Physicians' and nurses' expectations and objections toward a clinical ethics committee

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Abstract

The study aimed to explore the subjective need of healthcare professionals for ethics consultation, their experience with ethical conflicts, and expectations and objections toward a Clinical Ethics Committee. Staff at a university hospital took part in a survey (January to June 2010) using a questionnaire with open and closed questions. Descriptive data for physicians and nurses (response rate = 13.5%, $n = 101$) are presented. Physicians and nurses reported similar high frequencies of ethical conflicts but rated the relevance of ethical issues differently. Nurses stated ethical issues as less important to physicians than to themselves. Ethical conflicts were mostly discussed with staff from one's own profession. Respondents predominantly expected the Clinical Ethics Committee to provide competent support. Mostly, nurses feared it might have no influence on clinical practice. Findings suggest that experiences of ethical conflicts might reflect interprofessional communication patterns. Expectations and objections against Clinical Ethics Committees were multifaceted, and should be overcome by providing sufficient information. The Clinical Ethics Committee needs to take different perspectives of professions into account.

Keywords

Clinical ethics, communication, ethics consultation, healthcare professionals

Introduction

Medical interventions and decision-making processes in healthcare are becoming increasingly complex because of new knowledge based on medical research and the pluralism of modern societies regarding moral or religious values and lifestyles. Furthermore, healthcare systems undergo considerable economic strain. Public political, and medico-legal debates about patient autonomy, euthanasia and assisted dying raised the awareness of ethical implications in medicine. Therefore, the importance of ethics in the clinical field is increasingly noticed.¹ Ethical conflicts emerge if two or more principles or values collide with each

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other or with institutional constraints, and can result in moral distress for healthcare professionals (HCPs).² The different professional roles of involved professionals, for example physicians and nurses, might result in different perspectives on ethical conflicts or even cause ethical conflicts themselves.^{3,4} Lack of resources (time, staff, and beds), legislation colliding with clinical practice and conflict of interests (between patient and colleagues or between professions) may lead to ethical dilemmas in healthcare, while the prevalence of structures that provide a framework for discussing ethical conflicts is disproportionately low.⁵ Clinical Ethics Committees (CECs) as an institutional frame for clinical ethics consultation have been increasingly implemented in Germany, primarily in nonacademic, confessional hospitals, in order to mediate ethical conflicts.^{3,6} Their helpfulness in solving ethical conflicts and what fosters or hinders their work has yet to be studied more extensively.⁷ Despite being generally regarded as necessary and helpful, some authors describe possible objections of physicians toward a CEC, including being seen as redundant because ethics are already discussed on the wards and concerns that the CEC might exert pressure on physicians but not take responsibility.^{8,9} Nevertheless, these possible objections are not explored empirically.

At a university hospital, a CEC was implemented in 2010 after a 2-year preparation phase. This interdisciplinary body offers ethics case discussions for all hospital departments. Its implementation process alternately followed a bottom-up as well as a top-down approach. With this strategy, staff and management of different hierarchical levels were involved, which is important in achieving broad endorsement.¹⁰ To consider the needs with respect to ethics consultation and to increase the acceptance of the CEC by staff, the implementation process was accompanied by a two-step research project.

The aim of the project was to explore experiences of staff with ethical conflicts to determine the subjective need of ethics consultation, as well as expectations and objections toward formalized ethics consultation. In the first step, a qualitative analysis of the assessed expectations and objections was conducted. According to these results, HCPs expected competent support, structural integration, case-related ethical reflection, an objective, confidential setting, recommendation of procedures, and case reports. Objections were found regarding lack of impact on clinical everyday routine, problems in implementation, lack of case-related competence, lack of professional attitude and fear of the CEC seeking control over clinical decision-making.¹⁰ In this article, we focus on frequency of ethical conflicts and perceived importance of ethical issues as well as frequency of objections and expectations toward a CEC. We also explore differences between professions using a quantitative, explorative approach.

Methods

Ethical issues

Since no patient data was involved and participation was voluntary and anonymous, the University Medical Center Research Ethics Committee decided that no formal ethical review was required.

