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ORIGINAL RESEARCH

What Ethics Support for Resolving Ethical Conflicts Do Internists Use in Spanish Hospitals?

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Abstract *Background* Ethical conflicts generate difficulties in daily clinical activity. Which methods of ethical advice are most frequently used to resolve them among Spanish doctors has not been studied. The objective of this study is to describe what methods hospital internal medicine physicians in Spain use to resolve their ethical doubts and which they consider most useful. *Design* A cross-sectional observational study was conducted through a voluntary and anonymous survey and distributed through an ad hoc platform of the Spanish Society of Internal Medicine. *Measures* We measured methods by which to resolve doubts, types of tools sought, frequency of consulting the Clinical Ethics Committees, and satisfaction with resolution of ethical issues. *Results* Of 261 internists surveyed, 86 per cent resolve their ethical doubts with assistance, the most frequently used method being consultation with colleagues (58.6 per cent), followed by using specific protocols or guides (11.8 per cent) and consultation with experts in bioethics (9.6 per cent). The most preferred tools are the creation of protocols (30.3 per cent) and the establishment of a consultant/expert in bioethics (27.8 per cent). *Conclusions* Internists in Spain usually seek assistance to resolve their ethical doubts. Consulting colleagues is the most frequently adopted method. The majority regard tools to resolve ethical conflicts as necessary, seeking above all protocols and consultants/experts in bioethics.

Keywords Clinical ethics · Ethics committees · Ethics consultant · Internal medicine

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Introduction

Many internists in Spain frequently recognize that they face ethical conflicts in their regular clinical practice, which generate notable difficulties in the daily clinical activity for at least half of these professionals (Blanco Portillo, et al. 2021). The same is true in other European countries and in the United States of America (Hurst, Perrier, et al. 2007; Du Val, et al. 2004). Undergraduate training in bioethics has been increasing in the last decade thanks to the integration of the Spanish university system into the European Higher Education Area. Such integration has led to greater ethical awareness (Guzmán 2013; Ferreira-Padilla, et al. 2016), but not to greater moral reasoning (Esquerda, et al. 2019). Current training seems insufficient, as shown in a recent article which reports that only one out of four internists knows what the concept of limitation of therapeutic effort is (García Caballero, et al. 2021).

The most common ways for resolving ethical conflicts in daily practice are the use of protocols, formal consultations with Clinical Ethics Committees (CEC) or clinical ethics consulting services, and consultations with co-workers during clinical discussions or in informal settings. Most medical professionals appreciate having this external support to resolve these conflicts (Hurst, Reiter-Theil, et al. 2007). In Spain, the formal ethical advisory models are still rare and decision-making always rests with the clinician and never with the advisory body. The most widespread model are the CECs, which are hardly consulted in daily practice. According to published data, in Spain each CEC receives an average of two to four consultations per year (Ribas-Ribas 2006; Tamayo Velázquez 2016). In other European countries and the United States, consulting with experts (or consultants) in bioethics is regarded as the most useful tool (Hurst, Perrier, et al. 2007; Schneiderman, et al. 2003), although most doubts are resolved through informal consultations with colleagues (Gillon 1997; Sorta-Bilajac, et al. 2008; Aleksandrova 2008).

Clinicians, and in particular internists, must have useful support tools in order to optimally address and resolve ethical problems. In Spain, until now, it has not been studied which types of ethical advice are most commonly used by physicians or whether any of them is preferred over the others. Knowing these preferences and needs would be useful to outline the models of care and advice in clinical ethics that best fit the daily clinical reality. The objective of this study is to describe how hospital internal medicine physicians in Spain resolve their ethical doubts and which ways they consider most useful.

Materials and Methods

Study Design

This is a cross-sectional observational study through a voluntary and anonymous opinion survey, distributed through an ad hoc platform of the Spanish Society of Internal Medicine (SEMI) to SEMI members registered on the platform. This system guarantees that each user can only answer the survey once, that only internists can complete it, and that the answers are kept anonymous.

