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Field-testing the Euro-MCD Instrument: Experienced outcomes of moral case deliberation

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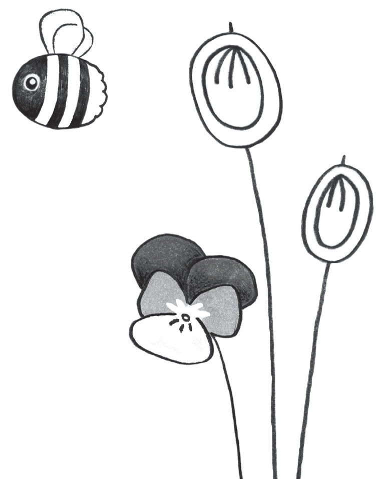

ABSTRACT

Background: Moral case deliberation is a form of clinical ethics support to help healthcare professionals in dealing with ethically difficult situations. There is a lack of evidence about what outcomes healthcare professionals experience in daily practice after moral case deliberations. The Euro-MCD Instrument was developed to measure outcomes, based on the literature, a Delphi panel and content validity testing. To examine relevance of items and adequateness of domains, a field study is needed.

Aim: To describe experienced outcomes after participating in a series of moral case deliberations, both *during sessions* and *in daily practice;* and to explore correlations between items to further validate the Euro-MCD Instrument.

Methods: In Sweden, the Netherlands and Norway, healthcare institutions that planned a series of moral case deliberations were invited. Closed responses were quantitatively analyzed. The factor structure of the instrument was tested using exploratory factor analyses.

Ethical considerations: The study was approved in Sweden by a review board. In Norway and the Netherlands, data services and review boards were informed about the study.

Results: The Euro-MCD Instrument was completed by 443 and 247 healthcare professionals after 4 and 8 moral case deliberations, respectively. They experienced especially outcomes related to a better collaboration with co-workers and outcomes about individual moral reflexivity and attitude, both during sessions and in daily practice. Outcomes were experienced to a higher extent *during sessions* than *in daily practice.* The factor structure revealed four domains of outcomes, which did not confirm the six Euro-MCD domains.

Conclusions: Field-testing the Euro-MCD Instrument showed the most frequently experienced outcomes and which outcomes correlated with each other. When revising the instrument, domains should be reconsidered, combined with theory about underlying concepts. In the future, a feasible and valid instrument will be presented to get insight into how moral case deliberation supports and improves healthcare.

BACKGROUND

Supporting healthcare professionals, patients and family in dealing with ethically difficult situations is the main goal of clinical ethics support: a service that can take various forms, such as individual ethics consultants, ethics committees and moral case deliberation (MCD) (Molewijk et al. 2015). MCD[1] has been implemented now for more than two decades in many healthcare settings (Bartholdson et al. 2014; Dauwerse et al. 2014; Lillemoen & Pedersen 2015; Spijkerboer et al. 2017). MCD is a group dialogue in which professionals (sometimes with patients and family) jointly investigate a moral question that emerges out of a situation they experienced in their daily practice, by reflecting on relevant values and norms from different perspectives and on possible solutions. The dialogue is led by a trained facilitator (Stolper et al. 2015).

In literature about MCD, various goals have been described, like improving collaboration among colleagues, learning to identify moral questions and, by becoming aware of one's own viewpoint, acknowledging viewpoints of others (Stolper et al. 2015; Metselaar et al. 2015; Grönlund et al. 2016). Furthermore, several studies have been carried out to evaluate MCD through ways of dealing with moral dilemmas (Söderhamn et al. 2014; Spijkerboer et al. 2017), satisfaction among MCD participants (Hem et al. 2015; Silén et al. 2016) and assessment of MCD-content (Grönlund et al. 2016; Rasoal et al. 2016; Tønnessen et al. 2015;2017). As such, these studies were qualitative in nature and focused on the experiences of participants *during* the MCD sessions. However, as far as we know, there is no quantitative research, and also not much known about what outcomes these participants experience *after* the sessions, i.e. in daily practice.

In the research field of clinical ethics support services like MCD, there is yet no consensus about what outcomes MCD *should* lead to (Molewijk et al. 2017). To evaluate experienced outcomes of MCD, both *during* sessions as well as *in daily practice,* a preliminary instrument has been developed: the Euro-MCD Instrument (Svantesson et al. 2014). It measures the perceived importance and experience of outcomes after a series of 4 (T.1) and 8 (T.2) MCD sessions. The reason for two moments for measurement is that the developers were interested in whether the experience of outcomes would increase after participating in more MCD sessions, as it might take time for outcomes to settle. Frequent participation in MCD sessions may have a learning effect, as participants for instance learn what norms and values mean in a certain situation. Therefore, the skill of identifying norms and values becomes stronger after frequent

1 Also referred to as 'ethics reflection groups' (Lillemoen & Pedersen 2015) or 'ethics case reflections' (Bartholdson et al. 2014).

participation. Furthermore, the experience of for instance mutual understanding and open communication may increase in iterative MCD sessions. Also, MCD participants are asked to rate experienced outcomes both with regard to the *MCD sessions* and *in daily practice*. The reason for this distinction is that it is yet unknown if there is a difference between experienced outcomes *during* the sessions and those *in daily practice,* and that especially the latter category is of great importance.

Focus on the experienced outcomes of the MCD participants themselves is needed because MCD-outcomes such as growth in moral attitude are difficult to capture through objective measures like duration of hospital stay or in patient-reported quality of care scores (Schildmann et al. 2013; Haan et al. 2018). Furthermore, insight in the outcomes of MCD is important for organizations who use or want to use MCD; they probably want to know the potential impact of MCD sessions (besides the value of MCD sessions themselves). Thus, learning how healthcare professionals report to act after participation in a series of MCD is highly relevant.

