leeway and enforcing a mechanistic application of organizationally prescribed ethical rules, as if applying sophisticated algorithms. For example, Facebook's moderators are expected to review as many posts as possible and enforce its ethical rules within a very limited timeframe[8]. Moderators risk facing punitive measures, or even being fired, if they do not apply Facebook's ethical rules consistently[9]. Under such a configuration, problematizing the ethical rules *in situ* is significantly undermined; as such, moderators may end up making decisions that defy

[8] https://www.nytimes.com/2018/12/27/world/facebook-moderators-takeaways.html
[9] https://www.theguardian.com/technology/2020/oct/26/facebook-moderators-workplace-treatment-us-election

common sense. Our study cautions against such configurations, which are premised on assumptions of rational reasoning. Our findings suggest that no matter how sophisticated the rules of ethical frameworks are, like computer algorithms, they alone are very unlikely to resolve equivocality in all situations – indexicality is an inherent feature of rules and linguistic statements at large (Garfinkel, 1967: 21). Rather, deploying critical thinking skills and exercising judgment in applying a framework's rules *in situ* is crucial for reducing ethical equivocality. The broader implication of these findings is that such skills can be particularly useful in avoiding potentially glaring ethical failures that can arise from the crude application of a prescriptive ethical framework.

Second, our study builds upon and extends the theoretical insight that ethical sensemakers "cope with tensions between universalizable reason and contextual judgment" (Reinecke and Ansari 2015: 879). In particular, ethical sensemakers may struggle to reconcile abstract principles, such as rationality, objectivity, and impartiality, prescribed by an ethical framework, with the particularities of real-world decision situations; they may end up "making exceptions" (op. cit.) that are context-specific, running counter to the systematic application of such principles. Our findings, however, paint a more nuanced picture by showing that the boundaries between universalistic reasoning and contextual judgments are blurred. Strikingly, our findings demonstrate that in making 'exceptional' individualized decisions, IFR panel members did not make contextual judgments at the expense of applying the framework's universalistic principles. Instead, by applying the general principle of "exceptionality" (and the associated "exceptionality test"), they were partially determining it in practice (Heritage, 1984: 121).

As Wittgensteinian scholars have shown, the application of a general principle, rule or concept is an "imaginative extension" (Johnson, 1993: 100; Lakoff and Johnson, 1999) of prototypical (in our case, "straightforward") cases. Particular acts of "evaluation" (Johnson,

1993: 89) are required to decide what counts as an "exceptional" IFR, which give particular form to general principles and concepts. Thus, in the "complex" and "outlier" cases, the framework is interpreted in situ, and how such interpretation occurs is a contingent matter. As several ethnomethodologists have noted, human agency is "always […] confronted with specific conditions and choices. Those conditions are not given, but are instead made relevant (or irrelevant) as a local matter" (Boden, 1994: 13; see also, Heritage, 1984; Garfinkel, 1967). Our findings show that when they examine a particular case, panel members select out, on the one hand, the relevant prescriptions of the framework, and, on the other, the relevant aspects of the case, trying to fit the two together. As our findings demonstrate, reaching a consensus on such fit might require several attempts and reiterations, whose outcome is precarious. Our study therefore suggests that, rather than working as mechanisms for navigating the inherent tension between "a universalistic mode of moral reasoning and a particularistic mode of contextual judgment" (Reinecke and Ansari 2015: 884), deliberative processes of ethical sensemaking may also contribute to the blending of the two); the general and the particular are mutually constituted (Luntley, 2003; Wittgenstein, 1958). We have unveiled how such blending is accomplished in practice.

More generally, our study advances current understanding of the role commonsensical rationality plays when enacting universal ethical principles. Like Garfinkel's jurors (1967) who were concerned with "justice", our panel members needed to treat requestors with "fairness" as well as ensure the panel's decisions and processes are legally accountable. In the juror case there is a judge who will ensure that the legality/correctness of the decision takes precedent when jurors vacillate between legal and commonsensical rationality. In our case, there is no specific judge, solely the "impartial spectator" who is conceived as an abstract evaluator of situated moral judgments. Importantly, we show how tensions emerge as "fairness" and accountability/correctness become misaligned. Most vividly in "outlier" cases, what feels fair

and what is correct appear to be significantly misaligned. Thus, our study offers new insights into the distinct challenges of reconciling *in situ* 'what is the (ethically) right thing to do' with 'what is the (legally) correct thing to do'.

