

Rapid #: -11085004

CROSS REF ID: **529947**

LENDER: **DGU :: Lauinger Library**

BORROWER: **ALM :: Main Library**

TYPE: Article CC:CCG

JOURNAL TITLE: Clinical Ethics

USER JOURNAL TITLE: Clinical ethics

ARTICLE TITLE: The impact of an end-of-life healthcare ethics educational intervention

ARTICLE AUTHOR: Molloy, C.

VOLUME: 11

ISSUE: 1

MONTH:

YEAR: 2016

PAGES: 28-37

ISSN: 1477-7509

OCLC #:

PATRON: **O'Connor, Erin**

Processed by RapidX: 10/11/2016 9:57:46 AM



This material may be protected by copyright law (Title 17 U.S. Code)



The impact of an end-of-life healthcare ethics educational intervention

Claire Molloy¹, Joan McCarthy² and Mark Tyrrell³

Abstract

Background: The impact of healthcare ethics educational interventions on participants' ethical development is rarely reported on and assessed; even less attention is paid to educational interventions that focus on end-of-life ethical issues. **Aim:** To evaluate the impact of the *Ethical Framework for End-of-Life Care Study Sessions Programme (EOLCSS)* on the moral development of healthcare staff who are delivering end-of-life care. **Methods:** The *EOLCSS* was delivered to 20 multi-disciplinary health care staff in Ireland in May 2013. Effect on moral reasoning was measured pre and post education using the Defining Issues Test 2 (DIT2). Inferential statistics were used to examine the relationships between change in DIT2 scores and demographic variables. **Results:** Participants experienced moral reasoning development following receipt of *EOLCSS*. Age and previous ethics education contributed to the observed changes in moral reasoning. **Conclusions:** Receipt of the *EOLCSS* may contribute to moral reasoning development in practicing healthcare professionals.

Keywords

Ethics, health professionals, end of life, education, moral reasoning

Introduction

Good end-of-life care (EOLC) has been defined as high quality care that responds to the individualised needs of dying people and ensures that they die in a dignified manner, free of pain and distressing symptoms and in the presence of their loved ones.^{1–3} In order to achieve good EOLC, the World Health Organisation (WHO) and many governmental and non-governmental organisations recognise that all healthcare staff require specific education.^{2–5} In particular, because of the frequency and gravity of ethical challenges that arise in relation to EOLC provision, several authors suggest that ethics education and support should form a part of that educational provision.^{6–8} The need for ethics education has also been highlighted in the Irish literature. In a recent qualitative study examining practitioners' perspectives on patient autonomy at end-of-life (EOL) in Irish hospitals, Quinlan and O'Neill⁹ observed frequent active or aggressive treatment of patients at EOL, which was deemed 'inappropriate and arguably, unethical' (p. 87). This finding was confirmed in a national audit on EOLC in Irish hospitals, which found that doctors and nurses 'were reluctant to make decisions to stop invasive treatments when patients were dying' (p. 29).¹⁰

Literature review

A search of the databases (PubMed/CINAHL/PsychINFO/Philosopher's Index and Embase) was conducted for empirical studies (2003–2013) which evaluated the effectiveness of classroom-based ethics-specific education programmes delivered to healthcare students and staff. Sixteen studies were subsequently included in the review. Of these, five studies evaluated the effects of ethics education on knowledge or other outcomes in single disciplines of undergraduate or practicing healthcare staff in countries outside of Ireland. In these studies ethics education was delivered as either ethics-specific education or as an integrated component of undergraduate training. Four out of five of the studies demonstrated positive effects of ethics education on change in knowledge or other outcomes.^{11–14} In all of these studies small group case discussion was

¹Millford Hospice, Limerick, Ireland

²University College Cork, Cork, Ireland

³Oaklodge Nursing Home, Cork, Ireland

Corresponding author:

Joan McCarthy, University College Cork, Brookfield Health Sciences Complex, Cork, T12 AK54, Ireland.
Email: j.mccarthy@ucc.ie

incorporated into the ethics education delivered. These studies suggest that ethics education programmes incorporating small group case discussion may contribute to the effectiveness of ethics education on change in knowledge. However it is impossible to generalise this finding due to their small sample sizes^{11,14} and high sample mortality.^{12,13}

Eight of the studies evaluated the effect of ethics education on moral reasoning in healthcare staff using either the Defining Issues Test (DIT)^{15–20} or the Moral Judgement Interview (MJI)-Form B.^{21,22} The DIT and the MJI-Form B are both paper-and-pencil tests, designed to evaluate moral reasoning based on responses to hypothetical ethical cases. The findings of the eight studies included in our literature review were inconsistent. Five of the studies failed to demonstrate that education incorporating an ethics component facilitated moral reasoning development in healthcare students and staff.^{23–27} For example, both Patenaude et al.²⁷ and Fleisher et al.²⁴ carried out studies using pre- and post-test designs to evaluate the effect of medical training incorporating ethics education on change in moral reasoning development among medical students in Quebec and Manitoba, respectively. While the precise nature and quality of the ethics education interventions were unclear in both studies, neither demonstrated any development in the moral reasoning of students as they progressed through their undergraduate education.