The Euro-MCD Instrument was the product of an extensive process including a literature review, a Delphi-panel and content validity testing (Svantesson et al. 2014). It needs further validation and therefore it is currently being tested in a large field study in Sweden, the Netherlands and Norway. So far, data about perceived importance of outcomes by healthcare professionals *before* their participation in MCD have been published (De Snoo-Trimp et al. 2017; Svantesson et al. 2019). The ultimate purpose of the larger field study is to test and further develop the Euro-MCD Instrument for use in clinical practice and future evaluation research. Exploring correlations of outcomes of the instrument can inform possible categorization of outcomes. A clear and reliable categorization of outcomes is relevant for future studies, as domain scores can be presented instead of the separate results of each individual outcome.

Aim

The aim of the current study was twofold: 1) to describe the experienced outcomes *after* a series of MCD sessions, both during the sessions as well as in daily practice, and 2) to explore the correlations between items of the Euro-MCD Instrument and to inform about possible domains.

METHODS

Design

Descriptive longitudinal field survey and psychometric testing.

Sampling and data collection

Convenience sampling was used to recruit a large number of healthcare institutions that wanted to organize a series of at least 4 and preferably 8 MCD sessions. This recruitment took place between 2012 and 2017. Healthcare institutions were asked to organize MCD sessions on a monthly basis. On average, the time between 4 and 8 MCD sessions was 4 months. In Sweden and the Netherlands, various kinds of healthcare institutions that wanted to implement MCD or ethics reflection groups were invited to participate. In Norway, institutions were included via a national project supported by the Norwegian government to implement ethics reflection within community care institutions. In total, 30 healthcare institutions (6 in Sweden, 10 in the Netherlands and 14 in Norway) were included to complete the instrument after a series of 4 MCDs (T.1). In 25 institutions (6 in Sweden, 5 in the Netherlands and 14 in Norway), MCD participants also completed the instrument after a total of 8 MCD sessions (T.2). The institutions included community care, somatic hospital care, psychiatry, care for mentally disabled people, the Dutch health inspectorate and policy departments of hospitals. The instrument was administered on paper in Sweden and both on paper and by e-mail in the Netherlands. In Norway, the questionnaire was sent via a web-based questionnaire. In all countries, two reminders were sent. Table 1 shows the background of the respondents, including country and healthcare setting.

The Euro-MCD Instrument

The Euro-MCD Instrument consists of 26 possible outcomes of MCD, categorized in six domains: 1) Enhanced emotional support; 2) Enhanced collaboration; 3) Improved moral reflexivity; 4) Improved moral attitude; 5) Impact at organizational level and 6) Concrete results. The instrument was developed in a process including a literature review, a Delphi-panel and content validity testing as described in more detail by Svantesson et al. (2014). The instrument was translated and culturally adapted into Swedish, Norwegian and Dutch with the use of two independent translators, back-translation and 'think-aloud'-interviews (in each country). The instrument was administered *after* participation in a series of 4 (T.1) and 8 (T.2) MCDs, asking *both* the *perceived importance* as well as the *experience* of the 26 outcomes based on all MCDs they participated in. In this paper, we will focus on the *experienced* outcomes. By 'experience' we mean whether they recognize the described outcome as being present, either during or beyond the MCD sessions.

Respondents rated the extent to which they had experienced each outcome both *during the MCD sessions* as well as *in their daily practice* on a 4-point Likert scale, from 'not at all' to 'in a high degree'. The answer option 'cannot take a stand' was also presented as a response option. Next to presenting the 26 outcomes, the survey also contained three *open* questions about experienced outcomes and aspects that should be improved during the MCD sessions; these results will be published elsewhere.

Data analysis

Statistical Package for Social Sciences (SPSS), version 22, was used for all analyses. Data was not normally distributed so non-parametric tests (Wilcoxon Signed Rank Test and Chi-Square Test) were used to calculate the significance of differences between experiences *during the sessions* and experiences *in daily practice,* and between T.1 and T.2.

We performed an Exploratory Factor Analysis to examine how many factors (i.e. a cluster of correlated MCD outcomes) could be detected in the responses to the instrument. This was examined with use of Principal Component Analysis to show the correlations between the ratings of items (De Vet et al. 2011). We were looking for a factor structure that represented both experienced outcomes *during the MCD sessions* as well as experienced outcomes *in daily practice*. The developers of the Euro-MCD Instrument suggested six different domains of outcomes (Svantesson et al. 2014): 1) Enhanced emotional support; 2) Enhanced collaboration; 3) Improved moral reflexivity; 4) Improved moral attitude; 5) Impact on organizational level and 6) Concrete results.

Ethical considerations

In Sweden, an advisory statement including "no objection to this study" was made by the Regional Ethical Review Board (dnr 2012/34). In the Netherlands, the Ethical Review Board (2017.612) and in Norway, the Norwegian Social Science Data Service were informed about the study.

Healthcare professionals of the participating institutions received the instrument accompanied by an information letter. In this information letter, the background and aim of the study were explained and it was specified that completing the instrument was on voluntary basis and that they could also withdraw from this study at any moment without giving reasons for that. Furthermore, they learned that responses would be handled confidentially and completed instruments would be sent directly to the researchers outside the institution.

