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2020

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citation for published version (APA)

de Snoo-Trimp, J. C. (2020). *Outcomes of Moral Case Deliberation: Using, testing and improving the Euro-MCD Instrument to evaluate Clinical Ethics Support*. [PhD-Thesis - Research and graduation internal, Vrije Universiteit Amsterdam].

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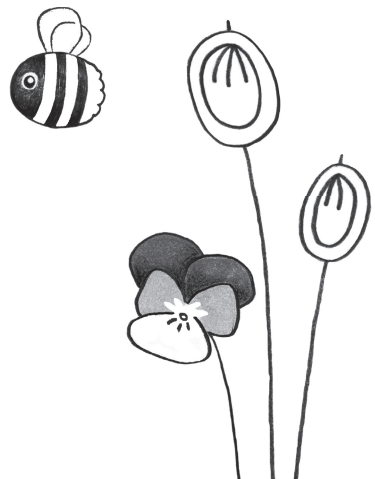
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Important outcomes of moral case deliberation: a Euro-MCD field survey of healthcare professionals' priorities

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Journal of Medical Ethics, 45:608-616.



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) 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.

BACKGROUND

Healthcare professionals in various settings are confronted by different ethical challenges (Rasoal et al. 2016; Tonessen et al. 2017). In order to deal with these, several types of clinical ethics support services have been developed (Molewijk et al. 2015). The services are usually conducted through clinical ethics committees, clinical ethics consultation, or moral case deliberation (MCD) (Molewijk et al. 2015). Increased awareness, through training programs, research, publications, conferences and professional networks related to clinical ethics support, indicate that clinical ethics support is gaining prominence as an important professional domain (Molewijk et al. 2017).

In Europe, MCD has received much attention in recent years (Dauwerse et al. 2014) and may be used as an umbrella term (Svantesson et al. 2014) for ethics rounds (Svantesson et al. 2008; Silén et al. 2016), ethical case reflection (Bartholdson et al. 2014), and ethics reflection groups (Lillemoen & Pedersen 2015). 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 upon: it is a facilitated collective moral inquiry into a concrete moral question connected to a real case made by healthcare professionals in their practice (Molewijk et al. 2011; Svantesson et al. 2014).

Despite existing evaluation (Kälvemark Sporrang 2007; Svantesson et al. 2008; Weidema et al. 2013; Lillemoen & Pedersen 2015; Hem et al. 2015) and implementation research on MCD (Weidema et al. 2016), 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 (Pfäfflin et al. 2009), i.e., 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 (Svantesson et al. 2014). 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 by its users, the Euro-MCD instrument includes a broad range of various outcomes. The included outcomes were selected after a thorough process using a literature review, a Delphi

panel, and content validity testing (Svantesson et al. 2014). 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 Moral Case Deliberation 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 empirical findings and those of other future Euro-MCD publications, we will reflect elsewhere upon the normative question relating to which MCD outcomes *should* be included in the new 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 (Rasoal et al. 2016; De Snoo-Trimp et al. 2017; Svantesson et al. 2018; Heidenreich et al. 2018), 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 contacted us (Molewijk B, VUmc) because they were planning to implement MCD. 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 (Svantesson et al. 2014) to either all healthcare professionals on the workplace 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 healthcare professionals, either on paper in their pigeonholes, or electronically by e-mail 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 healthcare professionals were also briefly informed about the common denominators for MCD (see Introduction) 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'* (Svantesson et al. 2014).

Table 1. Demographic data					
Respondents T.O. Euro-MCD Instrument					
		n (%)	Netherlands	Sweden	Norway
Respondents	Total	703	331	275	97
Gender	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 workplaces N; respondents N (%)	Community care services	28;137 (19)	1;9 (3)	5;35 (13)	22;93 (96)
	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

The Euro-MCD Instrument (Svantesson et al. 2014) 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 healthcare professionals participated in MCD, and asked about their perceived importance of the 26 outcomes. The instrument was also distributed *after* their participation in a series of MCDs and the results of that survey will be reported elsewhere (asking also about experienced outcomes). In this 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 (Svantesson et al. 2014).

