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Important outcomes of moral case deliberation: a Euro-MCD field survey of healthcare professionals' priorities

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ABSTRACT

Background There is a lack of empirical research regarding the outcomes of such clinical ethics support methods as moral case deliberation (MCD). Empirical research in how healthcare professionals perceive potential outcomes is needed in order to evaluate the value and effectiveness of ethics support; and help to design future outcomes research. The aim was to use the European Moral Case Deliberation Outcome Instrument (Euro-MCD) instrument to examine the importance of various MCD outcomes, according to healthcare professionals, prior to participation.

Methods A North European field survey among healthcare professionals drawn from 73 workplaces in a variety of healthcare settings in the Netherlands, Norway and Sweden. The Euro-MCD instrument was used.

Results All outcomes regarding the domains of moral reflexivity, moral attitude, emotional support, collaboration, impact at organisational level and concrete results, were perceived as very or quite important by 76%–97% of the 703 respondents. Outcomes regarding collaboration and concrete results were perceived as most important. Outcomes assessed as least important were mostly about moral attitude. 'Better interactions with patient/family' emerged as a new domain from the qualitative analysis. Dutch respondents perceived most of the outcomes as significantly less important than the Scandinavians, especially regarding emotional support. Furthermore, men, those who were younger, and physician-respondents scored most of the outcomes as statistically significantly less important compared with the other respondents.

Conclusions The findings indicate a need for a broad instrument such as the Euro-MCD. Outcomes related to better interactions between professionals and patients must also be included in the future. The empirical findings raise the normative question of whether outcomes that were perceived as less important, such as *moral* reflexivity and *moral* attitude outcomes, should still be included. In the future, a combination of empirical findings (practice) and normative reflection (theories) will contribute to the revision of the instrument.

INTRODUCTION

Healthcare professionals in various settings are confronted by different ethical challenges.[1,2] In order to deal with these, several types of clinical ethics support services have been developed.[3] The services are usually conducted through clinical ethics committees, clinical ethics consultation or moral case deliberation (MCD).[3] Increased awareness, through training programmes, research, publications, conferences and professional networks related to clinical ethics support, indicate that clinical ethics support is gaining prominence as an important professional domain.[4]

In Europe, MCD has received much attention in recent years[5] and may be used as an umbrella term[6] for ethics rounds,[7,8] ethical case reflection[9] and ethics reflection groups.[10] Using MCD as an umbrella term implies that MCD can represent several methods and is not a standardised method. However, common denominators across all methods have been agreed on: it is a facilitator-led collective moral inquiry into a concrete moral question connected to a real case made by healthcare professionals in their practice.[6,11]

Despite existing evaluation[8,10,12–14] and implementation research on MCD,[15] little is known about which outcomes are found to be important to MCD participants. This knowledge is normatively relevant, as MCD is designed to *support* healthcare professionals. Hence, it can improve the way in which the ethics service is tailored. Nota bene, in addition, there is a lack of clarity and consensus on how we define MCD outcomes and which MCD outcomes one *should* aim for,[16] that is, there is a lack of conceptual and normative clarity. In order to stimulate both the conceptual and normative discussion of these outcomes, the Euro-MCD instrument was developed to measure how healthcare professionals value and experience outcomes.[6] The instrument was primarily designed to be used as a tool for evaluating MCD sessions, but also to assist in tailoring MCD to its users, while acknowledging contextual and demographic differences. As we wanted to discover which possible outcomes are perceived to be most important, the Euro-MCD instrument includes a broad range of outcomes. They were selected after a thorough process using a literature review, a Delphi panel and content validity testing.[6] As such, in the instrument, we do not normatively define key outcomes for MCD or which outcomes should be more important, neither do we suggest that all these outcomes will, can and should appear. In fact, one of the key motivations for conducting this study was that so many MCD outcomes have been suggested without sufficient empirical evidence to support them. Thus, the main aim of the present study was to use the Euro-MCD instrument to examine the importance of various

Table 1 Demographic data

Respondents T.0 instrument		Total	Netherlands	Sweden	Norway
Respondents/gender	n (%)	703	331	275	97
	Female	564 (81)	227 (69)	250 (91)	89 (92)
	Male	133 (19)	101 (31)	25 (9)	8 (8)
Age	Median (range)	44 (20–68)	42 (22–65)	47 (21–65)	44 (20–68)
Profession, n (%)	Nurses	344 (49)	163 (49)	135 (49)	46 (47)
	Nurse assistants	119 (17)	4 (1)	73 (27)	42 (43)
	Therapists*	113 (16)	88 (27)	23 (8)	2 (2)
	Doctors	50 (7)	26 (8)	23 (8)	1 (1)
	Managers†	44 (6)	22 (7)	17 (6)	5 (5)
	Others‡	32 (5)	27 (8)	4 (2)	1 (1)
Prof. experience	Median years (range)	17 (0–50)	15 (0–43)	20 (1–45)	16 (1–50)
Workplaces/provinces, n		73/16	34/7	16/4	23/5
Healthcare settings	Community care services	28;137 (19)	1;9 (3)	5;35 (13)	22;93 (96)
n workplaces;respondents, n (%)	Somatic hospital care	16;343 (49)	4;99 (30)	11;240 (87)	1;4 (4)
	Psychiatric care	22;174 (25)	22;174 (52)		
	Mentally disabled care	6;49 (7)	6;49 (15)		

*Including social workers, physiotherapists, psychologists and spiritual caregivers.
†Including policy makers and heads of departments.
‡Including interns, trustees, secretary, clients, researchers and volunteers.

