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EMPRICAL RESEARCH QUALITATIVE

Protective factors of ethical conflict during a pandemic—Quali-Ethics-COVID-19 research part 2: An international qualitative study

Anna Falcó-Pegueroles PhD, MSc, RN, Professor[1,2] | Elena Viola PhDc, MSc, RN, Clinical Nurse[3,4] | Silvia Poveda-Moral PhD, MSc, RN, Professor[5] | Dolors Rodríguez-Martín PhD, RN, Professor[1] | Gemma Via-Clavero PhD, MSc, RN, Assistant Professor, Advanced Practice Critical Care Nursing[1,3] | Serena Barello PhD, Professor[6] | Alejandro Bosch-Alcaraz PhD, MSc, RN, Professor[1] | Loris Bonetti PhD, MSc, RN, Professor[7,8]

[1]Faculty of Nursing, University of Barcelona, Barcelona, Spain

[2]Consolidated Research Group 325 Bioethics, Law and Society (BIOELSi), University of Barcelona, Barcelona, Spain

[3]Hospital Universitari Bellvitge, L'Hospitalet de Llobregat, Barcelona, Spain

[4]Nursing and Health Doctoral Program, University of Barcelona, Barcelona, Spain

[5]University School of Nursing and Occupational Therapy, Terrassa, Barcelona, Spain

[6]Università Cattolica del Sacro Cuore, Milan, Italy

[7]Nursing Research Competence Centre, Ente Ospedaliero Cantonale, Bellinzona, Switzerland

[8]University of Applied Sciences and Arts of Southerm Switzerland, Manno, Switzerland

Correspondence
Anna Falcó-Pegueroles, Faculty of Nursing, Health Sciences Bellvitge Campus, University of Barcelona, Pavelló de Govern, Feixa Llarga s/n, 08907, L'Hospitalet de Llobregat, Barcelona, Spain.
Email: annafalco@ub.edu

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Official College of Nurses of Barcelona

Abstract

Aims and Objectives: To determine which factors can be considered protective of ethical conflicts in intensive care unit healthcare professionals during a pandemic.

Background: The COVID-19 pandemic gave rise to new ethical concerns in relation to the management of public health and the limitations on personal freedom. Continued exposure to ethical conflict can have a range of psychological consequences.

Design: A qualitative design based on phenomenological approach.

Methods: A total of 38 nurses and physicians who were regular staff members of Barcelona and Milan's public tertiary university hospitals and working in intensive care units during the first wave of the COVID-19 pandemic. Semi-structured online in-depth interviews were conducted. A thematic analysis was performed by two independent researchers following the seven steps of Colaizzi's methods. We adhere COREQ guidelines.

Results: One theme 'Protective factors of ethical conflict in sanitary crisis' and four subthemes emerged from the data: (1) knowledge of the infectious disease, (2) good communication environment, (3) psychological support and (4) keeping the same work team together.

Conclusions: Four elements can be considered protective factors of ethical conflict for healthcare professionals during a sanitary crisis. While some of these factors have already been described, the joint identification of this set of four factors as a single element is, in itself, novel. This should help in ensuring the right mechanisms are in place to face future pandemics and should serve to improve institutional organisation and guarantee safe and high-quality patient care in times of healthcare crisis.

Relevance to Clinical Practice: Future strategies for the prevention of ethical conflict during sanitary crises, pandemics or other catastrophes need to consider a set of four factors as a single element. These factors are the knowledge of the infectious disease, a good communication environment, psychological support and keeping the same work team together into joint consideration.

KEYWORDS
COVID-19, ethicss, intensive care unit, nurses, pandemic, physicians, protective factors

1 | BACKGROUND

A sanitary crisis, characterised by the worldwide transmission of an emerging infectious disease—as illustrated recently by the COVID-19 pandemic—can, as we have seen affect millions of people and result in a significant number of deaths (Fernández-Castillo et al., 2021; WHO, 2022). The complexity of such a situation creates a disturbing imbalance between the demand for healthcare and the resources immediately available to address that crisis (Faggioni et al., 2021; Miljeteig et al., 2021). Indeed, the unpredictable nature of such crises places unprecedented demands upon healthcare systems generating as a result major ethical challenges and increasing exposure to ethical conflict (Barello, Falcó-Pegueroles, et al., 2020; Falcó-Pegueroles et al., 2020; Rhéaume et al., 2022; Robert et al., 2020; Svantesson et al., 2021; Vincent & Creteur, 2020).

Various studies have stressed the psychological impact of sanitary crises on health workers exposed to these extremes. In a meta-analysis conducted by Yunitri et al. (2020), the following risk factors of post-traumatic stress disorder were identified during the recent pandemic: being under the age of 65, having worked in COVID-19 units, being a female nurse and being from the European continent. In a similar vein, Saragih et al. (2021) concluded that the most prevalent mental disorders among healthcare workers were post-traumatic stress, followed by anxiety and depression, while Dragioti et al. (2022) found that while nurses suffered more often from anxiety, depression and sleep problems, doctors reported a higher prevalence of stress and post-traumatic disorders.

Additionally, the literature widely documents a positive correlation between ethical conflict and psychological consequences, ranging from psychological discomfort attributable to depression and anxiety through to burnout (Glasberg et al., 2007; Juthberg et al., 2008; Severinsson, 2003). For example, Villa et al. (2021) reported psychological distress and different levels of ethical conflict between nurses working in COVID-19 units and those working elsewhere. Further, Maben et al. (2022) find links between the psychological consequences of ethical conflicts and the guilt and residual anxiety generated among professionals who felt unable to care for their patients as they would have wanted. In this same line, several studies describe the moral distress suffered by healthcare professionals when unable to provide care in accordance with their values and ethical responsibility as professionals (Czyż-Szypenbejl et al., 2022; Falcó-Pegueroles et al., 2015; Jameton, 2017; Jia et al., 2020).