Pre- and post-test studies on physiotherapy and occupational students ($n=108$) in Mexico²³ and ophthalmology residents ($n=57$) in New York²⁵ also failed to demonstrate that an ethics education programme leads to moral reasoning development. Finally, the Park et al.'s²⁶ descriptive study of first and final year ($N=1137$) nursing students, attending eight four-year undergraduate nursing programmes in South Korea, using the shortened Korean DIT found that there was a non-significant difference in moral reasoning scores between the first and fourth year nursing students, indicating that the educational programmes which incorporated ethics education did not facilitate moral reasoning development.

In contrast to the findings of the five studies discussed above, three studies reported that ethics education facilitated moral reasoning development in healthcare staff.^{28–30} These studies were conducted with first ($n=266$) and final year ($n=278$) nursing students in Finland,²⁸ occupational and physiotherapy students ($n=548$), attending a university in Canada³⁰ and dental professionals ($n=30$) in the US.²⁹ It is unclear what contributed to the improved outcomes in these studies. All students in Auvinen et al.²⁸ received ethics education as part of their undergraduate nursing studies; however methods of education varied between

the four educational institutions included in the study. Reported methods of ethics education included lecture/cases/discussion/group work and individual work. The duration of education in each site was not specified. In addition the study did not compare DIT scores within students before and after education, thus making it difficult to determine whether the change in moral reasoning development was as a result of the ethics education intervention or other factors.

Geddes et al.³⁰ described their programme as consisting of a “pedagogical framework of problem based learning, incorporating small group and case based study”(p. 99), however, the content and duration of the ethics education were not specified. There were also a number of limitations in this study which may have biased the results in favour of the positive findings. Firstly, as acknowledged by Geddes et al.³⁰ the students who participated post the educational intervention may have been students who were ethically concerned in any case. Secondly, there were multiple factors in the students’ educational programmes, e.g. academic studies and clinical fieldwork, which could have enhanced moral development thus making it difficult to attribute the enhanced moral judgement abilities specifically to the ethics education received.

The programme implemented by Bebeau²⁹ (described in Baughcum et al.³¹), was an ethics-specific programme delivered to small groups of qualified dental professionals to address specific deficits in ethical capabilities. In this study, each professional received ethics education which consisted of 25 to 30 contact hours usually in two-hour face-to-face seminars over several months.²⁹ Learning materials included course directed reading, writing, self-assessment and self-reflection. All participants 30/30 (100%) completed the DIT successfully pre and post course. Bebeau²⁹ reported that there was a statistically significant improvement in DIT scores pre and post ethics education ($p < .0001$), indicating that participants experienced moral development as a result of the education programme. A strength of this study was that it isolated the effects of ethics-specific education on moral judgement development, as the ethics education was implemented in the form of an ethics-specific course in contrast to the studies of Auvinen et al.²⁸ and Geddes et al.³⁰ where the ethics education was integrated into professional education programmes. One of the main limitations of this study was that it lacked a control group.

Finally, three studies identified for inclusion in this literature review evaluated the effect of ethics education integrated into EOL or palliative care (PC) training in either single or multiple disciplines of practicing healthcare staff. These three studies examined the impact of circa a one- hour session on ethics as part of one or two day training sessions in EOCL.^{31–33} Baughcum et al.³¹

included a 45–60 minute module on ethics as part of a one day training workshop on palliation and EOL care for paediatric haematology/oncology fellows ($N=32$) in the US. Rogers et al.³³ provided nurses ($n=11$) with an hour of education on ethical/legal issues in EOL care of infants as part of a neonatal EOL educational program in the United States. Finally Quinn et al.³² provided one session (duration not specified) on ethical and legal challenges delivered to a mixed group of healthcare staff ($N=537$) as part of a two-day multi-disciplinary palliative care education program in Australia. While Rogers et al.³³ and Quinn et al.³² found some indications that the ethics sessions contributed positively to the comfort levels and perceived knowledge of the participants vis a vis EOL ethical issues, the small sample sizes and uncertain impact of all of the different variables that may have influenced the results make it impossible to draw any firm conclusions about the impact of the ethics sessions.

To conclude, there appears to be a need for large well-designed studies, which evaluate the effects of ethics education programmes delivered to single and multiple disciplines of healthcare staff. While, the literature review demonstrated that, in the main, authors assess the effectiveness of ethics education in terms of knowledge acquisition and enhanced moral reasoning – given the variable findings – only tentative conclusions can be drawn. The studies reviewed which demonstrated the effectiveness of ethics education programmes indicate that ethics educational interventions should focus on particular cohorts and/or particular gaps in learning²⁹ and/or focus on small group discussion and case based study.^{12,14,30} This is consistent with the conclusions of the meta-analysis of 55 studies using the DIT on various subject groups carried out by Schlaefli et al.³⁴ in 1985 which argued that the most effective type of ethics education programmes for facilitating moral reasoning development were those involving either dilemma discussion or personality development and with a duration of three to twelve weeks.