MCD outcomes, according to healthcare professionals, prior to participation. An additional aim was to compare differences among healthcare professionals across three European countries. Based on these findings and those of other future Euro-MCD publications, we will reflect elsewhere on the normative question relating to which MCD outcomes *should* be included in the revised Euro-MCD instrument.

METHOD
Design
We conducted a descriptive and comparative field survey employing both quantitative and qualitative methods. The results presented here form part of the larger observational Northern European evaluation project on MCD,[1 6 17–19] studying different existing MCD practices.

Sampling
A convenience sampling method according to observational design was applied, recruiting workplaces in Northern Europe: the Netherlands, Norway and Sweden. These workplaces, to

our knowledge, had planned to implement MCD in the near future due to an expressed need for reflection. Heads of departments or teams were approached first by phone, then through a formal invitation letter. In the Netherlands, heads of institutions or MCD facilitators planning to implement MCD contacted us (Molewijk AC, VUmc) . In Sweden, managers of workplaces in provinces in Middle Sweden with access to MCD facilitators that had communicated a need for ethical reflection were approached. In Norway, managers in provinces included in a governmental project to implement ethics reflection in community care were also approached. In addition, one care unit in somatic care was included.

In total, 73 workplaces in 16 provinces within four healthcare settings were recruited (table 1). Healthcare professionals in these workplaces who had no prior MCD experience were invited to participate.

Data collection and measures
Data were collected through a survey, distributing the Euro-MCD instrument[6] to either all healthcare professionals on the workplace

Table 2 The categorisation process of the framework method[21]

Stage 3: coding	MS and BM coded independently one-third of the Swedish and Dutch responses, respectively. The responses were sorted into one or more meaning units and coded with help from the software programme NVivo into categories and domains.	MS, BM
Stage 4: developing a working analytical framework*	Comparison of the two independent codings, then merging and recategorisation until agreement, developing a preliminary analytical framework. A working analytical framework was created departing from previous categorisation, resulting in seven domains and 82 subcategories.	MS, BM All authors
Stage 5: applying the analytical framework	The authors from each country continued deductively to sort the rest of the open responses to the categories in the working analytical framework.	All authors
Stage 6: charting data into the framework matrix	In this analysis charting implied quantification of data, because of the shortness of the responses. The categories from the three countries were quantified by computing frequencies.	MS
Additional step: revision and final agreement†	Discussions of reformulations of categories and of categorisation as well as comparisons between the countries until final agreement.	All authors

*Analysis meeting Örebro 2014 and Amsterdam 2015.
†Analysis meeting Oslo 2015.

Table 3 Perceptions of importance of the Euro-MCD predefined outcomes, ordered on basis of importance

Possible outcomes of MCD (bold marked outcomes also most often mentioned as as one of the five most important outcomes)	Domain	Percentage of respondents indicating Quite or very important			
		Total population, (n) %	Netherlands %	Sweden %	Norway %
Outcomes viewed as quite or very important by ≥90% of the respondents					
More open communication among coworkers	Collaboration	(672) 97	94**	98	100
Better mutual understanding of each other's reasoning and acting	Collaboration	(663) 95	94	97	95
Enables me and my coworkers to decide on concrete actions in order to manage the ethically difficult situations	Concrete results	(638) 93	90†***	97	90
Develops my skills to analyse ethically difficult situations	Moral reflexivity	(634) 92	88†**	94	95
I see the ethically difficult situations from different perspectives	Moral reflexivity	(634) 92	88***	95	96
I and my coworkers become more aware of recurring ethically difficult situations	Organisational	(625) 90	85†***	95	95
Find more courses of actions in order to manage the ethically difficult situation	Concrete results	(620) 90	85†***	94	95
Enhances mutual respect among coworkers	Collaboration	(609) 90‡	82†***	99	92
Outcomes viewed as quite or very important by <90% of the respondents					
Consensus is gained among coworkers in how to manage the ethically difficult situations	Concrete results	(608) 88	86		90
Enhances possibility to share difficult emotions and thoughts with coworkers	Emotional support	(603) 88	83†***	94	89
Contributes to the development of practice/policies in the workplace	Organisational	(600) 87	81†****	90	97
Develops my ability to identify the core ethical question in the difficult situations	Moral reflexivity	(599) 87	83**	90	92
I and my coworkers manage disagreements more constructively	Collaboration	(596) 88	82†***	92	92
I gain more clarity about my own responsibility in the ethically difficult situations	Moral attitude	(590) 86	79†***	92	93
Strengthens my self-confidence when managing ethically difficult situations	Emotional support	(575) 84	74†***	93	92
I and my coworkers examine more critically the existing practice/policies in the workplace/organisation	Organisational	(571) 84	84	85	81
Increases my awareness of the complexity of ethically difficult situations	Moral reflexivity	(563) 82	72***	90	93
Greater opportunity for everyone to have their say	Collaboration	(560) 82	70†***	94	94
I become more aware of my preconceived notions	Moral attitude	(556) 81	69†***	91	94
Outcomes viewed as quite or very important by ≤80% of the respondents					
Enables me to better manage the stress caused by ethically difficult situations	Emotional support	(547) 80	67†***	92	87
Increases awareness of my own emotions regarding ethically difficult situations	Emotional support	(540) 79	66†***	91	87
I understand better what it means to be a good professional	Moral attitude	(544) 80‡	70†***	90	88
I feel more secure to express doubts or uncertainty regarding ethically difficult situations	Emotional support	(532) 78	68***	86	91
Enhances my understanding of ethical theories (ethical principles, values and norms)	Moral reflexivity	(528) 76	73*	78	84
I listen more seriously to others' opinions	Moral attitude	(525) 80‡	67†***	91	94
Gives me more courage to express my ethical standpoint	Moral attitude	(509) 76‡	64†***	85	89