Analysis

Quantitative analysis

The ratings of the 26 predefined outcomes and responses to the fixed-choice question were analysed descriptively using Statistical Package for Social Sciences (SPSS), version 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 Appendix. For this calculation, the response options were dichotomized 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 (Gale et al. 2013) (steps 3-6) (see Table 2). The frequencies of the categorised meaning-units (i.e., words or phrases that describe one outcome) were computed for each country and compared.

Table 2. The categorisation process of the framework method (Gale et al. 2013).

<i>Stage 3: Coding</i>	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 program NVivo into categories and domains.	MS, BM
<i>Stage 4: Developing a working analytical framework*</i>	Comparison of the two independent codings, then merging and re-categorisation 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
<i>Stage 5: Applying the analytical framework</i>	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
<i>Stage 6: Charting data into the framework matrix</i>	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
<i>Additional step: Revision and final agreement†</i>	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*

RESULTS

In total, 703 healthcare professionals in Northern Europe returned responses to the Euro-MCD Instrument (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 331/15x34). The respondents were predominantly women. There were 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 amongst co-workers. 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).

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 one of the five most important outcomes.)*Outcomes viewed as quite or very important by $\geq 90\%$ of the respondents***More open communication among co-workers****Better mutual understanding of each other's reasoning and acting****Enables me and my co-workers to decide on concrete actions in order to manage the ethically difficult situations**

Develops my skills to analyse ethically difficult situations

I see the ethically difficult situations from different perspectives

I and my co-workers become more aware of recurring ethically difficult situations

Find more courses of actions in order to manage the ethically difficult situation**Enhances mutual respect amongst co-workers***Outcomes viewed as quite or very important by $< 90\%$ of the respondents*

Consensus is gained amongst co-workers in how to manage the ethically difficult situations

Enhances possibility to share difficult emotions and thoughts with co-workers

Contributes to the development of practice/policies in the workplace

Develops my ability to identify the core ethical question in the difficult situations

I and my co-workers manage disagreements more constructively

I gain more clarity about my own responsibility in the ethically difficult situations

Strengthens my self-confidence when managing ethically difficult situations

I and my co-workers examine more critically the existing practice/policies in the workplace/organisation

Increases my awareness of the complexity of ethically difficult situations

Greater opportunity for everyone to have their say

I become more aware of my preconceived notions

Outcomes viewed as quite or very important by $\leq 80\%$ of the respondents

Enables me to better manage the stress caused by ethically difficult situations

Increases awareness of my own emotions regarding ethically difficult situations

I understand better what it means to be a good professional

I feel more secure to express doubts or uncertainty regarding ethically difficult situations

Enhances my understanding of ethical theories (ethical principles, values and norms)

I listen more seriously to others' opinions

Gives me more courage to express my ethical standpoint

* = $p < 0.05$ ** = $p < 0.01$ *** = $p < 0.001$ ^ = missing >25 respondents † = also significant in multivariable logistic-regression

Domain	Percentage of respondents indicating 'Quite' or 'Very' important			
	Total population (N) %	Netherlands %	Sweden %	Norway %
Collaboration	(672) 97	94**	98	100
Collaboration	(663) 95	94	97	95
Concrete results	(638) 93	90†***	97	90
Moral reflexivity	(634) 92	88†***	94	95
Moral reflexivity	(634) 92	88***	95	96
Organisational	(625) 90	85†***	95	95
Concrete results	(620) 90	85†***	94	95
Collaboration	(609) 90^	82†***	99	92
Concrete results	(608) 88	86	89	90
Emotional support	(603) 88	83†***	94	89
Organisational	(600) 87	81†****	90	97
Moral reflexivity	(599) 87	83**	90	92
Collaboration	(596) 88	82†***	92	92
Moral attitude	(590) 86	79†***	92	93
Emotional support	(575) 84	74†***	93	92
Organisational	(571) 84	84	85	81
Moral reflexivity	(563) 82	72***	90	93
Collaboration	(560) 82	70†***	94	94
Moral attitude	(556) 81	69†***	91	94
Emotional support	(547) 80	67†***	92	87
Emotional support	(540) 79	66†***	91	87
Moral attitude	(544) 80^	70†***	90	88
Emotional support	(532) 78	68***	86	91
Moral reflexivity	(528) 76	73*	78	84
Moral attitude	(525) 80^	67†***	91	94
Moral attitude	(509) 76^	64†***	85	89