What does this paper contribute to the wider global nursing community?

- Healthcare professionals identify four protective factors of ethical conflict during the pandemic: knowledge of the infectious disease, good communication environment, psychological support and keeping the same work team together.
- Nurses and physicians used ethical words such as *justice*, *demanding*, *dedication* and *moral distress* to describe their experiences during the sanitary crisis, demonstrating the complexity of the situation faced.
- Healthcare institutions and organisations have to consider these four factors to face future pandemics for guaranteeing safe and high-quality patient care in times of healthcare crisis and protect their professionals.

Although a sizeable number of studies describe the ethical conflicts and psychological consequences attributable to the recent pandemic among intensive care unit (ICU) professionals (Fanelli et al., 2020; Fernández-Castillo et al., 2021; Robert et al., 2020), comparatively few studies have sought to describe the factors that might provide protection in the face of such conflicts (Barello, Palamenghi, & Graffigna, 2020; Falcó-Pegueroles et al., 2020; Villa et al., 2021). As a public health emergency, it is critical that we can draw lessons from sanitary crises of this kind ensuring that the necessary preventive mechanisms are in place to control or to limit as far as possible, their negative ramifications. This means, when facing future health emergencies, professionals are, among other aspects, prepared to protect themselves from the potential ethical conflicts that are likely to arise.

The qualitative study we report here forms part of a larger study examining ethical conflicts in the ICUs of Italy and Spain—among the first European countries to be hit by the emergency—during the first wave of COVID-19. In the first part of this study we describe the ethical conflicts directly attributable to the health emergency and how decisions were taken in response (Falcó-Pegueroles et al., 2023). In the second part, we examine the factors that proved useful in preventing these conflicts during the

decision-making process. In short, the aim of this study is to explore the factors identified by healthcare professionals as being protective or preventive of ethical conflicts in ICUs during a pandemic.

2 | METHODS

2.1 | Study design

A qualitative design was adopted based on a phenomenological approach. Such a method makes it possible to describe and understand the live experiences of ICU professionals and to discover the meanings they attach to these experiences (Creswell & Poth, 2017). In doing so, consolidated criteria for reporting qualitative research (COREQ) guidelines (Tong et al., 2007) were followed (Appendix S1).

2.2 | Participants and settings

Our study included nurses and physicians from Italy and Spain. More specifically, the healthcare professionals were drawn from four hospitals in Milano (Italy) (Ospedale Fatebenefratelli, Ospedale Luigi Sacco, Ospedale San Paolo, Ospedale San Carlo) and one in Barcelona (Hospital Universitari de Bellvitge). All five are public, university hospitals that serve as tertiary referral centres for their metropolitan areas. Moreover, each was involved in the management of the COVID-19 pandemic from the very outset. Additional beds were provided for ICU patients in order to treat as many critical patients as possible and many nurses and physicians, with no previous experience of ICU care, were transferred from the wards to the ICU to address staff shortages. The inclusion criteria for participation in the study were (1) being a healthcare professional working in an ICU, (2) having worked in critical care during the COVID-19 pandemic and (3) forming part of the hospital's regular staff. The exclusion criteria were being a postgraduate or master's trainee nurse, being a trainee doctor with no contractual ties to the ICU and not having access to the equipment needed to participate in an online interview. Purposive sampling was used to recruit the participants taking into account heterogeneity criteria of age, gender, profession, years of professional experience and shift worked. Sampling ceased when data saturation were reached and no new information was obtained (Hennink & Kaiser, 2022).

2.3 | Data collection

In depth, semi-structured interviews were conducted between December 2020 and May 2021. Participants were informed about the study by means of posters hung in the ICUs themselves or directly via a member of the research team in each country. The healthcare professionals who agreed to participate in the study were subsequently contacted by a research team member, who requested an email address to which details about the study could be sent. After signing the informed consent (which was sent and returned by mail before the interview), the participant named the best time and day for conducting the online interview.

Owing to COVID-19 restrictions, all interviews had to be conducted via online platforms (e.g. Zoom or Google Meet), with both audio and video streams being recorded with the informed consent of the participants. In most of the interviews, only the participant and interviewer were present, although in some of the interviews conducted in Italy the principal investigator attended as an observer, again with the consent of the interviewee. None of the interviewers were related in any way with the participants, but the latter were fully informed about the authors of the study and their respective affiliations, and about the aim and methodology of the study. The two principal investigators drew up guidelines in Italian and Spanish versions for the respective research teams, in order to clarify concepts and to ensure the same system was implemented to obtain the data.

Before initiating the interviews, and to guarantee participant anonymity, each interviewee was assigned a code or alias. The first part of the interview was concerned with gathering relevant sociodemographic data, including, the participants' age, sex, shift worked, the hospital in which they work, profession, years of professional experience, years of ICU experience, the period during which they worked with COVID-19 patients, education and the service they worked in before transferring to the COVID-19 unit. In the second part, each participant responded to open-ended questions focused on factors affording them protection from ethical conflict. For the purposes of this study, responses to just six of the 11 open-ended questions were used (Table 1). Contextual, methodological and inferential notes were recorded in a field diary.

All interviews were recorded and transcribed. Afterwards, transcriptions were sent to participants to approve and/or correct/reject the text or any parts of it. Having obtained a participant's approval, the text was considered suitable for analysis. Only two participants made slight changes concerning a particular expression or word used but they did not delete any of the information given nor did they alter the meaning of the transcription.

TABLE 1 Open-ended questions linked to the ethical conflicts thematic axis.