*P<0.05, **p<0.01, ***p<0.001.
†Also significant in multivariable logistic regression.
‡Missing >25 respondents.
Euro-MCD, European Moral Case Deliberation Outcome Instrument; MCD, moral case deliberation.

or the professionals selected to participate in MCD, prior to the start of MCD being set up. First, researchers provided verbal information about the study during workplace meetings. Second, the instrument was distributed to individual professionals, either on paper in their pigeonholes or electronically by email or through a web-based questionnaire, depending on the preferences of each workplace. Two reminders were sent. When distributed, the instrument was accompanied by an information letter about the voluntary nature of responding, and informed consent was obtained by virtue of them having responded. Responses were handled confidentially. The professionals were also briefly informed about the common denominators for MCD (see the Introduction section) and were given the following definition for an ethically difficult situation: '*a situation in which you experience unease or uncertainty about what is right or good to do or there is disagreement about what should be done*'.[6]

The Euro-MCD instrument[6] contains 26 possible MCD outcomes, sorted into the following six domains: 'enhanced emotional support', 'enhanced collaboration', 'improved moral reflexivity', 'improved moral attitude', 'impact at organisational level' and 'concrete results'.

In this study, the instrument was administered *before* the professionals participated in MCD, and asked about their perceived importance of the outcomes. The instrument was also distributed *after* their participation in a series of MCDs and the results of that survey is published elsewhere[20] (asking also about experienced outcomes). In the present study, the following three questions were used:

1. Open-ended question: 'Please formulate in your own words 3 to 5 outcomes that you consider important to reach in order to support you and your co-workers in managing ethically difficult situations in everyday clinical practice' (instructed not to read ahead).
2. Closed questions for each of the 26 predefined outcomes: 'How important is the outcome to you?' A four-point adjective response scale was used: 'not important', 'somewhat important', 'quite important' and 'very important'. The option 'cannot take stand' was also offered.
3. Fixed-choice question: 'Finally, please list 5 of the above outcomes that you consider as *most* important (of the 26 outcomes)'.

The instrument was translated into Dutch, Norwegian and Swedish.[6]

Analysis
Quantitative analysis
The ratings of the 26 predefined outcomes and responses to the fixed-choice question were analysed descriptively using SPSS V.22. χ^2 tests were used to test for differences of proportions (percentages) between countries, healthcare settings, professions, years of experience, genders and ages. To assess the independent influence of these variables, each was included in both a univariate- and a multivariable logistic regression analysis. Odds ratios are presented in the online supplementary file. For this calculation, the response options were dichotomised into 'not/somewhat important' and 'quite/very important'.

Qualitative analysis
For analysis of the open-ended responses to question 1, the researchers, MS and BM, experienced in qualitative data analysis, steered the analysis process, guided by the framework analysis method[21] (steps 3–6) (see table 2). The frequencies of the categorised meaning units (ie, words or phrases that describe one outcome) were computed for each country and compared.

RESULTS
In total, 703 healthcare professionals in Northern Europe returned responses to the Euro-MCD instrument, section A (table 1), before participating in MCD. Swedish response rate was 85% and Norwegian 23% (workplaces varied in size from 7 to 93). In the Netherlands, the number of distributed questionnaires was not registered, but the estimated response rate is 65% (average 15 employees per workplace, with 34 workplaces, the response rate becomes 331/15×34). The respondents were predominantly women. There was marked differences regarding inclusion of healthcare settings between the countries. In the Netherlands, the healthcare domain of psychiatry dominated; in Sweden, hospital care, and in Norway, community care. Thus, Sweden and Norway included more nurse assistants, while, in the Netherlands, there were more therapists, men and younger respondents.