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

Outcomes	HEALTHCARE DOMAINS			
	Psych-iatry	Somatic care	Comm. care	Mentally dis. care
ENHANCED COLLABORATION				
More open communication among co-workers	93**	98	99	96
Better mutual understanding of each other's reasoning and acting	90***	98**	96	96
Greater opportunity for everyone to have their say	66***	87**	94†***	84
I and my co-workers manage disagreements more constructively	83*	88	94*	88
Enhanced mutual respect amongst co-workers	81***	93*	95*	90
ENHANCED EMOTIONAL SUPPORT				
Enables me to better manage the stress caused by ethically difficult situations	66***	85**	89**	67*
I feel more secure to express doubts or uncertainty regarding ethically difficult situations	64***	80	90***	78
Enhances possibility to share difficult emotions and thoughts	79***	91*	92	90
Increases awareness of my own emotions regarding ethically difficult situations	68***	81	88***	76
Strengthens my self-confidence when managing ethically difficult situations	70***	86	94***	90
IMPROVED MORAL REFLEXIVITY				
Develops my skills to analyse ethically difficult situations	87*	90	98**	98
I see the ethically difficult situations from different perspectives	86***	94	96*	86
Increases my awareness of the complexity of ethically difficult situations	74**	83	92***	75
Enhances my understanding of ethical theories	73	73	85**	86
Develops my ability to identify the core ethical question in the difficult situation	80**	86	95**	94
IMPROVED MORAL ATTITUDE				
Gives me more courage to express my ethical standpoint	63***	80*	87**	63*
I listen more seriously to others' opinions	69***	81	92***	80
I gain more clarity about my own responsibility in the ethically difficult situation	76***	88	94**	88
I become more aware of my preconceived notions	67***	84	92***	83
I understand better what it means to be a good professional	72**	81	89**	80
CONCRETE RESULTS				
Consensus is gained amongst co-workers in how to manage the ethically difficult situations	90	89	90	86
Enables me and my co-workers to decide on concrete actions in order to manage the ethically difficult situations	84	93	93	94
Find more courses of actions in order to manage the ethically difficult situations	87	89	96**	92**
IMPACT ON ORGANISATIONAL LEVEL				
I and my co-workers examine more critically the existing practice/policies	85	82	82	94
Contributes to the development of practice/policies in the workplace	79***	87	95**	90
I and my co-workers become more aware of recurring ethically difficult situations	83***	91	96**	92

† = also significant in multivariable logistic-regression * = $p < 0.0$ ** = $p < 0.01$ *** = $p < 0.001$

PROFESSIONS					GENDER		AGE		
Nurse ass.	Nurses	Physicians	Thera pists	Managers	Female	Male	<39	40-49	>50
99	97	96	92†**	98	98 †**	92	94	97	98†**
97	97	88*	90**	98	97†***	88	94	96	96
96***	82	71*	77	79	86†***	69	76	85	86†**
92	89	78†*	84	90	89	83	83	89	90†**
100***	89	90	83**	93	92***	82	86	93	92**
95***	84**	60†***	62†***	74	84†***	63	74	83	83**
94***	76	57	75	81	82†***	62	75	78	81
96**	88	86	84	86	91†***	77	86	88	91
92***	79	69	67**	86	81**	69	71	81	85**
97***	84	69**	78*	83	88†***	67	83	84	85
96	90	88	90	100	92	88	92	91	91
96	91	88	90	96	94†***	83	90	91	94*
94***	83	68†**	73**	84	86†***	69	73	84	88†***
92†***	74	56†***	72	76	78*	70	69	77	83†**
95**	84*	84	85	98	89†**	79	80	89	90†**
89***	76	57†**	69	78	79***	63	71	79	76
96***	81	69*	65***	78	83**	70	70	84	87†***
97***	86	74†**	81	90	90†***	71	84	88	87
94***	80	61†***	79	88	85†***	67	78	84	81
96†***	92	59†***	76	76	83***	69	78	82	82
93	88	82	91	93	88	87	83	91	89
97	92	92	82	95	93	90	90	94	93
96*	89	82*	89	100	92**	83	88	91	91*
84	83	82	85	93	85	79	84	82	85
95**	88	76*	79**	93	89†***	76	81	88	90†**
98**	90	84	84*	98	93†***	80	91	88	91

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 Appendix for fuller description of the analyses (Odds Ratios).

