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Aspects of Ethical Conflicts and their Implications for Work-Related Well-Being: A Cross-Sectional Study among Health and Social Care Professionals

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ABSTRACT

Moral distress is a pervasive phenomenon in health and social care organisations when employees feel unable to follow their ethical convictions, leading to impaired well-being and staff turnovers. While previous research has focused on identifying external root causes of moral distress, it has overlooked the subjective and multidimensional nature of ethical conflicts in explaining moral distress and its detrimental consequences for occupational well-being. We argue that ethical conflicts and moral distress are compounded, and it is important to investigate how employees themselves interpret situations that make them prone to moral distress. For this purpose, we surveyed 1,279 health and social care professionals who reported and assessed a recent ethical conflict from their work. Results showed that ethical conflicts involved three dimensions: ethical responsibilities to clients, ambiguous decision-making in organisations, and conflicting demands arising from relationships. Conflicting demands predicted general health, job satisfaction and turnover intentions, and ambiguous decision-making predicted general health and job satisfaction. Job autonomy, time pressure and organisational justice remained the most powerful predictors for indicators of work-related well-being. In resolving ethical conflicts and managing moral distress, organisational means are necessary. In particular, managers should be able to lead discussion about values with employees. In future, research should pay more attention to the social, dynamic and versatile nature of ethical conflicts in work organisations.

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KEYWORDS:

ethical conflicts; moral distress; professions; work organisation; health and social care employees

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INTRODUCTION

Advanced ethical decision-making is a fundamental dimension of nursing and caring practices that aim to serve people's well-being. Nurses, social workers and medical doctors represent professions that lean on expert knowledge and thus have epistemic authority and decision-making power over their clients. Besides legal accountability and competence demands, professionals are expected to be committed to professional values emphasising responsibility to take care of their clients, even in difficult situations (Airaksinen, 2012). Consequently, they are confronted with ethical issues on everyday basis. In practice, ethical choices are constrained by several internal and external factors, such as standard regimens and budget allocations, or demands from teams and management (Haahr et al., 2020) This may lead to *moral distress* that has been identified as a key phenomenon explaining professionals' compromised ethical choices and having detrimental effects on their well-being (Epstein et al., 2019; Oh & Gaastmans, 2015).

According to Jameton's (1984) original definition, moral distress means repeated feelings of a painful psychological disequilibrium that occurs when nurses feel unable to follow their ethical convictions due to institutional constraints. It has been described as a two-staged process including initial and reactive moral distress. Initial distress refers to the feelings of frustration, anger and anxiety workers experience when faced with institutional obstacles and conflict with others about values, whereas reactive distress develops when they cannot act upon their initial distress (Jameton, 1993). Consequently, accumulating reactive distress tends to build up 'moral residue' so that workers are exposed to even stronger distress in forthcoming situations (Webster & Bayliss, 2000).

Moral distress is manifested in various negative emotional and physiological reactions, feelings of powerlessness and emotional withdrawal (Rittenmeyer & Huffman, 2009), fatigue (Ulrich et al., 2007), compassion fatigue and burnout symptoms, emotional exhaustion and depersonalisation (Austin et al., 2017; Meltzer & Huckabay, 2004; Ohnishi et al., 2010). Moral distress has further notorious consequences for organisations, while it is associated with reduced job satisfaction and turnover intentions (DeTienne et al., 2012; Epstein et al., 2019; Hamric et al., 2012; O'Donnell et al., 2008). It compromises the quality of care (Gutierrez, 2005) and makes professionals leave their jobs, leading to shortages of competent workers (Epstein et al., 2019; Ulrich et al., 2007).

Moral distress as a phenomenon has initially been documented among nurses, but it has increasingly been established common among other professionals, especially physicians and social welfare workers (Austin et al., 2017; Epstein et al., 2019; Lamiani et al., 2017; Lev & Ayalon, 2018). Interestingly, moral distress has emerged as a lay concept "ethical stress" in public discussion during recent years. Health care and social welfare services in Finland are suffering from the severe crisis due to a lack of workforce. In 2020, services lacked 43% of social workers, 21% of general physicians, and 17% of nurses, nurses being the largest group in numbers (Tevameri, 2022). The Covid-19 pandemic has made the situation leading to industrial actions and strikes in spring 2022 worse. Employees have issued to resign from their jobs because they feel incapable of working according to their values due to the scarcity of time and poor management (e.g., Lantela & Maskonen, 2022). Not surprisingly, moral distress is prevalent among Finnish health and social care employees, especially in eldercare (Selander et al., 2022).

Moral distress and ethical conflicts are different theoretical concepts. While ethical conflicts are characterised by uncertainty about the right action, moral distress is expected to arise when one knows that something is the right thing to do but is constrained in executing it (Jameton, 1984). Ethical conflicts, also called ethical dilemmas in research literature, can be defined as work-related moral conflicts in which one feels unsure about what they should do according to moral or ethical standards (Wark & Krebs, 1996), "moral" referring to personal standards and "ethical" to professional ones. From the psychological perspective, however, ethical conflicts and moral distress are compounded phenomena: on one hand, moral distress can be a reaction to an ethical conflict and on the other, the inability to take an ethically appropriate action may constitute an ethical conflict.