1. When having to make decisions during the COVID-19 pandemic, what do you think could have helped you improve your ethical decision-making?
2. And what recommendations or changes would you make to improve conditions for improving ethical decision-making in your centre or service?
3. What elements or factors do you think could have prevented or protected professionals from suffering more ethical conflicts during the COVID health crisis?
4. Could you define in one word what the COVID-19 pandemic represents or has represented for you?
5. Could you define in one word of an ethical or moral nature (values, principles, ethical conflicts, etc.) your experience in relation to the COVID-19 pandemic?
6. If you believe that things could be changed or improved in your service to improve decision-making and to avoid exposing professionals to ethical conflicts, what changes or improvements would you make?

2.4 | Data analysis

A thematic analysis of the transcriptions was performed by two independent researchers following the seven steps specified for that purpose by Colaizzi (1978). Briefly, a multiple reading was made to ensure familiarisation with the data collected and to obtain a broad picture of the participants' experience. Significant statements were then identified and, on the basis of these, keywords were established. We then sought to formulate meanings based on researcher reflection of the significant statements, clustering these meanings into common themes and subthemes. We were then in a position to formulate an exhaustive description incorporating all the above themes and to elaborate the essential structure of the phenomena (Morrow et al., 2015). Finally, verification of this description and structure was obtained. Again, to ensure participant anonymity, all attributed quotations were identified by means of an *alias_profession_age_city* code. All the recordings, transcripts, analysis work and the field diary were stored in files to which only certain members of the research team had access.

2.5 | Trustworthiness

Trustworthiness was guaranteed in terms of its credibility, confirmability, dependability and transferability, in line with Guba and Lincom (1981). To ensure credibility, the interviewers underwent rigorous training in data collection techniques; while to guarantee confirmability, three researchers (AFP, LB, EV) analysed the text independently. Later, triangulation meetings were held to reach a consensus. If discrepancies were identified between interpretation and coding, these were resolved in discussions with another researcher. To ensure dependability, the participants' statements were reposted verbatim in each section of the analysis; while to guarantee transferability, all the data concerning the study design, participants, setting, data collection and analyses were clearly described and reported. Steps were also taken to ensure that the proximity of the two PIs to the phenomenon under investigation did not lead to interpretive bias. This was achieved via the critical and rigorous use of their knowledge and experience concerning the work of ICUs. The researchers engaged in reflexivity through the use of field diaries, synthesis and reflection, all of which proved helpful in differentiating between what the participants said and what the researchers understood or believed.

2.6 | Ethical considerations

The directives of the Belmont Report (1979) and the Declaration of Helsinki (World Medical Association, 2013) on conducting research involving human participants were strictly adhered to at all stages of this study. Additionally, our research received the approval of the Bioethics Commission of the University of Barcelona (IRB 00003099) and the Ethics Committees of the corresponding Italian and Spanish hospitals. All participants were fully informed about the nature and goals of the study and gave their written consent to participate and to be recorded before the interviews were scheduled. All interviews were individual and confidential and all data were codified to guarantee participant anonymity.

The meeting was recorded for subsequent transcription and analysis of the data obtained; however, both recordings and transcriptions were treated as confidential and deposited in a University of Barcelona SharePoint folder specially created for this purpose with the appropriate data protection guarantees provided by the University. This folder was only accessible to those team members that participated in the interviews, data analysis and management of other documents, including the informed consent forms. The respective laws currently in force on the Protection of Personal Data and Guarantee of Digital Rights (European Parliament and of the Council, 2016) in both countries were adhered to at all times.

3 | RESULTS

3.1 | Characteristics of the sample

Data saturation were reached after 38 interviews (22 in Spain and 16 in Italy). The healthcare professionals that participated in the study were sufficient to represent the heterogeneity of the sample in terms of gender, profession, years of experience, shift worked, service and country (Table 2). The total recording time was 19 h, with a mean of about 30 min (range 17–58 min) per interview. The Spanish sample comprised 17 nurses and 5 physicians (9 male and 13 female) and the Italian sample comprised 8 nurses and 8 physicians (9 male and 7 female). The average age of the participants was 38.2 years (range 23–62). All the Spanish nurses held a Master's degree in critical care, while just one Italian nurse held this qualification.

Based on our data analysis, we identified as a theme 'protective factors of ethical conflict in sanitary crises' and the following four subthemes: *(1) knowledge of the infectious disease (in this case COVID-19), (2) good communication environment, (3) psychological support and (4) keeping the same work team together.* An infographic was designed to represent these results (Figure 1).

3.2 | Protective factors of ethical conflict

3.2.1 | Knowledge of the infectious disease (COVID-19)

Uncertainty about the evolution, treatment efficacy and prognosis of patients infected by SAR-CoV2 was, together with the lack of resources and the high demand for care, the main cause of ethical conflicts. The first point to emerge clearly from the interviews was the need expressed for more knowledge about the disease and its evolution, especially during the first wave. Experience with COVID-19 patients allowed the healthcare professionals to acquire more

TABLE 2 Alias code and characteristics of the sample.