Preparation of the Questionnaire

The questionnaire was prepared by a multidisciplinary team made up of internists and experts in bioethics and research methodology. For this, two bibliographic searches were carried out: the first to determine the main ethical conflicts described by internists, the second to determine the questionnaires used to explore the presence of these conflicts. The survey was drawn up based on these searches. A trial was conducted with ten specialists in internal medicine and ten residents of the specialty to optimize the writing of the survey.

Variables

The main variable is the manner of ethical conflict resolution usually used by internists, which was studied with the question "How do you usually resolve doubts about ethical conflicts?" Seven possible single-response options were offered: a) consulting with colleagues, b) using protocols, c) alone, d) consulting an expert in bioethics, e) consulting a CEC, f) I have no doubts, and g) I don't know how to solve them. The survey also asked which ethical advice tool the respondents would prefer, for which five options were presented (none, improve training, protocols/recommendations, advice from a CEC, advice from a

bioethics consultant), with the possibility of multiple responses.

Other questions addressed the frequency of satisfactory resolution of ethical conflicts (response on a Likert-type scale with scores between one and four, one being almost never and four almost always), the degree of satisfaction in solving them (response on a Likert-type scale between zero and five, zero being totally dissatisfied and five totally satisfied) and the existence of a CEC in the usual workplace. If there was a CEC in the workplace, a follow-up question addressed whether clinicians had consulted it and how often. Demographic variables (age, sex, nationality), length of professional practice, position and professional activity in the institution, type and size of the hospital, and training in bioethics were also collected. Finally, a space was offered to present participants' opinion.

Sample Size Calculation and Statistical Analysis

The sample size was calculated based on the total number of SEMI members at the time of starting the study (n = 5,866). To achieve a confidence level of 90 per cent and a limit of 5 per cent, with an estimated frequency of occurrence of ethical conflicts of 50 per cent, the minimum estimated sample size was 259. Since there are no previous studies to calculate the frequency, a frequency of 50 per cent was used.

Qualitative variables are described using frequency tables and quantitative variables with the mean and standard deviation. For the independence analysis between qualitative variables, a $\chi 2$ test or Fisher's test was performed, as appropriate. The level of significance was $p < 0.05$.

The data were initially recorded in an Excel® document (Microsoft Co., Redmond, WA, USA) and were exported and analysed using SPSS Statistics 22® (IBM, Armonk, NY, USA).

Ethical Aspects

The study complies with the ethical research norms and standards reflected in the Declaration of Helsinki of the World Medical Association and in the Oviedo Convention (Council of Europe 1997) to human rights and biomedicine. Given its characteristics as a voluntary survey, it did not require prior evaluation by an Ethics Committee for Clinical Research. All data were treated with the utmost confidentiality, in accordance with current legislation (Spanish Government 2018).

Results

Three dispatches of the survey were made (until the required sample size was reached): on June 2, 2017, with two subsequent reminder messages at two-week intervals. The response period ended on July 10, 2017. In total, 261 surveys were analysed, 4.4 per cent of the sample. Of all responders, 53 per cent were men, the mean age was forty-five years and the mean length of professional practice was twenty years. The rest of the characteristics are summarized in Table 1.

Regarding the most used way for the resolution of ethical conflicts, 86 per cent of the respondents (225 professionals) solve ethical doubts with help, 11.5 per cent (30) solve them alone, 1.1 per cent (3) do not know how to solve them and 1.1 per cent (3) have no doubts. The most common tool to resolve conflicts is consulting colleagues (59 per cent), followed by using protocols (12 per cent) and consulting experts in bioethics (9.6 per cent). In last place is consultation of the CEC (6.1 per cent). Table 2 summarizes the frequencies of use of these tools according to the degree of satisfaction of the professional when solving them, the years of work experience, and the training in bioethics. Although the differences found are not statistically significant, in our sample the least satisfied internists do not know how to solve ethical doubts (9.5 per cent versus 0.4 per cent); they solve them alone (19 per cent versus 10.8 per cent) or consult colleagues (61.8 per cent versus 58.3 per cent). Those with more years of experience consult colleagues less (44.5 per cent versus 74.2 per cent; $p < 0.001$) and solve them more alone (15.6 per cent versus 6.3 per cent; $p < 0.05$), while those with more training in bioethics consult more with colleagues (65.1 per cent versus 49.5 per cent; p 0.01) and solve them less alone (8 per cent versus 16.5 per cent; p 0.03).