Data collection

From January to June 2010, all staff members working at our university hospital were invited to take part in the study. During three prelaunch information sessions, potential participants were informed about the aim of the CEC and procedural aspects and invited to take part in the accompanying study. Additionally, all departmental directors were informed about the study via hospital email. After a few weeks, invited staff were reminded through informal visits of the researcher on the wards. Participation was voluntary and data sheets were collected anonymously by either returning them into a box placed in wards or at the end of information sessions, or by sending them back in an unmarked envelope.

The CEC study questionnaire was divided into two major parts of closed and open questions. Details of the questionnaire can be found in Figure 1. The first part was based on a questionnaire developed by Neitzke.⁶ Participants were asked whether and how often they had experienced ethical conflicts in their work environment during the past 12 months and how important ethical issues are and should be rated by different professions in their work environment. Participants were also asked whether and how often they had discussed ethical issues with others. Similar to Neitzke, we did not predefine ethical conflicts in our questionnaire as we wanted to assess the necessity of ethics consultation based on subjectively perceived situations of ethical conflicts.⁶ In the second part, the participants were encouraged to describe their expectations, wishes, and objections regarding the implementation of a CEC in their own words. Demographic characteristics (gender, age and clinical profession) and whether participants had previous experiences with a CEC were assessed in the last part.

The answers to the open questions were analyzed using content analysis. The essences of all free text answers were identified by text reduction technique (coding). Subsequently, similar codes were amalgamated through abstraction, and main categories were derived (see introduction).¹¹ Since the questions regarding expectations and wishes toward a CEC produced similar statements, they were analyzed as one system of categories.

In this article, we analyzed the frequency of objections and expectations toward CECs and focused on accordance and discordance between physicians and nurses as the main actors within decision-making processes.

Statistical analysis

In order to facilitate the interpretation of numerical data and due to the small sample size, we categorized the 10-step scales into three groups: ethical issues regarded as not important (1–3), somewhat important (4–7) and very important (8–10) to nurses or physicians. As we wanted to know to what extent individuals judge the relevance of ethical issues unequally for the different professions, we combined the respective items for physicians and nurses (item 2a and 2b) per individual. Rating of importance to physicians was subtracted from rating of importance for nurses for each respondent. Large differences indicated a greater importance of ethical issues to physicians (defined as –10 to –4) or nurses (4–10). Equal values or low differences, indicating a similar relevance of ethical issues to both professions, were defined as the range from –3 to 3. According to the intent of an exploratory analysis, we did not test for significance. Descriptive statistical analysis was performed using PASW Statistics 18, Release Version 18.0.0 (SPSS Inc., 2009, Chicago, IL, www.spss.com).

Results

Sample

In total, 30 physicians (25.6%) and 71 nurses (60.7%) responded to 750 questionnaires (response rate = 13.5%). Since only 12 members of other professions (three working in administration, five social workers/spiritual care providers, and four medical students) answered the questionnaire, they were not included in the analysis.

Nurses were predominantly female and older than physicians, while physicians were mostly male. Table 1 shows the demographic characteristics in detail.

Previous experiences with ethical conflicts and customs

About one-quarter of the respondents, more nurses than physicians, attended one of the preceding information events. The majority of the participants reported no previous experience with any form of ethics

6. What *personal* wishes do you have concerning the clinical ethics committee?

7. What objections do you have towards the clinical ethics committee?

III. Personal data

8. Gender: ☐ female ☐ male

9. Age: ☐ < 20 ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ ≥ 60

10. I work ... (please answer questions a) and b)!)
a) ☐ as a physician ☐ in an executive position
☐ as a nurse ☐ in a non-executive position
☐ in the administration
☐ as a social worker; as a spiritual care giver
☐ as: _____

11. I have previous experience of ethics consultation via a clinical ethics committee:
☐ yes ☐ no

12. I have attended an information session on the clinical ethics committee:
(Please fill in this question!)
☐ yes ☐ no

Figure 1. Continued

Table 1. Demographic characteristics for physicians and nurses in %.

		Physicians (n = 30)	Nurses (n = 71)	Total (N = 101)
Gender	Female	33.3	70.4	59.4
	Male	66.7	28.2	39.6
	Missing	0	1.4	1
Age	20–29 years	6.7	15.5	12.9
	30–39 years	57.6	21.1	31.7
	40–49 years	23.3	35.2	31.7
	50–59 years	13.3	28.2	23.8
Experience with CEC	Yes	16.7	5.6	8.9
	No	80	93	89.1
	Missing	3.3	1.4	2
Attendance of information session	Yes	20	31	27.7
	No	76.7	66.2	69.3
	Missing	3.3	2.8	3

CEC: clinical ethics committee.

consultations (Table 1). Nevertheless, the vast majority had experienced ethical conflicts within their working environment during the past year, almost half of them even weekly or daily (Table 2).