	Alias code	Gender	Age	Years of professional experience	Work shift	Unit
1	AGOSTINO_NUR_37_MIL	M	37	10	Rotating	ICU
2	ALESSANDRO_NUR_52_MIL	M	52	28	Rotating	ICU
3	ALICE_PHY_57_MIL	F	57	32	Not defined	ICU
4	ÁNGELA_NUR_24_BCN	F	24	1	Afternoon	Polyvalent ICU
5	AZZURRA_NUR_56_MIL	F	56	35	Morning	ICU
6	CARMEN_NUR_28_BCN	F	28	6.5	Afternoon	Post-surgical ICU
7	CARLA_NUR_30_BCN	F	30	8	Tarde	ICU
8	CATERINA_PHY_32_MIL	F	32	32	Rotating	ICU
9	CLAUDIA_NUR_23_BCN	F	23	1.5	Afternoon	ICU
10	CRISTINA_NUR_23_BCN	F	23	1.5	Afternoon	ICU
11	DANIELE_PHY_44_MIL	M	44	19	Not defined	ICU
12	DIEGO_PHY_41_BCN	M	41	6	Mornings + on-call shift	Intensive Medicine
13	ELEONORA_NUR_28_MIL	F	28	5	Morning + on-call shift	ICU
14	ÉRICA_NUR_29_BCN	F	29	7	Afternoon	Post-surgical ICU
15	FABRIZIA_NUR_33_MIL	F	33	10	Rotating	ICU
16	GABRIELE_NUR_57_MIL	M	57	26	Rotating	ICU
17	GIACOMO_PHY_62_MIL	M	62	33	Not defined	ICU
18	GIANLUCA_PHY_56_MIL	M	56	30	Not defined	Cardiac ICU
19	JUANA_NUR_27_BCN	F	27	5	Mornings	Cardiac ICU
20	JOSEFA_NUR_26_BCN	M	26	5	Mornings	Cardiac ICU
21	KAUFMAN_NUR_27_BCN	M	27	8	Mornings	ICU
22	LUCÍA_NUR_28_BCN	F	28	5.5	Afternoon	ICU cardiac
23	LUIGINA_PHY_44_MIL	F	44	12	Rotating	COVID ICU
24	MAR_NUR_46_BCN	F	46	20	Mornings	ICU
25	MARCO_NUR_32_MIL	M	32	8	Rotating	ICU
26	MAURO_PHY_58_MIL	M	58	32	Morning	ICU
27	MICHELA_NUR_26_MIL	F	26	1	Rotating	ICU
28	MÓNICA_NUR_26_BCN	F	26	4	Mornings	ICU
29	NEUS_NUR_55_BCN	F	55	25	Mornings	Post-surgical ICU
30	NICOLA_PHY_40_MIL	M	40	14	Rotating	COVID ICU
31	ORIOL_NUR_35_BCN	M	35	12	Afternoon	ICU
32	PAU_NUR_32_BCN	M	32	8	Afternoon	ICU
33	RAÚL_NUR_50_ BCN	M	50	12	Afternoon	Post-surgical ICU
34	SANTIAGO_PHY_30_BCN	M	30	6	Mornings	ICU
35	SOFÍA_PHY_30_BCN	F	30	5	Mornings	ICU
36	SUSANA_NUR_44_BCN	F	44	24	Mornings	ICU
37	TONI_PHY_44_ BCN	M	44	17	Mornings	ICU
38	VICTOR_PHY_42_BCN	M	42	15	Mornings + on-call shift	ICU

Abbreviations: BCN, Barcelona; F, female; M, male; MIL, Milano; NUR, nurse; PHY, physician.

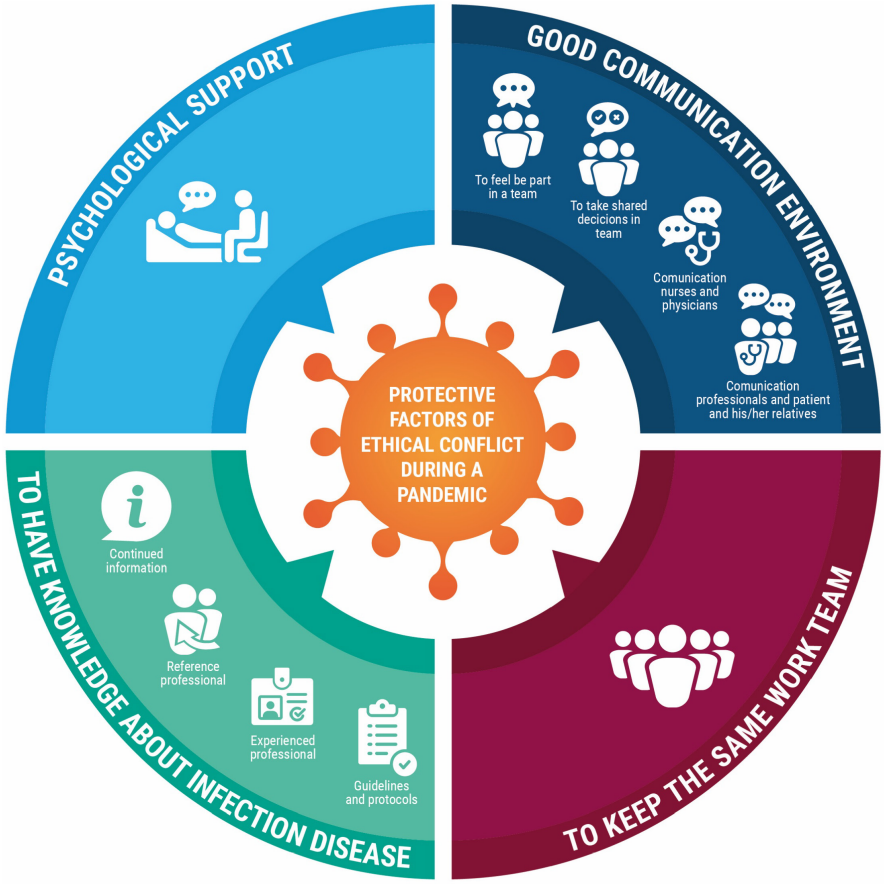

FIGURE 1 Protective factors of ethical conflicts in sanitary crisis.

knowledge about the infection and this facilitated their decision-making process.