Third, our study alters current conceptualizations of moral reasoning, which are often embedded in prescriptive ethical frameworks. Specifically, existing scholarship conceptualizes moral reasoning as "conscious, language-based thinking" on moral matters (Haidt, 2001: 816)– a "step-by-step" (Trevino et al. 2014: 638) logical process whereby actors first become morally aware, carefully weigh all available evidence, and then deduce from rational analysis what the most ethically appropriate course of action is (Haidt, 2001). Our study expands this understanding by showing that moral reasoning is a dialogical accomplishment. Moral reasoning, we found, is not just a conscious and cognitively effortful process of mobilizing universal ethical principles, evaluating the evidence, and applying rules of rational analysis to make a decision. Rather, it is an emergent social interactional process, in which elements beyond logic, such as sensegiving and sensebreaking skills, attunement to the temporal unfolding of dialogical exchange, and appeals to authoritative texts, are deployed to make a situated moral judgment. Our study therefore suggests that, mobilizing moral reasoning, as is often espoused in prescriptive ethical frameworks, is a social practical activity, requiring dialogical and critical coping skills from decision makers. This insight also casts doubt on the idea that moral reasoning can be encoded in (Awad et al., 2018), and/ or 'learned' by, increasingly 'intelligent' algorithms, such as ChatGPT, insofar as these artificial agents have no inherent moral sense with which to adapt and problematize an ethical framework *in situ* (Véliz, 2021).

Fourth, our research enriches the concept of "ethical expertise," i.e., the set of skills that "enable people to put into practice the moral values of their organization" (Dane and Sonenshein, 2015: 5; Dreyfus and Dreyfus, 1991). In particular, our study provides new

insights into how such expertise may develop through gaining experience in applying a prescriptive organizational ethical framework. Specifically, on the one hand, in situations of low equivocality, actors are able to "dwell in" the prescriptions of an ethical framework, namely assimilate and "interiorize" the framework (Polanyi, 1958:10) for it to be competently used, just like what they would be doing when using any other tool (Polanyi, 1958; Tsoukas, 2012). As mentioned by one IFR panel member, dealing with straightforward cases enabled them to "internalize" the framework, and develop an intuitive feel for when and how to apply it. On the other hand, situations emerge (such as in the more complex IFR cases) that call for sensemakers to expand their ethical expertise by deploying and developing new discursive and reflective skills. For example, IFR panel members developed "knowing how" (Nicolini, 2011: 610) to efficiently read and sift through the usually voluminous IFR documentation in order to construct convincing arguments; bring the imaginative voice of the 'impartial spectator' to bear upon their deliberations; respond to "argumentative pressure" (McMahon, 2009); and tacitly assent to a verdict of an authoritative source (e.g., the report of an expert group), to mention some of such skills.

Finally, our study highlights the disciplining role that prescriptive ethical frameworks play in organizational life. We found that, since an ethical framework demarcates clear normative boundaries on ethical behavior, it can induce disciplinary action. That is, organizationally-inscribed power and authority (e.g., the Chair of the IFR panel) can be used to detect 'deviant' ethical behavior, as defined by the framework, and bring group members who enact such behaviors back within the normative boundaries of the framework. As seen in our findings, this can happen through sensebreaking interventions, such as reprimanding and reminding. In other settings, of course, the boundaries of what constitutes 'deviant' ethical behavior may be articulated less clearly within a framework than in IFR cases (recall the explicit denunciation of the 'rule of rescue' in the IFR framework) or may point in an alternate

direction. For example, emotions (such as sympathy) might be recognized as a legitimate, or even essential, component of moral behavior (see Bishop et al., 2020). Future research is needed to explore disciplinary dynamics in the enactment of organizational ethical frameworks in other settings.

Boundary Conditions and Future Research

Like all qualitative studies, care should be taken when transferring the insights generated by our research to other settings (Tsoukas, 2009). Our study centered on highly formalized public bureaucracies where legal and rational norms prevailed (Brunsson, 1990) and, accordingly, findings are directly transferable to similarly structured organizations. The focal organizations in our study were also subject to significant public scrutiny and external pressures for transparency in their reporting, while the authority of science-based clinical texts and the "objectivity" of biomedical research was taken for granted (Cambrosio et al., 2006). When framing and navigating ethical equivocality through the framework's formula, panel members were confident that their practices conformed to broadly legitimate conventions and their decisions could be found legitimate by external audiences (Boltanski and Thévenot, 2006).

