Postprint Version: Nursing Ethics 2014, 1–14. ª The Author(s) 2014
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DOI: 10.1177/0969733014549883

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Title: Ethical conflict in critical care nursing: correlation between exposure and types

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Acknowledgements

The authors would like to thank the participating nurses from intensive care services, as well as the nursing supervisors from each of the ten participating services. Thanks are also in order to the nursing directors and members of the committees of the Bellvitge University Hospital and the Clinic Hospital of Barcelona for having authorized the investigation in their centers.

Funding

This study received a Research Support Grant for the sum of €1,500 from School of Nursing of The University of Barcelona (PREUI 09/2009).

Award

This article is part of a wider study that has been awarded the 2013 Research Prize in Bioethics of the Víctor Grífols and Lucas Foundation.

Author contributions

AFP and TLLC conceived and described the model and designed the study, as well as preparing the article along with JRM and JGT. AFP administered the questionnaire and analyzed the results. JGO provided statistical expertise and reviewed the data analysis. All of the authors critically reviewed the article and approved the final version.

Competing interests

The authors declare that they have no competing interests.

Title: The ethical conflict in critical care nursing: correlation between exposure and types of conflict

Abstract

Background: Ethical conflicts in nursing have generally been studied in terms of temporal frequency and the degree of conflict. This study presents a new perspective for examining ethical conflict in terms of the degree of exposure to conflict and its typology.

Objectives: The aim was to examine the level of exposure to ethical conflict for professional nurses in critical care units and to analyze the relation between this level and the types of ethical conflict and moral states.

Research design: This was a descriptive correlational study. Central and dispersion, normality tests, and ANOVA were carried out.

Participants and research context: Two-hundred three nurses from two third level teaching hospitals in Spain. Both centers are part of the University of Barcelona Health

Network. Participants filled out the Ethical Conflict in Nursing Questionnaire-Critical Care Version.

Ethical considerations: This investigation received the approval of the ethical committees for clinical investigation of the two participating hospitals. Participants were informed of the authorship and aims of the study.

Findings: The index of exposure to ethical conflict was $\bar{x}$ =182.35. The situations involving analgesic treatment and end-of-life care were shown to be frequent sources of conflict. The types of ethical conflict and moral states generally arranged themselves from lesser to greater levels of index of exposure to ethical conflict.

Discussion: The moderate level of exposure to ethical conflict was consistent with other international studies. However, the situations related with family are infrequent and this presents differences with previous research. The results suggest that there is a logical relationship between types of conflict and levels of exposure to ethical conflict.

Conclusions: The types of ethical conflict and moral states were related with levels of exposure to ethical conflict. The new perspective was shown to be useful for analyzing the phenomenon of ethical conflict in the nurse.

Keywords: ethical conflict model, types of ethical conflict, moral distress, critical care nursing.

Introduction

Ethical conflict is a problem that arises both within and between people. In ethical terms, the obligation to 'do good' or to do things more properly becomes the central element in this type of conflict. The individual's scale of values and ethical principles, sense of responsibility, and ethical sensitivity all come into play.

Interest in exploring the phenomenon of ethical conflict in healthcare professionals has been on the increase in recent years. There is general agreement that technological advances and increased complexity in the providing of healthcare to people have brought with them a rise in the number of situations that may be potentially conflictive from an ethical point of view.[1-6]

Various studies have identified the repercussions of ethical conflict on the individual, both personally and professionally. They have demonstrated that repeated experiencing of ethical conflicts may generate discomfort, anger, frustration, feelings of guilt, a decrease in self-esteem, rage, or even a feeling of impotence.[7-12]

Ethical conflicts have also been related with problems in communication in working in teams, as well as with nurses' abandoning services seen as conflictive, or even the profession itself.[4,5,8,10,13-19]

Some studies have found a positive relation between ethical conflict and professional burnout[19-22], and lower job satisfaction[19].

It is clear, then, that ethical conflict is a problem with negative consequences for the development of quality nursing care and professional moral integrity.[4] This alone is sufficient justification for analyzing the level of exposure to ethical conflict of nursing professionals in critical care units so as to shed greater light on this complex phenomenon.

Background

Types of ethical conflict and moral states

The philosopher Andrew Jameton[23] was the first person to identify three types of ethical conflict that the nurse might experience in caring for an individual or a group: moral uncertainty, moral dilemma, and moral distress. Moral uncertainty occurs when the individual intuits a conflict of an ethical nature but is unable to identify the values and ethical principles involved, which prevents decision-making.[23] The nurse perceives that something is not going as well as it might.[12]

A moral dilemma occurs when the nurse observes that two or more ethical principles are involved in the making of a decision, each of which offers up a different course of action,[3,23,24] both either morally correct *a priori* or with different extremes of morality,

thereby making it difficult to choose between them. The moral dilemma is a conflict of values, so the solution implies having to sacrifice one of them, which is necessarily a complex circumstance.[25]

Moral distress occurs when the nurse experiences difficulty in acting according to his or her own morality due to an external barrier.[14,23] Unlike the types of conflict described above, in moral distress the nurse is conscious of the values and ethical principles involved in a situation, and is able to identify the action best suited to the care of the patient, but cannot carry it out because someone or something prevents doing so. The nurse, then, is unable to translate the moral decision or option into moral action.[23,24]