> First of all, experience, the fact that we have learned to know what was going on and what we are still experiencing, so now we know how to manage it better and knowing how to manage it better helps us to better manage some situations involving ethical decisions. I think preparation, and with preparation at all levels, technical preparation, actually understanding what resources are needed, so that since resources are not lacking you can work better, for a full, better management of some situations; if you know a situation, a problem, you surely know how to cope in the best way possible.
>
> FABRIZIA_NUR_33_MIL

In the main, the Spanish participants expressed the need for ongoing education, in the form of protocols to ensure that they acted in accordance with good clinical practice:

> ...protocols, because at the end of the day when you let people make their own decisions, what we understand we should do isn't always the same as what everyone else believes they should do. So the more protocolized these kind of things are, I think, ultimately, they improve as far as patient safety and the decision-making that affects them are concerned.
>
> JOSEFA_NUR_26_BCN

Likewise, the Italian physicians highlighted the need for guidelines to help them make clinical decisions. Following the publication of the recommendations by the Italian Society of Anaesthesia regarding end-of-life decisions in COVID-19 patients, some physicians saw this document very much as a protective factor:

> What was done was very important, that is to issue guidelines, recommendations, 'behave like this, it's not your fault, you can't do better than this'. I think this is a fundamental thing to say from a scientific society, and it has been done.
>
> DANIELE_PHY_44_MIL

Second, related to knowledge and experience, the participants considered that working alongside more experienced colleagues served as a protective factor since it allows for ongoing comparisons and the sharing of experiences:

> Explaining what we were experiencing, explaining just that. This helped... that is, to see that it hadn't only happened to you or that it wasn't something that

was your fault. But because of the situation, this happened and it's because, let's say, of outside causes.

CRISTINA_NUR_23_BCN

The healthcare professionals recognised the need for a group of critical care experts. The nurses, for example, identified the following as a protective factor: the presence of an advanced practice nurse (APN), who could be reached 24 h a day, 7 days a week to handle doubts, provide specific training and share information of interest. Likewise, the physicians recognised the importance of having access to a group of COVID experts they could turn to help in the decision-making process:

There is a group of experts on this disease. And this helps us a lot in getting the support we need, you see? In the sense that what we're doing… each of us gets a review or a personal review, right? And it's shared with all our other colleagues but it's always good to have a point of reference, you see? A point of reference since this helps us make decisions.

TONI_PHY_44_BCN

… and to have someone we can turn to who we know – for example, in this case, the clinical nurse – who we know can help us if we have any doubts, doubts about some apparatus or a device we've never used, or about how to provide, you know, care.

CLAUDIA_NUR_23_BCN

3.2.2 | Good communication environment

The possibility of communicating with colleagues, being able to count on their support, to talk about experiences and to know another's point of view emerged as an important protective factor that helped participants in making ethical decisions. The participants highlighted the value of being part of a team.

It was a team effort rather than a personal one, we had a lot of discussions and if you had any doubts of any kind, it was never just me having to make a decision all on her own [...] Comparing ideas with my colleagues was fundamental.

ELEONORA_NUR_28_MIL

This possibility of working in a good communication environment gave the healthcare workers the chance to make decisions as a team, without the responsibility falling on one sole individual:

What makes you feel a little bit more secure and confident in the decisions you have to make is having the support of colleagues, not making decisions all alone. And I always had this kind of support, because there were always at least four of us on each shift, so I was never alone, I could always turn to colleagues who were more experienced than me. In short, what helped me most to overcome the difficulties was being able to share decision-making with others.

CATERINA_PHY_32_MIL

The Italian nurses speak of their efforts to enhance the environment by improving communication with the physicians or spending time debriefing with them:

Definitely comparing and contrasting ideas, discussing motivations [...] why one makes that type of choice, why one makes that choice for specific motives, if he gives reasons that can be more or less shared, of course, they don't have to be accepted by everyone, but if you give me an explanation about the whys and wherefores, it is easier too to share possibly weightier choices.

AZZURRA_NUR_56_MIL

While some of the nurses focus mainly on the need for good communication between professionals as a protective element against their ethical problems, the physicians speak more about the importance of transmitting information to patients and family members so that they can understand the situation in which the patients find themselves and the most appropriate therapeutic options in each case.

3.2.3 | Psychological support

All the participants stressed the importance of receiving psychological support as a tool for preventing ethical conflict:

We had the support of psychologists [...] I think that having this extra factor, that if at any moment you felt overwhelmed or that the situation was getting, personally, a little out of control, knowing you can fall back on this kind of support also gives you some… help.

TONI_PHY_44_BCN

Second is also the role of the psychologist, we have meetings with moderators, a training project even for professionals, this undoubtedly was of help. I did some training related to death, for example, where there was a psychologist too and, I must say, it's been very interesting, it helped me out.

AGOSTINO_NUR_37_MIL

Group sessions with a psychologist were offered to the healthcare workers at the end of the first wave and these were maintained during

the following waves. Some participants thought, however, they should have been made available sooner.

> Let's say that the psychological preparation was not good, though psychological debriefing has been implemented in some situations, [...], with the first responders in June, there was just one decompression day with an emergency psychologist.
>
> ALICE_PHY_57_MIL

3.2.4 | Keeping the same work team together

During the first and second waves, hospitals expanded their response capacity by generating new critical care services. These new ICUs were staffed by professional experts in critical care alongside professionals from other services or specialist fields. This meant that many previously consolidated critical care teams had to be broken up, with nurses and physicians taking up positions in these new units. However, a number of participants in the study highlighted the importance of keeping the same team together as a protective factor against ethical conflicts.

> I would keep teams together for a while. I mean, build stable teams always with the same people. Of course, in the ICUs you have to move people on after they have been there for a while because, if not, you end up creating teams that create conflicts, but, yes, I'd prioritize the same team for a year so that those people end up knowing how to work together.
>
> JOSEFA_NUR_26_BCN

> So, in my opinion, prevention would be just that, to work much more as a team because unfortunately, but I have to be honest, it is something that is not done.
>
> ALESSANDRO_NUR_52_MIL

3.3 | Concepts associated with the crisis and proposals for improving conflict management in ICUs

The words, ideas or concepts deemed as best representing the experiences of the participating professionals and the challenges they faced during the health crisis were various, although the most frequently mentioned were the following: *personal* and *professional growth*, *challenge*, *fear*, *impotence*, *uncertainty*, *sacrifice* and *loneliness* (Figure 2). Similarly, the words or terms deemed as best representing the ethical conflicts they had faced were *justice*, as a bioethical principle that could not be guaranteed, and *demanding* (Figure 3).

