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WHAT OUTCOMES DO DUTCH HEALTHCARE PROFESSIONALS PERCEIVE AS IMPORTANT BEFORE PARTICIPATION IN MORAL CASE DELIBERATION?

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Keywords
clinical ethics support, moral case deliberation, outcomes

ABSTRACT

Background: *There has been little attention paid to research on the outcomes of clinical ethics support (CES) or critical reflection on what constitutes a good CES outcome. Understanding how CES users perceive the importance of CES outcomes can contribute to a better understanding, use of and normative reflection on CES outcomes.*

Objective: *To describe the perceptions of Dutch healthcare professionals on important outcomes of moral case deliberation (MCD), prior to MCD participation, and to compare results between respondents.*

Methods: *This mixed-methods study used both the Euro-MCD instrument and semi-structured interviews. Healthcare professionals who were about to implement MCD were recruited from nursing homes, hospitals, psychiatry and mentally disabled care institutions.*

Results: *331 healthcare professionals completed the Euro-MCD instrument, 13 healthcare professionals were interviewed. The outcomes perceived as most important were 'more open communication', 'better mutual understanding', 'concrete actions', 'see the situation from different perspectives', 'consensus on how to manage the situation' and 'find more courses of action'. Interviewees also perceived improving quality of care, professionalism and the organization as important. Women, nurses, managers and professionals in mentally disabled care rated outcomes more highly than other respondents.*

Conclusions: *Dutch healthcare professionals perceived the MCD outcomes related to collaboration as most important. The empirical findings can contribute to shared ownership of MCD and a more specific use of MCD in different contexts. They can inform international comparative research on different CES types and contribute to normative discussions concerning CES outcomes. Future studies should reflect upon important MCD outcomes after having experienced MCD.*

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INTRODUCTION

Ethically difficult situations are part of daily healthcare practice. They arise when healthcare professionals feel uncertain, powerless or uncomfortable about the care of their patients, or when they disagree about what constitutes good care.[1] Not dealing appropriately with ethically difficult situations may lead to moral distress, which may result in reduced job satisfaction and even burnout.[2] Various forms of clinical ethics support (CES) services are increasingly implemented in healthcare to help healthcare professionals to deal with ethically difficult situations.[3]

One form of CES is moral case deliberation (MCD).[4] In an MCD session, healthcare professionals jointly reflect on an ethically difficult situation that they have encountered in daily practice and which resulted in a moral question.[5] Supported by a trained facilitator who does not give substantial advice with respect to the moral question at stake, participants discuss what constitutes morally good care in the specific situation and the basis for this.[6] In Scandinavian countries and the Netherlands, MCD is becoming a common practice in CES in various healthcare domains: psychiatry, hospitals, elderly care and care institutions for mentally disabled people.[7] A recent study reported that, based on a national survey, 44% of Dutch healthcare institutions make use of MCD.[8]

MCD has its theoretical background in pragmatic hermeneutics and dialogical ethics: it focuses on the actual context of the situation and on perspectives and experiences of all involved.[9] The final response to the moral question arising from the case is not formulated by an external ethical expert but found through a collective investigation of the case, taking into account the perspectives of all involved.[10] An important issue in organizing MCD within an institution is making the participants owners of MCD: they themselves should be actively involved, listened to, and made responsible for which themes need to be discussed and how to successfully organize MCD on a structural basis.[11] Ownership implies that MCD should be tailored to some extent to the needs and prioritized outcomes of the participants.

Several studies have identified the goals and aims of MCD from a theoretical stance or based on views of managers and local coordinators of MCD, for instance: developing the moral competences of participants (such as a reflective and cooperative attitude), and jointly agreeing on the right course of action and improving quality of care.[12]

[1] M. Kristoffersen, F. Friberg, B.S. Brinchmann. Experiences of moral challenges in everyday nursing practice: in light of healthcare professionals' self-understanding. *Nord J Nurs Res* 2016; 1–8; G. Lamiani, L. Borghi, P. Argentero. When healthcare professionals cannot do the right thing: A systematic review of moral distress and its correlates. *J Health Psychol* 2015; 1–17; L. Lillemoen & R. Pedersen. Ethical challenges and how to develop ethics support in primary health care. *Nurs Ethics* 2012, 20: 96–108; C. Varcoe et al. Nurses' perceptions of and responses to morally distressing situations. *Nurs Ethics* 2012, 19: 488–500.

[2] Lamiani et al., *op. cit*. note 1.

[3] Lillemoen & Pedersen, *op. cit*. note 1; E. Doran et al. 2016. Clinical ethics support in contemporary health care. Origins, practices and evaluation. In: *The Oxford Handbook of Health Care Management*. E. Ferlie, K. Montgomery, A.R. Pedersen, eds. Oxford: Oxford University Press: 164–187; L.M. Johnson et al. Ethics consultation in pediatrics: Long-term experience from a pediatric oncology center. *AJOB* 2015; 15: 3–17; Swiss Academy of Medical Sciences (SAMS). 2012. *Ethics support in medicine.* Basel: SAMS; L. Dauwerse et al. Prevalence and characteristics of moral case deliberation in Dutch health care. *Med Health Care Philos* 2014; 365–375; A.J. Tarzian. Health care ethics consultation: An update on core competencies and emerging standards from the American Society for Bioethics and Humanities' Core Competencies Update Task Force. *AJOB* 2013; 13: 3–13; S.A.M. McLean. What and who are clinical ethics committees for? *J Med Ethics* 2007; 33: 497–500; A. Slowther et al. Development of clinical ethics committees. *BMJ* 2004; 328: 950–2; M.P. Aulisio, R.M. Arnold, S.J. Youngner. *Ethics consultation: From theory to practice.* London: The John Hopkins University Press; 2003.