The moral distress research in healthcare contexts strongly builds on the notion of root cause (McCarthy & Gastmans, 2015). Consequently, moral distress has been operationalised as workers' responses to numerous predetermined situations in recent measures (Epstein et al., 2019; Lev & Ayalon, 2018). This methodological approach might have unintentionally downplayed the moral autonomy of health and social care practitioners: how they themselves perceive, interpret and solve situations that make them prone to moral distress. It has also been argued that the concept does not convey the subjective and multi-faceted nature of ethical conflicts and is therefore limited to explain constraints in ethical decision-making (Campbell et al., 2016; Mänttäri-van der Kuip, 2020). This brings ethical conflict as a useful concept back to the fore. To our knowledge, there is virtually a lack of studies concerning the nature of ethical conflicts and their implications occupational well-being, with few exceptions (Haahr et al., 2020; Pihlajasaari et al., 2015).

In order to respond to the above-mentioned research limitations, we build a holistic approach to ethical

conflicts and moral distress in this study. Our aims are three-fold. First, we aim to broaden understanding of the nature of ethical conflicts professionals face in their work through multidimensional approach derived cognitive moral psychology. Second, we aim to investigate whether the identified aspects of ethical conflicts combined with moral distress predict the definite indicators of work-related well-being: general health, job satisfaction and turnover intentions. Third, we aim to compare the impact of ethical conflicts with other organisational factors as predictors for work-related well-being. The research questions are formulated as follows:

1) What are the aspects of ethical conflicts among health and social care professionals?
2) Do aspects of ethical conflicts predict indicators of work-related being, including general health, job satisfaction and turnover intentions, among health and social care professionals?
3) How do aspects of ethical conflicts compare with organisational factors, including job autonomy, organisational justice, participative safety and time pressure, in predicting indicators of work-related well-being?

CHARACTERISTICS OF REAL-LIFE ETHICAL CONFLICTS

Ethical conflicts have traditionally been defined as classic moral dilemmas; that is, a conflict of opposing values with equally unwelcome alternatives (Jameton, 1993; Kohlberg, 1984). However, a large body of studies suggests that ethical problems in real-life seldom appear as a pure conflict of values (Banks & Williams, 2005; Goethals et al., 2010; Hopia et al., 2016, Hyde, 2012; Power & Lundsten, 2005, Ulrich et al., 2010). Indeed, they involve everyday concerns, such as how to provide best care or how to deal with organisational or bureaucratic issues (Haahr et al., 2020). These problems might appear cognitive simple but can be psychologically hard to solve, because people need to consider the actual costs and consequences of their choices for themselves as well as others (Wark & Krebs, 1997).

Carol Gilligan (1982) was among the first ones to point out the mundane nature of real-life moral conflicts. She observed that moral conflicts women face in their everyday lives related to responsibilities in relationships could not be adequately resolved through abstract concepts of justice, which were regarded as the primary mode of moral judgment and professional ethics at that time (Juujärvi & Helkama, 2020). While the ethic of justice emphasises upholding role-related duties and commitments, standards, rules and principles as the primary moral criteria for ethical decision-making, the ethic of care emphasises promoting the welfare of others, preventing harm or relieving burdens, hurt and suffering as such (Gilligan, 1982). Previous studies have evidenced that both care and justice-based considerations are required in professional ethical decision-making (Juujärvi & Helkama, 2020).

Gilligan's findings pushed researchers to develop appropriate methods for the examination of real-life moral conflicts. Wark and Krebs (1996) established a taxonomy of real-life moral dilemmas (conflicts) we utilise in this study. The taxonomy includes prosocial, antisocial and social pressure dilemmas as the main types of moral conflict. Prosocial dilemmas can be further divided into subtypes of reacting to needs of others and reacting to conflicting demands, and antisocial dilemmas into types of reacting to transgressions and temptation.

Wark and Krebs' taxonomy has proved to be sensitive to socio-cognitive conflict embedded in moral problems (Myyry & Helkama, 2007). Socio-cognitive conflict refers to a situation in which different viewpoints are represented by different people in a way that makes it difficult for the moral agent to comply with their opinions, and her or his responses are directly relevant to relationships with others (Doise & Mugny, 1984). Myyry and Helkama (2007) found that perceived socio-cognitive conflict would be high with regards to conflicting demands and social pressure dilemmas. With the first one, two or more people make inconsistent demands for the moral decision-maker who is conflicted about whose expectations to fulfil, and with the latter one, the decision-maker feels explicitly or implicitly pressured by other people to engage in identity-inconsistent behaviours that violate their values (Wark & Krebs, 1996).

Wark and Krebs' (1996) taxonomy was developed with a student sample and therefore lacks types of dilemmas describing rule-bounded nature of work organisations. A recent study in the health and social care context added two other types of dilemmas: Applying Rules refer to the consideration of laws, regulations and instructions that employees need to comply with, uphold or apply. Internal Conflict in turn refers to the experience of discrepancy between the task requirements and one's own resources (Juujärvi & Myyry, 2021).