Additionally, the participants made proposals to improve the management of ethical conflicts during the pandemic (albeit that they are equally applicable to other clinical contexts) aimed at reducing

FIGURE 2 Words, ideas or concepts deemed as best representing the experience of the professionals during pandemic.

FIGURE 3 Words, ideas or terms of ethical or moral natures deemed as best representing the professional experience during pandemic.

exposure to such conflicts and improving the ethical well-being of professionals. These proposals, collected in Table 3, revolved around the active participation of nurses in the decision-making process, ensuring interdisciplinarity and collaboration between the different teams, ensuring a greater focus (from the hospital and its managers) on the needs of patients and healthcare professionals alike, guaranteeing sufficient numbers of professionals and resources, involving the patients' families more and providing direct, face-to-face attention, having an advanced practice referral nurse on the unit, and, finally, receiving training in bioethics and access to an expert in bioethics to advise on decision-making.

4 | DISCUSSION

Despite coming from different countries and working in different healthcare contexts, the nursing and medical professionals participating in this study concur in their identification of four protective factors of ethical conflict based on their experience of the sanitary

TABLE 3 Participants' proposals for improvements to ICU services to reduce ethical conflicts.

Active participation of nurses in decision-making process	Joint visits and good communication with doctors. One day a doctor can't just decide to limit this, the next day you'll find the patient still there, right? Because someone or other has decided not to limit it. And so, no. We all have to pull as one, because it is a single person, it is one diagnosis. It's fine if you have your doubts, but you can't be like that 2 weeks in a row. It is just not on. And joint visits because after all we're the ones that were going in. LUCIA_NUR_28_BCN
	You share information, you have an idea, you manage to involve all the other professionals, including the nursing team, when you have the opportunity to involve in a good way – this is the wrong word – however, to somehow allow contact with the family, I think it's a good way, however, this is my advice. LUIGINA_PHY_44_MIL
Team interdisciplinarity and collaboration	One visit each shift with the medical team, patient by patient, and all together in one group. Not just nursing staff and the doctor. So, we need to meet, see the situation and assess using all possible measures, clinical as well as ethical and social. Then, well, I think that this would be a good point to take into account, but the medical team aren't really up for it, but what the heck. KAUFMAN_NUR_27_BCN
	The professional must consider the ethical problem whatever patient he is facing, without being overwhelmed, having the possibility of being supported… the possibility of talking about it and a shared path, even though the problem must be raised… it must be shared with all the personnel, without being something said in the silence of our own room, it rather must be a formal moment in which this aspect is being addressed. To stress the habit of doing it, to make it systematic, to have the courage to say uncomfortable things. ALICE_PHY_57_MIL
More attention to be given to patients and healthcare professionals	In my opinion, it'll sound obvious, putting the needs of patients and professionals above all else, because, at the end of the day, if you want you can, it's just that there are economic and political interests that we must take into consideration, and to protect the individual who may be either the patient or the professional, bear in mind that we don't work with objects, we work with people, whether it is a colleague or a patient. ELEONORA_NUR_28_MIL
	There's always room for improvement, there's plenty of scope. For instance, compartmentalizing properly the procedures that are done throughout the day. There are tasks that are perhaps done at night that could be done during the day to help the sick get more rest at night, right? But, well, these are organizational matters and, at the end of the day, an adjustment of functions can be easily made. SANTIAGO_PHY_30_BCN
Guarantees of sufficient numbers of professionals and resources	I would say an adequate number of health personnel; when it comes to deciding, it has a greater impact. Having more time available to manage patients, to take care of them, not only at the nursing level, but also at the human level, the ethical component, as you said, changes a lot. GABRIELE_NUR_57_MIL
	I always see the problem as a structural problem, of availability of space and resources. A part of our difficulties is also fatigue, so we want a lot, but perhaps in such a difficult situation we would need to have recovery times to be able to face the… GIACOMO_PHY_62_MIL
Involving the family more and providing direct, face-to-face contact	The family, because of the whole thing with the pandemic and the lockdown, the family was absent. So, maybe always, because we, well, within the limits of what is possible… ultimately the decisions are made by the families … sorry, we make them because they are very complex decisions. But, yes, we do get the family involved, in the way we explain a little how this disease is going to pan out, how this disease is going to develop and the potential complications that may arise because of the decisions taken when deciding to do all kinds of therapy when, well, we believe that there could be some kind of therapeutic response to what we do, right? TONI_PHY_44_BCN
	What I mentioned before about relatives, having a direct discussion with the family and, by saying 'direct', I mean talking to them face-to-face, not on the phone; this would have been incredibly useful, perhaps not so much to make the decision, but to make it more calmly [widely accepted] by both parties. MAURO_PHY_58_MIL
Training in bioethics and access to an expert in bioethics	So, yes, we do need to have an intermediary for these situations of… OK, we have the code, I mean… we, in nursing, have ethical resources, in effect, where you can send your problem or your doubts and they answer you, OK? But there are also times, and also because it has happened to me before COVID, that we've had situations in which I would have gone to the Ethics Committee and they've stopped me. By the fact of saying 'hang on, but this would make the hospital look bad', 'hey, be careful, who you are gunning [makes sign of air quotes with fingers] for, this doctor so and so', or… So you kind of lose your nerve, you know? LUCIA_NUR_28_BCN
	So, reading and studying gives health workers, if they're doctors or nurses, it doesn't matter, it provides the right knowledge of that specific field that makes them more confident and firmer in making decisions that are somehow more solid, better documented, that's for sure. MAURO_PHY_58_MIL

crisis attributable to the COVID-19 pandemic. A number of these factors have, in fact, been identified in isolation or indirectly in earlier studies, although they have not been spoken of in specific relation to ethical conflicts or decision-making (Gálvez-Herrero et al., 2022). Indeed, the concepts identified and the proposals for improvement that emerged from the interviews are by no means new to the literature, but they are in the specific context of a healthcare crisis, given that during the COVID-19 pandemic these factors were perceived as being absent. Thus, considering these elements as a set of protective factors of ethical conflict—and not only in relation to such phenomena as burnout, interprofessional discrepancies, the humanization of care, etc.—allows us to draw up a multifactorial strategy that might address in a comprehensive, safe, preventive fashion the threats to the ethical well-being of

professionals. Moreover, such a strategy can be specifically related to the experience and prevention of health crises, pandemics and other catastrophes.