[4] Moral case deliberation, also described as 'Ethics rounds', 'Ethics reflection groups' or 'Ethics case reflections', differs from, for example, clinical ethics consultation in which the consultant has a more formal-procedural and expert approach. A central goal of the ethics consultant is to answer the question "Who is the appropriate decision maker?" in a morally and legally correct way, which differs from the central question in MCD: "what constitutes good care and for what reason?" Within MCD, the facilitator focuses more on the reasoning of the MCD participants themselves and the systematic dialogue about what constitutes good care. The process, the role of the ethicist and the central question at stake seem to differ between MCD and CEC.

[5] B. Molewijk et al. Implementing moral case deliberation in Dutch health care; improving moral competency of professionals and the quality of care. *Bioethics Forum* 2008; 57–65; D. Rasaol et al. What healthcare teams find ethically difficult: Captured in 70 moral case deliberations. *Nurs Ethics* 2015; 1–13; F.C. Weidema et al. Aims and harvest of moral case deliberation. *Nurs ethics* 2013; 20: 617–631.

[6] Molewijk et al. *op. cit*. note 5; Rasaol et al., *op. cit*. note 5.

[7] Lillemoen & Pedersen, *op. cit*. note 1; Dauwerse et al., *op. cit*.note 3; Molewijk et al.; Rasaol et al., *op. cit*. note 5; L. Lillemoen & R. Pedersen. Ethics reflection groups in community health services: an evaluation study. *BMC Med Ethics* 2015; 16:25; M.H. Hem, R. Pedersen, B. Molewijk. Evaluating clinical ethics support in mental healthcare: A systematic literature review. *Nurs Ethics* 2014; 1–15; M. Silén et al. Ethics rounds: An appreciated form of ethics support. *Nurs Ethics* 2014; 1–11; M.J.P.A. Janssens et al. Evaluation and perceived results of moral case deliberation: A mixed methods study. *Nurs Ethics* 2014; 1–11; B. Molewijk et al. Implementing moral case deliberation in a psychiatric hospital: process and outcome. *Med Health Care Philos* 2008; 11: 43–56; B. Olofsson. Opening up: Psychiatric nurses' experiences of participating in reflection groups focusing on the use of coercion. *J Psychiatr Ment Health Nurs* 2005; 12: 259–267.

[8] Dauwerse et al., *op. cit*. note 3.

[9] Molewijk et al., *op. cit*. note 5; S. Metselaar, B. Molewijk, G. Widdershoven. Beyond recommendation and mediation: Moral case deliberation as moral learning in dialogue. *Am J Bioeth* 2015; 15: 50–51.

[10] Metselaar et al., *op. cit*. note 9.

[11] Metselaar et al., *op. cit*. note 9; M. Svantesson et al. Outcomes of moral case deliberation – the development of an evaluation instrument for clinical ethics support (the Euro-MCD). *BMC Med Ethics* 2014; 15: 30.

[12] Weidema et al., *op. cit*. note 5; L. Dauwerse et al. Goals of Clinical Ethics Support: Perceptions of Dutch Healthcare Institutions. *Health Care Anal* 2013; 21: 323–337.

Little is known, however, about how healthcare professionals who have not yet participated in MCD perceive the importance of the various outcomes that they imagine may result from MCD. Svantesson and colleagues therefore developed the Euro-MCD instrument to measure the perceived importance of MCD outcomes among participants.[13] This instrument takes the variety of suggested goals of MCD and the lack of consensus about what MCD outcomes *should* be reached as a positive starting point, and includes a wide range of possible outcomes. The selection of outcomes for the instrument was made after a thorough literature review, a Delphi panel with experts, and cognitive and content validity testing among healthcare professionals. The final instrument includes 26 concrete MCD outcomes within 6 domains: 1) enhanced emotional support, 2) enhanced collaboration, 3) improved moral reflexivity, 4) improved moral attitude, 5) impact on the organizational level, and 6) concrete results. These outcomes can be rated on importance by respondents to gain insight into their perceived important outcomes, before and after multiple MCD sessions.

Knowledge of outcomes perceived as important by participants is important given the pragmatic hermeneutical roots of MCD, which imply the need to focus on participant views and experiences in attending MCD.[14] This knowledge can contribute to answering the normative question about the appropriateness of different outcomes of MCD. It is, however, important to not only provide a general overview, but to focus on potential differences between subgroups and individual variety.

This study describes the MCD outcomes that Dutch healthcare professionals perceive as important, through the following research questions: 1) How do healthcare professionals rate and prioritize predefined MCD outcomes? 2) How do they describe important MCD outcomes themselves? and 3) How does the perceived importance of MCD outcomes differ between various professionals, considering healthcare domain, gender, age and profession? Findings could inform the theoretical understanding of MCD, future implementation strategies, new CES evaluation research, the education of MCD facilitators, and the current professional debate regarding the normative question 'What constitutes a good outcome of CES?'.

METHODS

Design

This was a descriptive mixed-methods study with healthcare professionals without experience in MCD. The quantitative core was the Euro-MCD instrument.[15] This was supplemented by qualitative interviews to explore and further deepen the quantitative findings, and to provide additional MCD outcomes not covered by the instrument. A complete overview of all perceived important outcomes could thus be presented. The quantitative and qualitative data was collected and analysed separately.

Sample

The respondents of the Euro-MCD instrument were healthcare professionals from various Dutch healthcare institutions. These institutions were recruited between 2013 and 2015 through convenience sampling with the criterion that they were planning to implement MCD on a structural basis, with no earlier experience with MCD. In total, 12 healthcare institutions participated, including hospital care (n=3), mental healthcare (n=6, including care for mentally disabled, homeless and psychiatric patients) and elderly care (n=3), from all regions in the Netherlands. The MCDs in most institutions were introduced by managers to healthcare professionals and presented as a meeting led by a facilitator, in which professionals' moral cases would be discussed using a stepwise procedure.

Interviews were held in 2015 with 13 healthcare professionals from those healthcare institutions in order to gain a more in-depth insight into the importance of MCD outcomes. They were recruited using purposive sampling, irrespective of their answers on the questionnaire, to include respondents from various professions and specialties. They also had no previous MCD experience.