In 1988, Judith Wilkinson[7] added to Jameson's classification a type of ethical conflict called moral outrage, describing it as the feeling generated by watching immoral actions carried out by others. In this circumstance the nurse does not participate in the act and does not feel responsible for immoral action, but rather feels impotence in sensing that he or she should do something to prevent the action but is unable to do so.[12]

Additionally, the absence of ethical conflict should be the morally ideal state if it corresponds to ethical well-being. That is, it is the positive state in which the professional displays congruence between thought and moral action. The person experiencing ethical well-being has assumed the values, principles, and ethical responsibilities of the profession as well as his or her own. He or she feels morally respected and recognized by others and is involved in the making of decisions.[6]

Nevertheless, there is the possibility of experiencing the absence of conflict from a position of moral indifference. This moral state carries with it a lack of responsibility and ethical sensitivity, given that it implies the lack of both inclination to and disinclination from questions of an ethical nature. Applied in the context of patient care and treatment, the moral indifference implies a failure to assume the ethical responsibilities of the profession, leaving one in a passive state that calls into question the moral integrity of the individual as well as imperiling the obligation to protect the vulnerable patient.[6]

Although different, both ethical well-being and moral indifference correspond to moral states but not to types of ethical conflict, given that the absence of conflictiveness is what differentiates them.

Situations that generate ethical conflict: the example of critical care units

Most of the research carried out in last 25 years on the subject of ethical conflict has centered on moral distress, so named by Jameton in 1984. A goodly number of these studies have focused on analyzing the ethical conflicts in nurses working in critical care units, as they are particularly exposed to the phenomenon. Three main sources of conflict are reported in these studies. First among these are decisions involving informed consent, confidentiality, and the protection of patient interests and

wishes.[11,16,19,25,27,28,29] Second, conflict arises from the administration of certain treatments and the carrying out of some clinical procedures, with special attention upon therapeutic futility and the limitations of life-support treatment.[6,7,11,15,27,28] Finally, situations of conflict have been described in relation to the perception on the part of nurses of working in an environment which looks askance at posing questions of a bioethical nature, and their lack of participation in the clinical decision-making.[6,7,11,16,25,27,30]

Measuring ethical conflicts in nursing care

The main instruments that have been developed to measure ethical conflict have been centered on the constructs of moral distress and stress of conscience. One of the first instruments designed to measure moral distress was Corley's *Moral Distress Scale* [15,27] later adapted by other authors in subsequent studies.[5,16-18,29,31-33] Another instrument created was the *Moral Distress Questionnaire* by Kälvemark et al., [25] designed to explore the relation among moral distress, ethical competence, and tolerance to stress on the part of healthcare professionals. This was also used in other research that followed.[30,34] Finally, the *Stress of Conscience Questionnaire* by Glasberg was designed to explore the relation between stress of conscience, a concept quite close to the notion of ethical conflict, and burnout syndrome—a relation that was confirmed by subsequent studies.[21,35-38] Most of these studies have looked at the phenomenon on the basis of an

analysis of two variables: the frequency of conflictive situations arising and the degree of conflict perceived by the professional. Regarding the relation between these variables and the moral distress conflict type, Corley et al.[39] and Pauly et al.[18] found a positive relation ($p<0.05$). Nevertheless, Corley concluded that the concepts of frequency and degree were distinct, and only the latter was capable of explaining ethical conflict. Glasberg et al.[21] , for his part, described the stress of conscience construct as the product of these two variables but this author started from a conceptually different idea close to our ethical conflict concept.

Following an exhaustive analysis of the literature on the topic it was noted that no studies had been carried out jointly examining the types of ethical conflict described by Jameton[14,23] and Wilkinson[7], nor were there studies positing the positive perspective or the absence of ethical conflict as a moral state. Furthermore, exposure to conflict had been studied very little, and no studies were found analyzing the relation between the conflict type and exposure to conflict. We felt that it was essential to learn about the type of ethical conflict experienced by a person who feels that he or she is in a conflictive situation. This would allow greater precision in identifying the barrier that blocks the making of decisions of an ethical nature. It would also help allow the phenomenon to be viewed through different prisms, in that it would explore in greater depth the underlying causes that generate the conflict.

Therefore, we believe that analysis of the phenomenon of ethical conflict should be undertaken from a new perspective that is underpinned by the following premises[6] : 1) the study of ethical conflict requires the consideration of two variables: 'exposure to ethical conflict' and 'type of ethical conflict'; 2) the variable 'exposure to ethical conflict' is the product of the variables 'frequency of ethical conflict' and 'degree of ethical conflict'; 3) the variable 'type of ethical conflict' should encompass the continuum of the presence-absence of conflict; and 4) the variable 'type of ethical conflict' encompasses four types of ethical conflict and two moral states. The four types of ethical conflict or categories defined by Jameton[14,23] and Wilkinson[7] —moral uncertainty, moral dilemma, moral distress, and moral outrage—are found in the area concerning the presence of ethical conflict. And in the area pertaining to the absence of conflict we consider two categories that correspond to the two moral states: moral well-being and moral indifference.

