A validity study of a questionnaire about the perception of conscience among care professionals in primary health care in Lithuania

A two part study:
Part 1: Literature review (study I)
Part 2: Empirical study (study II)

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ABSTRACT

Health care professionals often are in ethically difficult situations. They experience distress when they either face a situation with contradictory demands or are hindered to take actions they experience as ethically demanded. Health care professionals who have high moral sensitivity will experience ethical demands that may give them bad conscience, when they do not act in accordance with these demands. How they react on bad conscience is connected to their perception of the origin and significance of conscience.

The thesis is designed as a two-part study. Overall aim for the thesis was to describe the essence of the concept of conscience reflected by the care professionals in primary health care. Study part 1 was performed as a literature analysis based on nine articles from 1992-2004, of the databases of CHINAL, PubMed and ELIN, with the purpose to review and summarize past research about the conscience of care professionals.

The aim of study part 2 was to examine the validity of the questionnaire of ‘Conscience’ among care providers in primary health care. Two interpreters translated the questionnaire, which was originally in English, into Lithuanian. In order to test language validity, another 2 interpreters translated the Lithuanian version back into English. Face validity and content validity aspects have been used to test the validity of questionnaire ‘Conscience’ Lithuanian version. This validation process has been carried out to judge if the items are relevant and furthermore clear, understandable and relevant for care professionals.

The pilot study has been performed with the revised and final version of the questionnaire. 40 health care professionals from primary health care center participated in pilot study. The data has been analyzed by factor analysis. Sixteen items were retained in the factor analysis, and they loaded in six factors.

Through the factors were extracted the factors with the labels ‘Individual conscience’, ‘Inner voice (God)’, ‘Silent conscience’, ‘Interpretation of conscience’, ‘Listening the conscience’ and, ‘Conscience and human development’.

Key words: conscience, bad conscience, quilt, shame, health care professionals, and ethically difficult situations.
GENERAL INTRODUCTION

Economic and social situation has changed during the last 10 years in Lithuania. A lot of economic and social problems arouse among people in this reform time. There are such problems as unemployment, low salaries, and growing prices. The differences between different social groups are growing up too. All these problems have influence on people health. Health reform is going on together with other reforms. According to the primary health reform people can choose general practitioner or family doctor, who they want. Nurses and family doctors are working together and help to solve all aroused nursing and health problems. Physicians and nurses have reception in primary health care center together three or four hours every day. After that they have home visits. Care providers, especially the nurses’, salary is one of the lowest salaries in Lithuania. Nurses and physicians who are working in primary health care are very close to families and their problems. It is difficult to act according the own conscience in some care situations for health care professionals, why they feel a stress of conscience.

Reasons for that can be higher strain in their job, when staff did not have enough time to complete their tasks and worried that their jobs would be affected by organizational changes (Brodaty et al, 2002), overload, problems in coping with expectation from the patients and the relatives (Astrom et al, 1990) and others.

According to the Altun (2002), nurses may sometimes feel stressed when carrying out their basic tasks of promoting and maintaining the health of individuals, families and community, preventing illness, helping patients with their recovery process, relieving pain, and so on.

Care providers meet people who need help but sometimes they can’t help because some of those people haven’t money for medicine or are unemployed. In such cases they feel helplessness, guilt, shame and powerlessness because they cannot to provide care they feel they to have. Sometimes nurses and physicians are in conflict with their own conscience. In cases when they cannot help as they want and according to their conscience care provides experience a moral stress.

Lutzen, Cronqvist, Magnusson & Andersson (2003) state’s that all health care can be viewed as a moral enterprise embedded in the one-to-one relationship. Nurses are aware of patients’ vulnerability, made evident by diminished health causing a dependent relationship, and feel a moral responsibility to provide care that is in the best interest of the patient.
Moral stress begins when nurses are morally sensitive to patients’ lack of autonomy and believe that they have no control over the situation. Monat and Lazarus (1985) point out that theoretical distinction can be made in definitions of stress, commonly from three perspectives: physiological, psychological and social stress. Theorell (1997) refers to stress as the nonspecific physical reaction to any kind of stimulus. An individual’s reaction depends just as much as when a person is exposed to the stimulus as to its type. Benner & Wrubler (1989) draw definition of stress on the work of Lazarus and his colleagues. According to them stress is the disruption of meanings, understandings and smooth functioning so that harm, loss, or challenge is experienced, and sorrow, interpretation, or new skill acquisition is required. Moral stress is related with conscience.

Health care professionals who have high moral sensitivity will experience ethical demands that may give them bad conscience when they do not act in accordance with these demands. How they react on bad conscience is connected to their perception of the origin and significance of conscience. High level of resilience and good social support will help them cope with stress of conscience.
BACKGROUND

CONCEPT OF CONSCIENCE

The concept of conscience is a creation of the Greek and Roman spirit. Costigane H. investigated a history of the Western idea of Conscience. She claims that the word ‘conscience’, derived from the Latin conscientia (con meaning ‘with’, scio meaning ‘I know’), is originally found in a range of Greek texts from the sixth century BCE to the seventh century AD as syneidesis. The main word in the group-synoida- has a basic meaning of ‘I know in common with’ (from syn and eido, ‘with’ and ‘I know’). Syneidesis itself generally refers to the goodness or badness of specific actions performed by an individual, but one who is in relationship with others (Hoose, 1999). Tillich (1963) argues that the basic Greek word synneidenai (‘knowing with’, i.e., with oneself; ‘being witness of oneself’) was common in popular language long before the philosophers utilized it. It described the act of observing oneself, often as judging oneself. In the philosophical terminology it received the meaning of ‘self-consciousness’. The Roman language, following the popular Greek usage, united the theoretical and practical emphasis, in the word conscientia, while philosophers like Cicero and Seneka admitted it to the ethical sphere and interpreted it as the trial of oneself, in accusation as well as in defense.

We found the description of conscience in Encyclopedia Britannica, that it is … a personal sense of the moral content of one’s own conduct, intentions, or character with regard to a feeling of obligation to do right or be good. Conscience, usually informed by acculturation and instruction, is thus generally understood to give intuitively authoritative judgments regarding the moral quality of single actions. And other description, which claims that ‘conscience as… knowledge of one’s own thoughts or actions, … The faculty, power, or inward principle which decides as to the character of one’s own actions, purposes, and affections, warning against and condemning that which is wrong, and approving and prompting to that which is right; the moral faculty passing judgment on one’s self; the moral sense. My conscience has a thousand several tongues, and every tongue brings in a several tale, and every tale condemns me for a villain’. Shak. ‘As science means knowledge, conscience etymologically means self-knowledge…but the English word implies a moral standard of action in the mind as well as a consciousness of our actions…. Conscience is the reason, employed about questions of right and wrong, and accompanied with the sentiments of approbation and condemnation’. Whewell. Adam Smith states that conscience supposed the existence of some such faculty, and properly signifies our consciousness of having acted
agreeably or contrary to its directions. According to the Chaucer conscience is described as tenderness of feeling, pity (Encyclopedia, 2001).

In Webster’s Revised Unabridged Dictionary (1998) we found definitions of conscience: 1) motivation deriving logically from ethical or moral principles that govern a person’s thoughts and actions (syn: scruples, moral sense, sense of right and wrong); 2) conformity to one’s own sense of right conduct; 3) a feeling of shame when you do something immoral. Conscience is that faculty of the mind, or inborn sense of right and wrong, by which we judge of the moral character of human conduct. It is common to all man.

Fuchs (1987) states that nobody doubts the fact that conscience exists as a phenomenon. We can find many definitions of the phenomenon of conscience from the viewpoint of various disciplines: developmental and social psychology, law, philosophy (ethics), moral theology, education and psychotherapy. There are many theories of conscience in philosophy, theology, and psychology.

**CONSCIENCE IN PHILOSOPHY**

In the history of ethics, the conscience has been looked upon as the will of a divine power expressing itself in man’s judgments, an innate sense of right and wrong resulting from man’s unity with the universe, an inherited intuitive sense evolved in the long history of the human race, and a set of values derived from the experience of the individual. Schalow (1995) did phenomenological analysis of Heidegger’s concept of conscience. He distinguishes the linguistic dimension of conscience as the reticent voice of care, the individualized transmission of the call as a testimony of the authentic self and, the evocate message of conscience as designating the locus of responsibility (guilt). Heidegger predicates conscience’s existential mode of ‘holding for true’ on the dynamic advent of truth as concealing-revealing, in stark contrast to Descartes’ view of truth as correctness. In one of his earliest allusions to this phenomenon, Heidegger describes conscience as the self’s readiness to cultivate death as a possibility. He described conscience as a voice, which the self both utters and heeds. For him, conscience is not a human mode in which the voice of God becomes present, but rather the recoil from absence, which prefigures any turn toward enlightenment and self-discovery. Heidegger turned to St. Paul and St. Augustine to uncover conscience as God’s way of seeking out what is most troublesome or of foremost concern to us, as an appeal corresponding to the Divine *logos* which stands for God’s conscience. As
Kisiel emphasizes, in this Pauline-Augustinian context Heidegger suggested that conscience involves the response of troubling oneself to take care of the troubling situation.