Data-collection

This study collected data in two ways: 1) using the Euro-MCD instrument; and 2) by conducting interviews.

THE EURO-MCD INSTRUMENT

The Euro-MCD instrument contains two sections: a questionnaire to be administered *before* (Section I) and *after* (Section II) actual participation in MCD (23). Section I was used in the current study. The questionnaire was the Dutch version of the original English Euro-MCD questionnaire, which was translated and validated using two independent translators, content validity indexing, 'think-aloud'-interviews, back-translation, and cultural adaptation in the developmental process of the Euro-MCD instrument, as described in more detail by Svantesson et al.[16] It was administered on paper.

[13] Svantesson et al., *op. cit*. note 11.
[14] Ibid; Molewijk et al., *op. cit*. note 5.
[15] Svantesson et al., *op. cit*. note 11.
[16] Svantesson et al., *op. cit*. note 11.

The questionnaire includes 26 predefined MCD outcomes, the importance of which is each to be rated on a Likert scale ranging from 1 (not important) to 4 (very important). The option 'Cannot take stand' was also possible. After the list of 26 outcomes, a fixed-choice question asks respondents to prioritize the five most important MCD outcomes from the list of 26. The ratings of the 26 predefined outcomes and the answers to the fixed-choice question provide an answer to the first research question of this study ('How do healthcare professionals rate and prioritize predefined MCD outcomes?').

The questionnaire includes an open-ended question at the start asking for three to five MCD outcomes perceived as important by the respondent. This question identifies outcomes described spontaneously by respondents without having read the 26 predefined outcomes. It is posed at the start of the questionnaire and explicitly asks respondents not to look ahead to the next page with the list of 26 outcomes. In this way, the answer to the second research question ('How do healthcare professionals describe important MCD outcomes themselves?') could be assessed.

For the third research question ('How does perceived importance of MCD outcomes differ between various professionals, considering healthcare domain, gender, age and profession?'), extra data was collected on healthcare domain, gender, age and profession.

Lastly, during the data collection process, a question was added at the start of the questionnaire, asking for current MCD experience to check whether they had indeed not yet participated in MCD.

INTERVIEWS

The first author conducted semi-structured interviews to gain additional insights into all the research questions of this study. The interview guide included questions about the outcomes that healthcare professionals perceived as important for themselves, the team, client and organization. Respondents were invited to explain why they perceived their outcomes as important and how outcomes could be realized. A pilot interview resulted in the addition of the first question, about their general understanding of MCD, so that if necessary MCD could be explained briefly as a group meeting in which a moral question is discussed from their actual daily practice, supported by a facilitator and with the use of a stepwise procedure. The interviews lasted on average 29 minutes (range 14–46 minutes) and took place at the respondent's workplace. Interviews were audio-taped and transcribed verbatim.

Quantitative analysis of 26 outcomes and fixed-choice question

The ratings of the 26 predefined MCD outcomes and the answers to the fixed-choice question about the five most important outcomes in the Euro-MCD instrument were analysed descriptively using Statistical Package for Social Sciences (SPSS), version 22. For every rated outcome, the mean score was calculated. In line with the third research question, the ratings of the 26 outcomes were analysed for subgroups, considering a p value of <0.05 to be statistically significant, using non-parametric statistical tests (Mann-Whitney U Test and Kruskal-Wallis). For outcomes that varied between more than one subgroup, further stratified analyses were performed to determine which factor mainly explained the differences.

Qualitative analysis of open-ended question and interviews

The qualitative findings, collected from the open-ended questionnaire in the Euro-MCD instrument and from the interviews, were analysed inductively using open coding, as described by Strauss and Corbin.[17] Answers to the open-ended question 'Please describe 3–5 outcomes you find important' were labelled and categorized by JCS and ACM independently. They compared their codes and jointly decided on categories and subcategories. The categorization was then discussed with MS until final agreement was reached. Interview transcripts were repeatedly read through for familiarity with the data. Open codes were then assigned to text fragments, which were then compared (JCS and ACM) and merged into subcategories and categories. The categorization was then examined and discussed with another author (GAMW) and re-categorization continued until there was full agreement on categorization between the authors.

Ethical considerations

Written consent was obtained at the start of the interviews. Participation was voluntary. Completed questionnaires and interview transcripts were anonymously processed.

RESULTS

In total, 331 healthcare professionals completed the Euro-MCD instrument and 13 healthcare professionals were interviewed. The characteristics of the Euro-MCD respondents are presented in Table 1. The majority were

[17] A.L. Strauss & J.M. Corbin. 1990. *Basics of qualitative research*. Newbury Park, CA: Sage.

female (68%), and nurses (50%), and psychiatry was the prevailing specialty (53%). For each predefined outcome, an average number of 7 respondents (2%, range 2–12) gave no answer or selected 'Cannot take stand', and 65 respondents (20%) did not answer the open-ended question. For the fixed-choice question, 267 respondents (81%) described 5 outcomes, others described less than 5 (7%) or none (12%). Table 2 shows the characteristics of the 13 interviewed healthcare professionals.

The results are presented in the order of the research questions. Firstly, the outcomes perceived as important are shown (Research Question 1, 'How do healthcare professionals rate and prioritize predefined MCD outcomes?'), based on the ratings of the predefined outcomes and the answers on the fixed-choice question in the Euro-MCD instrument. Secondly, the findings of the open-ended question and the analysis of the interviews are presented to answer the second research question ('How do healthcare professionals describe important MCD outcomes themselves?'). Finally, the differences between subgroups are described (Research Question 3, 'How does perceived importance of MCD outcomes differ between various professionals, considering healthcare domain, gender, age and profession?').