The Study

Aim

The aim of the study was to examine the level of exposure to ethical conflict for professional nurses in critical care units, and the relation between the level of exposure to ethical conflict and the types of ethical conflict and moral states. This last aim would

allow for determination of the suitability of the new perspective proposed for the analysis of ethical conflict. We started from the hypothesis that ethical conflict types and moral states were related with the level of exposure to ethical conflict. Well-being and moral indifference would be correlated with low levels of exposure. Uncertainty and moral dilemmas would be correlated with moderate levels of exposure. And outrage and distress would be correlated with high levels of exposure to ethical conflict.

The questions that we posed in this investigation were as follows:

- What is the level of exposure to ethical conflict for professional nurses working in critical care units?
- What types of ethical conflict are most frequently experienced?
- What is the relation between the level of exposure to ethical conflict on the one hand, and the type of ethical conflict and moral states?

Design

The design of the study was descriptive and correlational. The descriptive part allowed for the examination of the level of exposure to ethical conflict for professional nurses in critical care units. The correlational part permitted us to establish the relation between the level of exposure to ethical conflict and the types of ethical conflict and moral states.

Sample

The study sample was made up of 203 of the 292 nurses working in the critical care units of the Bellvitge University Hospital (n=100, 49.3%) and the Clinic Hospital (n=103, 50.7%), both third level hospitals located in Barcelona, Spain. The convenience criteria were followed for the sample selection. The participation was, therefore, 69% of those eligible. The two centers are part of the University of Barcelona Health Network. Included were professional men and women nurses with more than one year of clinical experience who were affiliated with the participating critical care units. Excluded were master's nursing students doing their practicum in critical care units or shiftwork.

The participants came from ten intensive medicine services specializing in eight pathology areas (respiratory diseases, neurotrauma, weaning and semi-critical patients, surgery unit, digestive and hepatic diseases, coronary disease, cardiac surgery, and multiple intensive vigilance). The average age was 38.8 years (SD 10.6) with a range of 23-61 years (based on the 171 nurses who provided this information). Some 83.7% (n=170) were female and 14.8% (n=30) were male. The majority of nurses were involved in patient care (94.6%); 31.5% had more than 20 years of experience in nursing. Among other results, some 31.5 % (n=64) were professionals working on the night shift and 30.5% (n=62) were on days. Professionals on weekend day and night duty made up 8.3% (n=17) of the sample.

Data collection

Data were collected using the Ethical Conflict in Nursing Questionnaire-Critical Care Version (ECNQ-CCV, by Falcó-Pegueroles[40], a self-administered instrument designed on the basis of the above-described model for the analysis of ethical conflict. In some services, the heads of nursing in the units were charged with distributing and then collecting the questionnaires once they were filled out, after which they were returned to the chief investigator of the study. In others services a sealed box was set up that allowed the participants to deposit their completed ECNQ-CCV. Data collection was carried out during the months of October-December, 2009.

Measurement

The ECNQ-CCV was devised to analyze ethical conflict in intensive care nursing derived from 19 situations that are potentially sources of conflict. These situations emerged from the process of reviewing the literature on ethical conflict in intensive care units and the process of validation of the contents by two committees of experts, one ethical and bioethical and the other intensive nursing. The situations included, among others, issues such as the limitation of life support treatment, therapeutic futility, informed consent, confidentiality, treatment not in the patient's interest, excessively aggressive treatment, and participation in decision-making (Table 1). In terms of the

psychometric properties of the ECNQ-CCV, analysis of the reliability revealed a global Cronbach α value of 0.882, and the construct validity was estimated by means of exploratory factorial analysis that showed the appropriateness of the main factors responsible for 33.414% of the total variance, analyzed on the basis of the 'Index of Exposure to Ethical Conflict' (IEEC) variable. This unidimensionality was attributed to the global nature of the concept 'ethical conflict' which the instrument evaluated. The ECNQ-CCV evaluated the following variables: 'frequency with which ethically conflictive situations emerged' with 6 categories and 6 scores (never (0), almost never (1), at least once a year (2), at least once every six months (3), at least once a month (4), at least once a week5)); 'degree of ethical conflict experienced by the nurse' with 5 categories and 5 scores (not problematic (1), a little problematic (2), somewhat problematic (3), moderately problematic (4), very problematic (5)); 'type of ethical conflict' with 6 categories (moral indifference, moral well-being, moral uncertainty, moral dilemma, moral distress, moral outrage). Regarding this variable, the tool offered a definition of each type of ethical conflict in order to help participants; and, finally, there was the variable 'exposure to ethical conflict'. This last variable was not directly evaluated in the ECNQ-CCV but rather came up as the product of the variables 'frequency with which ethically conflictive situations emerged' and 'degree of ethical conflict experienced by the nurse.' Considering the scores assigned to each category for these two variables (0-5), the IEEC ranged between 0 and 25, and the sum of the 19

potentially conflictive situations from the ethical perspective put forth in the ECNQ-CCV ranged from 0 to 475.[40] Low, moderate and high exposure to ethical conflict were defined, as per Bond, [41] < 1 standard deviation below the mean and >1 standard deviation above the mean.

The ECNQ-CCV was originally in Spanish; the authors did a translation for the benefit of English-speaking readers.