Schalow (1995) states that Heidegger uncovers the evocative power of language. According to Heidegger the language is most primitive sense. Language’s disclosedness preserves the power from which the human act of speaking originates the economic preservation of that capacity through silence. Silence draws upon the primeval power of *logos* as it intersects with the disclosure process through which *Dasein* as a speaking being participates. We thereby arrive at silence as the distinctive trademark of conscience’s call, that is, as a tribute to the ultimate economy of speech. According to Heidegger, the call of conscience says “nothing”. By saying nothing, the call provides the necessary provocation to awaken the self to its own possibilities, including the unique prospect of death. The *logo, which is* expressed in the silent, call supplies the governance to direct the self-back to who it already is.

Crowell (2001) claims that Heidegger’s analysis of the two sides of conscience—‘what is talked about’ and ‘what is said’—elucidates the positive role of first-person self-awareness. By ‘what is talked about’ Heidegger means that ‘to which the appeal is made’; by ‘what is said’ he means what conscience ‘gives to understand’ about that to which the appeal is made. Analyzing the first, Heidegger provides an existential ontological account of the peculiarities of first-person self-reference; analyzing the second, he shows the philosophical significance of subjectivity. According to Crowell (2001), Heidegger distinguish one-self and the ‘Self’. The phenomenon of conscience belongs to the breakdown of the one-self, because as Heidegger claims only the ‘Self’ of the one-self gets appealed to and brought to hear, the ‘one’ collapses.

Heidegger discovered the path to describe conscience in phenomenological terms, namely, as the silent call of care. With only a short step he recognized that silence becomes the point of attraction by which the self who is lost can be rescued in order to appreciate the full extent of its potentiality (Schalow, 1995).

According to Schalow (1995) Heidegger by observing Kant made an important advance by addressing conscience according to idea of the moral law and the respect for personhood implied therein. With this statement, Heidegger recalls the neo-Kantian roots of his teacher, Paul Natrop. Natrop fused Eckhart and Luther in order to elicit from Kant’s Enlightenment-notion of dignity the root of conscience as the “little castle”, as the personal side of our self-legislative natures.
The destructive strategy implied in Heidegger’s analysis of conscience becomes faintly evident in the attempt to uncover the ‘not’ or ‘negativity’ which pervades that entire phenomenon. Such negativity in the most discreet message of conscience, namely, that Dasein is already “guilty”. Heidegger adopts his notion of guilt from Jaspers’ rendition of it as marking an important aspect of the “limit-situation” and as suggesting the doubling of concern for one’s existence. As such, guilt points to the opposite end of the limit-situation, which is circumscribed by death, and qualifies as a preliminary response to the inevitable fact of mortality. Heidegger argues that the call of conscience antedates any sense of regret, the kind of “bad conscience” which Nietzsche exposed in his attack on Christian morality. As such, Heidegger does not attribute guilt to the outcome of any specific action, but instead distinguishes it as the ingredient of finitude configuring in advance our power to act. The potential to be guilty thereby marks the finite allocation of Dasein’s capacity to act, the disclosure of its selfhood through those specific possibilities granted within a given situation (Schalow, 1995).

According to the Crowell (2001) Heidegger’s description of ‘what is said’ in the call, namely, the accusation ‘Guilty!’ Heidegger formalizes the everyday notion of guilt in such a way that those ordinary phenomena of ‘guilt’ which are related to our concernful being with others will drop out – phenomena related to everyday ‘reckoning’ as well as ‘any law or ought’.

Sandorf S. Levy (1999) analyzed Thomas Reid’s definitions of morality. Principles of morality are obtained by what he calls ‘conscience’, ‘the moral faculty’, ‘the moral sense’, or ‘intuition’. Reid claims that we should ‘receive the testimony of’ conscience, that conscience is to trusted, and that it is not fallacious. When Reid says that conscience is not fallacious, he means that there are moral facts and that, when carefully used, conscience is a reliable guide to them.

Levy (1999) claims that it is ‘psychologically possible to deny that the dictates of conscience are true in a way that it is not psychologically possible to deny the truth of the dictates of the senses…’ A reviewer for History of Philosophy Quarterly has pointed out that the example of the person who, contrary to the dictates of conscience, throws someone into the fire does not show this. As I understand it, the criticism is that this is simply an example of a person who acts contrary to conscience. That, indeed, is a common phenomenon. Save on certain prescriptive view, it is perfectly possible to act contrary to conscience and to continue to say tat conscience speaks truly. Guilt is the common result of such actions (p. 433).
Levy (1999) states that when he speak of denying conscience, he not merely talk about acting contrary to conscience. It is that one can also deny conscience in the sense of denying that it delivers objective moral truth, even though it speaks clearly and violating it yields guilt. He writes ‘… consider a warm-up case in which I continue to think that there is an objective moral truth, but that my own conscience is corrupt and unlikely to be an accurate guide to it. Where I to be persuaded that for the good of my soul, and that of my victims, I must toss them into the fire, I have no doubt that I would suffer. Wishing to do well, I could act contrary to my conscience in the face of intense guilt. I would simply say that my conscience, and my sense of guilt, were not trustworthy’. (p. 434).

Lederman (2003) analyzed conscience and bodily awareness. He states that existential moral awareness is based on conscience.

As Buber (1965) claims that ‘Conscience means to us the capacity and tendency of man radically to distinguish between those of his past and future actions, which should be approved, and those, which should be disapproved. Conscience can naturally distinguish and if necessary condemn in such a manner not merely deeds but also omissions, not merely decisions but also failures to decide, indeed even images and wishes that have just arisen or are remembered’ (p. 134).

According to the Lederman (2003) conscience is personal. It relies on the freedom of existence. He states that man reflects on himself. Conscience calls him to take leave of a state of falsehood or in authenticity and to seek to establish himself on the level of true selfhood or authenticity. Because of Conscience, man feels the duty to cope with his life. He feels guilty if he fails before his conscience. Freedom is exercised in carrying out the demands made by conscience.

**CONSCIENCE IN PSYCHOLOGY**

Conscience is a multifaceted construct with diverse affective and behavioral manifestations (Kochanska, De Vet, Goldman, Murray & Putman, 1994). According to the Baker (1995) conscience has been defined as a person’s system of moral values, standards of behavior; and sense of right and wrong. Its elements consist of a sense of accountability, including both responsibility for past actions and feelings and obligation in regard to future ones, a capacity for self-criticism, and standards and ideals (Loevinger, 1976). Conscience is linked to concern about compliance with standards of conduct, apology, confession, and reparation, as well as
empathy and prosocial themes, and concern about social relationships (Kochanska, Padavich, & Koenig, 1996).

Fuchs (1987) analyzes the phenomenon of conscience from various aspects. He states that psychology investigates how certain types of psychological motivation determine the behavior of young children, who undoubtedly lack moral conscience, and also often that of juveniles and adults. The Freudian Super- Ego can play a predominant part in the way we conduct our lives and are far too often in danger of being mistaken for moral conscience. L.Kohlberg’s studies on moral maturity and immaturity clearly show that not all orientation for life is call of moral conscience.

Rose (1999) described Kohlberg moral development theory. Kohlberg posited 6 stages of moral development (2stages at each of 3 major levels). At the first or premoral level, the first stage is marked by heteronomy and an orientation toward punishment. At the second stage, morality is pragmatic and based upon the satisfaction of needs, primarily one’s own needs. At the second level, Morality of Conventional Role-Conformity, in stage 3, morality is defined in terms of conventional social standards and the emphasis is upon superficial niceness. At stage 4, morality reflects the belief in maintaining the social order and obeying authority.

The third level is the Morality of Self-Accepted Moral Principles. As in Piaget, s Stage III in the development of moral thought, consciousness of rules, at Kohlberg’s stage 5 people understand and believe that rules can be changed if everybody agrees to such a change. Kohlberg’s highest stage, 6, is characterized by the presence of self-selected standards as well as true respect for other individuals (Rose, 1999).

Morality, according to Fuchs (1987), thus presupposes that human action is not a spontaneous reaction but follows decisions based on insight of conscience.