1. MCD OUTCOMES PERCEIVED AS MOST IMPORTANT

Table 3 shows the frequencies of answer options for each predefined MCD outcome of the Euro-MCD instrument, ranged by descending mean scores on a Likert scale of 1–4. The outcomes perceived as most important were 'More open communication' (mean 3.39), 'Better mutual understanding of each other's reasoning and acting' (3.35), 'Concrete actions to manage the situation' (3.26), 'See the situation from different perspectives' (3.20), 'Consensus on how to manage the situation' (3.15), 'Find more courses of action to manage the situation' (3.14), 'Identify core ethical question in difficult situations' (3.13) and 'Develop skills to analyse' (3.13. These outcomes fall under the Euro-MCD domains of 'Enhanced collaboration', 'Improved moral reflexivity' and 'Concrete results'.

The outcomes that were most often given when respondents were asked to select the five most important outcomes from the list of 26 were very similar to the outcomes scored as most important when respondents were asked to rate each of the 26 predefined outcomes (Table 4). Specifically, the eight outcomes that were described most frequently in response to the fixed-choice question were also among the nine outcomes with the highest ratings for importance (see Table 3 and 4). The outcomes 'Concrete actions to manage the situation' and 'Find more courses of action to manage the situation' were prioritized more highly in the fixed-choice question than when responding to the 26 predefined outcomes.

Sixty two individuals (19%) did not prioritize any of the five outcomes rated as most important by the respondents in general, as presented in Table 4. Most of these 62 were nurses (53%) and the majority worked in psychiatry (60%). These 62 individuals prioritized 'Strengthened self-confidence to manage the situation' (12 times), 'Enhanced mutual respect' (11 times) and 'Better understanding of being a good professional' (9 times).

2. PERCEIVED IMPORTANT OUTCOMES IN THE OPEN-ENDED QUESTION AND INTERVIEWS

Analysis of answers to the open-ended question, asking for three to five intuitive important outcomes, resulted in the categorization presented in Table 5. Ten answers were found to be described exactly the same as predefined outcomes and were therefore not counted as intuitive outcomes. Several categories were related to highly rated predefined MCD outcomes in the instrument. Some new outcomes concerning teamwork were added.

The healthcare professionals who were interviewed perceived outcomes as important within the following categories: 1) Better dealing with the ethically difficult situation; 2) Becoming a better professional; 3) Better teamwork; 4) Improving quality of care; and 5) Positive impact on the organization (see Table 6). The findings of the analyses of both the open-ended question and the interviews will be elucidated below, including similarities and differences between these qualitative and the former quantitative findings.

1) Better dealing with the ethically difficult situation

Interview respondents found it important to participate in MCD to find more tools to deal with ethically difficult situations. The solution could be made with more consideration as a result of MCD. Some interviewees and respondents to the open-ended question said that MCD should lead to a concrete result, for instance a more creative solution on which everyone could agree.

> a person who refuses to eat or drink, the nutrition assistants are obliged to put down food and drinks. [. . .] Well, I think that if you can discuss this in a moral case deliberation, that maybe you can find a much more creative solution than simply putting the food or drink there. *(Interview resp. M: therapist, nursing home)*

This is in line with the quantitative results, which showed that a concrete result is one of the most

important outcomes (mean score: 3.26). For others, it was important to obtain clarity or a new perspective, and a concrete solution for a case was not that important.

> Look, it's not like there is a ready solution to all questions, at least, I don't expect there to be. But you might experience an eye-opener now and then. *(Interview resp. B: nurse, hospital)*

Several answers to the open-ended question were related to this outcome and categorized as 'Reach a common ground'. This is comparable to the highly rated predefined outcome 'Consensus on how to manage the situation' (mean score: 3.15). The term 'consensus' was not used by the interviewees.

> Determining a position together, so it might be easy to assess how colleagues would approach something in actual practice. *(Respondent Euro-MCD instrument)*

2) Becoming a better professional

Interviewees found it important to become a better professional by becoming more reflective, learning to deal with emotions and stress and gaining knowledge about ethics. They stressed the importance of understanding the core principles and values of their work and being aware of those during daily work. By going into more depth, by participating in an MCD, they could better express what they believed in, also perceived to be important. In this way, MCD could enhance job satisfaction and the ability to let go of past things. The related predefined questionnaire outcome 'Better understanding of being a good professional' was, however, less highly rated (mean score: 2.80). Interviewees further thought they would have a better attitude towards others by placing themselves in someone else's shoes and learning to be open to different views. The outcome of seeing the situation from different perspectives, one of the most important predefined outcomes (mean score: 3.20), was also often answered in the open-ended question.

> [It's important] that you start using a broad approach, that is, outside your normal thinking pattern. So that you can jointly develop a concrete way to deal with situations. *(Respondent Euro-MCD instrument)*

> . . .I think sometimes you all get stuck in the fixed idea. [. . .] And a moral case deliberation [. . .] might open things up a little and give you a slightly different perspective. *(Interview resp. K: therapist, nursing home)*

3) Better teamwork

In the interviews and in answers to the open-ended question, many outcomes concerning the team were noted as important. The important outcomes, described earlier, of 'More open communication' (mean score: 3.39) and 'Better mutual understanding' (mean score: 3.35) were also found. One head of department within a hospital said about open communication:

> as head of the department I feel it's very important that people can do their work, on the ward [. . .] that we also feel free to discuss, did we do the right thing in this situation? Have we really done everything we wanted to do? And that the environment or mutual relationships are so open that I am comfortable enough to voice my opinion. *(Interview resp. F: head of department, hospital)*

An interviewed psychiatric nurse explained the improvement of mutual understanding as follows:

> ". . .you all have a very different outlook on life and you attach importance to different things [. . .] that is the most important thing, that you are aware of each other. That you think, well OK, but it is important to her to do it this way, or you don't address that element because you find it difficult, so let me do it because I have less of a problem with it. *(Interview resp. D: nurse, psychiatry)*

These outcomes were believed to be important because they would contribute to mutual respect between colleagues, to know each other better and to deal with different opinions and ways of working. For some, it was already important to have a set moment to talk with their colleagues about personal opinions and questions.

It was further important to establish a feeling of safety within the team.