In other organizations, however, which are organized differently and in which institutionalized expectations are less pronounced, a normative ethical framework may not be explicitly articulated and operationalized (see Anteby, 2013). "Postbureaucratic" (Kellogg et al., 2006) organizations may not dedicate the same level of organizational resources to building such an elaborate ethical framework. Other frameworks may also be openly contested (Pitesa and Thau, 2013), or less prescriptive and invite exploration of diverse ethical perspectives, such virtue ethics (Bardon et al., 2017; Shotter and Tsoukas, 2014), Kantian ethics (Williams,

2006; Bowie, 2017), or discourse ethics (Scherer and Palazzo, 2007; Palazzo and Scherer, 2006).

That said, insights from our study are of relevance for organizations that are structurally different from the ones we studied. Many organizations operate under norms of rationality and, with the availability of social media, are increasingly subject to public scrutiny, being expected to be accountable for their actions (Greenwood et al., 2008). The particular bureaucratic organizations we studied provide an "ideal type" (Weber, 1949: 104) whereby certain organizational features are accentuated, thus sensitizing us, scholars and practitioners alike, to certain facets of, and operating tendencies in, organizational life at large (Sandberg and Tsoukas, 2011). Future research can fruitfully build on the insights of our study to explore and specify how an organizational ethical framework becomes constitutive in other, less tightly structured settings (e.g., entrepreneurial organizations) or in settings where the prescriptions imposed by an ethical framework are more contested among those expected to enact it (e.g., in inter-professional work). Such research has important practical implications, too, for gauging how, when, and if ethical frameworks impact collective sensemaking in a meaningful way and what organizational supports may need to be in place.

Finally, in our study, the ethical framework's designers were different from those who put it into action (panel members). The ethical framework had evolved over time, and it is likely that its constitutive role also evolved alongside the development of other organizational structures and routines. In other organizations, ethical frameworks may be designed by those who use them. Do such frameworks become constitutive in a different way? Are frameworks modified based on the lessons its users derive from ongoing application enhance their constitutive role?

Conclusion

Prescriptive ethical frameworks and sophisticated ethical guidelines are increasingly developed by a growing number of organizations facing perplexing ethical issues. In stipulating the use of such frameworks and guidelines in ethical decision making and other practices (one of the latest examples being designing trustworthy AI technologies), organizations hope to solve the diverse challenging moral problems they recurrently encounter. Through an in-depth inductive study of health organizations, we shed new light on the little understood process of applying a prescriptive organizational ethical framework in practice. Our research unveiled the invisible collective sensemaking work involved, the challenges and tensions that arise, and the variety of dialogical skills deployed, in enacting such a framework. We showed that deciding 'What is the right thing to do?', although organizationally addressed through a framework that is designed to be rational and formulaic, in practice is more open-ended, contradictory, and dynamic than realized. A prescriptive ethical framework, rather than being merely instrumentally used, is constitutive of the process of addressing that question of 'the right thing to do'. In our paper we showed how it is so.

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Table 1. Principles extracted from the ethical framework shared across organizations

Key ethical principles	Excerpt from framework
Impartiality	"The RHA considers all lives of all patients to be of equal value and in making decisions about funding treatments will seek not to discriminate on the grounds of age, sex, sexuality, race, religion, lifestyle, occupation, family and caring responsibilities, social position, financial status, family status (including responsibility for dependents), intellectual/cognitive functioning or physical."
Exclusive focus on clinical benefit	"Healthcare should be allocated justly and fairly according to need and capacity to benefit, such that the health of the population is maximized within the resources available. The RHA will consider the health needs of people and populations according to their capacity to benefit from health care interventions. Decisions can only be made on the grounds of the patient's clinical circumstances. Social and personal factors such as age, gender, caring responsibilities and family circumstances can only be taken into account where they are relevant to the patient's clinical outcome."
Clinical effectiveness	"The RHA will promote treatments for which there is good evidence of clinical effectiveness in improving the health status of patients. When assessing evidence of clinical effectiveness, the outcome measures that will be given greatest importance are those considered important to patients' health status."
Exceptionality	"Every patient has features of his or her condition which are specific to that individual and are not likely to be repeated in other patients with the same clinical condition at the same stage of progression of the condition. Exceptionality is not the same as individuality […] If a patient can be seen to be part of a group of patients for whom a treatment is not made available by the PCT under the PCT's existing policies then exceptionality for this individual patient is unlikely to be demonstrable."
Rational deliberation	"IFR decisions will be made rationally following a proper consideration of the evidence."