The first factor to emerge as a protector is disposing of an adequate understanding of the infectious disease itself. At the outbreak of the pandemic, a pneumonia of unknown aetiology was detected and this rapidly evolved into acute respiratory stress (Harapan et al., 2020; Jia et al., 2020). This lack of scientific evidence and, hence of knowledge, meant healthcare professionals were forced to make decisions in a situation of great uncertainty, much greater than what they were used to handling in the clinical context. This situation was exacerbated by the fact that the information available was subject to constant change (Fanelli et al., 2020; Rhéaume et al., 2022). All the professionals interviewed stressed that knowledge of the disease, acquired through experience or independent study, served as a protective factor in the following waves of the pandemic. Thus, having sufficient knowledge to provide good patient care and attention and, therefore, having the moral strength that underpins decision-making, is achieved thanks to continuous training in relation to emerging developments. Furthermore, having access to a professional who—despite the uncertainty—can act as a reference point and provide support to determine the best course of action in each case, working alongside professionals with experience in similar areas, and having up-to-date guidelines and or protocols to orient decision-making are all considered critical.

To protect healthcare professionals in such situations, it is essential to create good channels and efficient systems of information dissemination (Barello, Falcó-Pegueroles, et al., 2020). To this end, there need to be pre-existing emergency management plans, characterised by clear guidelines and procedures to help healthcare professionals cope with situations of crisis. These should be based on predefined plans, as with a routine decision-making situation, rather than presenting workers with constantly changing instructions (Fanelli et al., 2020; Robert et al., 2020).

Some participants also stressed the importance of the presence in the ICU of an advanced practice nurse or a group of experts in certain diseases or specific procedures, such as nurse managers and educators or infectious disease physicians. However, the figure of the APN only emerged as a protective factor in the case of the Spanish hospital. In fact, in Italy the presence of the APN is not currently provided for. As such, it would be interesting to know whether the introduction and development of this professional role could help in the prevention of ethical conflicts in emergency situations in the case of Italian ICUs, in, among other areas, clinical practice and the promotion of advanced practice nursing. Moreover, and in Italy above all, the sanitary crisis saw staff being delegated from other departments or non-tertiary hospitals to work in the COVID-ICU, despite them having no previous experience of treating critically ill patients (Fernández-Castillo et al., 2021; Villa et al., 2021).

To limit the ethical challenges posed by the healthcare crisis, professionals need to receive training in infectious diseases (Jia et al., 2020) and be fully versed in the practices of ICUs, because an inadequate skill level might increase the burden of work (Robert et al., 2020; Villa et al., 2021). In fact, the situations that gave rise to most ethical conflicts involved working with incompetent staff (Czyż-Szypenbejl et al., 2022; Donkers et al., 2021). In emergencies, it is often difficult to provide appropriately trained staff but it is clear that novice healthcare professionals can and should not be working in an ICU (Barello, Palamenghi, & Graffigna, 2020). According to our results and the literature, professional experience, even if it is in an area only similar to that which is currently perceived as unknown, is viewed as a protective factor (Villa et al., 2021). Therefore, in future emergencies, a solution for preventing conflict might involve ensuring an experienced ICU team is always trained and prepared (Villa et al., 2021). Spanish healthcare professionals, in particular, thought that working with their same, pre-existing, group, acted as a protective factor (Fernández-Castillo et al., 2021). Indeed, it has been reported that working in an unfamiliar environment and with little-known processes has consequences for the quality of care and the patients' safety (Donkers et al., 2021). It might also contribute to creating dilemmas about the quality of care provided and to interpersonal conflict (Czyż-Szypenbejl et al., 2022; Fernández-Castillo et al., 2021), while the reorganisation of an ICU or the reinforcement of teams may create a sense of vulnerability and loss of control (Robert et al., 2020).

In line with studies conducted prior to the pandemic, a good communication environment is also perceived as a protective factor of ethical conflict (Brooks et al., 2017; Heidi et al., 2017). However, while some of the nurses focus mainly on the need for good communication between professionals as a protective element against their ethical problems, the physicians speak more about the importance of transmitting information to patients and family members so that they can understand the situation in which the patients find themselves and the most appropriate therapeutic options in each case.

In periods not marked by crisis, an organisation needs to address the weaknesses of the health care group by ensuring adequate staffing and by strengthening teams (Barello, Falcó-Pegueroles, et al., 2020). Such a focus helps promote good communication with colleagues and build familiarity, identified as protective factors by our interviewees and the extant literature: A clear and consistent communication environment ensures healthcare professionals can work in a supportive environment sharing their experience and expertise (Gálvez-Herrero et al., 2022; Gray & Sanders, 2020; Ling-Xiao et al., 2022; Miljeteig et al., 2021). In this regard, several authors recognise the value of debriefing as an effective strategy for sharing and processing challenging emotions, for helping a team rebuild morale and for the early detection of burnout or mental health distress (Vincent & Creteur, 2020). A supportive, sharing environment enables a group to discuss the issues that affect it, analyse the roots of any ethical conflicts and take team decisions. In short, good communication means a team can ultimately work more efficiently and in an atmosphere of safety, solidarity and support.