> That everyone is able and feels free to express their own values in a safe environment. *(Respondent Euro-MCD instrument)*

> . . .if I don't understand why something is done the way it is done, I should feel free enough to ask a question about it. *(Interview resp. E: nurse, psychiatry)*

In this way, they would be better able to support one another. MCD could make the team stronger and in the end this would improve teamwork, team expertise and quality of care.

Several answers involved better listening to each other. A few nurses also emphasized in the interviews that other professions such as managers and physicians could listen better to them as a result of MCD, because they then better know the impact of decisions on nurses

personally. The predefined outcome 'Listen better to other's opinions' was, however, not highly prioritized (mean score: 2.78).

> the managers [. . .] need to know [. . .] what problems we encounter or what is important to us. . . And whether we would like to see things differently. [. . .] also especially, well yes, the ethical element. Like, well this is what you ask from us, but do you realize that that also has a totally different consequence? [. . .] . . .do they realize up there [. . .] what that means for all of us personally? *(Interview resp. D: nurse, psychiatry)*

Lastly, some interview respondents noted that outcomes were important for their colleagues rather than for themselves.

> I don't really have a problem, you know, with certain things, but maybe, for some people, it means that your work becomes more pleasant. *(Interview resp. G: nurse, hospital)*

4) Improving quality of care

Several interview respondents perceived quality of care as an important outcome of MCD. Quality of care was not a predefined outcome in the instrument and it is therefore not possible to compare this outcome with quantitative findings. Quality of care was found important because it was seen as the core aim of their work. The interviewees differed in opinions about the impact on the patient. In nursing homes, interviewees deemed it important to place the client nearer the centre through MCD. Some also said that the family of the client should benefit from MCD. Therapists noted the impact of a team approach to the patient, which was regarded as an important outcome of giving more space to discuss issues in an MCD.

> When I walk onto a ward and . . . (laughter) someone has a birthday and they have had cake with their coffee, and oh then they will get back to work in a good mood and then it is like 'oh, how are you?' and. . . whereas if they have just heard that there won't be any holiday replacement because there is no money. . . oh then it is so hard. . . So if such little things can affect what eventually reaches the client! Then I think, well if it is really easy to discuss some things, then, then they will have a little more breathing space. *(Interview resp. J: therapist, nursing home)*

In psychiatry, better care was also linked to a better approach to the client by the team, because in this way, actions are explained more clearly to the patient.

> . . .the clearer it is to us, the more clearly we can communicate it to patients. *(Interview respondent D, nurse, psychiatry)*

In hospitals, nurses perceived it as important that a patient would notice that professionals become more open towards them and that the patient might feel more safe and taken seriously because of this.

> . . .I hope they will notice that maybe it's possible to listen to them with an even more open attitude. [. . .] yes that they will notice there is safety, in that area also. That maybe they will feel free to express their opinions sooner. *(Interview resp. B: nurse, hospital)*

5) Positive impact on organization

In the interviews, the outcomes of MCD for the organization were also perceived as important. An organization might benefit from MCD by having more satisfied and competent employees. Interviewees also hoped that MCD would become easy to do whenever needed, as a sort of routine. Some pointed out the potential of changing policies within the organization. By implementing MCD an organization could further show that their care is not only about quantity but more about quality and focused on patient-cantered care. This could enhance their reputation.

> . . . I think it contributes to a qualitatively better way of providing care. [. . .] It is not only about 'has someone been washed?'. It's about so much more, [. . .] also the quality we deliver. *(Interview resp. K: therapist, nursing home)*

Several interviewees also emphasized that it is important to improve awareness at all levels.

Lastly, some respondents did not yet have ideas about important outcomes of MCD. In answers to the open-ended question, the answer '*no idea*' was found four times. Some interviewees said they found it difficult to answer the questions without having experienced MCD yet.

> No idea. I think we're doing pretty well. I'm curious to see what this will add. *(Respondent Euro-MCD instrument*

3. DIFFERENCES IN THE PERCEIVED IMPORTANCE OF MCD OUTCOMES BETWEEN SUBGROUPS

The subgroups of gender, profession, specialty, experience with MCD and age generated several differences in perception of important outcomes. Table 7 shows the significant differences. Women scored higher on all

outcomes than men, including many significant differences. Physicians and therapists rated some outcomes significantly lower compared to the other professions, and especially nurses and managers. Physicians scored significantly lower than all other professions on the outcome 'Better understanding of being a good professional', as did respondents working in hospital care compared to those working in mentally disabled care. Further stratified analysis showed that the difference between respondents working in mentally disabled care and those working in hospital care could be explained by the fact that more physicians were working in hospital care.

Respondents working in mentally disabled care scored higher on all outcomes, including several significant differences. The different scores for the outcome 'Listen more seriously to others' opinions' can, however, be explained by the fact that more nurses and managers were working in mentally disabled care. Respondents working in psychiatry rated the outcome 'See the situation from different perspectives' lower than others, but further stratification showed that this difference could be explained by the difference between women and men, as more men worked in psychiatry. The fact that more men worked in psychiatry also explained the significant difference between mentally disabled care and psychiatry, for the outcome 'Concrete actions'.

A substantial number of respondents (25%) already had experience with MCD, and since this question was added during the study, the experience of some other respondents (26%) is unknown. Given this relatively large number of respondents with experience, the scores of experienced respondents were compared with those of the other respondents. Statistical comparison showed that respondents with experience in MCD scored higher on the outcome 'Consensus on how to manage the situation', and had lower scores on the outcomes 'Develop skills to analyse' and 'Enhanced understanding of ethical theories'. For the outcome 'Develop skills to analyse', stratified analyses showed that this difference was not significant within the group of female respondents, which implies that this difference could be explained by the fact that there were more women without, or with unknown, MCD experience than men. Stratified analyses for the outcome 'Enhanced understanding of ethical theories' also showed that this difference could be explained by the fact that more respondents without, or with unknown, experience were working in mentally disabled care and/or belong to the professional groups of nurses, managers or others.