Instead of categorising ethical conflicts, however, we develop a multidimensional approach in the present study. We indeed assume that ethical conflicts in organisational contexts are multidimensional, involving several interrelated issues rather than unitary moral problems (Treviño, 1986). Supporting our assumption, Haahr et al. (2020) reviewed that nurses' ethical conflicts involved three intertwined themes: balancing harm and care for patients, work overload affecting quality of care, and navigating in disagreement with physicians. Juujärvi and Myyry (2021) further observed that both consideration of care and justice were present in singular ethical conflicts of health care and social welfare professionals.

To conclude, we ask participants to recall an ethical conflict from the recent past and evaluate it in terms of moral distress and the relevant characteristics discussed above. Due to the past contradictory findings, we do

not however have strong hypotheses about emerging dimensions, precluding the use of confirmatory factory analysis. Subsequently, we use exploratory factor analysis to identify relevant dimensions of ethical conflicts.

RELATIONS AMONG MORAL DISTRESS, ORGANISATIONAL FACTORS AND OCCUPATIONAL WELL-BEING

According to the recent theoretical reformulation, moral distress can be triggered at three levels: patient, team/unit and system. Unit-level causes include, for example, poor communication and inadequate collaboration, and system-level causes add poor staffing, pressure to reduce costs, and lack of adequate resources (Epstein et al., 2019).

With regard to unit-level causes, moral distress has frequently been associated with poor ethical climate (e.g., O'Donnell et al., 2008, Pauly et al., 2009; Silén et al., 2011). supporting its construct validity (Epstein et al. 2019; Hamric et al., 2012). Ethical climate is a part of organisational climate, referring to nurses' perceptions of how ethical issues are handled at the workplace, involving support from with colleagues, patients, managers, organisation, and physicians (Olson, 1998). In this study, we use participative safety (Kivimäki & Elovainio, 1999) as an indicator of ethical climate, involving support, sense of togetherness, and information-sharing within a team.

In particular, unequal nurse–physician relationships have been documented to inflict moral distress among nurses; they feel morally responsible for the quality of care but are subjected to physicians' decision-making in hierarchical healthcare organisations (Karanikola et al., 2014; Rittenmeyer & Huffman, 2009; Stein-Parbury & Liatchenko, 2007; Torjuul & Sorlie, 2006). Not surprisingly, moral distress has also been found to be negatively related to employees' perceptions of autonomy (Karanikola et al., 2014; Papathanassoglou et al., 2012). Organisational justice, in turn, refers to employees' perceptions of unfair treatment at workplace (Moorman, 1991) that might also be a potential source for unit-level moral distress.

Even though associations among distress and several organisational aspects are verified, few studies have compared their impacts on work-related well-being. DeTienne et al. (2012) found that moral stress, among other work stressors, independently predicted employee fatigue, job satisfaction and turnover intentions. Selander et al. (2022) found that lower moral distress was one of the significant predictors for work ability of health and social care employees, in addition to job autonomy, organisational justice, and effort-reward balance. Based on previous studies, we furthermore know that job autonomy, organisational justice and team climate are important factors predicting work-related well-being. Lindberg and Vingård (2012) reviewed that employees regard good collaboration and teamwork as the most important factor creating a healthy work environment. Low autonomy and organisational justice have been found to contribute to negative health effects and low job satisfaction (Karasek, 1979, Elovainio et al., 2002; Laschinger, 2001; Mengstie, 2020; Virtanen & Elovainio, 2018) and low organisational justice to turnover intentions, respectively (Elovainio et al., 2002; Mengstie, 2020; Virtanen & Elovainio, 2018).

To conclude, while the above-mentioned organisational factors can be expected to predict indicators of work-related wellbeing, they can also serve supportive structures inhibiting and mitigating moral distress in organisations. It is therefore warranted to study whether the experiences of ethical conflicts have unique impact on occupational well-being beyond autonomy, organisational justice and safe climate. For this purpose, we conduct a series of hierarchical regression analyses with the following hypotheses:

1) Aspects of ethical conflicts weighed with moral distress predict general health, job satisfaction and turnover intentions, even after controlling for job autonomy, organisational justice, participative safety, and time pressure;
2) Job autonomy, organisational justice, participative safety, and time pressure predict general health, job satisfaction and turnover intentions.

MATERIALS AND METHODS

DATA COLLECTION

The present study was part of the research project exploring competence needs of employees and organisational demands in the current transition in health care and social services in Finland. The study involved four frontline organisations providing public health care and social services in three regions. These regions had been active in restructuring and integrating health care and social services to anticipate the ongoing national reform. They had created regional-scale joint health and social care authorities to boost service integration and had started to develop innovative models of multi-professional collaboration. The key idea was to integrate health and social care under the same management, so that people could have all their services from one organisational unit and location (Keskimäki et al., 2018). The study was approved by the appropriate ethics committee and permissions were granted by participant organisations. Following the ethical guidelines by National Advisory Board on Research Ethics (2009), participation was voluntary, and anonymity of participants was assured. All employees and managers with permanent positions were informed about the study and invited to participate through a letter sent electronically by contact people in the organisations. They then delivered electronical surveys followed by two reminders in spring and summer 2017. In addition to

ethical conflicts and work-related well-being, the survey covered five other themes that are not addressed in this study.