As shown in Table 2 as well as Figures 2 and 3, ethical issues were considered to be very important to nurses (mean = 7.32; standard deviation (SD) = 1.91) by more than half of the participants, while less than a quarter rated them as being very important to physicians (Figure 3, mean = 5.43; SD = 2.37) but were overall considered to be very or rather important to both fields. Especially nurses considered ethical issues to be of more relevance to themselves than to physicians. More than a third of the nurses claimed a higher significance of ethical issues to their own profession than to physicians (mean difference of ratings = 1.89, SD = 2.36; physicians: mean = 0.4, SD = 1.79; nurses: mean = 2.54, SD = 2.29). These differences seem to be independent of gender differences, as Figures 2 and 3 imply. No participant estimated ethical issues to be of higher importance to physicians than to nurses. Moreover, a quarter of nurses and even 10% of physicians noted that physicians might consider ethical reflection unimportant. Nevertheless, participants agreed strongly that the deliberation of ethical issues should be given more weight in their working environment, with no difference between professions (mean rating = 8.86; SD = 1.95).

Ethical conflicts were discussed within one's own profession on a regular basis, that is at least weekly (physicians = 53.3%, nurses = 60.6%), but much more infrequently with other team professions (weekly to daily: physicians = 46.7%, nurses = 33.8%). Senior staff were only rarely involved; most participants (65.3%) reported discussing ethical conflicts with them once a month at the very most. More nurses (40.8%) than physicians (30.0%) discussed ethical conflicts with friends or family on a regular basis, that is, weekly or daily. A high percentage of nurses or doctors stated that they never discussed ethical conflicts with psychologists or spiritual care providers (42.6%) or with professional team supervisors (physicians = 80.0%, nurses = 60.6%).

Expectations and objections

One in seven participants stated they had no specific expectations toward ethics consultation or even were pessimistic about the possibility of changing clinical conditions. However, physicians showed higher percentages of pessimism than nurses (Table 3). About half of the participants, and a higher ratio of nurses than physicians expected "competent support" with respect to ethical conflicts, juridical questions, or

Table 2. Experience with ethical conflicts and CEC of physicians and nurses in %.

		Physicians (n = 30)	Nurses (n = 71)	Total (N = 101)
Experience of ethical conflicts in the previous 12 months	Daily	20	11.3	13.9
	Weekly	20	31	27.7
	Monthly	30	26.8	27.7
	Less than once a month	23.3	19.7	20.8
	None	6.7	7	6.9
	Missing	0	4.2	3
Importance ^a of ethical issues to nurses	High (8–10)	50	50.7	50.4
	Rather (4–7)	46.7	40.8	42.6
	Low (1–3)	3.3	4.2	4
	Missing	0	4.2	3
Importance ^a of ethical issues to physicians	High (8–10)	50	12.7	23.8
	Rather (4–7)	40	56.3	51.5
	Low (1–3)	10	26.8	21.7
	Missing	0	4.2	3.0
Difference of importance ^a rating for nurses and physicians	More to nurses (4–10)	26.7	71.8	58.4
	Same (–3 to +3)	53.3	19.7	29.7
	More to physicians (–10 to –4)	20	4.2	9.9
	Missing	0	4.2	3
Importance ^a ethical issues should have	High (8–10)	90	87.3	88.1
	Rather (4–7)	6.7	5.6	5.9
	Low (1–3)	3.3	5.6	5.0
	Missing	0	1.4	1

CEC: clinical ethics committee.

^aImportance of ethical issues rated on a 10-step verbal rating scale (1–10).

interprofessional communication, even including formats similar to team supervision. The need for “structural integration” of ethics consultations into day-to-day work, “easy accessibility,” and “reports on discussed cases” were mentioned by nurses more often. “Case related ethical reflections,” an “objective, confidential setting” and “recommendation of procedures,” however, were mentioned to the same extent by both professions (Table 3).