Ethical consideration

This investigation received the approval of the ethical committees for clinical investigation of the two participating hospitals, as well as the go-ahead from nursing management at the centers. Participants were informed of the authorship and aims of the study, and of its anonymous nature. In most of the participating nursing services a sealed box was set up that allowed the participants to deposit their completed ECNQ-CCV. The questionnaire design guaranteed confidentiality because no one was able to see the forms.

Data analysis

Data were analyzed using PASW v. 19. Descriptors and frequency tables were obtained for the variables 'temporal frequency' and 'degree of conflict'. The variability and

central trend measures for the variable IEEC were studied. Normality tests were carried out using the Kolmogorov-Smirnov and Shapiro-Wilk tests, with the aim of observing the goodness of fit of the distributions for the variable IEEC. The ANOVA test was applied (for categorically independent variables) with the aim of determining whether the quantitative variable—in this case the IEEC—was influenced by the qualitative variable, the 'type of ethical conflict'. Prior to this the Levene (F) statistic was studied, and the effect size was calculated.

Results

Frequency and levels of ethical conflict

The situations represented in the ECNQ-CCV that occurred at least once a week were 'Administering treatment and/or carrying out procedures without having been able to participate in the decision to undertake them' (n=98, 49.2%) and 'Caring for a patient without knowing whether he or she had a living will' (n=96, 48.7%). At the other extreme, the situations that almost never occurred were 'Having trouble giving relevant information to the patient and/or family as a result of the doctor's interference' (n=71, 35.5%) and 'Administering treatment and/or carrying out interventions following the wishes of the family when these are not in the patient's interest' (n=65, 32.5%).

As far as the degree of ethical conflict is concerned, of note were the following very problematic situations: 'Recognizing that the analgesic and/or sedative treatment given to the patient is not effective enough, and the patient is suffering' (n=99, 49.7%) and 'Working with medical professionals who do not appear to be competent' (n=90, 45.2%). At the other extreme, the situations that were not problematic or only a little bit so were 'Taking care of a patient in the ICU who should probably be in a ward' (n=73, 36.1%) and 'Breaking the confidentiality of the patient's clinical record by sharing it with others not attending the patient directly, and third parties' (n=44, 22.6%). Tables 2 and 3 show the scores obtained for these two variables in each of the 19 situations covered in the ECNQ-CCV.

In considering the situations that occur with the greatest frequency together with those that had the highest levels of conflict, it emerges that 'Recognizing that the analgesic and/or sedative treatment given to the patient is not effective enough, and the patient is suffering' and 'Administering treatment and/or carrying out tests that are seen as unnecessary because they only serve to prolong an irreversible terminal process' were situations of note for both variables. At the other extreme, 'Administering treatments and/or carrying out interventions when the family is unaware of the aims, benefits, and risks (when they have provided informed consent)' was a situation that occurred very infrequently and which generated low levels of ethical conflict).

Level of exposure to ethical conflict

Analysis of the distribution of the IEEC, the variable that resulted from the product of the frequency and the level of ethical conflict, was carried out on a sample of n=164 subjects—those professionals having experienced the 19 ethical conflict situations described in the ECNQ-CCV at least once, and therefore having been exposed to the phenomenon. At the descriptive level, the central trend measures showed a mean of $\bar{x}$ =182.35 (SD=71.304, range 31-389). Low exposure to ethical conflict was up to 111.046, moderate was 111.047 to 253.653, and high was 253.654 and above.

The results of the Kolmogorov-Smirnov Test (statistic= 0.095; gl 164; p= 0.001) and the Shapiro-Wilk Test (statistic= 0.096; gl 164; p= 0.004) indicated that the phenomenon observed in the sample did not fit the normal curve, even though the differences were minimal and there was a trend toward symmetry.

Types of conflict and moral states

Moral outrage was the ethical conflict type most frequently selected by the professionals in 10 of the 19 situations considered in the ECNQ-CCV. Following this was moral distress, selected in 5 situations. In third place, the types of ethical conflict most often chosen were indifference and moral dilemmas. Table 4 presents the relevant averages and numbers.

Relation between level of exposure to ethical conflict on the one hand, and type of ethical conflict and moral states

The results of the ANOVA test showed statistically significant differences between the IEEC and the type of ethical conflict and moral states ($p < 0.05$) in the 19 situations under consideration (Table 4). The scale of the effect was average (0.30 to 0.50) in 13 situations (Items 1, 2, 4, 5, 6, 9, 10, 11, 13, 14, 15, 16, and 18) and large (> 0.50) in the other 6 (Items 3, 7, 8, 12, 17, and 19).

It was observed that the types of ethical conflict and moral states put forward in the ECNQ-CCV generally arranged themselves from lesser to greater levels of IEEC. In line with this, the 'indifference' and 'moral well-being' moral states corresponded to low levels of exposure to ethical conflict, 'uncertainty' and 'moral dilemma' to intermediate levels of exposure, and 'distress' and 'moral outrage' to high levels of exposure to ethical conflict. In the figure it may be seen that the organizing structure of the types of ethical conflict posited in the model was demonstrated in 12 care situations (S1, S2, S3, S4, S5, S7, S9, S10, S11, S15, S16, and S17 (Figure 1). In the seven others it may be seen that while the same organizing structure was followed, there were two types of conflict that under certain circumstances yielded scores distinct from the rest. Thus, the 'moral well-being' type scored well under 'indifference' on the IEEC (S8, S14) while scoring equal to or greater than 'moral uncertainty' (S6, S12, S18). And the 'moral uncertainty' type scored above 'dilemma' on the IEEC (S13, S19). These results

confirm the hypothesis advanced in this study that the types of ethical conflict are related with the levels of exposure to ethical conflict, and they follow a set order.