For our purposes, the review also suggests the need to conduct studies which would examine the effectiveness of classroom-based EOL ethics-specific education programmes delivered to healthcare staff who are involved in EOCL. Moreover, given the dearth of information about ethics education provision in Ireland, it is imperative that we conduct studies to establish how healthcare staff access ethics education in Ireland, the nature of such education and the effects of such education – all the more so ethics education at the end of life.

Aim and objectives

The study aimed to evaluate the impact of the *Ethical Framework for End-of-Life Care Study Sessions*

(*EOLCSS*)³⁵ in a mixed group of healthcare staff who deliver EOLC to patients and families in the Republic of Ireland.

Ethics education intervention

The *EOLCSS*,³⁵ the educational intervention implemented and evaluated in this study, is a classroom-based, multi-disciplinary, ethics-specific education programme. The programme was developed by University College Cork, the Royal College of Surgeons in Ireland and the Irish Hospice Foundation in response to the need for EOLC ethics education in Ireland. It is one of the outputs of a national project lead by the Irish Hospice Foundation (2007–2012) with the overall aim of improving the culture of death and dying in Irish hospitals. Although the *EOLCSS* programme has been delivered in a variety of settings in Ireland, its impact has not been formally evaluated to date.

The programme consists of eight work books containing eight ethics study sessions covering the following topics: Explaining ethics, breaking bad news, healthcare decision making and the role of rights, autonomy in law and practice, ethics of managing pain, ethics of life prolonging treatments, ethics of confidentiality and ethical governance in clinical care (available online³⁵). Each session involves the presentation of an ethical case on one of the topics, followed by critical discussion of the case from ethical and legal perspectives, consideration of the professional obligations that it prompts and individual and group activities.

Method

Participants

Twenty volunteers drawn from a range of health and allied professions were recruited from the Health Service Executive and a facility which provides Specialist Palliative Care (SPC) and Older Person services in the Mid-West region of Ireland (see Table 1 for demographic details).

Procedure

The study was conducted in 2013 in the Mid-West region of Ireland. Volunteers were recruited via open email invitation and local advertising. Participation in the study was voluntary. Written consent was obtained from participants at the beginning of the study and all participants were advised that they could withdraw from the study at any time. Ethical approval and Risk Management approval were received from the Research Ethics Committee and Risk Management department, in the University Hospital Limerick.

Table 1. Demographic characteristics of participants.

Demographic variables	Number of participants	Percentage
Age		
Mean 38.63 years (SD 6.857)	20	100%
Gender		
Female	19	95%
Male	1	5%
Occupation		
Dietitian	3	15%
Physiotherapist	3	15%
Speech & language therapist	2	10%
Nurse	5	25%
Occupational therapist	3	15%
Nurse tutor	2	10%
Art therapist	1	5%
Chaplain	1	5%
Years practicing in occupation		
Mean 14.8 years (SD = 6.963)	20	100%
Work area		
Hospital	4	20%
Primary care	4	20%
Specialist palliative care	10	50%
Education	2	10%
Highest level of education completed		
Degree	8	40%
Post graduate diploma	6	30%
Masters	6	30%
Received prior ethics education		
None	10	50%
One or more ethics lectures	6	30%
Module on ethics	1	5%
Workshop or conference	2	10%
Missing data	1	5%

The lead researcher (CM) of this study delivered the *EOLCSS* to two groups of multi-disciplinary healthcare staff, with reported experience in delivering EOLC to patients and families in May 2013. Each group consisted of ten healthcare staff. Four ethics seminars were delivered once weekly, over a four-week period. Delivery duration of four weeks was chosen because of time constraints and because research suggests that a duration of three to twelve weeks is necessary in order to demonstrate the effect of ethical education on moral reasoning development, using the DIT as a measurement tool.³⁴ Each seminar lasted two hours and involved the delivery of two of the *EOLCSS*.

Design

The study used a one group pre-test post-test evaluation design and a convenience sampling technique.

Research instruments

Demographic survey. Each participant completed a short demographic questionnaire at the beginning of the ethics education programme. The demographic survey collected information on gender, occupation, age, experience delivering EOLC, previous educational level and ethics education experience.

Defining Issues Test 2. All participants completed the Defining Issues Test version 2 (DIT2) at the beginning and end of the education programme. The DIT2 was used to assess the effect of the ethics education programme on one aspect of moral development: moral reasoning pre and post receipt of the ethics education intervention. Moral reasoning was chosen as the outcome measure in this study due to time limitations and because moral reasoning was identified as the most frequently assessed outcome in similar studies.