PARTICIPANTS

For this particular study, respondents representing the main registered healthcare and social welfare professions were selected. Based on their reported current duty, 1,607 respondents were classified into six categories in line with official statistics (Statistics Finland, 2010). The formed categories were as follows: nurse, practical nurse, physician, social worker and social counsellor. Superiors formed an additional group comprising nurses, social workers and physicians with management positions in work units or middle management. To explain educational levels, practical nurses, corresponding internationally to auxiliary nurses, are educated at vocational schools and, nurses and social counsellors at universities of applied sciences, whereas social workers and physicians are educated at universities.

Because the invitations were sent via contact people and mailing lists, it is not known how many people actually received them. Based on the data from the personnel registers of the organisations, the calculated response rate was 22% for the original sample and 18% for the final sample including those who reported an ethical conflict. The response rate varies across the occupations as follows (the response rate for the final sample in parentheses): 22% (18%) for nurses, 15% (13%) for practical nurses, 16% (13%) for physicians, 45% (42%) for social workers, 64% (57%) for social counsellors and 48% (42%) for superiors.

MEASURES

Gender, age, education, occupation, sector and region

Respondents were asked to report gender, age, education, occupational duty, sector and region with choosing appropriate alternatives (see Table 1). Region refers to governmental areas of health and social organisations.

Aspects of ethical conflict

Two open questions were used to invoke a recent ethical conflict in respondents' work. Following Lyons (1983), questions were formed, avoiding the word "ethics", to cover the broad range of moral issues as follows: (1) Recall an event or situation from the recent past in your work in which you were unsure about how you should act in order to do the right thing. (2) How do you know whether you acted rightly or wrongly? These questions were intended to serve as stimuli for the following evaluative statements about the nature of the ethical dilemma, and the content analysis of the responses to the open-ended questions is beyond the remit of this study.

For the purpose of the study, 16 statements were designed to measure definite aspects of the described

VARIABLE	n	%
Gender		
Male	149	11.7
Female	1125	88.3
Age		
18–34	267	20.9
35–44	318	24.9
45–54	374	29.2
55–67	319	25.0
Region		
Region 1	421	32.9
Region 2	640	50.0
Region 3	218	17.0
Occupation		
Nurse	605	47.3
Physician	62	4.8
Practical nurse	274	21.4
Social worker	78	6.1
Social counsellor	124	9.7
Superior	136	10.6
Work sector		
Social services	182	14.3
Hospital	346	27.2
Primary health care	145	11.4
Services for older people	287	22.6
Administration	60	4.7
Mental health and substance abuse	134	10.5
Rehabilitation	71	5.6
Other	46	3.6
Frequency of ethical conflicts		
never	75	5.9
once a year	124	9.7
sometimes a year	301	23.5
monthly	377	29.5
weekly	340	26.6
daily	62	4.8
Intensity of ethical conflicts		
never	187	15.0
seldom	256	20.6
sometimes	418	33.6
often	286	23.0
continuously	97	7.8

Table 1 Description of background and moral distress variables (n, %).

Note: Valid percentages are reported. Missing values from total varied from 35 (3%, intensity of ethical conflicts) to 0 (0%, region, occupation, and frequency of ethical conflicts).

ITEM WORDING	FACTOR LOADINGS[1]			
	MEAN (SD)	ETHICAL RESPONSIBILITIES	AMBIGUOUS DECISION-MAKING	CONFLICTING DEMANDS
1. I felt a temptation to advance interests of my own or my work community by acting dishonestly, unfairly or against ethical codes[2]	1.21 (0.60)			
2. I had to decide how I should react to a transgression made by another person[2]	1.91 (1.27)			
3. I considered my responsibilities for the wellbeing or support of another person	3.50 (1.36)	0.58		
4. Several people had contradictory expectations towards me, and I had to decide among them	2.50 (1.36)			0.47
5. Other people pressed me, consciously or unconsciously, to act against my values	1.79 (1.16)			0.81
6. Some of my own values were in contradiction with each other, and I had to decide between them	1.86 (1.13)			0.50
7. I was unsure how a certain rule or instruction should be applied	2.19 (1.28)		0.71	
8. I did not have the expert knowledge to make the right decision	2.06 (1.20)		0.71	
9. The responsibility for decision-making was unclear	2.06 (1.24)		0.78	
10. I did not have the power in the ultimate decision-making regarding the problem	2.36 (1.42)		0.41	
11. I disagreed with other workers	2.05 (1.23)			0.67
12. I had difficulties to comply with demands of the more powerful party	1.91 (1.18)			0.67
13. The decision affected my relationships/relations with patients/clients and their close ones[2]	1.59 (1.0)			
14. The decision affected my relationships with my co-workers	1.57 (0.94)			0.66
15. I considered the rights and duties of the parties involved	2.99 (1.35)	0.86		
16. I considered the consequences of alternative solutions for the parties involved	2.99 (1.30)	0.87		
Eigenvalues		4.88	1.73	1.29
Percentage variance (%)		37.56	13.33	9.90
Cronbach's Alpha for selected items		0.80	0.76	0.83
Mean (SD)[2]		3.16 (1.11)	2.17 (0.98)	1.95 (0.85)

Table 2 Means and factor analysis for aspects of ethical conflicts.