Table 1 – Characteristics of respondents Euro-MCD Instrument

	Who completed T.1 (after 4 MCDs)	Who completed T.2 (after 8 MCDs)	Who completed both T.1 &T.2*
Total N	443	247	129
Country N (%)			
Sweden	130 (29)	142 (58)	81 (63)
Netherlands	232 (52)	53 (21)	31 (24)
Norway	82 (18)	52 (21)	17 (13)
Male/female %	20/80	13/87	13/87
Age, mean (range)	45 (21-75)	45 (20-65)	46 (23-65)
Years of experience, mean (range)	18 (0-45)	19 (1-45)	19 (1-45)
Profession N (%)			
Nurse[1]	160 (37)	126 (53)	65 (50)
Nurse assistant	73 (17)	58 (24)	31 (24)
Doctor/specialist/psychiatrist	18 (4)	6 (3)	2 (2)
Therapist[2]	121 (28)	23 (9)	13 (10)
Manager[3]	32 (7)	19 (8)	8 (6)
Others[4]	28 (7)	6 (3)	3 (2)
Respondents per setting N (%)			
Community care services	110 (25)	77 (31)	37 (29)
Somatic hospital care	140 (32)	119 (48)	63 (49)
Psychiatric care	148 (33)	31 (13)	16 (12)
Mentally disabled care	26 (6)	12 (5)	6 (5)
Health Inspection/policy departments	19 (4)	8 (3)	7 (5)
Institutions N	30	25	18
MCD participation, mean (range)	3 (0-6)	4 (0-10)	T1: 3 (0-5) T2: 5 (1-10)
missing MCD participation %	60	51	T1: 73 T2: 50

These respondents are also represented in the T.1 and T.2 colons
[1]Including registered nurses; support workers and psychosocial workers; [2]Including physiotherapists; psychologists; spiritual caregivers; social workers; [3]Including head of departments and policy makers, [4]Including volunteers, clients, researchers, trustees, secretary and interns

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RESULTS

The Euro-MCD Instrument was completed by 443 healthcare professionals after participating in 4 MCDs (T.1) and by 247 healthcare professionals after participating in 8 MCDs (T.2), of which 129 healthcare professionals completed both T.1 and T.2. The characteristics of these healthcare professionals, including countries, professions and healthcare domains are presented in Table 1. In the following part, we will outline the top-three outcomes as experienced in a 'quite high' or 'high' degree by most respondents, both during the MCD sessions and in daily practice, followed by the top-three of outcomes that were indicated as 'not experienced'. These outcomes (most experienced and not experienced) are considered most informative in view of the further validation of the instrument. Secondly, we present the results of the factor analyses.

Experienced outcomes during the MCD sessions

During the MCD sessions, all 26 items were experienced by 43 to 80 percent of the respondents in 'quite high' or 'high' degree (see Table 2). After 4 sessions (T.1), the top-three items that respondents experienced in a 'quite high' or 'high' degree were: 'I see the situation from different perspectives' (79%); 'Better mutual understanding of each other's reasoning and acting' (77%) and 'More open communication among co-workers' (74%) (no. 2, 8 and 9 in Table 2). After 8 sessions (T.2), the three highest scores occurred for the items: 'I listen more seriously to other's opinions' (80% at T.2); 'Greater opportunity for everyone to have their say' (80%) and (like T.1) 'Better mutual understanding of each other's reasoning and acting' (78%) (no. 8, 14 and 17 in Table 2). These items mainly come from the original Euro-MCD domain 'Enhanced collaboration'. Respondents who completed only the T.2 questionnaire rated their experience of 5 outcomes significantly higher than respondents who completed only the T.1 questionnaire (see Table 2). For these 5 outcomes, when looking at the groups of respondents who completed only T.1 or only T.2, percentages for experiencing it in a 'quite high' and 'high' degree at T.2 were on average 16 percent higher than at T.1 (range 10-28%) (not in a table). Respondents who completed both questionnaires (N=129) did not significantly change in their experience of outcomes at T.2 compared to T.1.

Experienced MCD outcomes in daily practice

In daily practice, all items were experienced to a 'quite high' or 'high' degree by 34 to 64 percent of the respondents. All outcomes were experienced to a significantly lower degree in this setting of daily practice than *during MCD sessions.* On average, at T.1, the percentage of respondents rating an outcome as having experienced it to a 'quite high'

or ‘high’ degree *during the sessions* was 13 percent (range 5 to 28%) higher than *in daily practice.* This difference was 14 percent (range 5-23%) at T.2 (*not in a table*). At both T.1 and T.2, two items were rated by most respondents as having been experienced to a ‘quite high’ or ‘high’ degree: ‘I see the situation from different perspectives’ (60% at T.1 and 62% at T.2), ‘Increases my awareness of the complexity of situations’ (57% at T.1 and 63% at T.2) (no. 9 and 11 in Table 3). At T.1, the item ‘Better mutual understanding of each other’s reasoning and acting’ (no. 8) was also experienced in a ‘quite high’ or ‘high’ degree (56%) and at T.2, the item ‘I listen more seriously to other’s opinions’ (no. 17; 64%) was also one of the top-3 items at T.2. When looking at the Euro-MCD domains, the most experienced outcomes belong to Improved moral reflexivity, Improved moral attitude and Enhanced collaboration. Table 3 presents the experience of MCD items in *daily practice*, comparable to Table 2. Respondents who completed only T.2 rated their experience significantly higher for 10 outcomes compared with respondents who completed only T.1, with a mean difference of 13 percent (4-18%) for experiencing it in a ‘quite high’ and ‘high’ degree (not in a table, Table 3 presents percentages of all respondents not only those who completed only T.1 or only T.2). Respondents who completed both T.1 and T.2 (N=129) did not significantly change in their experiences.