The term moral reasoning refers to the cognitive process that individuals use to determine a right or wrong action. Rest et al.¹⁵ define it as a 'psychological construct that characterises the process by which people determine that one course of action in a particular situation is morally right and another course of action is wrong' (p. 5). Rest et al.¹⁷ also suggest that three distinct schemas exist with regard to moral reasoning development: the Personal Interests (PI) Schema, the Maintaining Norms (MN) Schema and the Post Conventional (P) Schema. According to Rest et al.,^{17,20} the PI Schema is derived from stages 2 and 3 of Kohlberg's theory on moral reasoning development and appeals to the personal stake that an individual has in the consequences of an action. In this stage, moral decisions are made based on the consequences to the individual or those with whom the individual has a personal relationship. The MN Schema is derived from Kohlberg's stage 4 and appeals to societal concepts of law and order.^{17,20} In this stage, an individual makes moral decisions based on conformity with societal law or an established way of doing things. Finally, the P Schema appeals to shared ideals that are fully reciprocal and are open to scrutiny through debate, tests of logical consistency and community experiences.²⁰ In this stage, an individual makes moral decisions by appealing to ideals and logical coherence. According to Rest et al.²⁰ these schemas are developmentally ordered, with the PI schema representing the least developed schema and the P Schema representing the most advanced schema. Rest et al.¹⁹ suggest that individuals utilise these schemas to resolve ethical

problems. However individuals do not utilise one distinct schema when facing ethical problems, rather they utilise combinations of moral schemas. Rest et al.¹⁹ also suggest that these combinations change over time as individuals experience moral development. Consequently, moral development is not characterised by step by step progression from the PI schema to the MN schema and progressing onto the P schema. Instead, Rest et al.¹⁹ suggest that moral development is characterised by a reduction in the use of lower developmental schemas and an increase in the use of higher developmental schemas.

Following on from this understanding of schemas, Rest and colleagues developed the DIT, a multiple choice test, which presents participants with a set of hypothetical moral dilemmas, followed by three suggested courses of action for each dilemma and twelve statements relevant to the decision the participant has chosen.^{17,18} Each participant must select his/her preferred course of action to solve the dilemma and then rate and rank the importance of the twelve accompanying statements presented to the participant, in terms of the importance of each statement, when applied to the decision the participant has chosen. The statements presented to participants are designed to represent different moral schemas, as discussed above.

The DIT is reported to be an exceptionally well validated and reliable measure of moral reasoning.^{17,18,23,34,36} The most recently updated version of the DIT, the DIT2 was chosen as it was identified as having superior properties to the original DIT. As acknowledged by Rest et al.¹⁸ and Walker³⁶ it is shorter, more reliable and purges fewer participants than the original DIT. With regard to length, the DIT2 uses five moral dilemmas as opposed to the six dilemma format of the original DIT. In relation to reliability Cronbach's alpha is 0.76 for the original DIT and 0.81 for DIT2, reflecting superior validity of the DIT2.¹⁸

The paper-and-pencil version of the DIT2 was chosen in preference to the online version as the developers of the test recognise that the gold standard environment for administering the test is in a group-testing environment.³⁷

Data analysis

The Statistical Product and Service Solutions 14.0³⁸ programme was used to analyse the DIT2 and demographics data. Descriptive statistics were used to describe the demographic profile of participants. All pre- and post-tests were coded by the lead researcher (CM) of the study to anonymise participants' data and all data was entered into an excel spreadsheet. Anonymised DIT2 data was sent to The University of Alabama Office for the Study of Ethical Development

for scoring as this was considered to be standard practice. The University of Alabama Office for the Study of Ethical Development subsequently generated mean pre- and post-test PI, MN, P and N2 scores from anonymised DIT2 data.

As indicated above, analysis of completed DITs generates four scores: the PI, the MN, the P and the N2 score.³⁹ The PI score represents the proportion of items selected that appeal to the PI schema, the MN score represents the proportion of items selected that appeal to the MN Schema and the P score represents the proportion of items selected that appeal to the P Schema.³⁹ Accordingly, the PI, MN and P scores represent the degree to which the individual utilises each of these schemas when addressing moral problems. The N2 score represents the degree to which individuals reject lower stage items in preference for higher stage items.³⁹ All four scores are reported as numerical values of between 0 and 95.

Paired *t* tests were used to test for differences between mean pre and post PI, MN, P and N2 scores, to establish whether moral reasoning scores had changed between pre- and post-tests. Relationships between difference in PI scores (PI difference) pre- and post-test, difference in N2 scores (N2 difference) pre- and post-test and demographics variables were examined using inferential statistics. Pearson's product moment correlation was conducted to establish if there was a relationship between years practicing and PI difference or N2 difference and if there was a relationship between age and PI difference or N2 difference (It was not possible to examine relationships with the demographic variables of occupation, gender, care area of work or highest level of education completed as there were not sufficient numbers of subjects within subgroups for each of these variables.). Spearman's rank order correlation was conducted to establish if there was a relationship between number of education sessions attended and PI difference or N2 difference. In order to establish whether previous ethics education received by participants may have contributed to changes in PI and N2 scores, the mean PI difference and mean N2 difference was calculated for participants who reported having received ethics education previously and for participants who had not received ethics education previously. Independent samples *t* tests were used to test for differences in mean PI difference and mean N2 difference scores in both groups.

Results

Twenty healthcare staff participated in the *EOLCSS*. Eighty-five per cent of participants attended all four ethics education sessions, 10% attended three ethics

education sessions and 5% attended two ethics education sessions. All twenty participants completed the demographic questionnaire prior to receiving the ethics education intervention. The demographic characteristics of participants are displayed in Table 1.