Also a number of objections were reported: it was assumed predominantly by nurses that ethics consultation would have no impact on clinical practice. About one-third of the participants, a higher ratio of physicians than of nurses, explicitly mentioned having no objections at all. Only a few participants expected problems in the implementation process or a lack of medical or ethical competence or professional attitude. Some felt that the CEC could be misused in order to have an influence on clinical decision-making and exert quality control, thus diminishing one’s own decisional autonomy (Table 4).

Discussion

On the basis of 101 questionnaires, completed by nurses and physicians working at a university hospital, we studied their experiences with ethical conflicts and their expectations and objections toward a CEC. The analysis showed differences between the professional groups. Although both groups agreed on the importance of ethical issues in day-to-day work, nurses seemed to expect support from a CEC more often than physicians.

Figure 2. Importance of ethical aspects for nurses as seen by male and female physicians and nurses.

Figure 3. Importance of ethical aspects for physicians as seen by male and female physicians and nurses.

Perspectives on ethical conflicts

The results of this study showed a high frequency of ethical conflicts. This is in contrast to studies that found a low frequency of ethical dilemmas for physicians, as well as a low frequency of ethical conflicts and moderate levels of moral distress for nurses.^{12,13} This discrepancy might be due to the fact that participation in our study was probably based on experiences of conflicts and a general or specific interest in ethical issues; those who answered were likely to be especially aware of ethical issues. However, the results also show a critical perspective on ethics consultation.

Overall, there seems to be a perspective on ethical issues that is related to the professional background: Although experiencing the same quantity of ethical conflicts, physicians and nurses estimated the relevance of ethical issues for both professions differently. Nurses did not believe ethical issues to be of the same importance to physicians as to themselves; physicians, however, believed ethical issues to be of the same high importance for them as for nurses. This phenomenon is in line with other national and international studies.^{6,14}

The different roles of physicians and nurses result in specific professional perspectives and actions: physicians focus predominantly on their obligation to save life and the possible legal consequences of their

Table 3. Expectations toward ethics consultation and CEC implementation process in %.

Categories	Physicians (n = 30)	Nurses (n = 71)	Total (N = 101)
No expectations toward a CEC:			
were mentioned at all	23.3	5.6	11.0
Because change of status quo was not desired	0	1.4	1.0
Because changes were deemed fully unrealistic	3.3	1.4	2.0
Competent support by CEC (e.g. specialized and social competence of CEC members and members being able to solve ethical issues and to assist team communication)	40.0	57.7	52.5
Structural integration of ethics consultations (e.g. visibility of CEC in daily practice and easy accessibility for staff)	13.3	29.6	24.8
Case-related ethical reflection (e.g. appraisal of individual moral competence, respect for patient autonomy, and providing enough time for case-discussion)	20.9	26.8	24.8
Objective, confidential setting (e.g. close cooperation and independency and objectivity of CEC members)	16.7	16.9	16.8
Recommendation of procedures (e.g. advice for daily practice and provide guidance)	20.0	26.8	24.8
Reports on discussed cases (e.g. transparency of CEC members' activity)	0.0	14.1	9.9

CEC: clinical ethics committee.

Table 4. Objections against ethics consultation and CEC implementation process in %.

Categories and codes	Physicians (n = 30)	Nurses (n = 71)	Total (N = 101)
No objections toward CEC	43.3	32.4	35.6
Lack of impact (e.g. CEC as political trend and lack of consequences for daily practice)	10.0	26.8	21.8
Problems in implementation (e.g. difficult to access and neglect team competencies)	13.3	12.7	12.9
Lack of case-related competence (e.g. approach too theoretical, not practice oriented and no case-related specialized competence of CEC members)	6.7	15.5	12.9
Lack of professional attitude (e.g. too emotional and guided by personal interests)	10.0	2.8	5.0
Fear of institutional control (e.g. CEC as control committee)	3.3	0.0	1.0

CEC: clinical ethics committee.