Table 2 Experienced outcomes during MCD sessions after 4 (T.1) and 8 sessions (T.2)

	To what degree did you experience this outcome?		Not	Somewhat	Quite high & High	More or less experienced at T.2 than T.1?**
			% of respondents per answer option			
1	Develops my skills to analyze ethical difficult situations	T.1	3	31	65	
		T.2	2	30	68	
2	More open communication among co-workers	T.1	4	22	74	
		T.2	3	21	76	
3	Consensus is gained amongst co-workers in how to manage the situation	T.1	6	36	59	
		T.2	3	36	60	
4	Enables me to better manage the stress from the ethical situation	T.1*	22	34	45	
		T.2	13	45	43	
5	Contributes to the development of practice/policies in the workplace	T.1	12	45	43	
		T.2*	9	44	47	
6	Gives me more courage to express my ethical standpoint	T.1	11	30	60	
		T.2	7	24	70	
7	I feel more secure to express doubts or uncertainty regarding difficult situations	T.1	12	30	58	More (p=0.010)
		T.2	5	27	68	
8	Better mutual understanding of each other's reasoning and acting	T.1	3	21	77	
		T.2	1	21	78	
9	I see the situation from different perspectives	T.1	2	19	79	
		T.2	1	23	76	
10	I and my co-workers become more aware of recurring situations	T.1	7	25	68	
		T.2	1	28	71	
11	Increases my awareness of the complexity of the situation	T.1	6	26	68	
		T.2	3	22	75	
12	Enhances my understanding of ethical theories	T.1	13	37	50	
		T.2	7	36	57	
13	Enables to decide on concrete actions to manage the situation	T.1	9	35	55	
		T.2	4	34	62	
14	Greater opportunity for everyone to have their say	T.1	6	27	67	More (p=0.010)
		T.2	2	18	80	

Table 2 Continued

	To what degree did you experience this outcome?		Not	Somewhat	Quite high & High	More or less experienced at T.2 than T.1?**
			% of respondents per answer option			
15	Enhances possibility to share difficult emotions and thoughts	T.1	4	27	70	
		T.2	2	24	74	
16	Find more courses of action to manage the situation	T.1	5	31	64	
		T.2	2	30	68	
17	I listen more seriously to other's opinions	T.1	12	27	61	More (p=0.000)
		T.2	3	18	80	
18	Increases awareness of own emotions	T.1	12	31	58	More (p=0.009)
		T.2	5	27	67	
19	Strengthens my self-confidence when managing difficult situations	T.1	12	32	56	
		T.2	7	31	62	
20	Develops my ability to identify the core ethical question in difficult situations	T.1	8	35	58	
		T.2*	4	33	63	
21	I and my co-workers examine more critically existing practice/policies in workplace	T.1	14	34	53	
		T.2*	8	36	56	
22	I and my co-workers manage disagreements more constructively	T.1	14	35	52	
		T.2*	11	33	57	
23	I gain more clarity about own responsibility in difficult situations	T.1	10	34	57	
		T.2	4	30	66	
24	Enhances mutual respect amongst co-workers	T.1	10	28	63	
		T.2	4	24	72	
25	I become more aware of my preconceived notions	T.1	12	31	57	More (p=0.031)
		T.2	4	30	65	
26	I understand better what it means to be a good professional	T.1	12	32	56	
		T.2*	4	28	68	

**More than 15% of respondents answered the option 'Cannot take stand' or did not give any answer*

***Only significant changes are shown, in the independent samples t-test (Chi-Square): respondents who completed only T.1 (N=314) or T.2 (N=118), calculated on basis of mean score (on 1-4 Likert scale) for every item, p-value <0.05*

There were no significant differences in the dependent samples t-test (Wilcoxon signed-rank test), with 129 respondents who completed both T.1 and T.2, p-value<0.05

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Table 3 Experienced outcomes in *daily practice* after 4 (T.1) and 8 MCD-sessions (T.2)

	To what degree did you experience this outcome?		Not	Somewhat	Quite high & High	More or less experienced at T.2 than T.1?**
			% of respondents per answer option			
1	Develops my skills to analyze ethical difficult situations	T.1	10	48	42	More (p=0.004)
		T.2	4	46	50	
2	More open communication among co-workers	T.1	12	43	46	More (p=0.036)
		T.2	4	42	54	
3	Consensus is gained amongst co-workers in how to manage the situation	T.1	12	49	39	
		T.2	11	51	38	
4	Enables me to better manage the stress from the ethical situation	T.1	23	44	34	
		T.2*	19	36	45	
5	Contributes to the development of practice/policies in the workplace	T.1	15	48	37	More (p=0.035)
		T.2*	14	45	42	
6	Gives me more courage to express my ethical standpoint	T.1	13	41	47	
		T.2	10	32	58	
7	I feel more secure to express doubts or uncertainty regarding difficult situations	T.1	15	38	48	More (p=0.001)
		T.2	7	33	61	
8	Better mutual understanding of each other's reasoning and acting	T.1	7	36	56	
		T.2	3	38	59	
9	I see the situation from different perspectives	T.1	7	33	60	
		T.2	3	36	62	
10	I and my co-workers become more aware of recurring situations	T.1	10	39	52	
		T.2	6	36	58	
11	Increases my awareness of the complexity of the situation	T.1	8	35	57	More (p=0.015)
		T.2	4	33	63	
12	Enhances my understanding of ethical theories	T.1	19	38	43	
		T.2	14	41	45	
13	Enables to decide on concrete actions to manage the situation	T.1	16	40	44	
		T.2	11	37	52	
14	Greater opportunity for everyone to have their say	T.1	15	37	48	More (p=0.039)
		T.2	7	36	57	