How conscience develops is an important subject of theoretical investigation for the human service professions. Conscience development, which includes ethical and moral development, requires some degree of intellectual development. The growth of conscience involves the gradual increase in impulse control, the incorporation of parental moral standards, the development of shame and guilt, the learning of the consciousness and practice of rules, and the maturation of the sense of justice (Rose, 1999).
CONSCIENCE IN THEOLOGY

We can find different explanation of conscience in biblical foundations. Costigane (1999) finds that the Hebrew language has no specific word for conscience, though the idea of a judgment on actions performed is expressed by reference to the heart. The heart—meaning the inward part of a person as opposed to what is visible—is seen as the seat of the faculties and personality, and from it precedes thoughts and feelings, words, decisions, and actions. The Scriptures present the proper working of the heart in terms of seeking God, being in relationship with him, and listening to him. According to the Costigane (1999) in the Greek understanding, conscience seemed to be a function of reason, and that its pain was debilitating. The distinction between heart and conscience in the biblical texts is echoed by many of the early Christian writers: Augustine, Thomas Aquinas, Martin Luther, and John Henry Newman.

In the Greek sources, we see that the pain of conscience is something experienced by the individual. Theologians such as Soren Kierkegaard, John Henry Newman and Karl Barth have made statements on this subject of the individuality of conscience. The individuality of conscience—of one’s personal responsibility before God—has been much more than just idea for many individuals, but has had dramatic consequences for them and the communities within which they lived and died. So community plays important role in the formation of conscience (Costigane, 1999).

According to Kissling (2001) principle of the conscience certainly is Catholic, and it certainly is religious. Most faith groups that have a theologically centred reality include the central notion that an individual answers personally to God for what that individual has done. Since individuals answer for their behaviour, then those individuals must have the freedom to act on their deeply held, reflected beliefs. Conscience is not laissez-faire behavior. It involves deep reflection on one’s values.

We can find different view of conscience when looking from the outside different religious. According to Hoose (1999) Roman Catholic view of conscience as monolithic, based upon the view of the Magisterium and derived from natural law, in practice, this perception is far from truth and the complete picture is much more complex.

Hoose (1999) states that in discussing what is meant by mature Christian conscience within the Roman Catholics we face the tension for that Church between freedom of conscience and authority, and between a concern for the spirit of law with an emphasis on the development of
the mature person and the idea of freedom, and concern for the letter of the law, the role of the *Magisterium* as moral guardian and its concern that the law is disseminated and adhered to. This in turn provides a tension within the sphere of moral education, the *Magisterium* on the one hand adopting the role of teaching correct moral precepts and on the other being concerned with developing virtuous and mature individuals, and respecting the dignity of individual conscience.

Fuchs (1987) claims conscience meaning-particularly in Catholic Moral Theology-in a narrower sense the authority that determines good and right conduct in a concrete situation. In theology the emphasis has been laid on the obect-orientation of the conscience. Often it is considered as being ‘the Voice of God’. The formulation ‘follow your conscience’, often heard in connection with morality and pastoral matters is basically subject-related.

Fuchs (1987) discussed conscience in a specific situation. He states that judgment made by conscience in a specific situation, which is with respect to the person in a concrete situation, is exclusively judgment by subject who has to reach some decision on the spot. Conscience’s judgment on moral rightness, the conscience’s subject-orientated assessment and the personal moral decision all take place simultaneously. There is neither a preceding nor a subsequent situation from point of view of time, only from a logical point of view. This is the reason why the moral subject is quite alone with its conscientious decision; theologically speaking, with and before God.
AIMS

Overall aim for the thesis is to describe the essence of the concept of conscience reflected by the care professionals in primary health care.

AIM OF PART 1 (study I) - to describe and to illuminate aspects, which are the conscience connected in literature review.

AIM FOR PART 2 (study II) - to examine the validity of the questionnaire of ‘conscience’ among care professionals in primary health care.

RESEARCH QUESTIONS

- What are the aspects the perception of conscience described in literature?
- What is perception of conscience among care professionals in primary health care?
- How representative are the questions on conscience within questionnaire?
PART 1: LITERATURE STUDY (STUDY I)

METHOD

DATA SELECTION

A systematic survey of relevant literature was conducted using the electronics databases EBSCO, CINAHL (National Library and Allied Health Literature), ELIN and PubMed.

The search period was from February 2004 to January 2005. To cover the field of interest of the study, conscience was used as search term. This concept was combined with the terms nurse, care, health, treatment, patient, health care, and physicians.

The criteria for selection included scholarly articles with definition of the concept of conscience relevant to questionnaire of ‘conscience’, and research studies that investigated the understanding of conscience among care professionals. All reviewed literature was in English language.

Selection of articles followed three steps according to the Matrix Method: reviewing the abstracts, skimming the documents, and photocopying the documents. The literature review consists of reading, analyzing, and summarizing scientific materials of a specific topic (Garrard, 1999). Following steps did it: reviewing of the abstracts, skimming and photocopying the documents. Total 121 abstracts were found and 50 abstracts published in 1992–2005 were saved (Table 1).

Table 1. Number of articles selected for analyzing.

<table>
<thead>
<tr>
<th>Data base</th>
<th>Keywords</th>
<th>Number of found documents</th>
<th>Number of abstracts relevant to area</th>
<th>No of used abstracts</th>
</tr>
</thead>
<tbody>
<tr>
<td>ELIN</td>
<td>Conscience and care</td>
<td>38</td>
<td>20</td>
<td>9</td>
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<tr>
<td></td>
<td>Conscience and nurse</td>
<td>11</td>
<td>11</td>
<td>8</td>
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<td></td>
<td>Conscience and treatment</td>
<td>7</td>
<td>1</td>
<td></td>
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<tr>
<td></td>
<td>Conscience and health</td>
<td>12</td>
<td>12</td>
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<td></td>
<td>Conscience and physicians</td>
<td>2</td>
<td>2</td>
<td>2</td>
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<td></td>
<td>Health care and conscience</td>
<td>17</td>
<td>10</td>
<td>6</td>
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<td></td>
<td>Patient and conscience</td>
<td>14</td>
<td>14</td>
<td>5</td>
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<tr>
<td>PubMed</td>
<td>Conscience and care</td>
<td>357</td>
<td>23</td>
<td>7</td>
</tr>
<tr>
<td>CHINAL</td>
<td>Subject heading</td>
<td>39</td>
<td>18</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Conscience</td>
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<tr>
<td>EBSCO</td>
<td>Conscience and care</td>
<td>16</td>
<td>10</td>
<td>8</td>
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</tbody>
</table>

After examination the saved 50 abstracts was decided whether or not to keep a copy of the document for inclusion in the literature review. 5 abstracts with keyword ‘conscience and care’ found in EBSCO were duplicates found in ELIN. Of the 70 abstracts found in ELIN were 14 of them duplicates already was found in CHINAL and 12 in PubMed.
12 articles were selected relevant to the aim of the study.

According to Garrard (1999) review of found articles takes 3 steps: organizing the documents, choosing topics and abstracting the documents. Articles selected for review were red and abstracted from the oldest to the most recent by year of publication. The 12 of selected articles were presented in a matrix where the author, title, aim, method and general results are presented from each article. Eight empirical articles were presented in table 2 and four theoretical articles in table 3.

Table 2. Empirical articles selected for the data analyzing.