Table 2. Data collection table

Data sources	**RHA X**	**RHA Y**	**RHA Z**	**Total**
Non-participant observations of meetings	5	5	5	15
Decision processes observed	69	27	44	140
Semi-structured Interviews	4	4	4	12
Confidential documents (e.g., IFR documentation, meeting minutes)	Approx. 650 pages long	Approx. 750 pages long	Approx. 480 pages long	Approx. 1880 pages long
Public documents (policies, corporate publications)	31	22	33	85

Table 3. Data supporting the identified processes of ethical sensemaking

Representative evidence from IFR case discussions (fieldnotes)	**Ethical sensemaking process**
"This [IFR] is about the ankle. The patient is in severe pain. He would be able to go to work and go on with his daily life. It seems that his condition would massively improve with this procedure." *(IFR case: Autologous Chondrocyte Implant for Osteochondral Defect)* "The patient's BMI is 22.6. She is quite slim. The doctor says that the patient is under severe amount of psychological distress from her breasts. It is affecting her life in every way. She is unable to be happy. It is affecting her domestic situation, spoiling the relationship with her husband and children." *(IFR case: Breast reduction)* "The patient has had lower back pain for 18 months. He seems to be in quite a lot of pain and tried quite a few things. It's affecting his quality of life." *(IFR case: Acupuncture for Lower Back Pain)*	***Particularizing***: Detailing a person's plight, creating a plausible story of how the case came about
Patient's name removed from the application. *(IFR cases: Adalimumab for Chrohn's Disease; IVF; IFN Gamma Therapy for Neutrophil disorder; Acupuncture for Lower Back Pain; Genetic testing at a clinic; Plerixefor, etc.).* Patient's name removed from photograph (face not shown, only breast). *(IFR case: Breast reduction)* "The drug is requested for the purposes of peripheral blood stem cell harvesting prior to autologous haemopoietic stem cell transplantation… The average patient with hematological malignancy is eligible for autologous stem cells transplant, who has failed to mobilize stem cells with standard protocols." *(IFR case: Plerixefor).* "We should also not discuss non-clinical benefits. He may be able to return to work, but this is not relevant for our decision making. We are only considering clinical benefit." *(IFR case: Autologous Chondrocyte Implant for Osteochondral Defect*)	***Generalizing***: Editing out biographical details, referring to the individual as member of a group of equals (type of patient)

"There is some evidence (of effectiveness), not amazing. The outcome measure is stabilization. However, the published literature suggests that there is limited evidence of survival, while there is no evidence of cost effectiveness, I couldn't even calculate the QUALY (Quality Adjusted Life Years)… (looks worried) I am not even sure there is enough evidence (PH consultant)... This (request) is in the realm of research, not mainstream treatment." *(IFR case:* Yttirum - 90 DOTA octreotate*)* "If the patient's infection is not suppressed, then the patient's cochlear implants may be affected. Her health may severely deteriorate… There is limited evidence of clinical effectiveness that this procedure works [for this group of patients], as this is extremely rare. There is also no other reasonably substitutable treatment." *(IFR case: IFN Gamma Therapy for Neutrophil disorder)* "According to the patient's doctor: "He had atypical Hemolytic Uremic Syndrome when younger. Whereas the typical form follows an enteric infection with E Coli 0157 this did not.... Recently developed Type 1 Diabetes Proteinuria. We wish to define if it was a rare immunological defect..." Is there any convincing evidence on future health? The doctor says that there is some benefit in defining the risk of progression to chronic renal failure and risk to children… yet, we need documents of evidence of benefit [for this population of patients], not just letter." *(IFR case: Genetic testing at a clinic)*	***Gauging deservedness***: Critically assessing the evidence to determine the right thing to do