Table 3 Continued

	To what degree did you experience this outcome?		Not	Somewhat	Quite high & High	More or less experienced at T.2 than T.1?**
			% of respondents per answer option			
15	Enhances possibility to share difficult emotions and thoughts	T.1	12	39	49	
		T.2	5	43	52	
16	Find more courses of action to manage the situation	T.1	11	46	43	
		T.2	8	41	51	
17	I listen more seriously to other's opinions	T.1	14	32	54	More (p=0.000)
		T.2	4	32	64	
18	Increases awareness of own emotions	T.1	13	33	53	
		T.2	8	35	58	
19	Strengthens my self-confidence when managing difficult situations	T.1	16	35	49	
		T.2	9	35	57	
20	Develops my ability to identify the core ethical question in difficult situations	T.1	12	41	47	
		T.2*	6	41	53	
21	I and my co-workers examine more critically existing practice/policies in workplace	T.1	18	43	39	
		T.2*	14	44	42	
22	I and my co-workers manage disagreements more constructively	T.1	17	41	42	
		T.2*	13	48	40	
23	I gain more clarity about own responsibility in difficult situations	T.1	11	37	51	
		T.2	5	40	55	
24	Enhances mutual respect amongst co-workers	T.1	12	35	53	More (p=0.023)
		T.2	6	37	57	
25	I become more aware of my preconceived notions	T.1	15	37	48	More (p=0.009)
		T.2	5	37	58	
26	I understand better what it means to be a good professional	T.1	13	37	50	More (p=0.040)
		T.2*	5	36	60	

**More than 15% of respondents answered the option 'Cannot take stand' or did not give any answer*
***Only significant changes are shown, in the independent samples t-test (Chi Square): respondents who completed only T.1 (N=314) or T.2 (N=118), calculated on basis of mean score (on 1-4 Likert scale) for every item, p-value <0.05*
There were no significant differences in the dependent samples t-test (Wilcoxon signed-rank test), with 129 respondents who completed both T.1 and T.2, p-value<0.05

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Outcomes rated as 'not experienced' or 'cannot take a stand' or where no answer was given

Overall, the percentage of respondents who rated one of the items as 'not experienced' ranged from 1% to 23%. The three items rated most often as 'not experienced' were the same for experiences *during MCD sessions* and *in daily practice* (no. 4, 21 and 22 in Table 2 and 3): 'Enables me to better manage the stress from the ethical situation' (22% and 13% at T.1 and T.2 resp. *during MCD sessions* and 23% and 19% at T.1 and T.2 resp. *in daily practice*); 'I and my co-workers examine more critically existing practice/policies in workplace' (14% at T.1 and 8% at T.2 *during MCD sessions* and 18% and 14% at T.1 and T.2 resp. *in daily practice*) and 'I and my co-workers manage disagreements constructively' (14% and 11% at T.1 and T.2 resp. *during MCD sessions* and 17% and 13% at T.1 and T.2 resp. *in daily practice*). Nevertheless, all these outcomes were still experienced in a 'quite high' or 'high' degree by more than 40 percent of the respondents *during MCD sessions* and more than 34 percent *in daily practice*. Furthermore, regarding all items, 7-17 percent of the respondents (N=23-73) could not provide an answer (they filled in 'Cannot take a stand' or did not give an answer). In Tables 2 and 3, items with a high percentage (>15%) of respondents who could not take a stand are marked.

The factor structure of the outcomes

For the factor analyses, responses from T.1 and T.2 were merged in order to get sufficient power. For the respondents who completed both T.1 and T.2, we decided to take their responses at T.2. We assumed that these T.2 responses referred to their experiences in all MCD sessions. By this, we aimed to get the most complete and reliable insight in their experiences.

Table 4 shows the merged results of factor analyses for experience of outcomes *during MCD sessions* and *in daily practice*. In all analyses, no items correlated less than 0.2 or more than 0.9 with other items. Regarding the experienced outcomes *during MCD sessions*, Principal Component Analysis suggested that the items represent two different classes of outcomes (two factors). However, five out of 26 outcomes were associated with outcomes of both of these two factors, so the distinction was not adequate and thus, this factor model was not considered informative enough. Next, a forced three factor model was constructed by forcing SPSS to split the responses into three classes. This was not considered informative either since four outcomes were still associated with items of more than one factor (or class). Therefore, a forced four factor model was performed. This four factor model showed a better distinction of outcomes into four classes where only one outcome was associated with more than one factor, and only one outcome did not associate to any factor.

Regarding the experience of outcomes in *daily practice*, Principal Component Analysis primarily suggested a one factor model, indicating that outcomes represent only one class of outcomes. This was not considered distinctively powerful because we wanted to know how responses could be divided into separate (and thus more than one) classes. Therefore, we forced the data to divide responses into two and three factors, by performing forced two and three factor models. Both models did not show clear divisions of data either, since many (respectively 12 and 8) outcomes were associated with outcomes of more than one factor. Subsequently, in a four factor model, only three outcomes were associated with outcomes of more than one factor. Therefore, a four factor model for experienced outcomes in daily practice was considered to be the best informative model (see Table 4).