The participants also recognised the importance of psychological support as a protective factor, given the impact the pandemic has had on healthcare workers, ranging from discomfort, somatization and sleep disorders to emotional exhaustion, anxiety

and depression, among others (Benbenishty et al., 2022; Gálvez-Herrero et al., 2022). Such support, moreover, needs to be made available during the sanitary crisis and not solely once it has passed. Here, again several authors recognise that both debriefing and psychological support are crucial and should be offered before, during and after the outbreak of a public health emergency, the type of support offered being adapted to the particular phase of the pandemic (Barello, Palamenghi, & Graffigna, 2020; Robert et al., 2020; Vincent & Creteur, 2020). The psychological support strategies that might prevent ethical conflicts in ICUs can be usefully divided into two categories: first, interventions aimed at enhancing the working climate of the unit and, second, interventions aimed at helping individual healthcare professionals cope with their challenging working environment. However, it seems unlikely that any single intervention will be effective in preventing and treating the psychological sequelae of ethical conflict (e.g. burnout) in critical care professionals (Barello, Falcó-Pegueroles, et al., 2020). Rather, multidimensional interventions are required that can address the environmental culture of ICUs and individual practitioners. In this regard, it is vital that critical care professionals be taught how to recognise early signs of the risk factors of ethical conflict and to seek psychological support when needed. Indeed, healthcare practitioners need to accept personal responsibility for protecting their mental and physical well-being and for fostering resilience (Mealer et al., 2009). To achieve this, promoting psychological empowerment and positive collaboration within working teams are recognised as being effective strategies (Liu et al., 2022). In line with Gálvez-Herrero et al., (2022), the importance of being able to work within an established team also emerged from our interviews as a protective factor.

Finally, the fact that the participants reported both positive elements—for example, the opportunities for personal and professional growth—and negative —for example, fear and uncertainty—in the same degree as in previous studies (Benbenishty et al., 2022; Falcó-Pegueroles et al., 2020; Fernández-Castillo et al., 2021; Jia et al., 2020) shows the complexity of the situation faced by ICU nurses and physicians.

4.1 | Limitations

This study is not without its limitations. While our sample has included healthcare workers from two countries, we should stress the differences between the Spanish and Italian healthcare systems as far as the role of their respective nursing staffs are concerned. More specifically, the function fulfilled by advanced practice nurses in Spain has no equivalent in Italy. At a practical level, although recording online interviews allowed us to be flexible in finding suitable times to conduct the sessions (outside or during working hours; on weekdays or on holiday; at home or in the workplace, etc.), in some instances the connection failed and interrupted interventions, which meant participants had to reformulate their responses. Additionally, recruiting participants during the period of data collection proved challenging, given that the healthcare workers were still dealing with extreme workloads as a result of the pandemic. This obstacle was particularly evident in the case of Italy. Finally, interviewees from only one hospital in Spain were included, something that limits the transferability of our results. However, interestingly, the international scope of our study reveals that the protective factors that helped ICU professionals in these two countries to take ethical decisions largely coincided.

5 | CONCLUSIONS

During a sanitary crisis, the demands placed on the healthcare system are unpredictable and the pressure placed on its resources can be unsustainable. In such circumstances, healthcare professionals are extremely likely to be exposed to greater levels of ethical conflict. The complexity of decision-making during the recent COVID-19 pandemic has generated many studies of these ethical issues, but relatively little attention has been paid to the factors that might be perceived as protective of the risks of ethical conflict. Here, our results show that the nurses and physicians who cared for critically ill patients during the pandemic were aware of four main factors that could serve to limit these conflicts: namely, knowledge of the infectious disease, a good communication environment, psychological support and keeping the same work team together.

In the light of our findings, future strategies for the prevention of ethical problems in healthcare professionals during sanitary crises, pandemics or other catastrophes need to take these four factors into joint consideration. By so doing, professionals can be better trained for frontline action and the response of hospital institutions can be strengthened, ensuring safe, high-quality patient care.

6 | RELEVANCE TO CLINICAL PRACTICE

Future strategies for the prevention of ethical conflict during sanitary crises, pandemics or other catastrophes need to consider a set of four factors as a single element. These factors are the knowledge of the infectious disease, a good communication environment, psychological support and keeping the same work team together into joint consideration.

AUTHOR CONTRIBUTIONS

Anna Falcó-Pegueroles: Conceptualization, methodology, validation, data collection, analysis data, writing, review and editing, supervision, project administration. Elena Viola: Data collection, analysis data and reporting, writing. Silvia Poveda-Moral: Data collection, critical feedback. Dolors Rodríguez-Martín: Methodology, data collection, critical feedback. Gemma Via-Clavero: Methodology, critical feedback. Serena Barello: critical feedback. Alejandro Bosch-Alcaraz: Data collection, critical feedback. Loris Bonetti: Methodology, data collection, analysis data, writing, review and editing. All authors critically reviewed and approved the final version of the manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

NOT PATIENT OR PUBLIC CONTRIBUTION

Not applicable due to the methods employed.

ORCID

Anna Falcó-Pegueroles https://orcid.org/0000-0002-3702-3009
Elena Viola https://orcid.org/0000-0001-9368-4111
Silvia Poveda-Moral https://orcid.org/0000-0003-3447-7627
Dolors Rodríguez-Martín https://orcid.org/0000-0002-5523-9954
Gemma Via-Clavero https://orcid.org/0000-0002-4734-0796
Serena Barello https://orcid.org/0000-0002-8514-2563
Alejandro Bosch-Alcaraz https://orcid.org/0000-0001-6369-9697
Loris Bonetti https://orcid.org/0000-0003-0694-0880

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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