Table 4. Data about 'straightforward' cases

Representative evidence from IFR case discussions (fieldnotes)	**Applying the framework's prescriptions**
"We are unaware of the patient's occupation and what effect arthrodesis (alternative treatment) would have on his occupation and overall functional ability. This operation is normally undertaken on knees and there is no published evidence to support success of operation on ankles. The national technology appraisal guidance does not support treatment for knees, as there is so little evidence… There is insufficient evidence to support proposed procedure and no long-term information on clinical effectiveness. The evidence brought to the panel is just a case study and not even peer reviewed! It would be extremely unwise if we funded it. I am concerned about the long-term evidence available. There isn't any…" (*IFR case: Autologous Chondrocyte Implant for Osteochondral Defect)*	Panel members swiftly concluded that there is no evidence of clinical effectiveness
"All these reasons offered by the patient's doctor are in fact of cosmetic nature. There is also a long list of people with the same problem. There are no exceptional clinical circumstances. In fact the consultant says there is no indication to have any needle tests, or surgery. He does not make the case of exceptional circumstances. Do we agree that the suggested procedure is *largely* for cosmetic reasons? The request is motivated by how she looks. The consultant does say the cysts are benign and can be left alone. It is cosmetic… on the basis of the information we have it is cosmetic (i.e. a 'No')…, In view of our Policy on cosmetic procedures and on the basis of the information provided, the treatment appears largely cosmetic and no indication of a malfunction problem." *(IFR case: Breast reduction)*	Panel members swiftly concluded that there is no evidence of exceptional clinical benefit

"The patient may have good weight, is a non-smoker and has been trying to conceive for more than three years. Had she not been so old, the clinical benefit would have been more predictable. Apart from amplification of the patient's mental health status, there was no new relevant clinical information or indication of exceptional circumstances. Is she eligible in transitional age arrangement? The policy is quite clear, I am afraid. She does not meet the age criteria." *(IFR case: IVF treatment)*	Panel members swiftly concluded that there is no evidence of exceptional clinical benefit
"This is straightforward. The policy says people with BMI above 50 and with complexity are eligible. The public health consultant adds that the bariatric policy hasn't changed. The GP says that the case is clearly "below the borderline and there are no complications". There is no co-morbidity. The chair concludes "in view of our policy on Bariatric surgery for adults with morbid obesity, there are no significant co morbidities; the clinical indications outlined are expected with the BMI given; no evidence of weight management programs. Therefore, the patient does not meet the criteria and no indication of exceptional clinical circumstances."*(IFR case: Bariatric surgery)*	Panel members swiftly concluded that there is no evidence of exceptional clinical benefit

Table 5. Data supporting the use of sensegiving interventions in 'complex' cases

Representative evidence from IFR case discussions (fieldnotes)	**Sensegiving interventions**
"There is an RCT, which shows that treatment" [for the group of patients under which the requestor falls] to be effective. *(IFR case: IFN Gamma Therapy for Neutrophil disorder)* "There is strong evidence from clinical studies that the use of HDT and SCT improves survival compared with conventional chemotherapy…. National Guidelines IOG and clinical guidelines recommend NDT and SCT is considered an option." (IFR case: Rare cancer drug) "The 2008 National guidance on prostate cancer diagnosis and treatment - includes a recommendation that *'High intensity focused ultrasound (HIFU) and cryotherapy are not recommended for men with localized prostate cancer other than in the context of controlled clinical trials comparing their use with established interventions'*. The basis of this recommendation is that *'there was a lack of evidence on quality-of-life benefits and long-term survival, these interventions are not recommended in this guideline'*. Conventional treatment would be more appropriate in this case." *(IFR case: Cryoblation of prostate gland)*	***Mobilizing authoritative text***: Citing publicly available scientific reports
"Yet, still the question is: are there others to benefit? We have a responsibility to the population not only to the individual…We have no idea how many people have the same thing..." *(IFR case: Genetic testing at a clinic)* "Although the number of similar patients, who would benefit from this treatment, is small, it's predictable… the patient is not, in fact, exceptional but representative of a definable group of patients…. Others can benefit too. We need to consider funding this drug more holistically. We have a responsibility to the population not only to the individual." *(IFR case: Plerixefor)* "It [approving funding] would make a lot of difference to the patient's daily life..." Another panel member replies: "For sure, our decisions make a difference! Our responsibility is to meet the needs of the entire population." *(IFR case:* Yttirum - 90 DOTA octreotate*)* "There is a small, definable group of patients who could potentially benefit from this drug. This patient is not exceptional, in terms of her ability to benefit from this treatment. Although it's very sad, that potentially without further treatment this person may go blind anyway, but if you follow our policy, then the only decision you can make is not to fund." *(IFR case: Drug for eye treatment)*	***Invoking the 'impartial spectator'***: Referencing the needs of the wider population