Discussion

The nurses in critical care units analyzed in this study showed a moderate level of exposure to ethical conflict—a finding that is consistent with other studies despite the differences in theoretical focus and the instruments used.[5,10,39] It was found that nursing care associated with analgesic treatment was a noteworthy source of ethical conflict because of its relative frequency and high level of ethical conflict, as noted previously by Raines[8] and Corley[15]. This high level of conflict may be explained by the ethical responsibility of the nurse in relieving the suffering of the people they care for; the problem resides in the nurse's not being able to act in accordance with the responsibility inherent in being a professional. Also of note is the relation between the increased frequency and heightened degree of conflict produced in the situation of having to administer treatment that is perceived as unnecessary and which prolongs an irreversible process. As in other studies,[7,11,19, 27-29] bioethical questions were posed here such as that of therapeutic futility, the limitation of life-support treatments, and the responsibility of professionals in the proper management of healthcare resources. Also

observed is the fact that the experience of another's suffering by the nurse is a serious moral problem that gives rise to conflict.

In addition, it was observed that some potentially conflictive situations are infrequent or else present low levels of conflict, as was the case with the situation in which the family did not know the aims of or risks entailed in treatment administered to a patient. This may be explained by the fact that professionals carry out activities that avoid giving rise to these conflictive situations, as would be the case with maintaining the family informed about the treatment, risks, and prognosis of a critically ill patient, motivated by the ethical sensitivity of the professional but also by legal imperatives. These data should be analyzed more thoroughly in subsequent studies that examine which nursing activities or team activities allow for a reduction in ethically conflictive situations, with the aim of consolidating these positive measures in the routines of the providing services.

The phenomenon of ethical conflict is a complex construct that includes not only difficulty in a professional's transforming moral choice into action—that is, moral distress—but also other difficulties such as the lack of recognition of the ethical values and principles involved (moral uncertainty) and the difficulty in choosing between two counterpoised ethical values (moral dilemma), among other problems.

The results shed some light on the construct of ethical conflict. Until now no logical order had been demonstrated between the extremes of exposure to ethical conflict and

the different types of ethical conflict and moral states. In this line, moral indifference represents a new situation in which there is a lack of ethical sensitivity that may be expressed in terms of null exposure to ethical conflict. However, moral well-being is a state associated with very low levels of exposure to ethical conflict explained by the experiencing of a congruence between thought and action; that is, the professional identifies a situation as being ethically conflictive while having mechanisms and resources at his or her disposal to optimally resolve the conflict, thereby experiencing congruence between thought and action. Furthermore, moral uncertainty and dilemma have in common the circumstance under which the professional who experiences them does not know what is morally correct or which is the best option, and therefore is unable to identify what action should be taken. This fact, albeit a limitation, may offer protection when it comes to experiencing situations with a high level of ethical conflict.

Limitations

The fact that the sample analyzed had a small percentage of males may be considered a limitation if one wishes to generalize from the conclusions drawn in this study to other groups with parity between men and women.

Secondly, a limitation may be found in the theoretical model put forward, which considers the absence of conflict in binary terms, with the only situations being well-being and moral indifference.

Thirdly, the fact that we created a new model for the analysis of ethical conflict imposes a limitation on the generalizability of the results, in that theoretical models require large and heterogeneous samples for their validation.

Finally, the limitations of a self-administered questionnaire need to be taken into account when interpreting these results. The participants answered freely in accordance with their opinions, but this information was not verified by other means such as review of clinical histories or external observation of the intensive care units analyzed.

Conclusions

The new perspective for the analysis of ethical conflict proposed in this study, which puts forward a relation between exposure to ethical conflict (the product of the frequency and the intensity) and the type of ethical conflict and moral states experienced (from moral well-being to moral outrage), would appear to be useful for exploring the phenomenon of ethical conflict in the nursing profession. The results suggest that there is an order in which the types of conflict and moral states are associated with levels of exposure to conflict, ranging from lower to higher. In this line,

the well-being and moral indifference types are situated at low or null levels of exposure, while uncertainty and moral dilemma correlate with moderate levels of exposure to conflict. Distress and moral outrage, meanwhile, correspond to high levels of exposure. Nevertheless, more studies are needed to observe and confirm these exploratory data regarding this phenomenon.

This study has also revealed that the nursing professionals in the critical care units analyzed show moderate levels of exposure to conflict; the ECNQ-CCV, then, is a sensitive tool for the detection of exposure to ethical conflict and for the discrimination of the types of ethical conflict and moral states in the different areas of healthcare.

This perspective allows for deeper examination of the complex phenomenon of ethical conflict in the clinical setting. It is new in the sense that it relates the variables of 'exposure to ethical conflict' to those of 'type of ethical conflict.' This analysis may prove useful for the study of ethical conflict in more global terms, beyond moral distress. Being able to determine with greater precision what the level of exposure to ethical conflict of professionals is, and the types of ethical conflict and moral states that they most often experience, will in turn allow for the design of strategies aimed at reducing exposure to ethical conflict and at helping professionals make decisions that adhere to ethical standards.