Lastly, the outcomes 'Increased awareness of the complexity of the situation', 'Enhanced understanding of ethical theories' and 'Listen more seriously to others' opinions' were perceived as more important by respondents above the age of 45 than by younger respondents.

DISCUSSION

This study identified the important MCD outcomes perceived by 331 Dutch healthcare professionals before their actual MCD participation. Many important outcomes referred to the Euro-MCD domain of 'Enhanced collaboration': 'more open communication', 'better mutual understanding', 'feeling safe', 'mutual respect' and 'better listening'.[18] Other prioritized outcomes were linked to the Euro-MCD domain of 'Improved moral reflexivity': to 'see the situation from different perspectives', 'identify the core ethical question' and 'develop skills to analyse'. Respondents perceived 'concrete actions to manage the situation' and 'consensus on how to handle the situation' as important outcomes within the Euro-MCD domain 'Concrete results'.

In the interviews, MCD outcomes related to quality of care, professionalism and the organization were also noted. The latter two are more or less covered by the domains 'Improved moral reflexivity' and 'Enhanced collaboration'. Quality of care, however, was not included in the predefined 26 MCD outcomes in the instrument.

Women perceived outcomes as more important than men. Healthcare professionals caring for people with a mental disability scored higher than other specialties on all predefined MCD outcomes. Physicians and therapists further perceived being a good professional, communication, understanding ethical theories and managing stress as less important than nurses and managers, although scores were still high. Lastly, the interviewed nurses perceived the outcome of being listened to as highly important.

Prior MCD evaluation studies reported that MCD participants experienced several outcomes regarding collaboration. The importance of more open communication is described both as expected before participation[19] and experienced during MCD.[20] Better mutual understanding was also described in the literature as an outcome experienced.[21] Several studies explained that MCD participants saw the situation from different perspectives, which was perceived as highly important in the current study.[22]

In the quantitative part of this study, healthcare professionals perceived a concrete action as an important outcome for MCD; the professionals interviewed,

[18] Svantesson et al., *op. cit*. note 11.
[19] Weidema et al., *op. cit*. note 5.
[20] Ibid; Hem et al.; Molewijk et al., *op. cit*. note 7.
[21] Weidema et al.; Molewijk et al., *op. cit*. note 5; Janssens et al.; Molewijk et al., *op. cit*. note 7; M. Svantesson et al. Learning a way through ethical problems: Swedish nurses' and doctors' experiences from one model of ethics rounds. *J Med Ethics* 2008; 34: 399–406.
[22] Weidema et al.; Molewijk et al., *op. cit*. note 5; Silén et al.; Molewijk et al., *op. cit*. note 7; Olofsson, *op. cit*. note 7; Svantesson et al., *op. cit*. note 21; R. Førde, R. Pedersen, V. Akre. Clinicians' evaluation of clinical ethics consultations in Norway: a qualitative study. *Med Health Care Philos* 2008; 11: 17–25.

however, were not unanimous about the importance of finding a concrete result. In literature, some studies about the experiences of MCD showed that respondents were disappointed by the lack of clear answers.[23] For instance, Svantesson and colleagues described how 'there was a "wish for the answer book"'.[24] Førde et al., however, described the experiences of physicians and found that 'finding the "single right" solution was not seen as the most important outcome'.[25] It might therefore be useful to distinguish concrete results from finding the right answer. This issue deserves further investigation.

Interview respondents noted the importance of improving quality of care by MCD. Improving care has also been described as a goal of MCD.[26] The Euro-MCD instrument used in this study currently does not include outcomes explicitly referring to quality of care. It was discarded for being 'too vague' in the developmental process.[27] The qualitative findings nevertheless indicated that healthcare professionals viewed this outcome as important. This might indicate a need to reconsider the instrument by including outcomes about quality of care in future versions, possibly more specified and concrete.

The current study further showed that the outcomes of MCD were perceived as more important by respondents working in care for people with a mental disability than by other respondents. It is unknown whether this is because respondents in care for people with a mental disability experience more moral dilemmas, or currently receive less ethical support. Ethical issues in this field mainly seem to concern autonomy, dependency and vulnerability of patients and their sometimes challenging behaviour.[28] There is also some evidence for a link between caring for people with a mental disability, more stress and potentially being at risk of developing burnout, in which case increasing support for those caregivers is suggested as a solution.[29] It might therefore be that MCD is seen as a welcome support service for those caregivers.

The qualitative findings showed a difference between nurses and physicians and managers, especially regarding the importance of better listening to each other. Nurses perceived this outcome as more important than managers and physicians did. This might suggest the experience of some nurses not being involved in decision-making by their managers or physicians, but this conclusion should be treated cautiously, as the respondents were not asked about the current situation and it was not found in the quantitative part of the study. Nevertheless, nurses and managers also perceived many other outcomes as more important than did therapists and physicians. This might suggest a strong need for CES among nurses and managers, which is also suggested in the literature.[30] One reason could be that nurses encounter more situations in which they feel uncertain, powerless or unsupported, since they work more closely with patients. Lillemoen and Pedersen found that 'nurses experienced ethical challenges related to unsatisfactory care more often and also reported the ethical challenges to be more burdensome than the other large professional groups working closest to the patient'.[31] Physicians and therapists might already have better access to CES or participate in other forms of problem-solving group discussions, such as peer supervision. The high prioritization of outcomes by nurses might therefore be explained by the possibility that MCD is the first type of CES that also reaches out to nurses at their workplace. Managers are also usually involved in organizing MCD, which may explain why they are positive about it, and perceived outcomes as highly important in the current study.