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Aim</th>
<th>Method</th>
<th>General results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palsson M. B., Norberg A. (1995). Scand J Caring Sci 9, 17-27.</td>
<td>District Nurses’ Stories of Difficult Care Episodes Narrated during Systematic Clinical Supervision Sessions</td>
<td>To illuminate district nurses’ lived experiences of demanding care situations narrated in systematic clinical supervision sessions.</td>
<td>Phenomenologic al-hermeneutical interpretations of narratives.</td>
<td>The following themes emerged in the analysis of the stories: coming too close to the patient; keeping and restoring patient’s hope; conflicting opinions; feeling powerless; meeting unrealistic demands; patients’ trust in alternative medicine; feeling disgust, shame and guilt; relations to patients’ families; and communication gaps. The findings strongly emphasize that district nurses experienced problems in the home care of seriously ill patients. They must not only serve for patients' emotional strain, but they also have to support relatives in their anxiety. Findings also showed that there was often a balance between negative and positive dimensions in these meetings with dying patients and their families. It seems important to form support groups to help district nurses deal with demanding care situations and to relieve them of feelings and thoughts aroused in the provision of care. Support in the form of clinical supervision may impact the quality of care in a positive way.</td>
</tr>
<tr>
<td>Nelms, T.P. (1996). Journal of Advanced Nursing. 24,368-374.</td>
<td>Living a caring presence in nursing: a Heideggerian hermeneutical analysis</td>
<td>To illuminate nurses’ shared practices and common meanings of living a caring presence in nursing</td>
<td>Five nurses wrote a story, one they would never forget, of living a caring presence. The stories were analyzed and interpreted against a background of Heideggerian philosophy to reveal the constitutive pattern, “caring as the presenting of being”.</td>
<td>The stories were analyzed and interpreted against a background of Heideggerian philosophy. Meaning and complexity of the pattern were revealed in themes that illuminate and articulate the essence of nursing and phenomenon of caring. Themes were the timeless and spacelessness of caring, creating home, and the call to care as the call of conscience. Heideggerian conscience is in the nature of a call to our innermost potentiality for being ourselves. All nurses in this study heard and heeded this call, a wordless, silent call. The call is precisely something we ourselves have neither planned nor prepared for nor voluntarily perform. It calls against our expectations and against our wills.</td>
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<td>Table 2 (Continuation)</td>
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<td>----------------------------------------------------------------------------------------</td>
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<tr>
<td>Perioperative Nurses, Encounter with Value Conflicts: A Descriptive Study</td>
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<tr>
<td>To gain a better insight into perioperative nurses’ experience in a value conflict that has arisen in the perioperative caring environment and how they deal with it. To understand the meaning of nurses’ experiences and how the nurses act in a value conflict situation.</td>
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<tr>
<td>Descriptive study</td>
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<td>A value conflict is something that nurses have become part of against their own will. They are prevented from giving the good care they want to give, they are in conflict with themselves and have a bad conscience, and they feel guilt and shame for not having prevented the value conflict. The nurse who involved in a value conflict aims, for the sake of the patient, to be a professional caring nurse. The nurse chooses to be the patient’s neighbor, the one who suffers along with the patient and represents the patient’s cry for help.</td>
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<td>Challenge of culture conscience and contract to general practitioners’ care of their own health: qualitative study.</td>
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<td>To explore general practitioners’ perceptions of the effects of their profession training on their attitude to illness in themselves and colleagues.</td>
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<td>Qualitative study using focus groups And in-depth interviews. 27 general practitioners participated.</td>
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<td>Participants were concerned about the current level of illness within the profession. They described their need to portray a healthy imagine to both patients and colleagues. This hindered acknowledgement of personal illness and engaging in health screening. Embarrassment in adopting the role of a patient and concerns about confidentiality also influenced their reactions to personal illness. Doctors’ attitudes can impede their access to appropriate health care for themselves, their families, and their colleagues. A sense of conscience towards patients and colleagues and the working arrangements of the practice were cited as reasons for working through illness and expecting colleagues to do likewise.</td>
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<td>The meaning of being in ethically difficult care situations in pediatric care as narrated by female Registered Nurses</td>
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<td>To illuminate the meaning of female Registered Nurses’ lived experience of being in ethically difficult care situations in pediatric care.</td>
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<td>Phenomenologic al-hermeneutic study. Interpretation the transcribed interview from twenty female Registered Nurses.</td>
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<td>Nurses felt that something was missing They missed self-confirmation from their conscience. This gave them an identity problem. They were regarded as good providers but at the same time, their conscience reminded them of not taking care of all the ‘uninteresting’ patients. This may be understood as ethics of memory where their conscience ‘set them a test’. The emotional pain nurses felt was about remembering the children they overlooked, about bad conscience and lack of self-confirmation. Nurses felt lonely because of lack of open dialogue about ethically difficulties, between colleagues and about their feeling that the wrong things were prioritized in the clinics.</td>
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<td>Kalvemark S., Hoglund A.T., Hansson M. G., Westerholm P.and Arnetz B. (2003). Social Science &amp; Medicine 58 (6), 1075-1084.</td>
<td>Living with conflicts-ethical dilemmas and moral distress in the health care system</td>
<td>To identifies situations of ethical dilemmas and moral distress among health care providers of different categories. The study includes both hospital clinics and pharmacies.</td>
<td>Focus group method. Study was done in a clinical department of cardiology, haematology and pharmacy. In each group 5-7 persons participated: physicians, nurses, auxiliary nurses and pharmacists.</td>
<td>All categories of staff interviewed express experiences of moral distress. Moral distress does not occur as only a consequence of institutional constraints preventing the health care giver from acting on his/her moral considerations, which is the traditional definition of moral distress. Moral distress must focus more on the context of ethical dilemmas. The work organization must provide better support resources and structures to decrease moral distress. The results point to the need for further education in ethics and a forum discussing ethically troubling situations experienced in the daily care practice for both hospital and pharmacy staff.</td>
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<td>Sorlie V., Kihlgren and Kihlgren M. (2004). Nursing Ethics 11(2), 179-189.</td>
<td>Meeting Ethical Challenges in Acute Care Work as Narrated By Enrolled Nurses</td>
<td>To illuminate the experience of ENs being in ethically difficult care situations and on working in an acute care unit</td>
<td>Phenomenologic al-hermeneutical interpretation. Five enrolled nurse were interviewed as part of a comprehensive investigation into the narratives of registered nurses, ENs and patients about their experiences in an acute care ward.</td>
<td>The most prominent feature was the focus on relationships, as expressed in concern for society’s and administrators' responsibility for health care of older people. Other themes focus on how nurse managers respond to the ENs work as well as their relationship with fellow ENs, in both work situations and shared social and sports activities. Their reflections seem to show an expectation of care as expressed in their lived experiences and their desire for a particular level and quality of care for their own family members. A lack of time could lead to a bad conscience over the 'little bit extra' being omitted. This lack of time could also lead to tiredness and even burnout, but the system did not allow for more time.</td>
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<td>Hurst SA, Hull SC, Duval G, Danis M. (2005). J Med Ethics 31(1), 7-14.</td>
<td>How physicians face ethical difficulties: a qualitative analysis</td>
<td>To identify strategies used by physicians dealing with ethical difficulties in their practice</td>
<td>Qualitative analysis of 310 ethically difficult situations described by physicians encountered them in their practice</td>
<td>When faced ethical difficulties, the physicians avoided conflict and looked for assistance, which contributed to protecting, or attempting to protect, the integrity of the conscience and reputation, as well as the integrity of the group of people participated in the decisions. These efforts sometimes reinforced ethical goals such as following patients' wishes or their best interests, but they sometimes competed with them. The goals of avoiding conflict, obtaining assistance protecting the respondent’s integrity and that of group of decision making could also compete with each other.</td>
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Without the eight empirical articles selected for data analyzing four theoretical articles (discussion, debate, guidelines and review essay) were used to have wide understanding the concept of conscience among care professionals.
<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Aim</th>
<th>Method</th>
<th>General results</th>
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<tr>
<td>James F. Childress</td>
<td>Conscience and Conscientious Actions in the Context of MCOs</td>
<td>To explore a few themes in conscience and conscientious actions and examine how some problems of conscience may arise in conflicts of obligation and conflicts of interest in MCOs.</td>
<td>Discussion</td>
<td>Ranges of acts of non-cooperation that may express and protect an individual’s conscience-conscientious objection or refusal, withdrawal, whistle blowing, and so forth. Some forms of non-cooperation, deceptively gaming the system, are themselves morally problematic. In the case, the moral decisions may be quite difficult. It is important not put all the moral burden on the individual professional’s conscience. We should praise morally heroic actions, but as a society enact public policies to reduce the demands on conscience, to reduce conflicts of interest that create incentives for breaches of conscience, and to reduce the risks for conscientious actions, for example, the risks of being dismissed.</td>
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<tr>
<td>May, Thomas</td>
<td>Right of Conscience in Health Care</td>
<td>To describe a model for Right of Conscience in Health care</td>
<td>Debate/Discussion on about two case descriptions</td>
<td>Professional life in a liberal constitutional society involves a balancing of values professional and client. A liberal society is concerned with protection an individual conscience. One does not lose these protections simply because one becomes a health care professional, and general should not be required to offer services that conflict with their own moral or religious beliefs. Right of conscience in health care should be exercised on the grounds that one objects to the question, and not because one disagrees with the patient about the relative desirability of an not object type</td>
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<td>William A Nelson, Cedric K Dark</td>
<td>Evaluating Claims of Conscience</td>
<td>To evaluate a claim of conscience clauses</td>
<td>Guidelines</td>
<td>The responsibility for evaluating claims of conscience should be dispersed across several levels of leadership. The supervisor has the duty to evaluate the validity of the claim. Review board composed of members from various ethnic, religious, and academic settings. The mission of the review board is to determine whether valid claims of conscience are indeed genuine claims. Conscience clauses protect the ethical right of physicians and others involved in patient care to object to performing a particular treatment on the basis of their moral or religious views. Often, the types of treatment providers can refuse are limited to reproductive health or end-of-life issues, e.g., abortion, sterilization, and physician-assisted suicide.</td>
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Table 3 (Continuation)

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<td>The Nature and Limits of the Physician’s Professional Responsibilities: Surgical Ethics, Matters of Conscience, and Managed Care</td>
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<tr>
<td>To explore the physician’s professional responsibilities in the areas of surgical ethics, matters of conscience, and managed care.</td>
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<tr>
<td>Review essay</td>
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<td>Professional conscience concerns boundaries of behavior that no physician should cross, because to do so would be inconsistent with and undermine intellectual and moral integrity, what the Quinlan Court called an “ineluctable bar”. Individual conscience concerns boundaries of behavior set by the integrity of physicians from sources other than professional medical ethics, e.g., religious beliefs and other core personal values, that pertain to the individual physician but not in his or her professional role.</td>
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DATA ANALYSIS

The integrative research review was used for the literature analysis. The purpose of this kind review according to Kirkevold (1997) is to interconnect isolated elements from existing studies. According the Cooper (1989) one of the most effective and widely used methods of integrative research is the use of prior research to develop a more comprehensive account of a specific phenomenon or relationship than each of the related research reports separately. This is sometimes referred to as integrative research reviews.