Table 6. Data supporting the use of sensegiving interventions in 'outlier' cases

Representative evidence from IFR case discussions (fieldnotes)	Sensegiving Intervention
"There is no relevant commissioning policy. [According to the ethical framework, the panel should avoid making decisions on such an intervention when a cohort of similar patients could also benefit]. We need to give him a chance. The patient is profoundly deaf, I'd say YES! " The panel was swayed by this remark and approved the case. (*IFR case: Bilateral Cochlear Implant)* "The patient doesn't meet the eligibility criteria, and the requested intervention is generally considered to be of a cosmetic nature (little, if any proven clinical benefit). I feel sorry, we are being stingy, it is inexpensive. It would make a lot of difference. Over the years the alternative would exceed the cost of laser. Another member adds that the GP who wrote the letter "is a very conscientious and fair person and that therefore the case must be really as difficult as the letter." The chair now intervenes and asks if he is right to recollect that "in preceding occasions, we agreed that the face is a special case" and therefore this would militate for a yes. All participants agree. *(IFR case: Laser treatment for face hair removal)* The chair summarizes her interpretation of the case. She says that the case has "demonstrable comorbidity…" She says that the patient is on the brink of redundancy… (reading from the letter)… She is "favorable". The PH consultant says that when she first read it she said no, but adds that there are significant complications and the patient will "soon be totally immobilized… so it is a yes from me." The chair concludes: "so, we say yes… even though the case is slightly outside, there are sufficient exceptional circumstances. The patient has exhausted all channels and has very significant and potentially severe complications of the indicated co morbidities (bilateral knee replacement, lymphodaemia)." *(IFR case: Bariatric surgery)*	***Stressing sympathy and common humanity*** Relying on 'gut feelings' to complement the generic ethical guidance offered by the framework.
"There is a relevant commissioning policy, and the patient does not fit the eligibility criteria. The policy may need to be adjusted. It doesn't seem fair for the patient. Isn't it entirely reasonable to approve?" *(IFR case: Request for IVF treatment)* The PH consultant says that "published support in scientific journals is very limited. However, the patient is a young man… there is going to be a lot of benefit." Others nod. The chair summarises: "so our decision is to approve despite the lack of good scientific evidence. Although the volume of published evidence is limited in support of this device, the correspondence within the request indicates clear, positive clinical outcomes." *(IFR case - IPPB device for breathing in Ciliary Dyskinesia)* A PH consultant notes that "There is a problem with publications. Papers are accepted only if there are positive results to be reported. " Another member notes that "the patient is not, in fact, exceptional but representative of a definable group of patients". The PH consultant ardently responded: "Your rules horrify me! Stick for service development when there is danger for death. How do we sell that to the public?" The panel agreed to approve of the case. *(IFR case - Rituximab for Chronic Kidney Disease)*	***Highlighting the incompleteness of the organization's framework*** Pointing out what's wrong if strictly adhering to the framework's decision making formula

Table 7. Data supporting the use of *sensebreaking* interventions

Representative evidence from IFR case discussions (fieldnotes)	**Sensebreaking intervention**
The panel discusses a previously made case, which had been approved by the public health consultant. She said: "I had approved the case because the patient would have gone blind... [another panel member replies]. "This should not happen again. The rule of rescue does not apply here." The member, who made the decision, looks uncomfortable and replies, accepting the criticism: "Yes, I do understand that. That's the ideal course of action…" (the critic replies again). We have just set a precedent that we may regret… by approving that particular case, it would be difficult to reject similar cases in the future." *(IFR case: emergent eye treatment)* "He [the requestor] has many conditions, added together (expressing sympathy) ... [another panel member replies]. We need to set emotions aside, [and] ask the question: is he really exceptional?" *(IFR case: Genetic testing at a clinic)* A panel member says that she feels sorry for the patient and adds that they can also save money. Following her opening remarks, another member voiced her concerns: "We are not the Wellcome trust! We must not emphasize the money saved if we approve but that this case is experimental! This is an ethical issue. We can't say that if it saves money well then stuff evidence and do it anyway!" *(IFR case: cancer drug)*	***Reprimanding:*** Condemning the expression of emotions and sympathy as well as poor adherence to procedures
"It's sad this lady will go blind, but, according to the policy we cannot make a decision to fund a request whereby doing so a precedent would be set. We have to reject." *(IFR case: Plerixefor)* "Such a sad story… a young female [requestor] who was diagnosed with leukemia in childhood which at that stage went into remission. Last year she suffered from 6 extreme pyogenic infections and was admitted to ITU 6 times!... [another panel member replies] Unfortunately, we have to use the framework. Let's stick to it. The first question is: Is there evidence of exceptionality?" *(IFR case: IFN Gamma Therapy for Neutrophil disorder)*	***Reminding***: Referencing the overriding responsibilities of the group to consistently apply the framework's ethical principles