Finally, based on the idea that the phenomenon of ethical conflict is universal and that the repercussions, both personal and professional, that it may engender are known, we

recommend that it be studied among various groups of healthcare professionals and analyzed in mixed samples. Our perspective and findings are applicable to other areas of care and are valid for other professional disciplines, clinical or otherwise.

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Table 1 – Situations that were described in ECNQ-CCV.

Scenario 1	Administering treatments and/or performing tests that I consider unnecessary because they serve merely to prolong a terminal, irreversible process.
Scenario 2	Having to administer treatments and/or carry out procedures without the critical patient, who is conscious, knowing their purpose and the risks involved.
Scenario 3	Caring for a patient who I believe should be on an ordinary hospital ward rather than in a critical care unit.
Scenario 4	Carrying out interventions that put institutional or health service interests before those of the patient.
Scenario 5	Failure to keep a patient's clinical data confidential by sharing them with third parties or with people who are not directly involved in the patient's care.
Scenario 6	Administering treatments and/or carrying out interventions without the patient's family knowing the objectives, benefits and risks involved (when the patient has consented to the family being informed)
Scenario 7	Realizing that the analgesia and/or sedation being given to the patient is not effective enough and that the patient is suffering.
Scenario 8	Using all available technical and/or human resources despite believing that they will produce no significant improvement in the clinical status of the critical care patient.
Scenario 9	Working with medical staff who I consider to be professionally incompetent.
Scenario 10	Administering treatments and/or carrying out interventions in accordance with the family's wishes, despite knowing that these clash with the patient's interests.
Scenario 11	Administering treatments and/or carrying out procedures that are too aggressive given the status of the patient, and in so doing causing the patient additional suffering.
Scenario 12	Working with a nurse or nursing assistant who I consider to be professionally incompetent.
Scenario 13	Acting contrary to my own moral beliefs due to not having enough time to care properly for the patien
Scenario 14	Administering treatments in the context of a clinical trial or research project without, as a nurse, being given all the information I consider necessary to carry out this task
Scenario 15	Finding it difficult to give timely information to the patient and/or his/her family because the medical team discourages nurses from taking the initiative in this regard.
Scenario 16	Caring for a patient without knowing whether or not he or she has made a living will declaration, or in the event that such a document exists not knowing its content

Scenario 17	Administering treatments and/or carrying out procedures without, as a nurse, having been previously involved in the decision to do so.
Scenario 18	Failure to respect properly the privacy of the patient's body when carrying out procedures and/or exploratory tests.
Scenario 19	Lacking the means (space) and/or resources (time) that would enable the clinical team to consider the ethical problems they have to face.

Table 2- Frequencies and percentatges for 'frequency with which ethically conflictive situations emerged'.

Situations that are potentially ethical conflictive	Never		Almost never		At least once a year		At least once every six months		At least once a month		At least once a week		N
	n	%	n	%	n	%	n	%	n	%	n	%	
Scenario 1	2	1,0	13	6,4	18	8,9	82	40,6	73	36,1	14	6,9	202
Scenario 2	15	7,4	50	24,9	25	12,4	30	14,9	47	23,4	34	16,9	201
Scenario 3	5	2,5	28	13,9	32	15,8	58	28,7	64	31,7	15	7,4	202
Scenario 4	17	8,4	41	20,3	23	11,4	55	27,2	44	21,8	22	10,9	202
Scenario 5	36	18,2	57	28,1	19	9,6	25	12,6	37	18,7	24	12,1	198
Scenario 6	57	28,5	63	31,5	22	11,0	19	9,5	28	14,0	11	5,5	200
Scenario 7	2	1,0	26	12,9	20	10,0	35	17,4	87	43,3	31	15,4	201
Scenario 8	6	3,0	3	1,5	26	12,9	62	30,7	77	38,1	28	13,9	202
Scenario 9	15	7,4	58	28,6	36	17,7	32	15,8	36	17,7	26	12,8	203
Scenario 10	62	30,8	65	32,3	37	18,4	31	15,4	4	2,0	2	1,0	201
Scenario 11	10	4,9	37	18,2	41	20,2	60	29,6	47	23,2	8	3,9	203
Scenario 12	3	1,5	50	24,6	45	22,2	45	22,2	38	18,7	22	10,8	203
Scenario 13	36	17,8	38	18,8	21	10,4	38	18,8	42	20,8	27	13,4	202
Scenario 14	32	15,9	53	26,4	48	23,9	41	20,4	19	9,5	8	4,0	201
Scenario 15	60	30,0	71	35,5	23	11,5	16	8,0	15	7,5	15	7,5	200
Scenario 16	41	20,8	17	8,6	11	5,6	11	5,6	21	10,7	96	48,7	197
Scenario 17	10	5,0	12	6,0	11	5,5	23	11,6	45	22,6	98	49,2	199
Scenario 18	17	8,5	45	22,4	14	7,0	31	15,4	39	19,4	55	27,4	201
Scenario 19	20	10,0	32	16,0	18	9,0	31	15,5	53	26,5	46	23,0	200

Table 3 – Frequencies and percentatges ‘degree of ethical conflicte experienced by the nurse’.