In short, the factor structure of all experienced outcomes (both *during the sessions* and *in daily practice*) did not confirm the 6 Euro-MCD domains (see Method section) because it revealed a division of the items into four classes (i.e. factors, or domains). Both factor analyses of outcomes experienced *during MCD sessions* and outcomes experienced in *daily practice* finally provided a four factor model, although the contents partly differed among each other. We see – to some extent – the following content in these four factors: firstly, outcomes referring to virtues were correlated (e.g. respect and being a good professional). In another factor, outcomes involving skills for ethical analysis were correlated (e.g. identifying difficult situations and the core ethical question). Next, outcomes about sharing feelings (like feeling secure to express doubts and mutual understanding) associated in the same factor, and fourthly, outcomes about actions (concerning the development of policies and concrete decisions) were correlated. To facilitate readability, both an overview of outcomes that loaded at the same factor in both factor analyses (of during MCD sessions and of after MCD in daily practice), as well as an overview of the outcomes that were associated with each other in *only one of these two* factor analyses, is presented in Table 5. For every factor, at least three outcomes were associated with each other in both analyses of *MCD sessions* and *daily practice* (see also Table 4). Also, the link with the original Euro-MCD domain is shown in Table 5.

Table 4 – Factor loadings of items Euro-MCD Instrument (during MCD sessions and in *daily practice*)

Item		Experienced in MCD or practice:	Factor loading			
			1	2	3	4
1	Develops my skills to analyze ethical difficult situations	MCD		0.651		
		practice				0.659
2	More open communication among co-workers	MCD			0.624	
		practice		0.692		
3	Consensus is gained amongst co-workers in how to manage the situation	MCD				0.563
		practice		0.747		
4	Enables me to better manage the stress from the ethical situation	MCD	-	-	-	-
		practice		0.523		
5	Contributes to the development of practice/policies in the workplace	MCD				0.702
		practice		0.705		
6	Gives me more courage to express my ethical standpoint	MCD			0.653	
		practice			0.502	
7	I feel more secure to express doubts or uncertainty regarding difficult situations	MCD			0.593	
		practice			0.530	
8	Better mutual understanding of each other's reasoning and acting	MCD			0.638	
		practice		*0.552*	*0.570*	
9	I see the situation from different perspectives	MCD		0.700		
		practice			0.679	
10	I and my co-workers become more aware of recurring situations	MCD		0.605		
		practice			0.657	
11	Increases my awareness of the complexity of the situation	MCD		0.605		
		practice			0.630	
12	Enhances my understanding of ethical theories	MCD		0.678		
		practice				0.501
13	Enables to decide on concrete actions to manage the situation	MCD				0.534
		practice		0.578		

Table 4 – Continued

Item		Experienced in MCD or practice:	Factor loading			
			1	2	3	4
14	Greater opportunity for everyone to have their say	MCD			0.551	
		practice		0.559		
15	Enhances possibility to share difficult emotions and thoughts	MCD			0.591	
		practice	0.581			
16	Find more courses of action to manage the situation	MCD		0.540		
		practice		0.519		
17	I listen more seriously to other's opinions	MCD	0.711			
		practice	0.647			
18	Increases awareness of own emotions	MCD	0.708			
		practice	0.575			0.519
19	Strengthens my self-confidence when managing difficult situations	MCD	0.618			
		practice	0.518			0.558
20	Develops my ability to identify the core ethical question in difficult situations	MCD		0.592		
		practice				0.632
21	I and my co-workers examine more critically existing practice/policies in workplace	MCD				0.676
		practice	0.627			
22	I and my co-workers manage disagreements more constructively	MCD				0.578
		practice	0.665			
23	I gain more clarity about own responsibility in difficult situations	MCD	0.617			
		practice	0.627			
24	Enhances mutual respect amongst co-workers	MCD	0.585			
		practice	0.691			
25	I become more aware of my preconceived notions	MCD	0.718			
		practice	0.693			
26	I understand better what it means to be a good professional	MCD	0.693			
		practice	0.686			

Table 5 – Overview outcomes per factor compared to Euro-MCD domains

Factor		No. Item Euro-MCD Instrument	Euro-MCD domain^
1	Outcomes clustering in both experiences *during MCD* and *in daily practice*	17. I listen more seriously to other's opinions	4
		18. Increases awareness of own emotions*	1
		19. Strengthens my self-confidence when managing difficult situations*	1
		23. I gain more clarity about own responsibility in difficult situations	4
		24. Enhances mutual respect amongst co-workers	2
		25. I become more aware of my preconceived notions	4
		26. I understand better what it means to be a good professional	4
	only *in daily practice*	15. Enhances possibility to share difficult emotions and thoughts	1
		21. I and my co-workers examine more critically existing practice/policies in workplace	5
		22. I and my co-workers manage disagreements more constructively	2
2	Outcomes clustering in both experiences *during MCD* and *in daily practice*	1. Develops my skills to analyze ethical difficult situations	3
		12. Enhances my understanding of ethical theories	3
		16. Find more courses of action to manage the situation	6
		20. Develops my ability to identify the core ethical question in difficult situations	3
	only *during MCD*	9. I see the situation from different perspectives	3
		10. I and my co-workers become more aware of recurring situations	5
		11.Increases my awareness of the complexity of the situation	3
	only *in daily practice*	14. Greater opportunity for everyone to have their say	2
		18. Increases awareness of own emotions*	1
		19. Strengthens my self-confidence when managing difficult situations*	1
3	Outcomes clustering in both experiences *during MCD* and *in daily practice*	6. Gives me more courage to express my ethical standpoint	4
		7. I feel more secure to express doubts or uncertainty regarding difficult situations	1
		8. Better mutual understanding of each other's reasoning and acting*	2
	only *during MCD*	2. More open communication among co-workers	2
		14. Greater opportunity for everyone to have their say	2
		15. Enhances possibility to share difficult emotions and thoughts	1
	only *in daily practice*	9. I see the situation from different perspectives	3
		10. I and my co-workers become more aware of recurring situations	5
		11.Increases my awareness of the complexity of the situation	3
4	Outcomes clustering in both experiences *during MCD* and *in daily practice*	3. Consensus is gained amongst co-workers in how to manage the situation	6
		5. Contributes to the development of practice/policies in the workplace	5
		13. Enables to decide on concrete actions to manage the situation	6
	only *during MCD*	21. I and my co-workers examine more critically existing practice/policies in workplace	5
		22. I and my co-workers manage disagreements more constructively	2
	only *in daily practice*	2. More open communication among co-workers	2
		4. Enables me to better manage the stress from the ethical situation	1
		8. Better mutual understanding of each other's reasoning and acting*	2
Not associated with any factor (during MCD)		4. Enables me to better manage the stress from the ethical situation	1