Outcomes perceived to be the most important
Based on the quantitative analysis, all 26 outcomes in the Euro-MCD instrument were perceived as either quite or very important by 76%–97% of the respondents (table 3). There were missing responses (including the option cannot take stand) averaging 14 missing responses for each item (2%) (Table 3).

Outcomes in the domain enhanced collaboration were rated as most important, comprising more open communication, better mutual understanding and mutual respect among coworkers. The other prominently important outcomes concerned the domain concrete results, covering items about enabling decisions on concrete actions and finding more courses of actions in order to manage the ethically difficult situation. Outcomes assessed as least important comprised mostly outcomes in the domain improved moral attitude, such as listening more seriously to others' opinions, and having the courage to express an ethical standpoint (table 3). The results of the fixed-choice question about the five most important outcomes (perceived from the list of 26) are also presented in table 3 (bold items) and these correspond with the above-mentioned results concerning most important outcomes.

Differences in perceptions among respondents
The scandinavians perceived 23 of the 26 outcomes as significantly more important compared with the Dutch respondents (table 3). Professionals working in community or disabled care services, nurse assistants, women, older respondents and those with more years of professional experience, were significantly more likely to perceive most of the outcomes as quite or very important. Respondents working in psychiatry, physicians and men, perceived most of the 26 outcomes as significantly *less* important as the other groups (but still found most outcomes quite important) (table 4).

The multivariable analysis appeared to provide better explanations and showed that differences († in tables 3 and 4) could mostly be explained by the variable 'country' in 16/26 items, but also indicated that many of the differences could be explained by the variable 'gender' (14/26), and some by age or being a physician (or both, in 8/26 items). Regarding differences between healthcare settings, it appeared that, after adjustment for the variables of country, gender and 'professional group', none of these differences were statistically significant. See the online supplementary file for fuller description of the analyses (OR).

Further subgroup analyses of healthcare settings and healthcare professions represented in more than one country, that is, within the group of registered nurses and within somatic hospital care, were conducted. This also showed country differences. In somatic hospital care, 21 outcomes were perceived as statistically significantly more important by the Swedes compared with the Dutch. The Scandinavian nurses perceived 18 outcomes as significantly more important as did the Dutch nurses.

The largest statistically significant differences of perceptions of importance between various subgroups concerned the items 'greater opportunity to have a say'; 'I listen more seriously to others' opinions'; 'strengthens my self-confidence when managing ethical difficult situations'; 'enhances possibility to share difficult emotions and thoughts with coworkers'; and 'enables me to better manage stress caused by ethically difficult situations'. These items mainly belong to the domains enhanced emotional support, enhanced collaboration and improved moral attitude (tables 3 and 4). Considering these findings in light of the domains (tables 3 and 4), multivariable analysis showed that the differences in perception of importance of items in the domain enhanced emotional support could especially be explained by the variable country (Scandinavia vs the Netherlands (p<0.001)). However, these differences could also be explained by the variable gender (p<0.01 to p<0.001 for these items). Being Dutch was also an explanation for scores of less importance in the domain improved moral attitude (p<0.001), but this could also be explained by being a physician (p<0.05 to p<0.001). The domain enhanced collaboration was significantly more highly valued in Scandinavia, while some of the differences among the items within this domain could also be explained by being a woman or older. Outcomes in the domain concrete results revealed the least differences between all subgroups (tables 3 and 4).

Old and new outcomes based on the open-ended responses
The qualitative analysis of the responses to the open-ended question, produced, in total, 82 different kinds of outcomes.

Outcomes related to the Euro-MCD instrument
At item level, all 26 predefined Euro-MCD items could be detected in the open-ended responses, containing one to 147 meaning units. Eleven of the 26 items dominated the top 20

Table 4 Differences between subgroups regarding percentages of respondents rating the outcomes as quite important or very important