This study also showed differences between individuals. This suggests that there might be healthcare professionals who do not recognize themselves in the outcomes that are perceived as most important in general in this study, as did 62 individuals in this study. It is therefore particularly useful to assess individual needs and only then list important MCD outcomes, instead of assuming generally perceived important outcomes. This is of crucial importance for managers and professionals who want to implement MCD within their institution. It may be useful to ask about, and discuss, the main goals of MCD with actual participants before starting MCD sessions. The finding that respondents differ in their perceived importance of MCD outcomes further confirms the complexity of studying MCD outcomes, and therefore, the views

[23] Molewijk et al., *op. cit*. note 7; Svantesson et al., *op. cit*. note 21.
[24] Svantesson et al., *op. cit*. note 21.
[25] Førde et al., *op. cit*. note 22.
[26] Molewijk et al., *op. cit*. note 5; Dauwerse et al., *op. cit*. note 12.
[27] Svantesson et al., *op. cit*. note 11.
[28] R.P. Hastings. Do challenging behaviors affect staff psychological well-being? Issues of causality and mechanism. *Am J Ment Retard* 2002; 106; 6: 455–467; E.F. Kittay. When caring is just and justice is caring: justice and mental retardation. *Public Culture* 2001; 13: 557–559; J. Morris. Impairment and disability: Constructing an ethics of care that promotes human rights. *Hypatia Special Issue: Feminism and Disability* 2001; Part 1; 46(4): 1–16.
[29] Hastings, *op. cit*. note 28; G. Mitchell & R.P. Hastings. Coping, burnout, and emotion in staff working in community services for people with challenging behaviors. *Am J Ment Retard* 2001; 106: 448–459; H. Ito, H. Kurita, J. Shiiya. Burnout among direct-care staff members of facilities for persons with mental retardation in Japan. *Ment Retard* 1999; 37: 477–481; S. Dyer & L. Quine. Predictors of job satisfaction and burnout among the direct care staff of a community learning disability service. *J Appl Res Intellect Disabil*. 1998; 11: 320–332.
[30] Lamiani et al., *op. cit*. note 1; T. Poikkeus et al. A mixed-method systematic review: support for ethical competence of nurses. *J Adv Nurs* 2013; 70: 256–271.
[31] Lillemoen & Pedersen, *op. cit*. note 1.

of targeted healthcare professionals should explicitly be taken into account and listened to, in order to make MCD a success.

The outcomes perceived as most important by participants in the present study are in line with outcomes discussed in the literature, referring to the philosophical basis of MCD. According to Metselaar and colleagues, the dialogical approach of MCD fosters a 'joint process of moral learning' through which participants can develop moral competences such as understanding each other's positions and being open to other perspectives.[32] The development of moral competencies such as a better listening attitude and more awareness of own behaviour is also shown in other studies.[33] Michael Parker uses the more manifest term 'moral craft' as the commitment of health care professionals 'to do their job well for its own sake [. . .], which informs their willingness and interest in learning about and discussing problems encountered by others.'[34] As shown in the current study, outcomes referring to moral competencies such as more open communication, seeing the situation from different perspectives, better mutual understanding of each other's reasoning and actions, and improved moral reflexivity are very important according to healthcare professionals.

The current study also brings to light outcomes which are not so prominent in the theoretical literature, however, such as mutual respect and feeling safe. These outcomes are related to establishing an ethical climate in which healthcare professionals have the opportunity, and feel supported, to speak openly about ethically difficult situations.[35] Several studies suggest the importance of moral competencies for promoting an ethical climate, which might enhance job satisfaction,[36] reduce moral distress[37] and medical errors.[38] In this way, quality of care could be improved.[39] A positive ethical climate is seen as both a precondition for, and the consequence of, developing moral competencies.[40] Respect for persons with different or even opposing viewpoints and the capacity to deal constructively with disagreement might be important moral competencies, and crucial for dealing with ethical challenges. To enhance moral competencies and the ethical climate, clinical ethics support has been suggested.[41] On the other hand, to successfully start clinical ethics support in order to stimulate the development of moral competencies, some preconditions regarding the ethical climate are also necessary.

The current findings can further be linked to the goals and aims described in literature regarding MCD. Dauwerse et al. described goals according to Dutch MCD coordinators: encouraging an ethical climate; fostering an accountable and transparent organization; developing professionalism and good care.[42] The goals of ethical climate, professionalism and good care are confirmed by the present findings about the team, personal development and quality of care. Local coordinators and healthcare professionals might therefore not differ substantially in their perceived important outcomes, which could strengthen the implementation of MCD within healthcare. The congruence regarding perceptions of quality of care as an important outcome confirms the need to reconsider including this in the instrument.

This study focused on MCD as one form of CES, which may give rise to the question of whether the findings would also be applicable to other CES services. For instance, clinical ethics committees aim to support, advise and reassure clinicians in dealing with ethically difficult situations and their focus on giving advice might therefore emphasize outcomes such as concrete results, which were also perceived as important in the current study.[43]

[32] Metselaar et al., *op. cit*. note 9.

[33] Molewijk et al., *op. cit*. note 5; Hem et al., *op. cit*. note 7; Dauwerse et al., *op. cit*. note 12.

[34] M. Parker. 2012. Moral Craft. In: *Ethical problems and genetics practice*. M. Parker. Cambridge: Cambridge University Press: 112–130.

[35] Silén et al., *op. cit*. note 5; O. Numminen et al. Ethical climate and nurse competence – newly graduated nurses' perceptions. *Nurs Ethics* 2014, 1–15; J.I. Hwang & H.A. Park. Nurses' perception of ethical climate, medical error experience and intent-to-leave. *Nurs ethics* 2014; 21: 28–42.

[36] Numminen et al., *op. cit*. note 35; C. Ulrich et al. Ethical climate, ethics stress and job satisfaction of nurses and social workers in the United States. *Soc Sci Med* 2007; 65: 1708–1719.

[37] Silén et al., *op. cit*. note 7; B. Pauly et al. Registered nurses' perceptions of moral distress and ethical climate. *Nurs Ethics* 2009; 16: 561–573.

[38] Wang & Park, *op. cit*. note 35.