decisions and actions.¹⁵ The physician is expected to make the right decision, even if the next therapeutical step is not obvious in a specific case.¹⁶ From the nurses' perspectives, physicians seem to act according to their own ethical values rather than to those of the patient, and therefore do not identify conflicting values.¹⁶ This implicit accusation of insensitivity does not take into account that physicians have to integrate medical needs, the patients' demands for autonomy and the nurses' requirements against the background of their responsibility for treatment decisions.⁹ The underlying reason for the diverging perspective of nurses might be a long-lasting and still existing consequence of a tendency in nurses' education to perceive physicians as technicians without moral commitment or holistic view.^{17,18}

Communicational aspects

Physicians as well as nurses discussed ethical conflicts most frequently with colleagues from their own profession. Interestingly, physicians reported discussing ethical conflicts with other team members, that

is nurses, more often than vice versa. A possible explanation is the different concepts of “discussion” in a clinical context, for example, informing the team about already made decisions as compared to debating underlying problems with others. This may leave nurses with uncertainty as to why and how a course of action has been taken.¹⁶

The different perception of communication is not a new phenomenon. As Thomas et al.¹⁹ already stated in 2003, physicians rate nurse–physician communication in an intensive care unit better than nurses do. Nurses in the same clinical context also seem to be less satisfied with decision-making and interprofessional cooperation than physicians.^{20,21} Underlying reasons could be (a) difficulties for nurses to speak up, (b) inappropriate solving of disagreements, (c) missing impact on decision-making and (d) nursing input not being well received, as reported by nurses.¹⁹ Furthermore, studies showed that, while nurses identified frequent conflicts with physicians, physicians did not mention ethical conflicts with nurses at all.^{16,22} As reported by Oberle and Hughes, nurses experienced moral distress because of their inability to influence decisions and courses of action, which can subsequently lead to conflicts with doctors. The authors also stated that, while physicians tended to question themselves, nurses questioned predominantly physicians.¹⁶ On the background of the above-mentioned problems in communication between physicians and nurses, it is reasonable that nurses consider team communication as a main source of everyday conflict, while physicians focus on decisions and responsibility, as reported by Neitzke.⁶ Research suggests that nurses feel they have an increasing influence on their practice environment(s) if they are involved in decision-making processes by means of discussing ethical dilemmas.²³

It can be assumed that some perceived ethical conflicts are in fact conflicts in communication. A Swedish study on ethical case discussions showed that interprofessional communication was a major topic of these discussions.²⁴ Although this is not the primary goal of ethics consultations, the mediated communication finally helped clinicians to understand each other’s point of view.²⁴

Expectations and objections toward a CEC

Although ethical conflicts seem to be a frequent issue in everyday work for nurses as well as physicians, we found profession-specific differences in expectations and objections concerning functions of and support by a CEC.

The majority of both professions expected a CEC to deliver subject-specific competent support. The fact that nurses stated this category more often than physicians might be related to the above-mentioned difficulties in communication perceived by nurses. It may indicate a higher need for ethical support, at least as perceived by the nurses themselves. This need is reflected in the nurses’ objection that the CEC may not have enough impact on daily practice. The wish for structural integration of ethics consultations, however, shows that nurses are planning to engage the assistance of the CEC. It was shown that an experienced ethical conflict, which is not brought to the committee, can cause even more moral distress.²⁵ Therefore, easy access is required and can also encourage nurses to involve the CEC, as there is generally low utilization of ethics committees by nurses.²⁶

The foci, specific to professions, on communicative support are also specified in the objections, that is, “lack of case-related competence” and “lack of professional attitude”. The percentage of statements implies that nurses need more case-related and comprehensive support, whereas physicians prefer objective and factual discussions. Interestingly, the objections described by Slowther et al.⁸ and Dörries⁹ are only partly reflected in our results. Especially the high relevance of “fear of institutional control” was not empirically confirmed.

Overall, physicians stated fewer expectations and objections toward CECs than nurses. Probable explanations are a lack of confidence in a practical effect or a lack of belief in the necessity of ethics consultation, although this was rarely mentioned explicitly.

These important professional specifications and perspectives have to be taken into consideration by CEC members when working with clinical personnel. Furthermore, the implementation process of the CEC can benefit from an extensive information campaign that fosters acceptance and deals with the HCPs' objections against ethics consultations.