Outcomes	Healthcare domains				Professions					Gender		Age (years)		
	Psychiatry	Somatic care	Comm. care	Mentally dis. care	Nurse ass.	Nurses	Physicians	Thera pists	Managers	Female	Male	< 39	40–49	>50
Enhanced collaboration														
More open communication among coworkers	93**	98	99	96	99	97	96	92†**	98	98†**	92	94	97	98†**
Better mutual understanding of each other's reasoning and acting	90***	98**	96	96	97	97	88*	90**	98	97†***	88	94	96	96
Greater opportunity for everyone to have their say	66***	87†**	94†***	84	96†***	82	71*	77	79	86†***	69	76	85	86†**
I and my coworkers manage disagreements more constructively	83*	88	94*	88	92	89	78†*	84	90	89	83	83	89	90†**
Enhanced mutual respect among coworkers	81***	93*	95*	90	100***	89	90	83**	93	92†***	82	86	93	92**
Enhanced emotional support														
Enables me to better manage the stress caused by ethically difficult situations	66***	85**	89**	67*	95***	84**	60†***	62†***	74	84†***	63	74	83	83**
I feel more secure to express doubts or uncertainty regarding ethically diff. sit.	64***	80	90***	78	94***	76	57	75	81	82†***	62	75	78	81
Enhances possibility to share difficult emotions and thoughts	79***	91*	92	90	96**	88	86	84	86	91†***	77	86	88	91
Increases awareness of my own emotions regarding ethically diff situations	68***	81	88***	76	92***	79	69	67**	86	81**	69	71	81	85***
Strengthens my self-confidence when managing ethically difficult situations	70***	86	94***	90	97***	84	69**	78*	83	88†***	67	83	84	85
Improved moral reflexivity														
Develops my skills to analyse ethically difficult situations	87*	90	98**	98	96	90	88	90	100	92	88	92	91	91
I see the ethically difficult situations from different perspectives	86***	94	96*	86	96	91	88	90	96	94†***	83	90	91	94*
Increases my awareness of the complexity of ethically difficult situations	74**	83	92***	75	94***	83	68†**	73**	84	86†***	69	73	84	88†***
Enhances my understanding of ethical theories	73	73	85**	86	92†***	74	56†***	72	76	78*	70	69	77	83†**
Develops my ability to identify the core ethical question in the difficult situation	80**	86	95**	94	95**	84*	84	85	98	89†**	79	80	89	90†**
Improved moral attitude														
Gives me more courage to express my ethical standpoint	63***	80*	87*	63*	89***	76	57†**	69	78	79***	63	71	79	76
I listen more seriously to others' opinions	69***	81	92***	80	96***	81	69*	65†***	78	83**	70	70	84	87†***
I gain more clarity about my own responsibility in the ethically difficult situation	76***	88	94**	88	97***	86	74†**	81	90	90†***	71	84	88	87
I become more aware of my preconceived notions	67***	84	92***	83	94***	80	61†***	79	88	85†***	67	78	84	81
I understand better what it means to be a good professional	72**	81	89**	80	96†***	92	59†***	76	76	83†***	69	78	82	82
Concrete results														
Consensus is gained among coworkers in how to manage the ethic diff. sit.	90	89	90	86	93	88	82	91	93	88	87	83	91	89
Enables me and my coworkers to decide on concrete actions in order to manage the ethically difficult situations	84	93	93	94	97	92	92	82	95	93	90	90	94	93
Find more courses of actions in order to manage the ethically difficult situations	87	89	96**	92**	96*	89	82*	89	100	92*	83	88	91	91*
On organisational level														
I and my coworkers examine more critically the existing practice/policies	85	82	82	94	84	83	82	85	93	85	79	84	82	85
Contributes to the development of practice/policies in the workplace	79***	87	95**	90	95**	88	76*	79**	93	89†***	76	81	88	90†**
I and my coworkers become more aware of recurring ethically difficult sit.	83***	91	96**	92	98**	90	84	84*	98	93†***	80	91	88	91

*P<0.05, **p<0.01, ***p<0.001.
†Also significant in multivariable logistic regression.

Table 5 Most frequently categorised outcomes based on the qualitative analysis of the responses to the open-ended questions

Categories of outcomes (new outcomes* and domain in bold)	Domain	n=meaning units	Netherlands n (% of 331 respondents)	Sweden n (% of 275 respondents)	Norway n (% of 97 respondents)
More open communication among coworkers	Collaboration	147	39 (12)	77 (28)	31 (32)
Better mutual understanding of each other's reasoning and acting	Collaboration	117	56 (17)	47 (17)	14 (14)
I see the ethically difficult situations from different perspectives	Moral reflexivity	88	44 (13)	32 (12)	12 (12)
Consensus is gained among coworkers in how to manage the ethically difficult situations	Concrete results	57	19 (6)	35 (13)	3 (3)
Enhanced sense of security in the team*	Collaboration	55	31 (9)	23 (8)	1 (1)
Enhanced mutual respect among coworkers	Collaboration	41	31 (9)	–	10 (10)
Reach a common ground*	Collaboration	39	25 (8)	11 (4)	3 (3)
Better support from each other*	Collaboration	36	19 (6)	12 (4)	5 (5)
Enhances possibility to share difficult emotions and thoughts with coworkers	Emotional support	36	5 (2)	24 (9)	7 (7)
Greater opportunity for everyone to have their say	Collaboration	35	27 (8)	–	8 (8)
I feel more secure when managing ethically difficult situations	Emotional support	34	5 (2)	23 (8)	6 (6)
Contributes to the development of practice/policies in the workplace	Organi-sational level	32	23 (7)	–	9 (9)
Increases my awareness of the complexity of ethically difficult situations	Moral reflexivity	30	9 (3)	17 (6)	4 (4)
Develop ethical routines to prevent recurring difficult patient situations	Organis-ational level	29	–	29 (10)	–
A better grounded decision-making process in the patient situation*	Concrete results	25	20 (6)	5 (2)	–
Get to know where we stand in ethically difficult situations*	Collaboration	26	23 (7)	3 (1)	–
Centre more on patients' wishes*	**Interaction with Pat/family†**	24	4 (1)	6 (2)	14 (14)
Responding better to patients and family*	**Interaction with pat/family†**	22	2 (0,6)	20 (7)	–
Enhanced work climate'	Collaboration	21	4 (1)	7 (2)	10 (10)
Better communication skills to manage patients and next-of-kin*	**Interaction with Pat/family†**	19	–	19 (7)	–

*New item.
†New domain.

list of the most frequently mentioned outcomes (table 5). These results are in agreement with the quantitative results (see tables 3 and 5).