Cooper (1989) states ‘integrative reviews summarize past research by drawing overall conclusions from many separate studies that are believed to address related or identical hypotheses. The integrative review hopes to present the state of knowledge concerning the relations of interest and to highlight important issues that research has left unresolved’ (p. 13).

RESULTS

The literature search produced a number of empirical studies and theoretical articles about understanding the conscience among care professionals. Empirical articles have been read and abstracted separately of theoretical articles. Articles with similar thoughts and ideas of general results were divided into four groups. After that, the articles have been read one more time. The main conclusions of different studies of the different groups of articles were fixed as titles of results. The themes of conclusions of empirical articles were: Call of conscience, Individual conscience, Professional conscience and Bad conscience and feelings of guilt, shame and emotional pain.

Only two themes of conclusions of theoretical articles were found: Professional conscience and Individual conscience. The results of empirical and theoretical articles were put together.
CALL OF CONSCIENCE

Nurses present stories about common meanings of living a caring presence in nursing. Themes were the timelessness and spacelessness of caring, creating home, and calls to care as common meanings of living a caring presence in nursing the call of conscience. All nurses in this study heard and heeded this call, a wordless, silent call. The call is precisely something we ourselves have neither planned nor prepared for nor voluntarily perform. It calls against our expectations and against our wills (Nelms, 1995).

The nurses’ stories of Nelms (1996) study were analyzed and interpreted against a background of Heideggerian philosophy to reveal the constitutive pattern, ‘caring as the presencing of being’. Heideggerian conscience is in the nature of a call to our innermost potentiality for being ourselves (Mehta, 1976; Graybell, 1990). According to Mehta (1976) the call is precisely something we ourselves have neither planned nor prepared for nor voluntarily perform. It calls against our expectations and against our wills. And yet the call reaches the ‘one’ who wants to be retrieved and moves the ‘one’ back resolutely to individualize authentic being.

The call of conscience, if understood through resoluteness, recalls us to an authentic openness, which in turn transforms our awareness of the ‘world’ and others. All of the stories in hermeneutical study reveal the silent call of conscience to authentic being heeded by each ‘one’ of these nurses that transformed the ‘world’ of nursing practice for them, their patients or student and their families, and possibly other members of the nursing staff (Nelms, 1996). Sorlie et al (2003) investigated the meaning of being in ethically difficult situations in pediatric care as narrated by female Registered Nurses. Nurses were regarded as good care providers but at the same time, their conscience reminded them of not taking care of all the ‘uninteresting’ patients. This may be understood as ethics of memory where their conscience ‘set them a test’.

INDIVIDUAL CONSCIENCE

Care professionals are persons with individual understanding of life, morality and different values. According to Kalvemark, Hoglund, Hansson, Westerholm and Arnetz (2003), a moral distress does not only occur as a consequence of institutional constraints preventing the health care giver from acting on his/her moral considerations. The staff members follow their moral decisions, but in doing this they clash with e.g. legal regulations. Jameton focuses on the
individual health care provider and her/his subjective moral convictions. They assumed that she/he is aware of what is ethically correct and necessary in different situations.

Professional life in a liberal constitutional society involves a balancing of values professional and client. A liberal society is concerned with protecting an individual conscience. One does not lose these protections simply because one becomes a health care professional, and general should not be required to offer services that conflict with their own moral or religious belief (May, 2001).

McCullough (2004) reviews the nature and limits of the physician’s professional responsibilities. He discussed individual and professional conscience. Individual conscience, according to McCullough (2004) concerns boundaries of behavior by the integrity of physicians from sources other than professional medical ethics, e.g., religious belief and other core personal values that pertain to the individual physician but not his or her professional role.

**PROFESSIONAL CONSCIENCE**

Professional conscience concerns boundaries of behavior that no physician should cross, because to do so would be inconsistent with and undermine intellectual and moral integrity, what the *Quinlan* Court called an ‘ineluctable bar’ (McCullough, 2004).

It is important not put the entire moral burden on the individual professional’s conscience. According to Childress (1997) we should praise morally heroic actions, but as a society enact public policies to reduce the demands on conscience, to reduce conflicts of interest that create incentives for breaches of conscience, and reduce the risks for conscientious actions, for example, the risks of being dismissed.

The results of qualitative study of general practitioners’ perception of the effects of their profession and training on their attitudes to illness in themselves and colleagues show that a sense of conscience towards patients and colleagues and working arrangements of the practice were cited as reasons for working through illness and expecting colleagues to do likewise (Thompson et al, 2001).

The care professionals have to thing, know and understand the conscience. Nelson and Cedric (2003) state that the responsibility for evaluating claims of conscience should be dispersed across several levels of leadership. The supervisor has the duty to evaluate the validity of the claim. Review board composed of members from various ethnic, religious, and academic
settings. The mission of the review board is to determine whether valid claims of conscience are indeed genuine claims. Conscience clauses protect the ethical right of physicians and others involved in patient care to object to performing a particular treatment on the basis of their moral or religious views. Often, the types of treatment providers can refuse are limited to reproductive health or end-of-life issues, e.g., abortion, sterilization, and physician-assisted suicide.

According to Hurst, Hull, Duval & Danis (2005), when faced ethical difficulties, the physicians avoided conflict and looked for assistance, which contributed to protecting, or attempting to protect, the integrity of the conscience and reputation, as well as the integrity of the group of people participated in the decisions.

Integrity of the conscience and reputation can be explained as integrity between professional and individual conscience.

BAD CONSCIENCE AND FEELINGS OF GUILT, SHAME AND EMOTIONAL PAIN

Post (1998) evaluated perioperative nurses, their experience in a value conflict that arises in the perioperative caring environment and how they deal with it. A value conflict is something that nurses have become part of against their own will. They are prevented from giving the good care they want to give, they are in conflict with themselves and have a bad conscience, and they feel guilt and shame for not having prevented the value conflict.

The nurses are in conflict with themselves and with their idea of how the care should be carried out. When they do not have a choice, they have to take part in the care even though it is in conflict with their own principles about respect for human dignity. An inner conflict may arise when a nurse is unable to defend her ideals, allowing her colleagues’ demands for effectiveness to control the care (Post, 1998).

According to the informants in Post (1998) study, it is the person in a value conflict who gives herself a bad conscience and takes on the guilt and the responsibility for what happened to the patient. The nurses feel that they have let the patient down when other colleagues behave impolitely and unprofessionally. They come into conflict with their own conscience, since they know what is right and wrong for the patient, here and now.

The bad conscience is the nurse’s intuitive awareness of what is required of a nurse.
The feeling of guilt remains for a long time or until they put the blame on the one who really subjected the patient to the unworthy care. As nurses, they feel ashamed of themselves when colleagues violate the patient’s dignity (Post, 1998).

Sorlie, Jansson & Norberg (2003) illuminated the meaning of female Registered Nurses’ lived experience of being in ethically difficult care situations in paediatric care. Nurses felt that something was missing. They missed self-confirmation from their conscience. This gave them an identity problem. They were regarded as good providers but at the same time, their conscience reminded them of not taking care of all the ‘uninteresting’ patients. This may be understood as ethics of memory where their conscience ‘set them a test’. The emotional pain nurses felt was about remembering the children they overlooked, about bad conscience and lack of self-confirmation. Nurses felt lonely because of lack of open dialogue about ethically difficulties, between colleagues and about their feelings that the wrong things were prioritized in the clinics (Sorlie, Jansson & Norberg, 2003).

According to Kalvemark, Hoglund, Hansson, Westerholm & Arnetz (2003) all categories of interviewed staff express experiences of moral distress. Moral distress does not occur as only a consequence of institutional constraints preventing the health care giver from acting on his/her moral considerations, which is the traditional definition of moral distress. Moral distress must focus more on the context of ethical dilemmas.

Moral distress is a consequence from the conflict between the time and work spent on patients in relation to time for administrative tasks. Care providers talk about ‘a constantly bad conscience’ and hold that they ‘would feel better’ if they had more time with the patients. According to their conscience their prime task is to be there for the patients (Kalvemark, Hoglund, Hansson, Westerholm & Arnetz, 2003).

Sorlie, Kihlgren & Kihlgren (2004) did the same conclusions. Phenomenological – hermeneutic interpretation of the narratives from five enrolled nurses found that a lack of time could lead to a bad conscience over the ‘little bit extra’ being omitted. This lack of time could also lead to tiredness and even burnout, but the system did not allow for more time.