[1] Factor loadings > 0.40 are reported.
[2] Items were excluded from the analysis due to poor communalities in preliminary analyses.

ethical conflict (see Table 2). Items 1 to 5 indicate Wark and Krebs' (1996) types of real-life moral conflicts, items 6 to 9 moral issues with applicable rules and internal conflict (Juujärvi & Myyry, 2021), items 10 to 14 high socio-cognitive conflict (Myyry & Helkama, 2007); and items 15 and 16 moral responsibilities in terms of the ethics of care and justice (Gilligan, 1982). Respondents were asked to evaluate to what extent the statements resemble a described conflict on a scale ranging from *not at all* (1) to *very much* (5).

Moral distress

In previous studies, moral distress has been operationalised as the frequency and the intensity of ethical conflict (Oh & Gastmans, 2015). Respondents were asked to evaluate approximately how often they face similar kinds of situations on a six-point scale (never, once a year, several times a year, monthly, weekly, daily). In addition, they were asked to evaluate how often these situations clearly disturb, worry or strain them on a five-point scale from *never or very rarely* (1) to *very often or*

continuously (5). The frequency and intensity of moral distress were summed as a composite score that was used in further analyses.

Organisational justice, job autonomy, participative safety and time pressure

Respondents were asked to assess statements on a five-point scale, ranging from totally disagree (1) to totally agree (5). Organisational justice was measured using three statements regarding procedures in the workplace: the right to state one's opinion on one's own matter, coherence in decision-making, and impartiality of the decisions (Elovainio et al., 2010; Moorman, 1991), yielding 0.76 for Cronbach's alpha. Similarly, job autonomy was measured based on the respondent's experiences within the past six months through three statements: independence in decision-making, having a say with regard to one's own work, and freedom to choose how to do one's work (Karasek, 1979), with 0.75 for Cronbach's alpha. Four statements, concerning information sharing, attitude of togetherness and feelings of acceptance comprised a measure of participative safety within a team (Anderson & West, 1994; Kivimäki & Elovainio, 1999), with 0.91 for Cronbach's alpha.

Time pressure was measured as a sum index of four indicators within the past six months: constant hurry or stress because of undone (unfinished) work, time limits to carry out work properly, and insufficient number of workers as well as interruptions (Harris, 1989), with 0.89 for Cronbach's alpha. Respondents were asked to evaluate each statement on a five-point-scale ranging from *never or very rarely* (1) to *very often* or *always* (5).

General health

General Health Questionnaire (Goldberg, 1972) was used as an indicator of physical well-being. Respondents were asked to evaluate their recent well-being (within the past week) in terms of loss of sleep, overwhelming difficulties, and feelings of strain and unhappiness, on a four-point scale ranging from *less than usual* (4) to *much more than usual* (1). Cronbach's alpha for the four items was 0.85.

Job satisfaction and turnover intentions

Job satisfaction (Hackman & Oldham, 1976) was assessed with a single item (*Generally speaking, I am satisfied with my work*), and, respectively, turnover intentions with a single item (*I have planned to change my workplace or employer*) on a five-point-scale ranging from *totally disagree* (1) to *totally agree* (5).

DATA ANALYSIS

Statistical analyses were performed using the IBM SPSS version 26.0 software package. We conducted an exploratory factory analysis to examine aspects of ethical conflicts and formed sum indices based on the identified factors. Cronbach's alpha was used for reliability checking of the sum indices. Means of moral distress were summed as the composite score that was used as a weighing variable with the sum indices (aspects of ethical conflict) in further analyses.

We calculated means and standard deviations of major variables and bivariate correlations (Table 3). We, then used hierarchical regression analyses to examine hypotheses concerning predictors of occupational wellbeing. Preliminary analyses revealed that among background variables, only age was a significant predictor and therefore was included in the analyses as a continuous variable. We ran separate analyses for general health, job satisfaction and turnover intentions as dependent variables.

Sum indices for ethical responsibilities, ambiguous decision-making and conflicting demands were multiplied with the composite score of moral distress, yielding weighed variables. Aspects of ethical conflict and age were implemented in the first step (Model A), and organisational justice, job autonomy, participative safety and time pressure were added in the second step (Model B). Multicollinearity of independent variables was checked, yielding acceptable VIF values, <.10. Variances of standardized residuals were also acceptable, ranging from 1.9 to 2.1 with Durbin-Watson's test. Missing values were excluded pairwise from the analyses.

RESULTS

MORAL DISTRESS

As Table 1 shows, 31.4 % of participants faced ethical conflicts (similar to the one they reported) at least weekly, 29.2 % monthly, and 39.6% sometimes a year or more infrequently. Participants felt strained due to ethical conflicts as follows: 30.8% often or continuously, 33.6% sometimes, and 35.6% seldom or never.