Regarding the ethical advisory tools preferred by professionals to resolve ethical conflicts, 99 per cent (258) believe it is convenient to have some kind of tool to resolve them. The preferred tools selected are the creation of accessible protocols and recommendations (160; 30.3 per cent), the establishment of the position of consultant or expert in bioethics

Table 1 Characteristics of the respondents.

Variable	N (%) or mean (SD)
Age (years)	45 (12.5)
Professional experience (years)*	19,5 (12.4)
<20 years	8,73 (5.3)
>20 years	30,43 (6.7)
Sex	
Male	138 (53)
Nationality	
Spanish	246 (94.3)
Others	15 (5.7)
Employment situation	
Head of service/section	61 (23.4)
Senior	160 (61.3)
Resident	38 (14.6)
Others	2 (0.7)
Hospital type	
Public *(tax-funded)*	215 (82.3)
Others	46 (17.7)
Hospital size	
≤200 beds	66 (25)
201–500 beds	125 (48)
501–1000 beds	51 (20)
>1000 beds	19 (7)
Clinical activity	
Inpatient	249 (95.4)
Outpatients	131 (50.2)
Emergency	57 (21.8)
Others	14 (5.4)
Training in bioethics	
None	26 (10)
Personal study	147 (56.3)
Undergraduate	92 (35.2)
Graduate courses	73 (28)
Teacher	11 (4.2)

*Five respondents did not describe the length of professional practice.

(147; 27.8 per cent), and the improvement of training in bioethics (122; 23.1 per cent). In last place are the CEC (96; 18.2 per cent). Regardless of the advisory way usually used, most professionals ask that there be accessible protocols and recommendations, except for those who resolve doubts by consulting experts, who would prefer to request the advice of a consultant (80 per cent versus protocols

Table 2 Resolution pathway for ethical conflicts according to the degree of satisfaction in resolving them, experience, and training in bioethics.

Conflict resolution ways	TOTAL (N = 261)	Low degree of satisfaction (0-2) (N = 21)	High degree of satisfaction (3-5) (N = 240)	χ^2 test or Fisher p value	< 20 years of experience (N=128)	> 20 years of experience (n=128)	χ^2 test or Fisher p value	Without bioethics training (n = 109)	With bioethics training (N = 152)	χ^2 test or Fisher p value
Consulting with colleagues	153 (58.6)	13 (61.9)	140 (58.3)	>0.05	95 (74.2)	57 (44.5)	<0.001	54 (49.5)	99 (65.1)	0.01
Using protocols	31 (11.8)	0	31 (12.9)	>0.05	11 (8.6)	20 (15.6)	>0.05	15 (13.8)	16 (10.5)	>0.05
Alone	30 (11.5)	4 (19)	26 (10.8)	>0.05	8 (6.3)	20 (15.6)	0.02	18 (16.5)	12 (7.9)	0.03
Bioethics consultant	25 (9.6)	1 (4.8)	24 (10)	>0.05	8 (6.3)	16 (12.5)	>0.05	12 (11)	13 (8.6)	>0.05
Consulting a CEC	16 (6.1)	1 (4.8)	15 (6.3)	>0.05	4 (3.1)	11 (8.6)	>0.05	7 (6.4)	9 (5.9)	>0.05
I don't have doubts	3 (1.2)	0	3 (1.3)	>0.05	0	3 (2.4)	>0.05	2 (1.8)	1 (0.7)	>0.05
I don't know how	3 (1.2)	2 (9.5)	1 (0.4)	>0.05	2 (1.5)	1 (0.8)	>0.05	1 (0.9)	2 (1.3)	>0.05

*DATA: % (N).