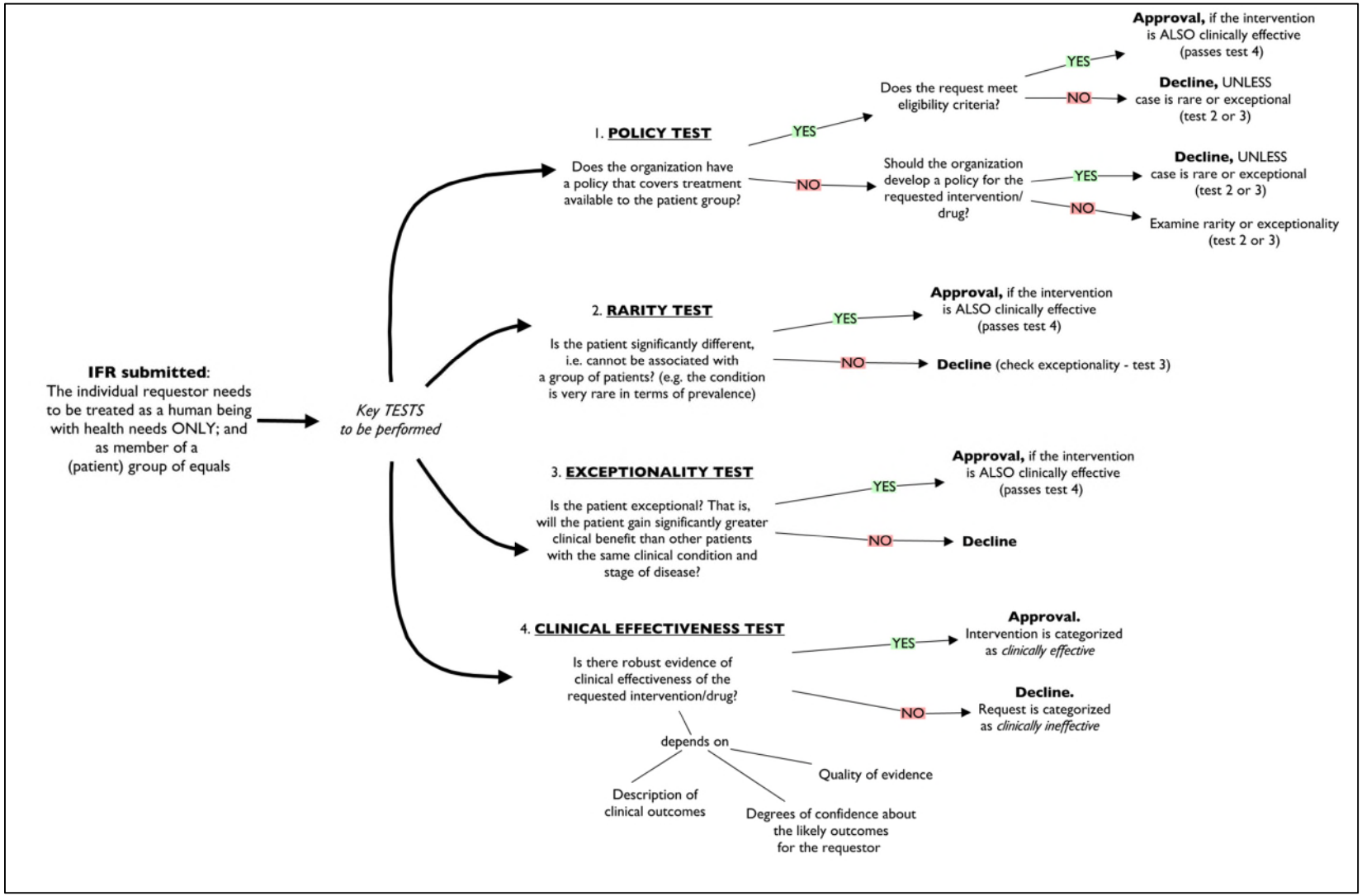

Figure 1. Visual representation of the framework's decision-making formula (constructed by the authors).