The following themes emerged in the analysis of the stories from Palsson and Norberg (1995): coming too close to the patient; keeping and restoring patient’s hope; conflicting opinions; feeling powerless; meeting unrealistic demands; patients’ trust in alternative medicine; feeling disgust, shame and guilt; relations to patients’ families; and communication gaps.
DISCUSSION

The aim of the literature study was to review and summarize past research about conscience of care professionals. Integrative review was used for literature analysis. According to Cooper (1989), ‘integrative reviews summarize past research by drawing overall conclusions from many separate studies’ (p. 13).

It was difficult to find empirical studies about conscience of care professionals. Eight qualitative studies were found relevant to the aim of the study; other four articles were theoretical: review essay, discussions and debates.

The results of literature study reinforced statements of philosophers and other scholars. Hermeneutical study where nurses’ shared practices and common meaning of living a caring presence in nursing showed that all of the stories reveals the silent call of conscience to authentic being heeded by each ‘one’ of the nurses that transformed the ‘world’ of nursing practice for them, their patients or students and their families, and possibly other members of the nursing staff (Nelms, 1996).

We thereby arrive at silence as the distinctive trademark of conscience’s call, that is, as a tribute to the ultimate economy of speech. According to Heidegger, the call of conscience says ‘nothing’. By saying nothing, the call provides the necessary provocation to awaken the self to its own possibilities, including the unique prospect of death. The *logo, which is* expressed in the silent, call, supplies the governance to direct the self-back to whom it already is (Scholow, 1995).

Schalow (1995) states that Heidegger distinguishes the linguistic dimension of conscience as the reticent voice of care, the individualized transmission of the call as a testimony of the authentic self and, the evocative message of conscience as designating the locus of responsibility. According to Shallow (1995) Heidegger described conscience as a voice, which the self both utters and heeds. For him, conscience is not a human in which the voice of God becomes present, but rather the recoil from absence, which prefigures any turn toward enlightenment and self-discovery.

May (2001), McCullough (2004) and Childress (1997) discussed individual and professional conscience. According to Kissling (2001), most faith religion groups that have a theologically centred reality include the central notion that an individual answers personally to God for what that individual has done. Since individuals answer for their behavior, then those
individuals must have the freedom to act on their deeply held, reflected beliefs. Conscience is not laissez-faire behavior. It involves deep reflection on one’s values.

Theologians such as Kierkegaard, Newman and Barth have made statements on this subject of the individuality of conscience. The individuality of conscience - of one’s personal responsibility before God – has been much more than just idea for many individuals, but has had dramatic consequences for them and communities within which they lived and died (Costigane, 1999).

May (2001) states that a liberal society is concerned with protecting an individual conscience. One does not lose these protections simply because one becomes a health care professional, and general should not be required to offer services that conflict with their own moral or religious beliefs.

According to Lederman (2003), conscience is personal. It relies on the freedom of existence. He states that man reflects on himself. Conscience calls him to take leave of a state of falsehood or in authenticity and seek to establish on the level of true selfhood or authenticity.

Childress (1997) claims that it is important not put the entire moral burden on the individual professional’s conscience. Health professionals often are in ethically difficult care situations. Post (1998) states that nurse’s experiences a value conflict when have become part of against their own will. They are prevented from giving the good care they want to give, they are in conflict with themselves and have a bad conscience, and they feel guilt and shame for not having prevented the value conflict.

The following themes emerged in the analysis of the stories from Palsson and Norberg (1995): coming too close to the patient; keeping and restoring patient’s hope; conflicting opinions; feeling powerless; meeting unrealistic demands; patients’ trust in alternative medicine; feeling disgust, shame and guilt; relations to patients’ families; and communication gaps. Sorlie, Kihlgren & Kihlgren (2004) found the same that a lack of time could lead to a bad conscience over the ‘little bit extra’ being omitted. The lack of time could also lead to tiredness and even burnout, but the system did not allow for more time.

Bad conscience and feeling of guilt claims Heidegger. According to Heidegger, the call of conscience antedates any sense of regret, the kind of bad ‘conscience’, which Nietzsche exposed in his attack on Christian morality. As such, Heidegger does not attribute guilt to the outcome of any specific action, but instead distinguishes it as the ingredient of finitude configuring in advance our power to act. The potential to be guilty thereby marks the finite
allocation of Dasein’s capacity to act, the disclosure of its selfhood through those specific possibilities granted within a given situation (Schalow, 1995).

Levy writes ‘… consider a warm-up case in which I continue to think that there is an objective moral truth, but that my own conscience is corrupt and unlikely to be an accurate guide to it. Where I to be persuaded that for the good of my soul, and that of my victims, I must toss them into the fire, I have no doubt that I would suffer. Wishing to do well, I could act contrary to my conscience in the face of intense guilt. I would simply say that my conscience, and my sense of guilt, was not trustworthy (p. 434).

In Webster’s revised Unabridged Dictionary (1998) the part of definitions of conscience is ‘…a feeling of shame when you do something immoral’. Conscience is that faculty of the mind, or inborn sense of right and wrong, by which we judge of the moral character of human conduct. It is common to all man and for care professionals too.

Nurses feel the emotional pain when they cannot care, as they want, when they remember about bad conscience and lack of self-confirmation. According to the Sorlie, Jansson & Norberg (2003) nurses felt lonely because of lack of open dialogue about ethically difficulties, between colleagues and about their feeling that the wrong things were prioritized in the clinics.

In writing about conscience, James Childress has noted that appeals to conscience involve appeals to moral standards, but conscience itself is not a moral standard. Like ‘integrity’ or ‘wholeness’, conscience needs content (Wildes, 1991).

Wildes (1997) argues that there can be an institutional moral integrity and an institutional conscience. The mission of the institution shapes institutional conscience, and it is implemented by the structures of the institution such as budgeting and planning.

Interpersonal relationship and management care are a very important aspect for conscience of care professionals. Childress (1997) explored how some problems of conscience may arise in conflicts of obligation and conflicts of interest in managed care organizations. He found that ranges of acts of non-cooperation that may express and protect an individual’s conscience-conscientious objection or refusal, withdrawal, whistle blowing, and so forth. Some forms of non-cooperation, deceptively gaming the system, are themselves morally problematic. In the case, the moral decisions may be quite difficult (Childress, 1997).
Understanding the voice, or silent call of conscience, acting according to the individual and professional conscience help to avoid bad conscience, feelings of guilt and shame for care professionals.
PART 2: EMPIRICAL STUDY (STUDY II)

METHOD

DESIGN

Norberg et al (2002) established the questionnaire of ‘Conscience’ for research project ‘Stress of conscience in relations to burnout among health care professionals’. Researchers strived to answer the question through the research: ‘Are there connections between bad conscience and burnout among health care professionals’.

The research project included four phases:


Phase 2 - Establishment of statistical connections / relationships between stress of conscience and burnout.

Phase 3 & 4. – Illumination of statistical connections / relationships between stress of conscience and burnout according to interpretations of narrative interviews.

Pilot studies started in Klaipeda (Lithuania), Ljubljana (Slovenia), Oslo (Norway), Copenhagen (Denmark), Montana (USA).

The questionnaire ‘Conscience’ includes 16 items related to conscience and every item could be evaluated by Lycert scale that consists of 6 points:

1 - No, totally disagree;
2 - No, almost totally disagree;
3 - No, partly disagree;
4 - Yes, partly agree;
5 - Yes, almost totally agree;
6 - Yes, totally agree.

The questionnaire validity has been tested in Sweden (Dahlqvist, 2004) and Slovenia (Pahor, 2004). As the validity of research instrument / questionnaire is defined as the degree to which the instrument measures what it aims to measure (Aaronson, Alonso & Burnam et al, 2002).

As Polit and Hungler (1995) states, the face validity refers to whether the instrument looks as though it is measuring the appropriate construct. Polit, Beck & Hungler (2001) suggest that the content validity of instrument is necessarily based on judgment; there are no completely objective methods of assuring the adequate content coverage of an instrument. Experts of specific activity area evaluate and analyze the items in order to assess do those items represent the hypothetical content universe in the correct proportions adequately (Polit & Hungler,
Aaronson, Alonso & Burnam et al. (2002) claim that the content-related validity is the ‘Evidence that the content domain of an instrument is appropriate relative to its intended use. Methods commonly used to obtain evidence about content-related validity include the use of lay and expert panel (clinician) judgments of the clarity, comprehensiveness, and redundancy of items and scales of an instrument’ (p. 200).

In Lithuania the content validity process of questionnaire ‘Conscience’ was performed by those steps, which illuminate the processes of content and face validity testing: 1) two interpreters translated the questionnaire from English to Lithuanian (a questionnaire originally was in English); 2) in order to test language validity, another two interpreters translated the Lithuanian version back into English; 3) double translation versions were compared by the author of this thesis and all translators in order to find inadequacies; 4) Lithuanian version was shown to four health care professionals - experts and four external experts (non – professionals, but ‘users’ of health care services) in order to test the clearness of items’ content (face validity) and after that the author of this thesis made corrections of the questionnaire (word - expression of items) according to the professionals' remarks.