** Correlated at >1 factor*

^ Original Euro-MCD domains:

1 = Enhanced emotional support
2 = Enhanced collaboration
3 = Improved moral reflexivity
4 = Improved moral attitude
5 = Impact on organizational Level
6 = Concrete results

DISCUSSION

The majority of the 561 healthcare professionals in this study indicated that *during the MCD sessions,* they experienced outcomes relating to a better collaboration with co-workers. These outcomes were also experienced by many respondents *in daily practice*, i.e. after the MCD sessions. Next, many respondents reported that they experienced outcomes about own moral reflexivity and attitude, both *during MCD sessions* as well as *in daily practice*. The factor analyses did not confirm the division of the six original Euro-MCD domains.

Experienced MCD outcomes

The findings are in line with previous literature about the impact of MCD on collaboration among colleagues (Hem et al. 2015; Spijkerboer et al. 2017; Haan et al. 2018; Magelssen et al. 2018) and moral self-reflection and moral attitude (Söderhamn et al. 2014; Silén et al. 2016; Spijkerboer et al. 2017). For instance, in the study of Söderhamn et al. (2014), healthcare professionals reported to have experienced an enhanced moral awareness of ethical issues and that they learned more about themselves in order to become better healthcare professionals. More recently, and also with use of a (quantitative) questionnaire, Spijkerboer et al. (2017) found that MCD fosters working together and fosters communication. Furthermore, a recent literature review reported that impact of MCD was mainly shown at both the individual level as well as in the relationships between professionals (Haan et al. 2018). These results seem to be plausible given the features of MCD itself: in MCD, ‘participants are encouraged in their attempts to put their moral understandings into words and to listen actively, to open up to the other and to put their prejudices into play’ (Widdershoven & Metselaar 2012). Yet, the fact that respondents say that they also experienced better collaboration and improved moral reflexivity and attitude after MCD, in daily practice, has not been demonstrated that systematically before.

Comparison of outcomes between during MCD sessions and afterwards in daily practice

As anticipated, MCD outcomes were experienced stronger *during MCD sessions* than *in daily practice* (although still more than one third reported to have experienced outcomes in quite high or high degree in the latter setting). First, a possible explanation is that Euro-MCD outcomes might be easier to link to the MCD sessions. For instance, an exchange of ideas does explicitly take place *during the session* and might thus rather directly lead to experiences of seeing others’ perspectives. Second, the MCD session is an intense and set moment that might be easier to link outcomes to than the

daily practice in which the experience of outcomes might be less readily recognized. Our findings showed that in evaluating MCD, it is important to distinguish between experiences *in* and *after* the sessions, since experiencing outcomes *during MCD* does not necessarily mean that MCD influences participants' thinking and acting in daily practice to the same extent. This difference between experiences *in* and *after* MCD was also shown in the study of Silén et al. (2016), in which healthcare professionals were interviewed after participating in ethics rounds (comparable to MCDs). They said to have obtained better insights in and more awareness of ethically difficult situations *in* the sessions, but that they had not experienced changes *afterwards,* in their daily work. However, Magelssen et al. (2018) recently showed that facilitators of ethics activities thought that the activities did have a significant impact on daily practice. Future observational research is needed to get more grip on the impact of MCD in *daily practice*.

Changes over time

The change in experience of outcomes between T.1 and T.2 was not significant for the group of respondents who completed *both* T.1 and T.2. Respondents who completed *only* T.2 experienced outcomes (both *during MCD* and *in daily practice*) to a higher extent compared to respondents who completed *only* T.1. The reasons for these differences are unclear as we do not know exactly why some respondents only responded to one of the two questionnaires. Some healthcare institutions organized only 4 sessions due to organizational issues, which made a T.2-questionnaire not possible. Another possible reason that respondents only completed only one of the two questionnaires might be staff-turnover during the time the fifth to eighth MCD sessions were held.

The finding that respondents who completed only T.2 highly rated their experience of outcomes might be due to selection bias, assuming that participants who had positive experiences with MCD outcomes participated more often in 8 sessions than those who were not that positive, as those who had less positive experiences did only attend 4 MCD sessions. It could also be that participants actually experienced more outcomes after attending more MCD sessions. But these are merely possible explanations. Therefore, we need to further reflect on the link between duration of the series of MCD sessions and the experience of MCD outcomes. This will also inform future MCD evaluation research: what is the right moment to ask MCD participants for their experienced outcomes?