Below, quotes from the open-ended responses for the three top outcomes are presented.

'More open communication among coworkers': '*More openness and honesty in the team*' (Dutch respondent), '*Dialogue, listen, understand. This applies to doctors, nurses, nurse assistants and managers*' (Swedish respondent), '*More open, honest and unbiased communication*' (Norwegian respondent).

'Better mutual understanding of each other's reasoning and acting': '*More consideration/taking into account what others think or see as a solution*' (Dutch respondent), '*Enhanced awareness on ward and for me what we do similarly and what we do differently, to open our eyes*' (Swedish respondent), '*Respect for differences in how to interpret situations*' (Norwegian respondent).

'I see the ethically difficult situations from different perspectives': '*Creating a different way of thinking to learn that there are also other solutions than only your own opinion*' (Dutch respondent), '*Interesting to hear the doctor's thinking about, for example, to resuscitate or not*' (Swedish respondent), '*Thinking holistically, by looking at the situation from different angles*' (Norwegian respondent).

New MCD outcomes (not fitting within outcomes of current Euro-MCD)

Fifty-six of the categorised outcomes could not be found in the predefined list of 26 outcomes. Nine of the new ones can be found in the top 20 list of most frequently categorised outcomes

(table 5). At domain level, most of the new outcomes could be categorised into the original domains in the Euro-MCD instrument, particularly in the domain enhanced collaboration:

'Enhanced sense of security in the team': '*To feel secure with each other in the team to be able to raise situations that haven't turned out well without anyone taking offence*' (Swedish respondent).

'Reach a common ground': '*Agreeing on a standpoint together, so that, in practice, you can easily estimate how a colleague would approach something*' (Dutch respondent).

'Better support from each other': '*To be able to 'think out loud' with colleagues in different situations and that they take time to listen*' (Norwegian respondent).

One new domain (not yet covered by the Euro-MCD domains)

One new domain emerged; 'Better interaction with patient/family' (table 5), illustrated by the following items and quotes:

'Centre more on patients' wishes': '*To ensure that patients are treated individually*' (Norwegian respondent).

'Responding better to patients and family': '*Better ability and support when responding to aggressive patients and relatives*' (Swedish respondent).

'Better communication skills to manage patients and next-of-kin': '*Better dialogue with relatives, easier to explain how we think around palliative treatment*' (Swedish respondent).

DISCUSSION

Surprisingly, the majority of the responding healthcare professionals in Northern Europe did not discriminate between

outcomes, instead scoring *all* 26 predefined Euro-MCD outcomes as quite important or very important (prior to MCD participation). This is essential to consider when reflecting on the results that Dutch healthcare professionals, men, those who were younger, and especially physician-respondents scored most of the outcomes as statistically significantly less important compared with the other respondents, yet still considered these as being somewhat important. With respect to the six domains of the Euro-MCD instrument, the outcomes that were perceived as most important belong to the domains; enhanced collaboration, and concrete results. One new domain emerged in the open responses: better interaction with patient/family.

The finding that most MCD outcomes were seen as important can be interpreted in different ways. First, it might be an indication of healthcare professionals' *need* for a variety of MCD outcomes: MCD is not seen as something with only one category of outcomes. This is consistent with other research about the need for ethical reflection.[14 22] Another interpretation of the high importance awarded to almost all of the MCD outcomes can be that the respondents did not know exactly what kind of outcomes to expect. Therefore, it will be interesting to compare the results described in this paper with their judgments of importance *after* their experiences of participating in MCD.

Reflection on perceived important outcomes in relation to goals of MCD

The top outcomes of 'collaboration' and concrete results fit well with the theoretical background of MCD (ie, hermeneutics, pragmatism and dialogical ethics) in which mutual dialogue and practical usefulness are import key values of MCD.[23 24] The main outcomes considered as important were apparently the need to communicate and understand each other better, as well as to determine concrete actions to take. This finding is consistent with previous MCD evaluation literature.[8 14] The above-mentioned theories presuppose that, in order to learn what to do in an ethically difficult situation, a joint learning process is needed, in which everyone expresses and shares their viewpoint on what is morally right. The MCD participants become open towards each other's viewpoints and they get to know and understand each other better.[14 25] Hence, openness towards one another and better collaboration are both important preconditions for and results of moral learning.[12 25]