In more detailed the process of validation included such content:

1. A face validation included work of experts who agreed to evaluate the content of questionnaire and clearness of its items to Lithuanian context. In this process were invoked four experts (one nurse, one physician, one midwife, one physiotherapists ) as expert panel and four external experts. This validation process has been carried out to judge are the items relevant, understandable and relevant for care professionals. For experts the author of this thesis established those criterions:
   a) Knowledge in Lithuanian and English languages;
   b) Knowledge of the concept of conscience;
   c) Knowledge and practical skills in research methodology.

2. All the experts - professionals compared English and Lithuanian versions of questionnaire separately and after that they discussed that in a group and formed recommendations for corrections.

3. Two interviews have been carried out with four external experts in order to test the ability and understanding of the translated questionnaire. Three statements were not clear for them. After correction those external experts assessed the questionnaire one more time.
4. After validation process a pilot study has been performed with the revised and final version of the questionnaire ‘Conscience’. The questionnaire has been distributed to 40 health care professionals.

5. Before the data analysis the coding has been performed in order to transform the research information from written documents to computer files so that computer could analyze the data. The data have been analyzed using SPSS for Windows, version 11.

**SELECTION/PARTICIPANTS (SAMPLE)**

This pilot study included 40 health professionals: 10 community nurses, 10 general practice physicians, 10 physiotherapists and 10 midwives (who work at health care center - Primary Health Care level). All participants were women. The age of participants varied between 32-60 years. The working experience was from 13 to 35 years and working time in this primary health care center from 1 year to 28. Fifteen of those who took part in the study have university education, five - higher non-university (college) nursing education and 22 higher nurses, midwives or physiotherapists education.

**DATA COLLECTION**

For data collection was used the research instrument – questionnaire (that is presented in subpart ‘Design’), which consisted of 16 close-ended items.

The health care professionals for pilot study were selected with assistance of chief nurse at primary health care center. Chief nurse handed out questionnaire ‘Conscience’ to three departments: Therapeutic, Rehabilitation and Midwifery department. The written information described the purpose of the study and the data collection method. It also contained of information about ethical aspects (that anonymity and confidentiality will be preserved). Health care professionals who agreed to participate in this pilot study had fulfilled the questionnaire. A week after questionnaires was handled out, i.e. were returned to researcher.

**ETHICAL CONSIDERATIONS**

Research that involves human subjects requires a careful consideration of the procedures to be used to protect their rights. The three major ethical principles that are incorporated into the
most guidelines are beneficence, respect for human dignity and justice, should always be observed (Polit & Hungler 1995).

Before research started all-ethical issues related to study were discussed. All-necessary permissions were obtained. The Ethical Committee of the College of Klaipeda gave their approval of the study and permission to carry it out was obtained from the Director of Klaipeda Primary Health Care Center.

All the participants were asked to participate in this study. They got written information about the purpose of the study and the data collection method. It also contained information that anonymity would be preserved as well as confidentiality. To protect the interviewed person’s right to privacy, confidentially and integrity, the questionnaires were coded and only the researcher had access to the key of the code system. To guarantee confidentiality and anonymity no interpretations and discussions that could reveal the participants were used.

**DATA ANALYSIS**

Quantitative analysis with advanced statistical procedure - correlation and factor analyses were used in order to test the structures of questionnaire items.

Statistical analysis is a method for rendering quantitative information meaningful and intelligible. Without the aid of statistics, the quantitative data collected in a research project would be little more than a chaotic mass of numbers. Statistical procedures enable the researcher to reduce, summarize, organize, evaluate, interpret, and communicate the numerical information (Polit & Hungler, 1995).

**Correlation analysis.** Correlation analysis that is based on calculation of Spearman coefficient ($\rho$) helps to diagnose the peculiarities of relationships between items that are invoked into questionnaire. Correlation coefficient ($\rho$) illuminates the relationships between one more items through numerical expression of such relationship. Spearman correlation size ‘sways’ from 0 [zero] (no correlation) until 1 (perfect correlation) and also may be positive and negative (Polit & Hungler, 1995). With the size of correlation coefficient here is presented possibility of statistical error $p$ ($p \leq 0.05$ or $p \leq 0.01$). Statistical error shows what is the possible error size of statistical solutions (Bühl & Zöfel, 2002). In this Master Thesis all the statistical solutions that do not satisfy condition $p \leq 0.05$, are treated as baseless.
**Factor analysis.** In research practice is applied the essential principle: problems / sums of a test / questionnaire that are in one factor forms subscale because in such case conditionally high internal consistency of a test / questionnaire is more or less guaranteed. Here is important to apply also other additional conditions (Bitinas, 1998; Mazeikienė, Merkys, 2001; Zydziunaite, 2003):

- Factor (subscale) should be interpreted theoretically: if the researcher cannot ground who exactly that complex of items is in one factor and what this complex means then the factorial analysis as a method has not reason.
- In s structure of factor should be at least three items that are correlated with the extracted factor enough high (r\(\geq\) 0, 60).
- Factor should explain at least 10 % dispersion of indications.

Factor analysis in this Master Thesis is performed by keeping the structure of original questionnaire / research instrument.

Contents of factors is analysed on the basis of those methodological criterions (Bühl & Zöfel, 2002):

1) **Factorial weight(s) (L).** It is statistical seizes from which consists a concrete factor (Fn).

2) **Solidity / ‘purenesses of a factor.** Factor is more solid more it includes items are with factorial weights that satisfy the condition L\(\geq\) 0,6. Factor is solid / ‘pure if at least three items are correlated with that factor and every of them satisfies the condition L\(\geq\) 0,6.

3) **Explained dispersion of a factor.** It is presented by percents (%) by using SPSS programme. Higher is percent of factor content (that invokes items) it means that better is explained that content quantitatively (especially, when it is \(\geq\)50, 00%).

4) **Cronbach α** (coefficient of internal consistency of indexes) is important: more it is near + 1, more significant if the index / scale (in this questionnaire – Lycert scale of every item).

Researches widely use factor analysis in order to develop, refine, or validate complex instrument. The major purpose of factor analysis, according to Polit and Hungler (1995), is to reduce a large set of variables into a smaller, more manageable set of measures. Factor analysis disentangles complex interrelationships among variables to go together as unified concepts.
The results of this study have been analysed by using factor analysis (factor loadings) to test the structures of the items. It was done by *factor extraction*.

Most factor analysis consists of two separate phases. The first step is to condense the variables in the data matrix into a smaller number of factors. Sometimes this phase is referred to as the *factor extraction* phase. The factors usually derived from the intercorrelations among the variables in the correlation matrix. The general goal is to seek clusters of highly interrelated variables within the matrix. There are various methods of performing the first step, each of which uses different criteria for assigning weights to the variables. Probably the most widely used method of factor extraction is called principal components (or principal factor axes) (Polit & Hungler, 1995). According to Polit and Hungler (1995), the results of the first step of the factor analysis are a *factor matrix* (sometimes labelled as the unrotated factor matrix), which contains coefficients or weight for each variable in the original data matrix on each extracted factor. The factor matrix produced in the first phase of factor analysis usually is rather difficult to interpret. For this reason, a second phase known as *factor rotation* is almost invariably performed on those factors that have met one or more of the criteria for inclusion. The rotation factor matrix is what the researchers normally work with in interpreting the factor analysis. The entries under each factor are the weights on that factor, which are called *factor loadings*. Factor loadings express the correlations between individual variables and factors (underlying dimensions) (Polit & Hungler, 1995).

**RESULT/FINDINGS**

Fourty health care professionals completed the questionnaire.

*Data adequacy*. Before using factor analysis the data adequacy was tested. Data adequacy shows KMO (Kaiser-Meyer-Olkin) and Bartlett’s Test of Sphericity. KMO indicator varied from 0 to 1. In case the indicator is closer to 1, data adequacy is higher. The criterion of Bartlett’s Test of Sphericity is Chi-Square value.

**Table 4. KMO and Bartlett’s Test.**

<table>
<thead>
<tr>
<th></th>
<th>Kaiser-Meyer-Olkin Measure of Sampling Adequacy.</th>
<th>Bartlett’s Test of Sphericity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>, 455</td>
<td>Approx. Chi-Square</td>
</tr>
<tr>
<td></td>
<td></td>
<td>182,585</td>
</tr>
<tr>
<td></td>
<td></td>
<td>df</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sig.</td>
</tr>
</tbody>
</table>
KMO indicator 0.455 shows that data is adequate near the average. It can be explained in this case because this is pilot study with only 40 participants. Bartlett’s Test of Sphericity shows that significant is valued perfectly because of the significance \( p \leq 0.01 \).