Change in moral reasoning

All 20 participants (100%) completed valid pre-test and post-test DIT2s. Mean pre- and post-test PI, MN, P, N2 scores and the results of the paired *t* tests performed on the pre- and post-test scores are displayed in Table 2. PI scores decreased by -5.76 points ($p = .071$) between the pre- and post-tests and this difference approached statistical significance. MN scores increased by $+5.04$ points between pre- and post-tests ($p = .154$) and P

scores increased by $+1.82$ points between pre- and post-tests ($p = .536$) however these differences were not statistically significant. Finally N2 scores increased by $+3.75$ points ($p = .085$) between pre- and post-tests and this difference approached statistical significance.

Change in moral reasoning and relationship with years practicing, age, number of education sessions attended and prior ethics education

The results of the statistical tests of the relationship between change in moral reasoning and demographic variables in this study are displayed in Table 3. A significant relationship was observed between age and change in moral reasoning and prior ethics education and change in moral reasoning.

Table 2. Mean pre-test post-test moral reasoning scores and paired samples statistics.

	Type of score	Mean score	Difference between pre- and post-test scores	N	SD	Sig. (2-tailed)
Pair 1	Pre PI	31.50	-5.76 points	20	15.188	.071
	Post PI	25.74		20	9.454	
Pair 2	Pre MN	31.00	$+5.04$ points	20	10.146	.154
	Post MN	36.04		20	13.689	
Pair 3	Pre P	33.60	$+1.82$	20	13.805	.536
	Post P	35.42		20	15.171	
Pair 4	Pre N2	29.25	$+3.75$	20	14.295	.085
	Post N2	33.00		20	15.324	

Table 3. Relationship between demographic variables and change in moral reasoning scores.

Relationship tested	Test	Result
a) Years practicing & b) PI difference (post PI-pre PI)	Pearson's product moment correlation	($r = -.007, p > 0.05$)
a) Years practicing & b) N2 difference (post N2-pre N2)	Pearson's product moment correlation	($r = .099, p > 0.05$)
a) Age & b) PI difference (post PI-pre PI)	Pearson's product moment correlation	($r = -.504, p < 0.05$)
a) Age & b) N2 difference (post N2-pre N2)	Pearson's product moment correlation	($r = .167, p > 0.05$)
a) Number of ethics sessions attended & b) PI difference (post PI-pre PI)	Spearman's rank order correlation	($r_s = -.133, p > 0.05$)
a) Number of ethics sessions attended & b) N2 difference (post N2-pre N2)	Spearman's rank order correlation	($r_s = -.086, p > 0.05$)
a) PI difference group with no ethics education & b) PI difference group with prior ethics education	Independent samples <i>t</i> tests	$t(17) = .115, p > 0.05$
a) Mean N2 score group with no ethics education & b) Mean N2 score group with prior ethics education	Mann-Whitney <i>U</i> tests	($U = 20, p < 0.05$)

Discussion

To the authors' knowledge this is the first study published in the last ten years that evaluated change in moral reasoning following receipt of a multi-disciplinary classroom-based EOL ethics-specific education programme. In this study lower stage moral reasoning scores (PI scores) decreased between pre- and post-tests and higher stage moral reasoning scores (MN and P scores) increased. Rest et al.¹⁹ suggest that moral reasoning development is characterised by decreasing use of lower stage moral reasoning scores and increasing use of higher stage moral reasoning scores. Thus, the results indicate that participants in this study experienced moral reasoning development following receipt of the *EOLCSS*. Moreover, Bebeau and Thoma³⁹ have acknowledged that an increase in N2 scores is indicative of the degree to which higher stage moral reasoning scores are prioritised over lower stage moral reasoning scores, thus reflecting moral reasoning development. Therefore the increase between pre-test and post-test in N2 scores in this study confirm that participants experienced moral reasoning development following receipt of the *EOLCSS*.

In this study there was a statistically significant relationship between age and change in PI score ($p < 0.05$), suggesting that age contributed to the change in moral reasoning observed in this study. This is an expected finding, as Rest and Narvaez⁴⁰ acknowledge that as people advance in age, their moral reasoning changes. There was also a statistically significant relationship between change in N2 score between pre- and post-tests and ethics education previously attended ($p < 0.05$), suggesting that ethics education previously attended may also have influenced the change in moral reasoning observed in this study.

Similar to the current study, Dieruf²³ and Geddes et al.³⁰ evaluated the effect of ethics education on changes in moral reasoning. The current study observed a +1.82 point increase in mean DIT2 P score in practicing multi-disciplinary healthcare staff who received a four week EOL ethics-specific education programme, indicating that participants experienced moral reasoning development following receipt of ethics education. This result conflicts with the findings of Dieruf,²³ who observed a decrease of 0.25 points in mean DIT P scores in Physiotherapy (PT) and Occupational Therapy (OT) students who had received small units of ethics education integrated into their respective professional training programmes at a University in New Mexico. However, Dieruf²³ suggests that the lack of moral development observed in her cohort may have been due to deficiencies in ethics education received, as 'neither programme included the recommended 3–12 weeks of ethical instruction'

(p. 28). In contrast, the current study delivered an ethics education programme over a four-week period. It is possible that the difference in results may be attributable to differences in duration of the ethics education programmes.