Limitations

The aim of this study was not to specify the underlying reasons and consequences of ethical conflicts. Therefore, detailed data is lacking about the nature of reported conflicts, if and how they are resolved, and whether they cause burden to the participants. The focus was rather on the perceived frequency of ethical conflicts, with whom HCPs talk about these topics and HCPs' attitudes toward a CEC. As studies showed, a high frequency of ethical conflicts does not inevitably imply a high burden for HCPs or a high need for ethics consultations.²⁷ Nevertheless, our results suggest a high need for clinical ethics consultations, especially from the nurses' perspective. The design of this study and the limited data do not allow assumptions on possible influences of experiences with ethical conflicts on attitudes toward ethics consultations. The response rate was low, though it is in line with a study that used a similar approach.⁶ Although this suggests a selective sampling bias, the participants of this study might be especially interested in ethical issues and therefore be more likely to use ethics consultation in future day-to-day practice as compared to other colleagues. Although all staff members were asked to participate, respondents from professions other than physicians and nurses were rare. While healthcare systems differ between countries and are difficult to compare, studies mentioned in this article suggest that our results are not limited to Germany.

Conclusion

Physicians bear the responsibility for medical treatment decisions while facing various restraints. Nurses are obliged to conduct these given medical orders while being in close contact with the patient concerned. Consequently, ethical aspects of medical decision making need to be discussed not only with the patient and his or her relatives but also with all team members. This communication process might be hindered by internal hierarchy. Involving nurses in the ethical discourse could help to empower their roles in ethical decision-making. CECs can furthermore support a structured decision-making process that could help to save time and to reduce stress. Moreover, structured ethical discussions are able to improve team communication while maintaining physicians' ethical responsibility.⁹ In day-to-day practice, ethics consultation needs to focus not only on the interests of the patient and on moral values but also on internal communication processes within a team that experiences ethical conflicts from different perspectives. Despite the described discrepancies between professions, there seems to be a common goal to provide healthcare of high quality and to be able to deal with ethical conflicts.

Practice implications and future research

One of the major causes for criticism of CECs is lack of utilization. When implementing, developing and evaluating a CEC, one needs to acknowledge that there are several and severe objections of hospital staff toward ethics consultation. Obstacles toward utilization of CECs can furthermore originate from hospitals' underlying hierarchical structures. In a top-down process, all professionals working in a hospital should therefore be encouraged to initiate ethics consultation when experiencing ethical conflicts.

A qualitative evaluation of the cases discussed in ethics consultations was initiated, in order to further deepen our understanding of perceived ethical conflicts and group processes in medical decision-making. Research on clinical ethics consultations can profit from both qualitative and quantitative research methods

that identify meanings and structures in depth as well as differences between groups. Future research on the work of CECs should not only focus on discussed cases. Conflicts that are not subject to formalized ethics consultation can provide valuable information about possible barriers to these consultations. Finally, the role of other HCPs, such as social workers or physiotherapists, in ethical conflict solving needs further investigation.

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Declaration of conflicting interests

Two of the authors, Friedemann Nauck and Bernd Alt-Epping, are members of the CEC.