Situations that are potentially ethical conflictive	Not problematic		Little problematic		Somewhat problematic		Moderately problematic		Very problematic		N
	n	%	n	%	n	%	n	%	n	%	
Scenario 1	6	3,0	24	11·9	77	38,3	78	38,8	14	7,0	201
Scenario 2	15	7,5	42	21·1	62	31,2	51	25,6	14	7,0	199
Scenario 3	40	19,8	73	36·1	39	19,3	40	19,8	5	2,5	202
Scenario 4	7	3,5	22	11,1	58	29,1	61	30,7	34	17,1	199
Scenario 5	16	8,2	44	22,6	44	22,6	34	17,4	21	10,8	195
Scenario 6	12	6,2	41	21,0	36	18,5	34	17,4	15	7,7	195
Scenario 7	6	3,0	14	7,0	21	10,6	57	28,6	99	49,7	199
Scenario 8	16	7,9	34	16,8	47	23,3	63	31,2	36	17,8	202
Scenario 9	2	1,0	12	6,0	30	15,1	50	25,1	90	45,2	199
Scenario 10	2	1,0	19	9,5	28	14,0	49	24,5	40	20,0	200
Scenario 11	1	0,5	15	7,4	34	16,8	65	32,2	77	38,1	202
Scenario 12	3	1,5	9	4,5	36	17,9	73	36,3	77	38,3	201
Scenario 13	2	1,0	8	4,0	30	15,1	64	32,2	60	30,2	199
Scenario 14	9	4,6	35	17,9	46	23,5	44	22,4	30	15,3	196
Scenario 15	11	5,6	31	15,7	33	16,8	39	19,8	23	11,7	197
Scenario 16	33	17,0	40	20,6	34	17,5	22	11,3	24	12,4	194
Scenario 17	14	7,2	46	23,7	48	24,7	47	24,2	29	14,9	194
Scenario 18	9	4,6	40	20,3	56	28,4	43	21,8	33	16,8	197
Scenario 19	2	1,0	22	11,3	58	29,7	52	26,7	41	21,0	195

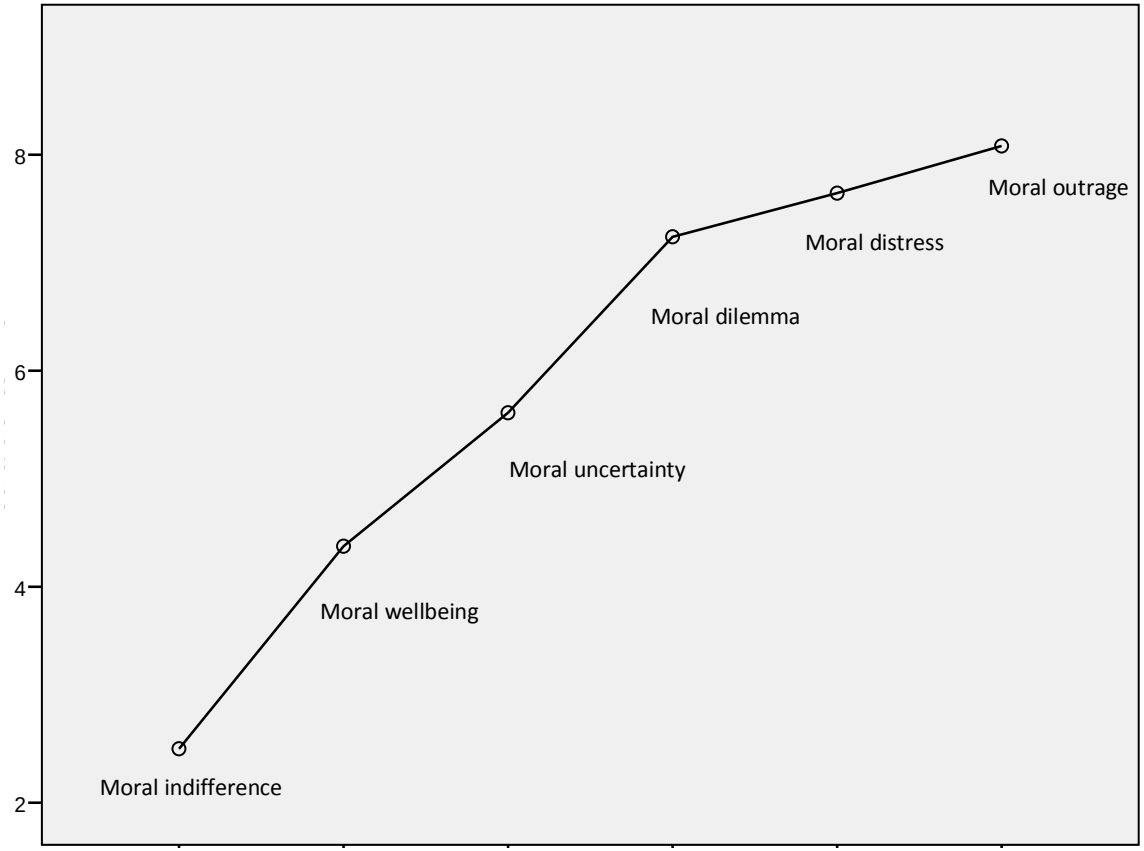
Table 4 – IEEC's ANOVA for type of ethical conflict.