In contrast to Dieruf's study,²³ Geddes et al.³⁰ concluded that ethics education, integrated into undergraduate OT and PT training, facilitated moral reasoning development. The results of the current study support and extend this finding. Geddes et al.³⁰ observed a statistically significant increase of +4.4 points ($p < 0.001$) in mean DIT N2 scores in PT and OT students, who received ethics education as an integrated component of their undergraduate professional training in a university in Canada. However, Geddes et al.³⁰ suggest that the change in moral development observed in their study may have been due to multiple factors in the educational programmes, e.g. academic studies, clinical fieldwork, mentorship, thus making it difficult to attribute the changes in moral judgement development specifically to the ethics education received. By contrast, this study has shown that changes in moral reasoning can be specifically attributed to the specific ethics education programme received by study participants.

Similar to the current study, Packer²⁵ evaluated the effect of ethics specific programmes on change in moral reasoning in practicing healthcare staff using the DIT, but with very different results. The current study observed an increase of +1.82 points ($p = .536$) in mean DIT2 P scores ($p = .536$) and an increase of +3.75 points ($p = .085$) in mean N2 scores, in multi-disciplinary healthcare staff following receipt of a four-week ethics education programme, demonstrating enhanced moral reasoning in multi-disciplinary healthcare staff following receipt of the intervention. In contrast, Packer²⁵ observed a mean decrease of -4.76 points in mean DIT P score ($p = .058$) and -1.64 points in mean N2 score ($p = .572$) in medical ophthalmology residents following receipt of a one year ethics education programme, demonstrating regression in moral reasoning following their intervention. A significant factor that may have contributed to this difference in findings was the difference in the ethics-specific education programmes implemented. In the current study, the ethics education programme implemented and evaluated was based on dilemma discussion, while Packer's²⁵ ethics education programme comprised of ethics lectures. Schlaefli et al.³⁴ has suggested that the most optimal ethics programmes for enhancing moral reasoning development are those that include either personality development or dilemma discussion.

The findings of the current study support and extend the findings of Bebeau,²⁹ who also found that

ethics-specific education facilitated moral reasoning development in healthcare staff. Bebeau²⁹ observed a statistically significant increase of +14.9 ($p \leq .0001$) points in DIT mean P scores of dental professionals, who had received ethics-specific education in Minnesota. The current study observed an increase of +1.82 points in mean P scores ($p = .536$), but this finding failed to reach statistical significance. There are, however, a number of differences between the two studies which may account for the difference in findings. Bebeau²⁹ utilised a larger sample size ($N = 30$) than the current study ($N = 20$) and the ethics education programme delivered was of significantly longer duration – 25–30 contact hours delivered over several months vs. eight hours delivered over four weeks. In addition, the ethics education programme in Bebeau²⁹ was delivered to small groups of one to five dental professionals, the content of each course being specifically designed to address deficits in the moral abilities of each individual as identified from an initial interview, diagnostic assessment and learning plan for each participant. These differences may account for the greater difference observed in pre and post scores compared with the current study.

Limitations and future recommendations

As this is the first study published in the last ten years that evaluated change in moral reasoning following receipt of a multi-disciplinary classroom-based EOL ethics-specific education programme, the results cannot be compared directly to similar studies. Consequently the authors compared the results of this study with the results of studies with a pre-test post-test design which evaluated the effect of broad ethics education delivered to undergraduate and practicing healthcare staff on change in moral reasoning to contextualise the current study findings.

The change in moral reasoning observed in this study did not reach statistical significance however this result may have been due to its small sample size. Accordingly, the study should be repeated in a statistically powered sample before drawing any firm conclusions about the effects of the education programme. This study was also limited by its use of a convenience sample of healthcare volunteers recruited from one setting in one region of Ireland. This restricts the ability to generalise the study findings to other areas in Ireland or indeed to populations abroad. The study should be repeated across multiple geographical sites before generalising the study's results.

Due to time limitations, this study evaluated the effects of the *EOLCSS* on only one component of moral development: moral reasoning. Arguably there are at least three others, e.g. moral sensitivity, moral

motivation, moral character,^{40,41} Future studies which evaluate the effects of the *EOLCSS*, or other ethics education programmes, should consider evaluating the effects on all four components of moral development and, furthermore, on the actual moral behaviour of healthcare staff.

Only one of the 20 participants in this current study was male and this under-representation of men is consistent with similar studies^{28,30} While several theorists and researchers, including Rest himself^{18,42,43} have contested Gilligan's original thesis⁴⁴ that gender impacts on the way in which individuals consider moral dilemmas, there are some who continue to raise interesting questions about the relationship between gender and ethical competence and understanding.^{45–47} As such, future researchers should ensure that their sample is sufficiently representative of both genders so that comparisons between their scores can be made. In addition, where studies such as ours include few male participants, it would be helpful to identify the factors that lead to this and to determine whether or not these factors were, in their turn, influenced by gender.