Furthermore, according to the theoretical background of MCD, MCD always starts with a moral challenge that is experienced in a concrete situation. It does not primarily aim at a theoretical insight or a final conceptual definition.[23 25] Rather, MCD aims at learning to deal with ethically difficult situations,[6] improving the quality of care and learning about what is morally right, based on moral reflections and reasoning.[23] Hence, the focus on reaching concrete results as an outcome of MCD fits well with MCD's normative aim of improving practices and learning through reflection about concrete situations.[23 25]

Besides the top domains, the new domain revealed in the responses to the open-ended questions, better interaction with patient/family, was an important reminder to not forget to focus on ethics support outcomes for the patient and for improving the quality of care as the basic goal of and justification for ethics support.[14 25 26] The main reason why this domain was not included in the original six domains of the Euro-MCD was that these outcomes were not found in the extensive literature search and were not suggested in the Delphi panel as the basis for the development of the instrument.[6] This is supported by the recent publication regarding the content of MCD in the Swedish component of the Euro-MCD project: establishing a responsible

relationship with the vulnerable patient formed the basis for the participants' moral reasoning and can be understood as relational autonomy.[18] Furthermore, this study showed how relational-oriented ethics may form a foundation for principle-based moral reasoning during MCD. This element, and paying more attention to the direct impact of MCD on patient care, is something that we will consider when revising the Euro-MCD instrument.

Discrepancy between MCD goal and a priori perceived importance of outcome

An essential element of MCD is reflecting on moral questions emerging from concrete experiences by means of moral reasoning and engaging in a joint critical moral inquiry.[23] MCD has been described as aiming to improve moral competencies.[27] It is therefore remarkable that the outcomes deriving from the domains of moral reflexivity (eg, analysis skills) and moral attitude (eg, courage) were not perceived as the most important outcomes. Perhaps the respondents did not explicitly think about improving their moral competencies in the first place. In fact, if this explanation is accurate, this assumption fits well with the pragmatist approach of ethics teaching, that is, that moral competencies are learnt by doing (eg, while reflecting on concrete cases).

Considering the differences between subgroups

Most of the differences in perceived importance between the subgroups (profession, healthcare setting and so on) can be explained by the variables, country and gender. However, some of the differences might also be explained by the variables 'age' and 'professional background'. Regarding professional background, the nurse assistants, who dominate Scandinavian community care, perceived most of the outcomes as significantly more important than the other professions. An explanation for this could be that nurse assistants in general have fewer opportunities for attending team meetings or educational activities, while at the same time being confronted with many ethically difficult situations in their daily work. The physicians found many outcomes significantly less important, but with large variation (56%–96%). This may be interpreted as their having a better confidence to discriminate between outcomes and/or simply valuing MCD less than other professions.

The finding that female respondents rated so many items higher than male respondents is surprising. It might be due to differences in perceived moral distress, as it could be assumed that experiencing a higher level of moral distress would contribute to a higher need for ethical reflection, and perceiving outcomes such as better stress management or feeling more self-confident as more important. In the literature, we found some evidence for gender differences in moral distress. Possible explanations have been provided by, for instance, Lutzky and Knight,[28] who suggested that men and women experience similar levels of moral distress, but that men may be reluctant to acknowledge their distress or may not even be aware of it, leading to biased results when assessing moral distress by use of self-reporting questionnaires.[28] More recently, this gender difference was found again in a study about experiencing moral distress among critical care nurses in the US.[29] We could therefore say that the possible influence of gender differences in experiencing moral distress, or in their ways of completing questionnaires, was also observed in our study. However, the female respondents form the majority of the sample (81%) and the male respondents were mainly drawn from those who work in the Netherlands , and who worked in psychiatry, as physicians or as therapists. Therefore, the differences between gender might overlap with the differences between countries. But, because of the low sample

size of male respondents, we were not able to further disentangle this possible influence.

There are several possible explanations for why the variable country showed large differences in ratings. First, there might be cultural differences regarding the rating across the countries, and one can only speculate about the reasons. One explanation might be that Scandinavian yearn for a forum for exchange and reflection, while in Dutch healthcare, various forums are more established (eg, in psychiatry, where 53% of the Dutch respondents worked). A second explanation could be the different approaches to responding to self-reported questionnaires in the three countries. Jürges[30] found that the Swedes are more likely to report good or better health than respondents in all other countries.[30] This tendency of Swedes, and perhaps all Scandinavian respondents, might also have occurred in our study. Third, the mode of administration of the questionnaire might have caused some differences between countries. However, no major differences in answering questions have been found in recent overviews.[31] Therefore, we think that, with regard to ratings of importance of outcomes of MCD, this might be less of an issue here.