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 co-workers'; 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 (Table 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' (Sweden and Norway versus 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 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 co-workers': *'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 4), 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)

Table 5. Most frequently categorized 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 co-workers	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 amongst co-workers 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 amongst co-workers	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 co-workers	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	Organisational 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	Organisational 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

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 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 to 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 (Dauwerse et al. 2011; Weidema et al. 2013). 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 (i.e., hermeneutics, pragmatism, and dialogical ethics) in which mutual dialogue and practical usefulness are key values of MCD (Abma et al. 2009; Widdershoven et al. 2010). 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 (Svantesson et al. 2008; Weidema et al. 2013). 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 (Molewijk et al. 2008; Weidema et al. 2013). Hence, openness towards one another and better collaboration

are both important preconditions for and results of moral learning (Molewijk et al. 2008; Hem et al. 2015).

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 (Molewijk et al. 2008; Abma et al. 2009). Rather, MCD aims at learning to deal with ethically difficult situations (Svantesson et al. 2014), improving the quality of care, and learning about what is morally right, based on moral reflections and reasoning (Abma et al. 2009). 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 (Molewijk et al. 2008; Abma et al. 2009).

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 (Molewijk et al. 2008; Dauwerse et al. 2013; Weidema et al. 2013). 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 (Svantesson et al. 2014). 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 (Heidenreich et al. 2018). 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 upon moral questions emerging from concrete experiences by means of moral reasoning and engaging in a joint critical moral inquiry (Abma et al. 2009). MCD has been described as aiming to improve moral competencies (Førde et al. 2008). It is therefore remarkable that the outcomes deriving from the domains of moral reflexivity (e.g., analysis skills) and moral attitude (e.g., 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 learned by doing (e.g., while reflecting upon concrete cases).

Considering the differences between subgroups

Most of the differences in perceived importance between the subgroups (profession, healthcare setting, etc.) 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 dominated 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 (1994), 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. More recently, this gender difference was found again in a study about experiencing moral distress among critical care nurses in the U.S.A. (O'Connell 2015). 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 (Dutch), 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 Swedes and Norwegians yearn for a forum for exchange and reflection, whilst in Dutch healthcare, various forums are more established (e.g., 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 (2007) found that the Swedes are more likely to report good or better health than respondents in all other countries. 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 (Muehlhausen et al. 2015). 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 (Svantesson et al. 2018). This raises the normative question as to what degree emotional support and psycho-social 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 (Molewijk et al. 2011).

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 (i.e., moral reflexivity and moral attitude) somewhat less important as compared to 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 (Metselaar et al. 2015). 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 health care 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, i.e. 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 organized 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 pigeonholes 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 don't know the exact response rate for the Netherlands, but the estimated response rate is in line with other questionnaire studies.

The 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 purposively included all possible MCD outcomes with few normative preferences (Svantesson et al. 2014). 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 new 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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APPENDIX. Odds ratio for determinants for perceiving more or less importance for the MCD outcome compared with the other subgroups. Odds ratio (OR) were considered clinically relevant if OR<0.5 or >2 (except age, calculated for each year).