Finally, the *EOLCSS* consisted of multiple educational components such as the workbooks, group discussions and group activities. Therefore, it is impossible to determine whether all components acted synergistically to promote moral development in study participants or whether individual components achieved this effect. Future studies evaluating the effect of the *EOLCSS* or similar educational interventions should consider, in the design phase, whether it is possible to isolate the effects of the individual components of the educational interventions.

Conclusion

This study demonstrated that the *EOLCSS* can be successfully delivered to multi-disciplinary groups of healthcare staff and that the effects on moral reasoning development can be evaluated using the DIT2. It is the first known study of its kind.

The results suggest that the *EOLCSS* may have contributed to moral reasoning development in multi-disciplinary healthcare staff involved in delivering EOLC to patients and families. However, in order to confirm and extend this finding, the programme should be evaluated in a larger sample of practicing healthcare staff in multiple sites across Ireland and elsewhere.

Given the dearth of research in the area of ethics education and, specifically, in the area of EOL healthcare ethics education, further studies that examine the impact of ethics interventions on the ethical understanding and practice of health professionals would be timely and appropriate.

Acknowledgements

The researchers wish to sincerely thank the following people whose assistance aided in the completion of this research: the study participants who kindly committed their time to attending the education programme and completing the evaluations; the staff and management team of the hospice for their support with implementing the Study Sessions; the Office for the Study of Ethical Development, Minnesota; Orla Keegan of the Irish Hospice Foundation.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

References

1. Donovan H. *Quality Standards for End-of-Life Care in Hospitals: Making End-of-life Care Central to Hospital Care*. Dublin: Irish Hospice Foundation, 2010.
2. National Health Service (NHS), Department of Health. *End of Life Care Strategy Promoting High Quality Care for all Adults at the End of Life Executive Summary*. UK: Department of Health, 2008.
3. World Health Organisation (WHO). *Palliative Care The Solid Facts*. Geneva: World Health Organisation, 2004.
4. Gamondi C, Larkin P and Payne S. Core competencies in palliative care: an EAPC White Paper on Palliative Care Education – Part 1. *Eur J Palliat Care* 2013; 20: 86–91.
5. Gamondi C, Larkin P and Payne S. Core competencies in palliative care: an EAPC White Paper on Palliative Care Education – Part 2. *Eur J Palliat Care* 2013; 20: 140–145.
6. Duval G, Clarridge B, Gensler G, et al. National survey of U.S. internists' experiences with ethical dilemmas and ethics consultation. *J Gen Intern Med* 2004; 19: 251–258.
7. Hurst SA, Perrier A, Pegoraro R, et al. Ethical difficulties in clinical practice: experiences of European doctors. *J Med Ethics* 2007; 33: 51–57.
8. Sorta-Bilajac I, Bazdaric K, Brozovic B, et al. Croatian physicians' and nurses' experience with ethical issues in clinical practice. *J Med Ethics* 2008; 34: 450.
9. Quinlan C and O'Neill C. *Practitioners' Perspectives on Patient Autonomy at End of Life*. Dublin: Irish Hospice Foundation, 2009.
10. Mc Keown K, Haase T, Pratschke J, et al. Dying in Hospital in Ireland: An Assessment of the Quality of Care in the Last Week of Life, Report 5, *Final Synthesis Report*. Irish Hospice Foundation: Dublin, 2010.
11. Al-Jalahma M and Fakhroo E. Teaching medical ethics: implementation and evaluation of a new course during residency training in Bahrain. *Educ Health (Abingdon)* 2004; 17: 62–72.
12. Chin JJ, Voo TC, Karim SA, et al. Evaluating the effects of an integrated medical ethics curriculum on first-year students. *Ann Acad Med Singapore* 2011; 40: 4–18.
13. Goldie J, Schwartz L, Mcconnachie A, et al. The impact of a modern medical curriculum on students' proposed behaviour on meeting ethical dilemmas. *Med Educ* 2004; 38: 942–949.
14. Schuh LA and Burdette DE. Initiation of an effective neurology resident ethics curriculum. *Neurology* 2004; 62: 1897–1898.
15. Rest J, Thoma S and Edwards L. Designing and validating a measure of moral judgment: stage preference and stage consistency approaches. *J Educ Psychol* 1997; 89: 5–28.
16. Rest J, Thoma S, Narvaez D, et al. Alchemy and beyond: indexing the defining issues test. *J Educ Psychol* 1997; 89: 498–507.
17. Rest J, Narvaez D, Bebeau M, et al. A neo-Kohlbergian approach: the DIT and schema theory. *Educ Psychol Rev* 1999; 11: 291–324.
18. Rest J, Narvaez D and Thoma SJ. DIT2: devising and testing a revised instrument of moral judgment. *J Educ Psychol* 1999; 91: 644–659.
19. Rest J, Narvaez D and Thoma SJ. *Postconventional moral thinking a neo-Kohlbergian approach*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc, 1999.
20. Rest J, Narvaez D, Thoma SJ, et al. A neo-Kohlbergian approach to morality research. *J Moral Educ* 2000; 29: 381–395.
21. Colby A and Kohlberg L. The measurement of moral judgment: Vol. 1. *Theoretical Foundations and Research Validation*. New York, NY: Cambridge University Press, 1987.
22. Colby A and Kohlberg L. *The Measurement of moral judgment: Vol. 2. Standard issue scoring manual*. New York, NY: Cambridge University Press, 1987.
23. Dieruf K. Ethical decision-making by students in physical and occupational therapy. *J Allied Health* 2004; 33: 24–30.
24. Fleisher WP, Kristjanson C, Bourgeois-Law G, et al. Pilot study of the defining issues test. *Canadian Med Assoc J* 2003; 169: 1145–1146.
25. Packer S. The ethical education of ophthalmology residents: an experiment. *Trans Am Ophthalmol Soc* 2005; 103: 240–269.
26. Park M, Kjervik D, Crandell J, et al. The relationship of ethics education to moral sensitivity and moral reasoning skills of nursing students. *Nurs Ethics* 2012; 19: 568–580.
27. Patenaude J, Niyonsenga T and Fafard D. Changes in the components of moral reasoning during students' medical education: a pilot study. *Med Educ* 2003; 37: 822–829.
28. Auvinen J, Suominen T, Leino-Kilpi H, et al. The development of moral judgment during nursing education in Finland. *Nurse Educ Today* 2004; 24: 538–546.
29. Bebeau MJ. Enhancing professionalism using ethics education as part of a dental licensure board's disciplinary action. Part 2. Evidence of the process. *J Am College Dent* 2009; 76: 32–45.
30. Geddes LE, Salvatori P and Eva KW. Does moral judgement improve in occupational therapy and physiotherapy