ASPECTS OF ETHICAL CONFLICT

Aspects of ethical conflict were examined by conducting a factor analysis for the pattern of 16 items, by using Generalised Least Squares as a factoring method and the Direct Oblimin Method as a rotation method. The analysis yielded an interpretable three-factor solution that fitted the data best (see Table 2). Three items (1, 2 and 13) had communalities of less than 0.3 and were excluded from the final analysis. The Kaiser-Mayer-Olkin measure of sampling adequacy (KMO) was 0.86, and Bartlett's test of sphericity was significant ($p < 0.001$). The final three-factor solution explained 51% of total variance.

The first factor, explaining 33% of total variance, was labelled as ethical responsibilities. It included three items: considerations of responsibilities for well-being of other people, rights and duties of each party involved in the situations, and consequences of decision-making for them. The second factor, named ambiguous

	MEAN	SD	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
1. Ethical responsibilities	10.91	5.43										
2. Ambiguous decision-making	7.64	4.72	.61***									
3. Conflicting demands	6.83	4.18	.75***	.66***								
4. Job autonomy	3.72	0.89	–.09**	–.17***	–.23***							
5. Organisational justice	3.58	0.90	–.15***	–.22***	–.24***	.41***						
6. Participative safety	3.83	0.95	–.18***	–.18***	–.25***	.32***	.63***					
7. Time pressure	3.61	0.99	.30***	.26***	.30***	–.23***	–.18***	-.10***				
8. General health	3.00	0.73	–.20***	–.28***	–.31***	.28***	.25***	.20***	-.35***			
9. Job satisfaction	3.82	0.39	–.17***	–.24***	–.28***	.49***	.40***	.36***	–.27***	.37***		
10. Turnover intentions	2.60	1.42	.22***	.24***	.30***	–.37***	–.37***	–.33***	.26***	–.38***	–.53***	
11. Age	45.26	11.01	.12***	.04	.12*	-.05	-.04	-.03	-.03	.05	-.05	.19***

Table 3 Means, standard deviations and Spearman's correlations for major variables.

** p < .01, *** p < .001 *Note. n*s vary from 1208 to 1274.

decision-making, explained 10% of total variance. This factor comprised four items describing uncertainty about responsibilities in decision-making and the right application of rules and instructions, a lack of expertise and decision-making power. Finally, the third factor, explaining 7% of total variance, was named conflicting demands. The six items covered feelings of social pressure against one's values, contradictory expectations from others, disagreement with other co-workers, difficulties to comply with the demands of a more powerful party, and conflicts between one's own values. Based on the three-factor solution, sum indices were formed, the values of Cronbach's alpha ranged from 0.76 to 0.82 (see Table 2).

The descriptive statistics of sum indices showed that the highest mean was 3.16 for ethical responsibilities, denoting the moderate assessment on a five-point scale. The item "I considered my responsibilities for the well-being or support of another person" received the highest ratings among all items (*M* = 3.50). Means for ambiguous decision-making and conflicting demands were 2.17 and 1.95, respectively, indicating modest assessments on average. It is worth noting that clearly the lowest ratings (*M* = 1.21) were given to item 1 ("I felt a temptation to advance interests of my own or my work community by acting dishonestly, unfairly or against ethical codes") that was dropped from the final analysis due to poor communalities.

ASPECTS OF ETHICAL CONFLICT AS PREDICTORS OF WORK-RELATED WELL-BEING

Hierarchical regression analyses were conducted to examine whether age and aspects of ethical conflict predict indicators of work-related well-being. Means and standard deviations of the included variables and their bivariate correlations are shown in Table 3. As Table 4 shows, all models were statistically significant, $p < .001$. Table 5 specifies β values for independent variables.

In the first step of the analysis, ethical responsibilities predicted job satisfaction, ambiguous decision-making predicted general health ($p < .001$) and job satisfaction ($p < .01$) and conflicting demands predicted general health and job satisfaction, and turnover intentions (all *ps* < .001). Ambiguous decision-making and conflicting

	MODEL 1		MODEL 2	
		ΔR^2		ΔR^2
General health	$F(4, 1179) = 36.20$	.11***	$F(8, 1175) = 39.23$	.21***
Job satisfaction	$F(4, 1178) = 30.10$	.09***	$F(8, 1174) = 74.41$	.33***
Turnover Intentions	$F(4, 1176) = 41.70$	.12***	$F(8, 1172) = 58.41$	.28***

Table 4 Summary of regression analyses for work-related well-being.
*** $p < .001$.

	GENERAL HEALTH	JOB SATISFACT.	TURNOVER INTENTIONS
Model 1			
Age	–.02	.04	-.17***
Ethical Responsibilities	–.01	.13**	-.03
Ambiguous Decision-making	–.14***	-.12**	.07
Conflicting Demands	.23***	-.30***	.27***
Model 2			
Age	.02	.03	–.17***
Ethical Responsibilities	.00	.05	.02
Ambiguous Decision-making	–.10**	–.07*	.02
Conflicting Demands	–.12**	–.09*	.11*
Job autonomy	.13***	.33***	–.20***
Organisational justice	.09**	.16***	–.17***
Participative safety	.04	.10**	–.11*
Time pressure	–.24***	-.14***	.14***

Table 5 Standardized coefficients for independent variables.
* $p < .05$, ** $p < .01$, *** $p < .001$

demands remained significant predictors, when organisational variables were entered in the analysis in the second step (Models 2). Ambiguous decision-making predicted general health ($p < .01$) and job satisfaction ($p < .05$), and conflicting demands predicted general health ($p < .01$), job satisfaction and turnover intentions, (ps < .05). Conflicting demands was the strongest predictor among aspects of ethical conflicts across all models. Age predicted only turnover intentions in both models (ps < .001), younger participants having more plans to leave workplace than older participants. Findings were in the accordance of the hypotheses, except for that ethical responsibilities predicted only general health in Model 2 and ambiguous decision-making did not predict turnover intentions in either models.