IEEC	Moral indifference		Moral well-being		Moral uncertainty		Moral dilemma		Moral distress		Moral outrage		F	gl	Sig.	ε^2
	Mean (SD)	n	Mean (SD)	n	Mean (SD)	n	Mean (SD)	n	Mean (SD)	n	Mean (SD)	n				
Scenario 1	3.25 (0.95)	4	5.83 (3.81)	6	9.47 (3.06)	30	11.19 (4.40)	31	12.02 (3.91)	57	12.00 (5.08)	71	6.422	5.198	.001	.377
Scenario 2	4.86 (4.34)	14	8.12 (3.91)	26	8.34 (3.85)	29	8.83 (5.02)	41	10.38 (6.32)	47	11.35 (6.27)	23	3.581	5.179	.004	.441
Scenario 3	4.87 (3.65)	69	5.50 (2.74)	28	7.60 (4.21)	20	9.92 (4.52)	12	11.26 (4.59)	35	12.53 (5.58)	32	21.827	5.195	.001	.711
Scenario 4	3.15 (3.21)	13	5.80 (4.49)	5	6.79 (4.34)	19	9.50 (5.04)	20	11.16 (5.54)	58	13.87 (5.73)	67	13.247	5.181	.001	.481
Scenario 5	4.15 (3.09)	26	4.28 (3.32)	18	7.77 (5.35)	22	9.27(4.75)	33	10.63 (5.15)	27	11.52 (6.69)	29	9.857	5.154	.001	.371
Scenario 6	3.04 (2.42)	24	4.94 (4.45)	18	4.96 (3.94)	23	8.78(4.98)	18	10.64 (6.02)	28	10.46 (6.33)	26	10.365	5.136	.001	.466
Scenario 7	without variability		8.92 (6.38)	26	9.80 (6.64)	5	12.73(4.26)	15	15.02 (5.23)	59	16.29 (6.76)	90	7.609	4.165	.001	.543
Scenario 8	8.50 (5.77)	10	6.81 (3.31)	27	9.83 (4.79)	35	11.40 (3.81)	20	12.86 (3.64)	44	15.13 (6.04)	60	14.227	5.195	.001	.532
Scenario 9	3.80 (3.56)	5	4.71 (5.05)	7	7.46 (4.84)	13	11.10(7.83)	10	11.51 (6.49)	45	13.05 (7.17)	104	4.688	5.183	.001	.442
Scenario 10	2.50 (1.29)	4	4.38 (3.46)	8	5.61 (3.23)	18	7.24 (3.74)	25	7.64 (3.88)	45	8.08 (5.37)	37	2.652	5.136	.026	.339
Scenario 11	6 (4)	3	6.13 (3.22)	8	8.33 (3.77)	15	8.92 (4.67)	25	11.46 (5.13)	59	13.04 (6.46)	81	5.300	5.190	.001	.331
Scenario 12	3.75 (2.86)	8	9.67 (6.41)	18	8.36 (4.54)	11	9.82 (5.11)	17	10.78 (5.55)	54	13.24 (6.70)	89	5.392	5.196	.001	.521
Scenario 13	without variability		6.00 (7.23)	7	10.86 (6.09)	7	9.33 (4.84)	24	13.04 (6.41)	84	15.69 (7.60)	39	5.052	4.161	.001	.411
Scenario 14	4 (2.53)	24	2 (0.63)	6	6.54 (3.41)	52	7.06 (4.83)	18	10.39 (6.16)	23	13.10 (6.51)	41	16.456	5.163	.001	.481

Scenario 15	1.67 (0.65)	12	2.92 (2.29)	26	6.42 (4.87)	12	6.45 (4.69)	31	11.87 (6.77)	23	14.06 (8.36)	32	17.024	5.135	.001	.454
Scenario 16	6.57 (3.36)	44	7.15 (4.72)	13	11.49 (5.70)	35	11.50 (6.06)	18	16.55 (6.42)	20	17.26 (8.53)	23	15.562	5.152	.001	.492
Scenario 17	7.57 (3.04)	30	9 (5.67)	17	11.61 (4.66)	33	13.90 (5.16)	20	15.72 (5.19)	39	16.49 (7.27)	43	13.783	5.181	.001	.574
Scenario 18	6.72 (4.30)	12	8.52 (6.16)	42	7.95 (4.789	20	9.44 (4.59)	18	13.04 (6.84)	45	16.79 (7.34)	38	10.932	5.174	.001	.332
Scenario 19	4.63 (2.56)	8	6.14 (6.01)	14	10.11 (5.45)	36	9.79 (4.68)	24	14.60 (6.25)	40	18.40 (6.58)	53	19.732	5.174	.001	.622

SD Standard desviation; df degree of freedom; p value < 0.05. ε^2 is effect size

Figure 1- Example of the organizing structure of the types of ethical (horizontal direction) conflict for twelve care situations from level of exposure to ethical conflict (vertical direction).


8
6
4
2
Moral indifference
Moral wellbeing
Moral uncertainty
Moral dilemma
Moral distress
Moral outrage