Table 3 Tools preferred to resolve conflicts depending on the conflict resolution ways they use.

Conflict resolution ways	N = 261	Tools preferred to resolve conflicts				
		None	Improve training	Protocols/ Recommendations	Advice from the CEC	Advice from a bioethics consultant
Consulting with colleagues	N = 153	0	72 (47)	97 (63)	55 (36)	90 (59)
Using protocols	N = 31	0	12 (39)	20 (65)	13 (42)	18 (58)
Alone	N = 30	3 (1)	15 (50)	18 (60)	11 (37)	10 (33)
Bioethics consultant	N = 25	0	12 (48)	14 (56)	8 (32)	20 (80)
Consulting a CEC	N = 16	0	7 (44)	8 (50)	8 (50)	7 (44)
I don't have doubts	N = 3	0	3 (100)	2 (66)	0	0
I don't know how	N = 3	0	1 (33)	1 (33)	1 (33)	2 (66)

**CEC: Clinical Ethics Committee*.DATA: % (N). The percentages refer to the number of respondents per block of usual conflict resolution way. The percentages add up to more than 100 because they could indicate several options.

56 per cent). Table 3 summarizes the preferred tools based on those commonly used.

Table 4 shows the proposed tools in relation to the degree of satisfaction when solving ethical doubts, the years of work experience, and the training in bioethics. Internists with shorter length of professional experience (30 per cent versus 25 per cent; p 0.017) and with the most bioethical training (32 per cent versus 22 per cent; p 0.002) more commonly preferred a bioethics consultant. The same trend, although not significant, is observed among the least satisfied internists (35.3 per cent versus 27.3 per cent; p> 0.05). The most satisfied internists with longer length of professional expertise and less training in bioethics seem to seek more protocols, although not significantly.

Sixty-four per cent of participants (167) have a CEC in their hospital, 21 per cent (55) do not, and 15 per cent (39) do not know. Table 5 summarizes the number of consultations participants make to CECs and the number they would make if they had a CEC in their hospital. In hospitals where CECs are present, 90 per cent (150) of the professionals affirmed that they never consult them or do so only sporadically. However, in the centres where there is no CEC (or it is unknown), 70.1 per cent (61) stated that they would use this resource at least once or twice a year and 20.6 per cent (18) would do so more than four times a year.

Regarding the frequency of satisfactory resolution of conflicts, 92.4 per cent (241) resolve them satisfactorily frequently or almost always, the average degree of satisfaction being 3.5 (SD ± 0.79). The degree of satisfaction is 4.07 (SD ± 0.63) among those who almost always resolve conflicts satisfactorily, 1.5 (SD ± 1.3) among those who almost never, 3.44 (SD ± 0.7) in those without training in bioethics, 3.54 (SD ± 0.81) for those with training, and 4 (SD ± 0.44) for those with a master's degree. Table 5 shows the degree of satisfaction in the resolution of ethical conflicts.

Discussion

Eighty-six per cent of internists resolve their ethical doubts with help, the most widely used way being consultation with colleagues, followed at a distance by the use of protocols and consultation with experts in bioethics, while the CECs are hardly consulted. One problem with receiving ethics advice from colleagues is that many of the colleagues consulted may not have specific training in ethics consulting, so the quality of the decision may not be optimal. Ninety-nine percent believe it is convenient to have a tool to help resolve ethical conflicts, mainly asking for protocols and recommendations, consultants/experts in bioethics, and more training in bioethics.

Internists have ethical conflicts that they want to resolve with some kind of assistance and prefer to ask colleagues first (58.6 per cent) as observed in other studies (42–94 per cent) (Du Val, et al. 2004; Aleksandrova 2008). This seems to be the case because clinicians prefer help from people involved

Table 4 Preferred tool for resolving ethical conflicts based on the degree of satisfaction in resolving them, experience, and training in bioethics.