ORGANISATIONAL-LEVEL VARIABLES AS PREDICTORS OF WORK-RELATED WELL-BEING

Organisational variables were added in the analysis in the second step. Job autonomy and time pressure predicted general health, job satisfaction and turnover intentions, all ps < .001. Organisational justice predicted general health ($p < .01$) and job satisfaction and turnover intentions, $p < .001$. Participative safety predicted job satisfaction, $p < .01$ and turnover intentions, $p < .05$. Thus, job autonomy ($\beta = .33$ for job satisfaction) and time pressure ($\beta = -.24$ for general health) were the strongest predictors among organisational variables. Findings supported the hypotheses, except for participative safety did not predict general health.

Table 4 displays that adding organisational values as independent variables increased the magnitude of the models. Adjusted R^2 values approximately doubled for general health and turnover intentions, and tripled for job satisfaction, after organisational values were entered in the analysis. As Table 5 specifies, all organisational variables except for participative safety were stronger predictors than aspects of ethical conflicts for indicators of work-related well-being.

DISCUSSION

The main aim of this study was to broaden understanding of ethical conflicts among health and social care professionals. To our knowledge, this study is among the first ones that conceptualise ethical conflicts in organisations as a multidimensional construct as proposed by Treviño (1986). Our approach is thus different from previous studies in moral psychology (Wark & Krebs, 1996, 1997) which have classified real-life moral conflicts into single categories as well as from studies on moral distress approach which have defined numerous sources for moral distress (McCarthy & Gaastmans, 2015). The strength of this study relies on its validity, because it is based on authentic ethical conflicts raised by participants.

As a result of the exploratory factor analysis, three dimensions of ethical conflicts emerged. Ethical responsibilities explained almost one-third of the total variance and combined the basic premises of the ethics of care and justice: considerations of care-taking and the rights and duties of the parties involved (Gilligan, 1982; Juujärvi & Helkama, 2020). The sum index of ethical responsibilities obtained the highest scores among aspects of ethical conflict, indicating that responsibilities for advancing the best interests of patients and clients is the most common feature of ethical conflicts for health and social care employees, consistent with previous discussions highlighting caring relationships that are fundamental for ethical practice in healthcare and social welfare services (Tronto, 1993; Woods, 2011).

Findings also showed that ethical responsibilities did not predict indicators of work-related well-being except for general health and this association disappeared after controlling for organisational factors. This suggests that moral burden arising from client relationships is an inevitable but manageable part of health and social care professionals' work that can be handled with ethical deliberation. According to the findings, however, it is immature to conclude that usual care-related ethical conflicts do not induce harmful distress. Due to the multidimensional nature, they can also involve challenges of implementation (ambiguous decision-making) or interpersonal conflicts (conflicting demands). Our findings are in line with Haahr et al. (2020) review on nurses' ethical dilemmas that also identified three intertwined dimensions: balancing harm and care, work overload influencing quality, and navigating in disagreement.

Ambiguous decision-making emerged as the second factor. It reflects the regulative nature of health and social care services leaning on laws, decision-making procedures, guidelines, evidence-based practices and so forth. On one hand, the factor encompasses uncertainties about the correct application of rules and responsibilities in decision-making and on the other, a lack of expertise and power in decision-making. Compliance with regulations have previously been pointed out as a source of moral distress and conflict (Hyde, 2012; Kälvemark et al., 2004). Findings are consistent with previous observations that balancing clients' needs and administrative duties are inherent in ethical conflicts. Rules obligate nurses to take care of a high number of patients, leading to work overload (Haahr et al., 2020). In social welfare services, the emergence of information technologies have increased confusion about professional and bureaucratic accountabilities (Burton & van den Broek, 2009). Consistent with these development trends, excessive documentation requirements have been added as a

new root cause in the revised measure of moral distress (Epstein et al., 2019). Ambiguous decision-making also predicted lower general health and job satisfaction.