[39] Wang & Park, *op. cit*. note 35; Varcoe et al., *op. cit*. note 1; C.C. Huang, C.S. You, M.T. Tsai. A multidimensional analysis of ethical climate, job satisfaction, organizational commitment, and organizational citizenship behaviors. *Nurs Ethics* 2012; 19: 513–529; M. Silén et al. What actions promote a positive ethical climate? A critical incident study of nurses' perceptions. *Nurs Ethics* 2012; 19: 501–512; J.J. Kish-Gephart, D.A. Harrison, L.K. Treviño. Bad apples, bad cases, and bad barrels: meta-analytic evidence about sources of unethical decisions at work. *J Appl Psychol* 2010; 95(1): 1; K. Lützén et al. Moral stress, moral climate and moral sensitivity among psychiatric professionals. *Nurs Ethics* 2010; 17: 213–224.

[40] Numminen et al., *op. cit*. note 35; Pauly et al., *op. cit*. note 37.

[41] Silén et al., *op. cit*. note 39; T. Poikkeus et al. Organisational and individual support for nurses' ethical competence. A cross-sectional survey. *Nurs Ethics* 2016; 1–17; C. Bartholdson et al. Healthcare professionals' perceptions of the ethical climate in paediatric cancer care. *Nurs Ethics* 2015.

[42] Dauwerse et al., *op. cit*. note 12.

[43] Slowther et al., *op. cit*. note 3; S.A. Hurst et al. Ethical difficulties in clinical practice: experiences of European doctors. *J Med Ethics* 2007; 33: 51–57.

It might be the case, however, that outcomes referring to teamwork and developing moral competencies, important to MCD participants, are less important to healthcare professionals who consult clinical ethics committees. Clinical ethics committees in general involve individual healthcare professionals who do not always participate themselves in the deliberation, thereby not influencing the team collaboration, group dynamics or moral competencies of those healthcare professionals.[44] It might therefore be expected that the different types and goals of CES services will be reflected in their perceived important and experienced outcomes. This needs to be investigated in further research, including different types of CES services.

Although perceptions of participants are essential for reflection on the aims of CES services, this does not imply that participant opinions about outcomes determine the final aim of CES services. There might be outcomes which are less appropriate, even if the majority of service users find them very important. On the other hand, outcomes not described by CES service users as important might be essential from a theoretical point of view. Empirical data from the MCD participants in this study, on the importance of certain outcomes, might inform and challenge theoretical and normative thinking on MCD and CES outcomes. In answering normative questions concerning outcomes of CES services, the perspectives and theoretical considerations should both be regarded as relevant. In line with ideas developed in empirical ethics, the views and experiences of professionals and the beliefs of ethical experts about what constitutes a good CES outcome should be integrated. This can be done by organizing an exchange in a reflective and dialogical way.[45] Ethics expert opinions also played a crucial role in the development of the Euro-MCD instrument.[46] A next step would now be to use the views of healthcare professionals as input for ethics expert reflection. The exchange between healthcare professionals' viewpoints of CES service users and theoretical considerations can further improve the Euro-MCD instrument and stimulate the appropriate use of CES in clinical practice.

Strengths and limitations

This is the first study to investigate MCD outcomes that are perceived as important according to a large group of healthcare professionals from various specialties and professions throughout the Netherlands. A key strength was the use of both quantitative and qualitative data, providing a rich overview of important outcomes. A limitation was that no healthcare professionals from mentally disabled care were interviewed. Another limitation was that specialties and professions were not distributed equally in the sample size, with a slight overrepresentation of nurses and psychiatry. Lastly, there was no insight into how the healthcare institutions specifically introduced MCD to their healthcare professionals and it was not known whether all respondents had already experienced an MCD. The actual experience of those who reported already having experience was unclear, however. For instance, some institutions had organized an introductory meeting which might be interpreted as an MCD but was not a complete one. Although the number of internal dropouts for the 26 predefined outcomes was low, several respondents did not answer the open-ended question and some interviewed healthcare professionals found it hard to think of outcomes without having any experience. This might suggest that the Euro-MCD instrument is difficult to complete for healthcare professionals who are completely uninformed about and unaware of MCD. This will be taken into account in future studies involving the Euro-MCD instrument.

CONCLUSION

This study provides information about outcomes perceived as important by professionals prior to participating in MCD, which may be relevant for evaluating MCD. Future research may assess the actual experiences of healthcare professionals with MCD and potential changes in outcomes perceived as important after having experienced MCD. The results of this study may contribute to the implementation of MCD within healthcare as it shows which outcomes are deemed important by the target group. Implementation can be improved by taking into account the needs of the professionals. It may also stimulate facilitators to investigate the expectations of participants in MCD meetings, to identify the extent to which these are in line with theoretically defined goals. This is not to say that outcomes perceived as important by participants are a priori the most relevant. It does mean that theoretical perspectives on core outcomes of MCD and practical views on what MCD should bring about should be compared and integrated to develop a more refined conception of the most important outcomes of MCD and CES in healthcare organizations.

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[44] Slowther et al., *op. cit*. note 3; Numminen et al., *op. cit*. note 35; Hurs et al., *op. cit*. note 43; M. Pfäfflin, K. Kobert, S. Reiter-Theil. Evaluating clinical ethics consultation: a European perspective. *Camb Q Healthc Ethics* 2009; 18: 406–419.

[45] Metselaar et al., *op. cit*. note 9; G. Widdershoven, T. Abma, B. Molewijk. Empirical Ethics as Dialogical Practice. *Bioethics* 2009; 23: 236–248.

[46] Svantesson et al., *op. cit*. note 11.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article at the publisher's web-site:

Table 1. Respondents Euro-MCD instrument (N=331)
Table 2. Respondents Interviews (N=13)
Table 3. Results on Euro-MCD instrument (N=331) ordered by descending means
Table 4. *Prioritized outcomes as described in the fixed-choice question of Euro-MCD instrument*: "Please list 5 of the above outcomes that you consider as most important (of the 26 outcomes)"
Table 5. *Categorization of answers to first open-ended question: spontaneously formulated outcomes* "Please formulate 3–5 outcomes you find important"
Table 6. Categories and subcategories of analysis of interviews
Table 7. Differences between subgroups in perception of important outcomes (only significant differences are shown)