Tools suggested to resolve conflicts	TOTAL (N = 528) *	Low degree of satisfaction (0-2) (N = 34)	High degree of satisfaction (3-5) (N = 494)	χ^2 test or Fisher p value	< 20 years of experience (N = 269)	> 20 years of experience (N = 251)	χ^2 test or Fisher p value	Without bioethics training (N = 219)	With bioethics training (N = 309)	χ^2 test or Fisher p value
None	3 (0.6)	0	3 (0.6)	>0.05	1 (0.3)	2 (0.7)	>0.05	3 (1.4)	0	>0.05
Better training in bioethics	122 (23.1)	7 (20.6)	115 (23.3)	>0.05	64 (23.4)	55 (22.3)	>0.05	55 (25)	67 (21.7)	>0.05
Protocols / recommendations	160 (30.3)	9 (26.5)	151 (30.6)	>0.05	78 (28.6)	80 (32.2)	>0.05	70 (32)	90 (29.1)	>0.05
Bioethics consultant	147 (27.8)	12 (35.3)	135 (27.3)	>0.05	82 (30.1)	63 (25.4)	0.017	49 (22.4)	98 (31.7)	0.002
CEC	96 (18.2)	6 (17.6)	90 (18.2)	>0.05	47 (17.4)	48 (19.1)	>0.05	42 (19.2)	54 (17.5)	>0.05

DATA: *% (N).* *Being a multi-answer question, the total sum is greater than the number of respondents; percentages refer to the number of responses in each column.

Table 5 Consultations to the CEC (Clinical Ethics Committee) according to whether or not they have in-house CEC (or do not know).

Number of annual consultations	In-house CEC available N = 167	No in-house CEC available* N = 87
None	61 (36.5)	3 (3.4)
Only sporadically	89 (53.3)	23 (26.4)
1-2/year	15 (9)	30 (34.5)
3-4/year	2 (1.2)	13 (15)
> 4/year	0	18 (20.6)

DATA: *% (N).*NOTE: Seven respondents did not complete this question.*

in patient care (Hurst, et al. 2005) and they place less value on being provided with ethics literature (20.9 per cent) or receiving help in communicating with the patient (24.3 per cent) (Hurst, Perrier, et al. 2007; Hurst et al. 2005). Interestingly, most practitioners are comfortable sharing ethical conflicts with colleagues. These interactions can foster further discussion and benefit both parties. However, a practitioner seeks not only to share situations but to achieve a prudent course of action. We believe that such outcome is more likely with as professional and as trained an approach as possible. According to our results, consulting colleagues is perhaps not the best help to resolve ethical conflicts since they are most likely not experts (only 4 per cent have a master's degree in bioethics).

As we have said, our study indicates that internists also use protocols or the advice of an expert/consultant in bioethics, but that they hardly attend the CEC (6.1 per cent). There are several possible reasons for this: because where there are CECs, users insist on the need for more efficient and confidential mechanisms and on the higher qualification of those consulted (DuVal, et al. 2004); because the consultation of ethical conflicts is perceived as a loss of control and responsibilities (Hurst, Perrier, et al. 2007; Orlowski, et al. 2006); because they do not recognize ethical problems or that these hinder their care activity (Blanco Portillo, et al. 2021); and because they avoid ethical conflicts for practical reasons or to avoid the ethical consultation process (Hurst, et al. 2005). Importantly, it must be acknowledged that a possible outcome of lack of consultation is poorer patient care (Reiter-Thail 2000).

The results of the study reinforce the importance of providing the clinician with tools that improve the management of ethical conflicts (DuVal, et al. 2001). Otherwise, ethical conflicts will be managed worse, therefore increasing moral stress in healthcare professionals (Mehlis, et al. 2018) with a consequent impact on their quality of life (Austin, Saylor, and Finley 2017) and risk of malpractice (García-Iglesias, et al. 2020).

Regarding the tools preferred, the protocols are the preferred help tool for internists. Sixty-five per cent of those who resolve ethical conflicts with protocols consider them a useful tool. Clinical ethics protocols are usually drawn up by the CEC, although they can also be developed by other bodies (other committees, professional associations, scientific societies) (Herreros et al. 2014). The problems with these protocols are that they are difficult to draw up, they are not properly distributed, and their impacts are not usually evaluated.