Relationship of the factor structure with the original Euro-MCD domains

The factor analyses suggested a division into four classes (covering partly overlapping items) for both experiences *during MCD sessions* as well as *in daily practice*, but different

from the original categorization of six domains of MCD outcomes. However, when looking at the outcomes that were associated with each other according to the factor analyses, some similarities between the classes and the Euro-MCD domains can be recognized. These links form useful suggestions for the further development of the Euro-MCD Instrument. First, outcomes from the Euro-MCD domains 'Improved moral attitude' and 'Improved moral reflexivity' were not correlated in the current factor analyses, indicating that they (as envisaged by the developers) indeed refer to different categories of outcomes (e.g. perhaps moral attitude might refer more to virtues and moral reflexivity more to skills). Furthermore, it seemed that the domain 'Improved moral attitude' was more closely linked to the domain 'Enhanced emotional support' than 'Improved moral reflexivity' since many outcomes from these domains clustered into one factor. Finally, the items of the domains 'Enhanced collaboration'; 'Impact on organizational level' and 'Concrete results' were associated with items from all other domains and might thus not be so clearly to interpret according to their original meaning. These items would therefore need thorough thinking and revision to be included (or not) as items with clear meanings in the future version of the instrument.

Various empirical data sources and normative reasoning determine content of revised Euro-MCD

We want to emphasize here that the final categorization of outcomes for the Euro-MCD Instrument should not be based on the results of these factor analyses only. Developing a measurement instrument for outcomes of a clinical ethics supportive intervention like MCD is a complex (but highly needed) process (Schildmann et al. 2016). For the revision of the Euro-MCD Instrument, various empirical findings from different field studies (Rasoal et al. 2017; De Snoo-Trimp et al. 2017;2018; Svantesson et al. 2018;2019) should be combined with conceptual and normative discussions on what outcomes *should* be included based on the (theoretically described) goals of MCD. The main relevance of the factor analysis as done in the current study is that it informs us about the correlations among items and about what possible clustering of items would be meaningful in the sense that items indeed refer to the same underlying construct. If clear factors are found in factor analysis, presentation of outcomes in future studies can be more limited as domain scores can be presented instead of presenting the separate results of each individual outcome.

Strengths and limitations

This study is unique in the field of evaluating clinical ethics support, since we were able to include a large sample of healthcare professionals from three countries and from different healthcare settings. Furthermore, the healthcare professionals participated in

multiple MCD sessions and could thus base their experience on not just a single session of ethics support. Besides, we were able to compare their experience on short (T.1) and long term (T.2) and to distinguish between their experiences *during* the sessions and *in daily practice,* which has not been done before. However, the large sample was highly heterogeneous with small sample sizes of subgroups from different countries and with different professional backgrounds. This, on the one hand, gave robust results over all included subgroups and is informative for further developing an actual *European* instrument that is applicable to various settings. But on the other hand, it made it impossible to reliably compare subgroups of respondents in how they experienced the outcomes. Furthermore, we could not provide data about the response rates for every country. Since this field study is primarily aimed at validating the instrument, we do not see this and the heterogeneity of our data as a major limitation. But one limitation is that we lack information from several respondents regarding how many sessions they actually attended (see Table 1). This means that the contrast between the groups completing the instrument after 4 sessions (T.1) and after 8 sessions (T.2) is not definitive. We can therefore not make any strong conclusions regarding the differences we found between T.1 and T.2. Finally, the number of respondents at T.2 was low, so that we had to merge the T.1 and T.2-answers to attain sufficient power for the factor analysis. Since respondents who completed both questionnaires did not significantly change their ratings between T.1 and T.2, as has been described before (and as shown in Table 2 and 3), the decision that we took their T.2-answers for factor analyses did not influence the results.

Future perspectives

The findings on the experienced outcomes and the factor structure add to the data from other Euro-MCD field studies to further validate and revise the Euro-MCD Instrument (Rasoal et al. 2017; De Snoo-Trimp et al. 2017;2018; Svantesson et al. 2018;2019). Other ongoing field studies include the perceived importance of the outcomes (by healthcare participants) after MCD participation, the facilitator's role and the manager's views on impact. In the overall process of developing a new Euro-MCD Instrument, which is currently taken place, the empirical evidence will be combined with normative reflections by the research team, ethics experts as well as healthcare professionals from the field. In the end, a feasible and valid tool to assess outcomes of MCD will be presented to be used in future evaluation research, the training of MCD facilitators and in clinical practice for those who are about to implement MCD in their healthcare organization. After finishing this validation process resulting in a revised instrument, validation should continue, as instrument validation will never end.

Conclusions

Healthcare professionals, after participating in a series of MCD sessions, seem to experience a better collaboration with their co-workers and a growth in personal moral reflexivity and moral attitude. Many of the Euro-MCD outcomes were experienced during MCD sessions and to a lesser extent in daily practice. Testing the factor structure of the Euro-MCD Instrument did not confirm the originally suggested six domains but revealed four different domains of outcomes with some overlap between experienced outcomes during the MCD sessions and experienced outcomes in daily practice (i.e. after the MCD sessions). The findings however suggested that items belonging to the domains of Improved moral reflexivity and Improved moral attitude refer to separate constructs and that the domain Enhanced emotional support might be close to Improved moral attitude. Results further showed that items from the other domains had no clear correlations according to their original categorisations. In the revision process of the Euro-MCD Instrument, the domains of items should thus be reconsidered, combined with theoretical thinking about the underlying concepts. The revised instrument will contribute to further outcomes research in order to professionalize the use of MCD as a form of clinical ethics to support and improve healthcare practices.

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