Determinants OR	HEALTHCARE DOMAINS				
	Netherlands vs Scandinavia	Psychiatric care vs other	Somaticcare vs others	Community care vs other	Ment. dis. care vs other
ENHANCED COLLABORATION					
More open communication among co-workers	0.29**	0.32**	NS	NS	NS
Better mutual understanding of each other's reasoning and acting	NS	0.27***	3.26**	NS	NS
Greater opportunity for everyone to have their say	0.15†***	0.26***	1.68**	3.99***	NS
I and my co-workers manage disagreements more constructively	0.40†***	0.58*	NS	2.55*	NS
Enhanced mutual respect amongst co-workers	0.14†***	0.30***	2.03*	2.18*	NS
ENHANCED EMOTIONAL SUPPORT					
Enables me to better manage the stress caused by ethically difficult situations	0.21†***	0.35***	1.93**	2.35**	0.49*
I feel more secure to express doubts or uncertainty reg ethically diff. sit.	0.31***	0.37***	NS	3.15***	NS
Enhances possibility to share difficult emotions and thoughts	0.37†***	0.36***	1.78*	NS	NS
Increases awareness of my own emotions regarding ethically diff. situations	0.21***	0.45***	NS	2.11***	NS
Strengthens my self-confidence when managing ethically difficult situations	0.21†***	0.31***	NS	3.61***	NS
IMPROVED MORAL REFLEXIVITY					
Develops my skills to analyse ethically difficult situations	0.43**	0.52*	NS	4.96**	NS
I see the ethically difficult situations from different perspectives	0.34***	0.40***	NS	2.79*	NS
Increases my awareness of the complexity of ethically difficult situations	0.27***	0.52**	NS	2.91***	NS
Enhances my understanding of ethical theories	0.69*	NS	NS	1.92**	NS
Develops my ability to identify the core ethical question in the diff. sit.	0.53**	0.49**	NS	3.29**	NS
IMPROVED MORAL ATTITUDE					
Gives me more courage to express my ethical standpoint	0.29***	0.42***	1.54*	2.37**	0.53*
I listen more seriously to others' opinions	0.18***	0.42***	NS	3.23***	NS
I gain more clarity about my own responsibility in the ethically diff. sit.	0.32†***	0.36***	NS	2.98**	NS
I become more aware of my preconceived notions	0.19†***	0.32***	NS	3.06***	NS
I understand better what it means to be a good professional	0.26***	0.53**	NS	2.31**	NS
CONCRETE RESULTS					
Consensus is gained amongst co-workers in how to manage the ethic diff. sit.	NS	NS	NS	NS	NS
Enables me and my co-workers to decide on concrete actions in order to manage the ethically difficult situations	0.47**	NS	NS	NS	NS
Find more courses of actions in order to manage the ethically diff. sit.	0.34†***	NS	NS	3.38**	2.60**
ON ORGANIZATIONAL LEVEL					
I and my co-workers examine more critically the existing practice/ policies	NS	NS	NS	NS	NS
Contributes to the development of practice/policies in the workplace	0.38†***	0.43***	NS	3.33**	NS
I and my co-workers become more aware of recurring ethically diff. sit.	0.28***	0.37***	NS	3.37**	NS

† = also significant in multivariable logistic-regression NS= not significant $p > 0.05$ * = $p < 0.05$ ** = $p < 0.01$ *** = $p < 0.001$

PROFESSIONS				GENDER/AGE	
Nurse assistants vs other	Nurses vs other	Physicians vs other	Therapists vs other	Female versus male	Older age vs younger age
NS	NS	NS	0.31 †**	0.27 †**	1.05 †**
NS	NS	0.33 *	0.39 **	0.23 ***	NS
5.45 ***	NS	0.5*	NS	0.36†***	1.03 **
NS	NS	0.45 †*	NS	NS	1.03 †**
+inf ***	NS	NS	0.44**	0.40***	1.03 **
5.59 ***	1.68**	0.35 †***	0.32 †***	0.32†***	1.02 **
5.42 ***	NS	NS	NS	0.35 ***	NS
3.21 **	NS	NS	NS	0.31 †***	NS
3.30 ***	NS	NS	0.48**	0.50**	1.03 **
6.42 ***	NS	0.40 **	0.61*	0.28 †***	NS
NS	NS	NS	NS	NS	NS
NS	NS	NS	NS	0.31 ***	1.03 *
4.12 ***	NS	0.43 **	0.51**	0.38 ***	1.04 †***
4.54 †***	NS	0.36 †***	NS	0.66*	1.03 †**
3.16 **	0.64*	NS	NS	0.46 **	1.03 **
3.06 ***	NS	0.40 †**	NS	0.44 ***	NS
8.16 ***	NS	0.51*	0.38 ***	0.50**	1.03 ***
5.28 ***	NS	0.41 †**	NS	0.29 †***	NS
4.29 ***	NS	0.32 ***	NS	0.37 †***	NS
6.16 †***	NS	0.32 †***	NS	0.45 ***	NS
NS	NS	NS	NS	NS	NS
NS	NS	NS	NS	NS	NS
2.69 *	NS	0.45 *	NS	0.42 **	1.02 *
NS	NS	NS	NS	NS	NS
3.30 **	NS	0.45 *	0.49 **	0.39 †***	1.03 †**
4.95 **	NS	NS	0.51*	0.31 ***	NS