Regarding formal consultations, a bioethics consultant is preferred, in contrast to the establishment of a CEC (27.8 per cent versus 18.2 per cent) and even more than the creation of protocols by those who claim to resolve conflicts by consulting an expert (80 per cent versus 56 per cent). This preference predominates among those least satisfied with the resolution of their conflicts, those with fewer years of work experience, and those with more training in bioethics. The preference for consultants has been attributed to the fact that they are closer to the clinician (Hurst, et al. 2005; DuVal, et al. 2001), more available (Hurst, Perrier, et al. 2007; Sorta-Bilajac, et al. 2008), and are more practical and quicker in their responses (Galván Roman, et al. 2021), which reinforces the explanation of consulting colleagues as the first way to resolve conflicts. If we add to this the fact that the most frequent ethical conflicts in medicine are related to the end of life (Blanco Portillo et al. 2021) and that these are usually time-sensitive, we can better understand these results. In Spain, the figure of the bioethics consultant is barely developed, but interest is increasing in a "new generation" of bioethicists who are committed to renewing it with internists as the central axis (Real de Asúa, Rodríguez del Pozo, and Fins 2018).

An interesting fact of the study regarding the need for a new type of ethical consultancy is that internists who do not have CEC in their centres affirm that they would use them at much higher rates than the actual recorded usage rates of established CECs, in a similar way to what happens in Europe. This could be due to both the "missing tile syndrome", or wanting what you lack, and a cognitive availability bias whereby we overestimate the effect of what it would mean to have a CEC because of how easy it is to think of examples where we would use a CEC.

Regarding training as a tool to resolve ethical conflicts, also regarded as necessary by the respondents (23.1 per cent), in some studies those with more training consult the committees more (Hurst, Perrier, et al. 2007), attributing it to a greater awareness of ethical conflicts (Blanco Portillo, et al 2021; Hurst, Reiter-Theil, et al. 2007). Nevertheless, there are also studies that suggest that those who are already trained consult less because they do not need an equally qualified third party (Orlowski, et al. 2006). In our study, physicians with training solve problems on their own less and consult colleagues more, and also preferred the use of a consultant more (31.7 per cent versus 22.4 per cent). However, the difficulty in solving ethical problems has been described both in professionals without training in bioethics and in those with training (Du Val, et al. 2004; Hurst, Reiter-Theil, et al. 2007). Our findings seem to be in line with the concept of "ethical erosion" (Feudtner, Christakis, and Christakis 1994), whereby physicians with basic training in bioethics are sensitized to ethical conflicts, but due to the "hidden curriculum" factor (Hafferty and Franks 1994) do not delve deeper into moral reasoning (Esquerda, et al. 2019) and do not know how to handle conflicts appropriately.

Our study has limitations inherent to an anonymous survey: not being able to ensure understanding of the questions and selection bias (it is possible that physicians that are more interested in the subject are more likely to participate), in addition to twelve data units having been lost due to a computer error. However, the sample size of the present work is larger than in previous studies, and the collection of ethical counselling models is exhaustive, which limits memory bias. We must consider that the sample of internists is representative of SEMI, which is the only society of internists in Spain. Another limitation of our study is that the survey only explores the physician's satisfaction with the resolution of the ethical conflict. Examining other views on the resolution of

the conflict, especially the patient's, is an important avenue for further research.

Studies are lacking to find out what reasons make internists prefer one tool or another and the impact generated by specialized training and specific tools on satisfaction in the resolution of ethical conflicts as well as on the quality of care. It can be concluded that internists in Spain usually resolve their ethical doubts with help, most commonly consultation with colleagues, followed by the use of protocols and consultation with experts in bioethics. Practically all participants believe it is convenient to have some help tool to resolve ethical conflicts, preferring above all protocols, consultants/experts in bioethics, and more training. The CECs are the tool that is least consulted and the least sought.

Data Availability The data that support the findings of this study are available from the corresponding author, [A. Blanco Portillo], upon reasonable request.

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