Another possible explanation for these variations relates to the differences in performing MCD in the different countries. That the Swedes and Norwegians valued outcomes related to the domain enhanced emotional support to a higher degree than the Dutch is in line with results obtained from a previous Swedish study about what MCD participants talked about during the MCDs linked to this project. A median of 29% of the spoken time was spent on reflections on the psychosocial work environment.[17] This raises the normative question as to what degree emotional support and psychosocial reflection should be a core component of MCD outcomes. Within the theoretical understanding of MCD that adheres to an Aristotelian view on emotions, emotions can be seen as part of moral wisdom and should therefore be an element of MCD.[11]

Finally, the data suggest that some of the differences could be explained by age. It seems that older respondents (>50) perceived many outcomes as being more important than the younger ones. An explanation might be that these older respondents have had more experience with difficult ethical situations and thus express a stronger need for engaging in ethical reflection.

Weighing empirical results versus normative thinking about MCD outcomes

It is only after collecting the perspectives of those who have engaged in MCD that the overall normative discussion on determining the appropriateness of MCD outcomes can begin. In this discussion, we, as authors, take a middle position in that we assume that neither theoretical viewpoints nor empirical results alone can determine what 'the' right MCD outcomes are. This means that, although respondents found outcomes relating to moral competencies (ie, moral reflexivity and moral attitude) somewhat less important as compared with other Euro-MCD outcomes, they could still be considered as important, given the fact that ethicists and MCD facilitators argue that MCD *aims* at, among other aims, fostering moral competencies.[32] Given the limited scope of this paper, we will elaborate on the integration of empirical findings from all Euro-MCD field studies and our normative reasoning about appropriate MCD outcomes in a future paper. Finally, we should not conflate the findings related to the importance of MCD outcomes with the aims of MCD; the outcomes and aims of clinical ethics support are not the same. Different groups and different countries seem to prefer different outcomes and different aims. For example, although

not studied explicitly yet, we know anecdotally that ethicists state a more limited number of aims of clinical ethics support. Furthermore, their aims are usually focusing more on the *moral* question and *ethical* analyses of the reasoning and arguments used. Future research on these different ranges of aims and preferred outcomes of MCD may have implications regarding how to introduce MCD within healthcare institutions, how to train the future MCD facilitators and on how to structure and steer the MCD sessions.

Strengths and weaknesses

A major strength in the study was the large number of responses enabling multivariable analysis. But a weakness was the heterogenic sampling of healthcare settings between the countries, which complicated comparisons between countries. However, the multivariable analysis provided evidence for healthcare setting not being associated with differences in responses. Furthermore, our main goal of the Euro-MCD project was to further develop the Euro-MCD instrument and to find out whether MCD makes a difference at all. The heterogeneity of inclusion is in line with the observational design, meaning not interfering with the real world, that is, the organisation of the MCD practices. However, in order to make a better generalisation, a larger field study is needed with more even distribution of subgroups in the different countries as well as including countries outside Northern Europe. This will, however, be postponed until the instrument is revised.

The survey was organised differently in the three countries with regard to recruitment of potential respondents and to the format of the questionnaire (paper, web-based, email). This might have affected the response rate in Scandinavia, as the Norwegian was web-based without personal contact and in Sweden, the questionnaires were distributed besides in pigeon holes also on information meetings and reminders on the coffee room tables. Another reason of low motivation to respond might be that the Norwegian part was associated with the governmental project. However, as the results of perceived important outcomes were similar between Sweden and Norway, we interpret that the differences in response rate may not have influenced the result. In Sweden, there were more respondents but fewer workplaces included and in Norway the vice versa, which complement each other. Unfortunately, we do not know the exact response rate for the Netherlands, but the estimated response rate is in line with other questionnaire studies.

Finding that almost all of the outcomes were perceived as quite or very important might indicate both a weakness and a strength of the Euro-MCD instrument. A weakness is the lack of discrimination between items and a ceiling effect in the Scandinavian results. A strength would be the good validation of the instrument, particularly as both the qualitative and the quantitative analysis revealed more or less the same important outcomes. We are surprised by this result, as we purposely included all possible MCD outcomes with few normative preferences.[6] The lower ratings of some items, such as those relating to 'courage to express my ethical standpoint', might imply a need for reformulation instead of deletion. A further weakness is the nature of open-ended questions, which cannot contribute with the same richness of information as qualitative interviews can.

CONCLUSIONS

Our findings indicate that, prior to participating in MCD, healthcare professionals have multiple priorities and perceive many outcomes of MCD as highly important. This indicates a

need for a broad instrument, such as the Euro-MCD, but also the need to anchor the outcomes included in the instrument to ethical theory. Outcomes related to the interaction between healthcare professionals and patients and family will also be taken into account when revising the Euro-MCD instrument.

The differences we found between countries and the complexity in understanding these, indicates that caution must be taken when making comparisons between international settings of MCD. The empirical findings also lead to another interesting question: should we delete items in the revised Euro-MCD instrument regarded as less important while, for normative theoretical reasons, one could consider these items as essential to MCD? The empirical findings in this study will not only help to develop the Euro-MCD instrument further, but can also be used to further discuss aims of clinical ethics support. Furthermore, the findings can be used by healthcare organisations when implementing MCD. Finally, although this study focused on MCD outcomes, we hope that these findings will inspire researchers planning evaluation of other clinical ethics support services.

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