The third factor, named conflicting demands, encapsulated the characteristics of high-level socio-cognitive conflicts, in accordance with the hypothesis. Participants' ethical conflicts were embedded in relationships that involve conflicts of values, contradictory expectations and difficulties to comply with more powerful others (Myyry & Helkama, 2007). These relationships may involve hierarchical relationships and chains of command, such as nurse–physician, social counsellor–social worker and employee–superior, as well as more equal relationships with co-workers and stakeholders, patients and their families. Disagreements among staff members, different professionals and management have been reported as common sources of ethical conflicts (Aitamaa et al., 2010; Haahr et al., 2020; Lev & Ayalon, 2018; Torjuul & Sorlie, 2006; Varcoe et al., 2004). Nurses and physicians are often in disagreement about treatment of patients (Haahr et al., 2020), whereas social welfare workers feel obliged to advance clients' interests and legal rights in multi-professional collaboration (Juujärvi et al., 2020). Among the aspects of ethical conflict, conflicting demands was the strongest predictor for all indicators of work-related well-being. Compared to other aspects of ethical conflicts, conflicting demands becomes apparent only when employees become aware about disagreements, through expressing their ethical convictions to others. These conflicts may involve incongruity between personal and organisational values that make professionals prone to leave their jobs and even the profession (Ulrich et al., 2007). Based on the present findings, these kinds of interpersonal conflicts are infrequent, but when emerging, they may build up intense moral distress over time.

Consistent with the hypotheses, job autonomy, organisational justice, and time pressure predicted all indicators of work-related well-being, and participative safety predicted job satisfaction and turnover intentions. In other words, opportunities for decision-making about one's work, the right to express one's opinions, and impartial decision-making procedures seem to enhance occupational well-being, in line with previous studies (Doef & Maes, 1999; Elovainio et al., 2002; Gilbert & Guimert et al., 2014; Mengstie, 2020). High time pressure indicates other factors such as a lack of workforce and budget constraints that have found to be related to both moral distress and impaired occupational wellbeing (Oh & Gaastmans, 2015; Mänttäri-van der Kuip, 2016). Present findings are comparable with Selander et al. (2022) study identifying moral distress one of the accumulating factors contributing to work ability of health and social care employees. Generally, the magnitudes of coefficients remained modest in the present study, suggesting that it did not capture all relevant factors explaining occupational well-being.

MANAGERIAL IMPLICATIONS

One of the key findings of the study is that organisational factors, except for participative safety, were more powerful predictors for work-related well-being than ethical conflicts. Autonomy has been regarded as a precondition to responsible professional decision-making (Airaksinen, 2012) and fair procedures provide means for resolving ethical conflicts. Findings furthermore suggest that a supportive team climate may help resolve interpersonal conflicts and inhibit staff turnover. To conclude, conditions enabling greater autonomy and transparent decision-making have to be taken into careful consideration when planning interventions promoting well-being in organisations.

Ethical conflicts are natural part of health and social care professionals' work and consequently, they should be treated in natural ways. Ethics reflection in groups is a usual and widely recommended method requiring however systematic implementation, competent facilitators, other organisational support and arrangements (e.g., Karlsen et al., 2019). Ethics reflection can take place as a part of regular activities, such as team and staff meetings or work supervisions, or as a form of ethics club or organisational ethics counselling. Even though ethics reflection is important for professional identity and empowerment, it is not sufficient to prevent moral distress. Ethical conflicts are unique personal experiences, they are critically tied to working conditions. Therefore, supervisors and managers are in key positions in managing moral distress in their organisations.

Instead of seeing ethical issues as employees' personal and private matters and leaving them alone (Devik et al., 2020), managers should recognise them as red flags that give important information about deficiencies in the organisations calling for attention. This requires that managers and supervisors themselves are aware of ethical dimensions of working practices and are prepared to raise ethics-related discussions in various contexts at the workplace. They are responsible for allocating resources and implementing planned changes, and therefore they must be able to articulate values behind organisational decisions. The ability to lead discussion about values is extremely important because multi-professional collaboration is expected to grow (Keskimäki et al., 2018) and the experiences of conflicting values pose a risk to occupational well-being. Opportunities to discuss ethical issues is one of the preconditions for ethical organisational culture (Kaptein, 2008) that in turn may reduce moral distress and promote occupational well-being (Huhtala et al., 2011). In order to be effective in a long run, discussions should also lead to amending actions in organisations.

LIMITATIONS

Each study has its limitations. The biggest limitation of this study is the modest response rate among nurses, practical nurses and physicians, even though two reminders were sent. The response rate was further reduced among all occupational groups, because about twenty per cent of respondents left all the questions about ethical conflicts unanswered and furthermore, about 6% left several items concerning aspects of conflicts unanswered. This is obviously due to the lengthy questionnaire that led to fatigue in terms of considering complex personal issues. However, the size of the sample remained substantial.

It is also worth remembering that the sample was cross-sectional and therefore causalities between independent and dependent variables in the regression analyses cannot be confirmed. This study was conducted among health and social care workers in their organisations, and the results are not directly generalisable to other areas of work. In the future, the multidimensional nature of ethical conflicts is worthy of study, as is their impact on employee well-being in other industries. In general, research should employ inter-disciplinary approaches and pay attention to the social, dynamic and versatile nature of ethical conflicts.

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COMPETING INTERESTS

The authors have no competing interests to declare.

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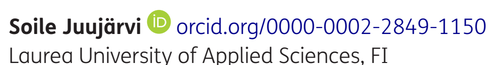
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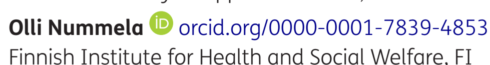
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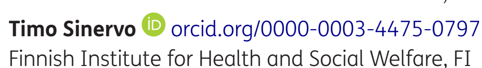
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