- students over the course of their pre-licensure training? *Learn Health Social Care* 2008; 8: 92–102.
31. Baughcum AE, Gerhardt CA, Young-Saleme T, et al. Evaluation of a pediatric palliative care educational workshop for oncology fellows. *Pediatr Blood Cancer* 2007; 49: 154–159.
 32. Quinn K, Hudson P, Ashby M, et al. Palliative care: the essentials: evaluation of a multidisciplinary education program. *J Palliat Med* 2008; 11: 1122–1129.
 33. Rogers S, Babgi A and Gomez C. Educational interventions in end-of-life care. Part I: an educational intervention responding to the moral distress of NICU nurses provided by an ethics consultation team. *Adv Neonatal Care* 2008; 8: 56–65.
 34. Schlaefli A, Rest JR and Thoma SJ. Does moral education improve moral judgment? A meta-analysis of intervention studies using the defining issues test. *Rev Educ Res* 1985; 55: 319–352.
 35. McCarthy J, Donnelly M, Dooley D, et al. *Ethical Framework for End-of-Life Care Study Sessions*. Dublin: Irish Hospice Foundation, 2010, <http://hospicefoundation.ie/publications/ethics/> (accessed 23 July 2015).
 36. Walker LJ. The model and the measure: an appraisal of the Minnesota approach to moral development. *J Moral Educ* 2002; 31: 353–367.
 37. The University of Alabama Office for the Study of Ethical Development. DIT Scoring. 2013. <http://www.ethicaldevelopment.ua.edu/dit-scoring> (accessed 23 July 2015).
 38. SPSS Inc. *SPSS Base 14.0 User's Guide*. Chicago: SPSS Inc, 2005.
 39. Bebeau MJ and Thoma SJ. *Guide for DIT-2: A Guide for Using the Defining Issues Test, Version 2 ('DIT-2') and the Scoring Service of the Center for the Study of Ethical Development*. Minneapolis: Center for the Study of Ethical Development, University of Minnesota, 2003.
 40. Rest JR and Narvaez D. *Moral Development in the Professions Psychology and Applied Ethics*. NJ: Lawrence Erlbaum Associates, Inc, 1994.
 41. Bebeau MJ. Enhancing professionalism using ethics education as part of a dental licensure board's disciplinary action. Part 1. An evidence-based process. *J Am College Dent* 2009; 76: 38–50.
 42. Bebeau MJ and Brabeck MM. Integrating care and justice issues in professional moral education: a gender perspective. *J Moral Educ* 1987; 16: 189–203.
 43. Rest J. *DIT Manual*. Minneapolis, MN: Center for the Study of Ethical Development, 1986.
 44. Gilligan C. *In a Different Voice*. Cambridge, MA: Harvard University Press, 1982.
 45. Bay D. A critical evaluation of the use of the DIT in accounting ethics research. *Crit Perspect Account* 2002; 13: 159–177.
 46. Bernardi RA and Arnold DF. An examination of moral development within public accounting by gender, staff level and firm. *Contemp Account Res* 1997; 14: 653–668.
 47. Piper T, Gentile M and Parks S. *Can Ethics Be Taught?* New York, NY: Praeger, 1993.