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Levels of exposure to ethical conflict in the ICU: Correlation between sociodemographic variables and the clinical environment☆

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Summary
Objectives: To analyse the level of exposure of nurses to ethical conflict and determine the relationship between this exposure, sociodemographic variables and perceptions of the clinical environment.
Design and setting: Prospective and descriptive correlational study conducted at 10 intensive care units in two tertiary hospitals affiliated to the University of Barcelona. Sociodemographic and professional data were recorded from a questionnaire and then the previously validated Ethical Conflict in Nursing Questionnaire-Critical Care Version was administered to obtain data regarding experiences of ethical conflict.

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Results: Two hundred and three nurses (68.6%) participated in the study, of whom only 11.8% had training in bioethics. Exposure to ethical conflict was moderate with a $\bar{x} = 182.35$ (SD = 71.304; [0—389]). The realisation that analgesia is ineffective and the administration of treatment without having participated in the decision-making process were the most frequently reported ethical conflicts. Professionals who perceived their environment as supportive for dealing with ethical conflicts reported lower levels of these events ($p = 0.001$).
Conclusions: Ethical conflict is an internal problem but it is strongly influenced by certain variables and environmental conditions. The involvement of nurses in the decision-making processes regarding the care of critically ill patients emerges as a factor that protects against ethical conflicts.

Implications for Clinical Practice

- ICU nurses present moderate levels of exposure to ethical conflicts.
- Ethical conflict is an internal, individual problem, but it is strongly influenced by certain variables and environmental conditions.
- The involvement of nurses in the decision-making processes regarding the care of critically ill patients emerges as a factor that protects against ethical conflicts in ICUs.
- The realisation that analgesia is ineffective and the administration of treatment without having participated in the decision-making process were the most frequently reported ethical conflicts.
- ICU nurses are trained in patient care but there are few who have postgraduate training in bioethics. This increases their exposure to conflict.

Introduction

Ethical conflict can be defined as a problem that arises when one senses that the idea of ''good'' or ''right'' in relation to other people's welfare or best interests is being compromised. In the specific field of health sciences, its study has focused on situations causing ethical or moral dilemmas, moral distress, moral uncertainty or moral indignation. These concepts all share a common feature, the stress involved in making ethical decisions when one does not know which is the morally correct option or is unable to implement it (Falcó-Pegueroles, 2012). Ethical conflict is intrinsic to the health professions, due basically to the interpersonal nature of health relationships and the ethical responsibilities that are generated in caring for people with health conditions. In the past 30 years, bioethics studies have suggested that ethical conflict is a phenomenon which, far from diminishing, has increased in line with the scientific and technical advances in medicine (Beauchamp and Childress, 2009; Breslin et al., 2005; Gamboa, 2010; Johnstone, 2009; Morris and Dracup, 2008). In this context, ICU professionals (and in particular critical care professionals) are especially likely to be exposed to ethical conflicts. In the multicentre, international conflicus study, Azoulay et al. (2009) found that 70% of ICU professionals experienced conflicts of various kinds, some of them of an ethical nature; those authors highlighted workload, inadequate communication and end of life care as areas in need of substantial improvement. Most studies of ethical conflict have analysed the phenomenon in samples of intensive care nurses (Cavaliere and Dowling, 2010; Corley, 1995; Dierckx de Casterlé et al., 2009; Gutierrez, 2005), although studies with mixed samples or intensive care physicians have also drawn attention to significant ethical conflicts and specific conflict situations (Ferrand et al., 2003; Forde and Aasland, 2008; Hamric and Blackhall, 2007; Hernández et al., 2006; Irribarren et al., 2007; Kälvemark et al., 2006; Kim and Kjervik, 2005).

One analysis of the literature on ethical conflicts in ICUs and of the ethical codes in force (Cabré et al., 2006) identifies three sources of conflict. The first involves conflicts arising in the context of interpersonal relationships with the patient and family and with other service professionals, related to issues of confidentiality, informed consent, or the best interests of the patient (Azoulay et al., 2009; Hamric and Blackhall, 2007; Kim and Kjervik, 2005). The second source is to do with treatments and medical procedures, especially concerning issues of therapeutic futility and decisions on limiting life-sustaining treatment, and the treatment of pain (Falcó-Pegueroles, 2012; Gutierrez, 2005; Hamric and Blackhall, 2007; Monzon et al., 2010). The third source is the dynamic of the particular work environment, for example, disagreements between doctors and nurses about certain decisions or procedures that may be ethically comprising, or the lack of time available to provide quality critical care (Azoulay et al., 2009; Falcó-Pegueroles, 2012; Pauly et al., 2009). In the same line, Papathanassoglou et al. (2012) found that lower autonomy to decision making was associated with increased frequency and intensity of moral distress and lower levels of nurse—physician collaboration.

In addition to its impact on decision making, implicit in its definition, ethical conflict may have negative consequences at other levels as well. Several authors have concluded that, at the personal level ethical conflicts generate unease, frustration, irritation and a sense of moral