References

1. Simon A and Neitzke G. Medizinethische Aspekte der Klinischen Ethikberatung [Aspects of medical ethics in clinical ethics consultations]. In: Dörries A, Neitzke G, Simon A, et al. (eds) *Klinische Ethikberatung: Ein Praxisbuch* [Clinical ethics consultation: a practice book]. Stuttgart: Kohlhammer, 2008, pp. 24–40.
2. Jameton A. *Nursing practice: the ethical issues*. Englewood Cliffs, NJ: Prentice Hall, 1984.
3. Vollmann J. Ethikberatung an deutschen Universitätskliniken. Empirische Ergebnisse und aktuelle Entwicklungen [Ethics consultation at German university hospitals. Empirical results and current developments]. In: Groß D, May A & Simon A (eds) *Beiträge zur klinischen Ethikberatung an Universitätskliniken* [Contributions to clinical ethics consultation at German university hospitals]. Berlin, Münster: LIT, 2008, pp. 31–47.
4. Gaudine A, LeFort SM, Lamb M, et al. Ethical conflicts with hospitals: the perspective of nurses and physicians. *Nurs Ethics* 2011; 18(6): 756–766.
5. Källemark S, Höglund AT, Hansson MG, et al. Living with conflicts: ethical dilemmas and moral distress in the health care system. *Soc Sci Med* 2004; 58(6): 1075–1084.
6. Neitzke G. *Ethische Konflikte im Klinikalltag: Ergebnisse einer empirischen Studie* [Ethical conflicts in daily hospital routine: results of an empirical study]. Bochum: Zentrum für Medizinische Ethik, 2007.
7. Gaudine A, Lamb M, LeFort SM, et al. The functioning of hospital ethics committees: a multiple-case study of four Canadian committees. *HEC Forum* 2011; 23(3): 225–238.
8. Slowther A, Hill D, and McMillan J. Clinical ethics committees: opportunity or threat? *HEC Forum* 2002; 14(1): 4–12.
9. Dörries A. Mixed feelings: physicians' concerns about clinical ethics committees in Germany. *HEC Forum* 2003; 15(3): 245–257.
10. Marx G, Nauck F, and Alt-Epping B. Implementierung eines Klinischen Ethikkomitees [Implementing a clinical ethics committee]. In: Frewer A, Bruns F & May A (eds) *Ethikberatung in der Medizin* [Ethics consultation in medicine]. Berlin, Heidelberg: Springer, 2012, pp. 115–127.
11. Mayring P. *Qualitative Inhaltsanalyse: Grundlagen und Techniken* [Qualitative content analysis: Fundamentals and techniques]. 9th ed. Weinheim: Beltz, 2007.
12. DuVal G, Clarridge B, Gensler G, et al. A national survey of U.S. internists' experiences with ethical dilemmas and ethics consultation. *J Gen Intern Med* 2004; 19(3): 251–258.
13. Corley MC, Minick P, Elswick RK, et al. Nurse moral distress and ethical work environment. *Nurs Ethics* 2005; 12(4): 381–390.

14. Walker RM, Miles SH, Stocking CB, et al. Physicians' and nurses' perceptions of ethics problems on general medical services. *J Gen Intern Med* 1991; 6(5): 424–429.
15. Lindseth A, Marhaug V, Norberg A, et al. Registered nurses' and physicians' reflections on their narratives about ethically difficult care episodes. *J Adv Nurs* 1994; 20(2): 245–250.
16. Oberle K, and Hughes D. Doctors' and nurses' perceptions of ethical problems in end-of-life decisions. *J Adv Nurs* 2001; 33(6): 707–715.
17. Stein LI, Watts DT, and Howell T. The doctor-nurse game revisited. *N Engl J Med* 1990; 322(8): 546–549.
18. Joudrey R, and Gough J. Caring and curing revisited: student nurses' perceptions of nurses' and physicians' ethical stances. *J Adv Nurs* 1999; 29(5): 1154–1162.
19. Thomas EJ, Sexton JB, and Helmreich RL. Discrepant attitudes about teamwork among critical care nurses and physicians. *Crit Care Med* 2003; 31(3): 956–959.
20. Ferrand E. Discrepancies between perceptions by physicians and nursing staff of intensive care unit end-of-life decisions. *Am J Respir Crit Care Med* 2003; 167(10): 1310–1315.
21. Hamric AB, and Blackhall LJ. Nurse-physician perspectives on the care of dying patients in intensive care units: collaboration, moral distress, and ethical climate. *Crit Care Med* 2007; 35(2): 422–429.
22. Gramelspacher GP, Howell JD, and Young MJ. Perceptions of ethical problems by nurses and doctors. *Arch Intern Med* 1986; 146(3): 577–578.
23. Penticuff JH, and Walden M. Influence of practice environment and nurse characteristics on perinatal nurses' responses to ethical dilemmas. *Nurs Res* 2000; 49(2): 64–72.
24. Svantesson M, Lofmark R, Thorsen H, et al. Learning a way through ethical problems: Swedish nurses' and doctors' experiences from one model of ethics rounds. *J Med Ethics* 2008; 34(5): 399–406.
25. Gordon EJ, and Hamric AB. The courage to stand up: the cultural politics of nurses' access to ethics consultation. *J Clin Ethics* 2006; 17(3): 231–254.
26. Redman BK, and Fry ST. Nurses' ethical conflicts: what is really known about them? *Nurs Ethics* 2000; 7(4): 360–366.
27. Włodarczyk D, and Lazarewicz M. Frequency and burden with ethical conflicts and burnout in nurses. *Nurs Ethics* 2011; 18(6): 847–861.