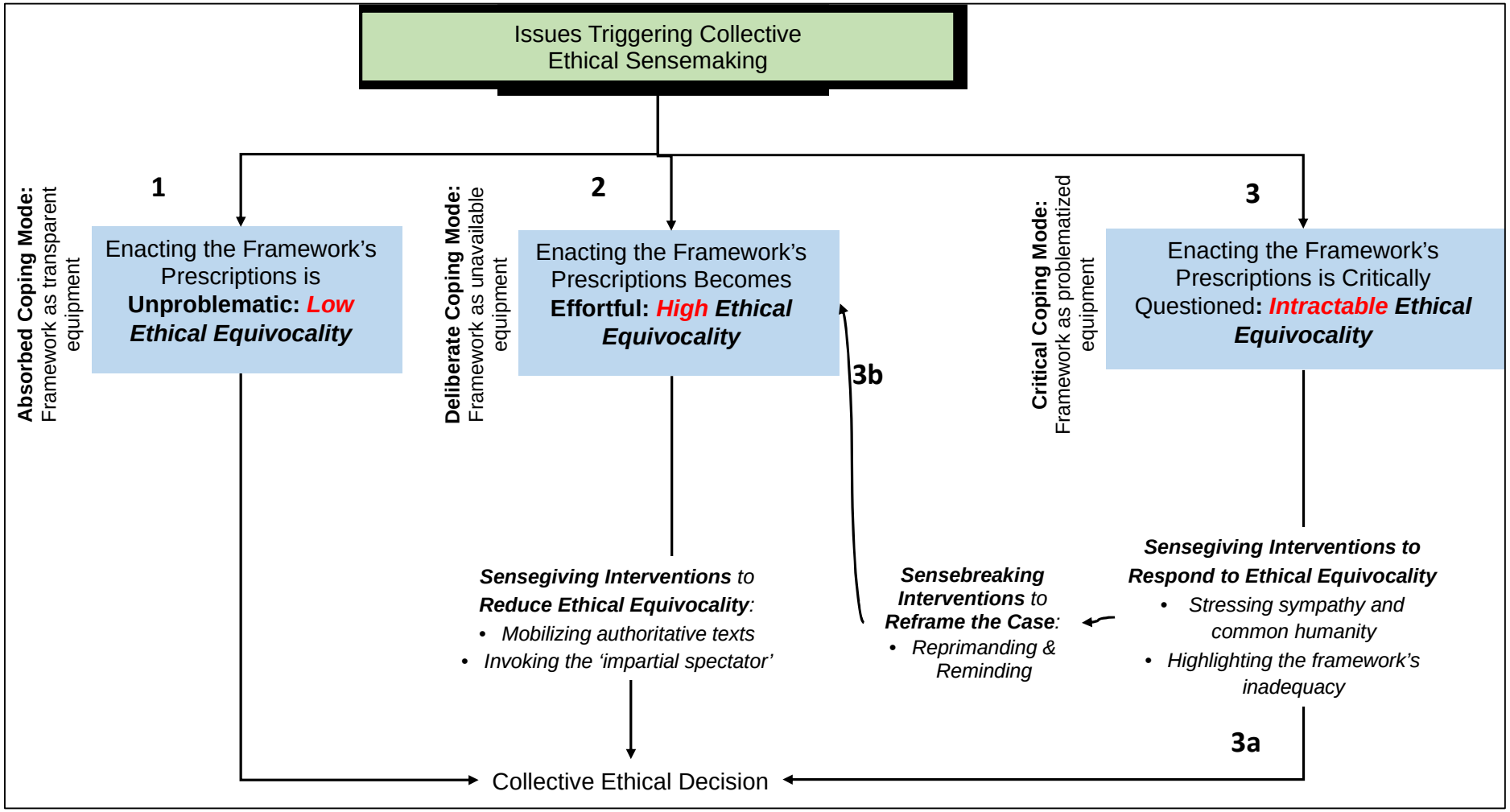

Figure 2. Enacting a prescriptive organizational ethical framework within processes of collective ethical sensemaking.