**Correlation analysis.** In order to check the data were performed the correlation analysis (Spearman correlation). In this research the size of correlation coefficients are treated as meaningful when it reaches a particular statistical significance, i.e. conventionally \( p = 0.05 \) being taken as the largest acceptable for this type of significance; also here is taken in account the statistical condition that the smallest size of correlation is acceptable in this research varies from 0.44 until 0.30\(^1\) (Robson, 2004).

The correlation data by the author of the Master Thesis were divided into the ranks\(^2\) in order to illuminate the strongest (significant and meaningful) and the weakest relationships among various items, which explain and describe the content of ‘conscience’ phenomenon that is experienced by health care professionals who work in PHC level. Thus the ranks that are meaningful in a context of the current empirical research are the following:

1) \( \rho \geq 0.6 \) (very strongly typical, common and meaningful correlation);
2) \( \rho \geq 0.5 \) (strongly typical, common and meaningful correlation);
3) \( 0.44 \geq \rho \leq 0.5 \) (intermediately typical, common and meaningful correlation);
4) \( 0.35 \geq \rho \leq 0.44 \) (weakly typical, common and meaningful correlation);
5) \( 0.30 \geq \rho \leq 0.35 \) (very weakly typical, common and meaningful correlation);
6) \( \rho < 0.30 \) (not meaningful and untypical; will not be presented).

Table 5 presents a correlation matrix among items that shows the Spearmann correlation coefficients for all the variables in the example, taken as correlation pairs (totally – 32 pairs).

---

\(^1\) Because of 0.28 is the smallest size when correlation pairs are until 30 (Robson, 2004); in this research here are 32 correlation pairs.

\(^2\) In order to illuminate the peculiarities that are significant and meaningful to concrete research the researcher may establish the individual ranking system for data analysis that is independent from traditional ranking system of correlation coefficients with quantitative orientation. Thus the researcher’s established ranking ‘system’ is creative and content – oriented, i.e. based on qualitative tradition that shows the depth of the investigated phenomenon (Robson, 2004).
## Table 5. Spearman correlation matrix.

<table>
<thead>
<tr>
<th></th>
<th>Conscience must be interpreted</th>
<th>We need tranquility in order to hear the voice of conscience</th>
<th>We cannot escape the voice of conscience</th>
<th>The conscience admonishes us not to hurt ourselves</th>
<th>The conscience admonishes us not to hurt others</th>
<th>We should obey our conscience irrespective of others' opinions</th>
<th>At my workplace, I can express what my conscience tells me</th>
<th>I am able to follow my conscience at my work</th>
<th>Our conscience can give us false signals</th>
<th>Our conscience is silenced if we do not listen to it</th>
<th>I have to silence my conscience in order to be able to continue working in the caring profession</th>
<th>Our conscience is too strict</th>
<th>One's individual conscience expresses society's values</th>
<th>God speaks through our conscience</th>
<th>By obeying my conscience I develop as a human being</th>
<th>When I cannot meet my own demands on myself, I get a bad conscience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conscience must be interpreted</td>
<td>1,000</td>
<td>-0.029</td>
<td>0.074</td>
<td>0.003</td>
<td>0.391</td>
<td>0.126</td>
<td>0.115</td>
<td>0.183</td>
<td>0.021</td>
<td>-0.127</td>
<td>-0.312</td>
<td>-0.208</td>
<td>0.102</td>
<td>-0.016</td>
<td>-0.153</td>
<td>-0.045</td>
</tr>
<tr>
<td>We need tranquility in order to hear the voice of conscience</td>
<td>-0.029</td>
<td>1.000</td>
<td>-0.153</td>
<td><strong>0.426</strong></td>
<td>-0.002</td>
<td>0.292</td>
<td>-0.264</td>
<td>-0.216</td>
<td>0.213</td>
<td><strong>0.501</strong></td>
<td><strong>0.376</strong></td>
<td>0.102</td>
<td>0.100</td>
<td>0.269</td>
<td>0.172</td>
<td>-0.193</td>
</tr>
<tr>
<td>We cannot escape the voice of conscience</td>
<td>0.074</td>
<td>-0.153</td>
<td>1.000</td>
<td>0.284</td>
<td>0.118</td>
<td>0.305</td>
<td>0.019</td>
<td><strong>0.463</strong></td>
<td>0.207</td>
<td>0.076</td>
<td>0.217</td>
<td>0.055</td>
<td>0.203</td>
<td>0.240</td>
<td>-0.044</td>
<td>0.166</td>
</tr>
<tr>
<td>The conscience admonishes us not to hurt ourselves</td>
<td>0.003</td>
<td><strong>0.426</strong></td>
<td>0.284</td>
<td>1.000</td>
<td>0.408</td>
<td>0.238</td>
<td>0.115</td>
<td>-0.030</td>
<td>0.086</td>
<td><strong>0.352</strong></td>
<td><strong>0.368</strong></td>
<td>0.289</td>
<td>0.078</td>
<td>0.204</td>
<td>-0.020</td>
<td>0.082</td>
</tr>
<tr>
<td>The conscience admonishes us not to hurt others</td>
<td><strong>0.391</strong></td>
<td>-0.002</td>
<td>0.118</td>
<td>0.408</td>
<td>1.000</td>
<td>-0.048</td>
<td>0.146</td>
<td>0.231</td>
<td>0.173</td>
<td>0.320</td>
<td>-0.012</td>
<td>-0.076</td>
<td><strong>0.383</strong></td>
<td>0.181</td>
<td>0.011</td>
<td>0.340</td>
</tr>
<tr>
<td>We should obey our conscience irrespective of others' opinions</td>
<td>0.126</td>
<td>0.292</td>
<td>0.305</td>
<td>0.238</td>
<td>-0.048</td>
<td>1.000</td>
<td>0.262</td>
<td><strong>0.397</strong></td>
<td>-0.018</td>
<td>0.086</td>
<td>-0.108</td>
<td>0.174</td>
<td>0.306</td>
<td>0.167</td>
<td>0.203</td>
<td><strong>0.385</strong></td>
</tr>
<tr>
<td>At my workplace, I can express what my conscience tells me</td>
<td>0.115</td>
<td>-0.264</td>
<td>0.019</td>
<td>0.115</td>
<td>0.146</td>
<td>0.262</td>
<td>1.000</td>
<td>0.322</td>
<td>-0.379</td>
<td>-0.273</td>
<td><strong>0.553</strong></td>
<td>0.068</td>
<td>0.117</td>
<td>0.008</td>
<td>-0.030</td>
<td><strong>0.397</strong></td>
</tr>
<tr>
<td>I am able to follow my conscience at my work</td>
<td>0.183</td>
<td>-0.216</td>
<td><strong>0.463</strong></td>
<td>-0.030</td>
<td>0.231</td>
<td><strong>0.397</strong></td>
<td>0.322</td>
<td>1.000</td>
<td>0.173</td>
<td>0.028</td>
<td>-0.292</td>
<td>-0.251</td>
<td><strong>0.411</strong></td>
<td>0.024</td>
<td>0.241</td>
<td><strong>0.529</strong></td>
</tr>
<tr>
<td>Our conscience can give us false signals</td>
<td>0.021</td>
<td>0.213</td>
<td>0.207</td>
<td>0.086</td>
<td>0.173</td>
<td>-0.018</td>
<td><strong>-0.379</strong></td>
<td>0.173</td>
<td>1.000</td>
<td><strong>0.492</strong></td>
<td><strong>0.666</strong></td>
<td>0.077</td>
<td>0.036</td>
<td>0.086</td>
<td>0.023</td>
<td>0.100</td>
</tr>
<tr>
<td>Our conscience is silenced if we do not listen to it</td>
<td>-0.127</td>
<td>0.501</td>
<td>0.076</td>
<td><strong>0.352</strong></td>
<td>0.320</td>
<td>0.086</td>
<td>-0.273</td>
<td>0.028</td>
<td><strong>0.492</strong></td>
<td>1.000</td>
<td><strong>0.482</strong></td>
<td>0.250</td>
<td>0.215</td>
<td>0.335</td>
<td>0.121</td>
<td>0.076</td>
</tr>
<tr>
<td>I have to silence my conscience in order to be able to continue working in the caring profession</td>
<td>-0.312</td>
<td><strong>0.376</strong></td>
<td>0.217</td>
<td><strong>0.368</strong></td>
<td>-0.012</td>
<td>-0.108</td>
<td><strong>-0.553</strong></td>
<td>-0.292</td>
<td><strong>0.666</strong></td>
<td><strong>0.482</strong></td>
<td>1.000</td>
<td>0.330</td>
<td>-0.171</td>
<td>0.227</td>
<td>-0.169</td>
<td>-0.193</td>
</tr>
<tr>
<td>My conscience is too strict</td>
<td>-0.208</td>
<td>0.102</td>
<td>0.055</td>
<td>0.289</td>
<td>-0.076</td>
<td>0.174</td>
<td>0.068</td>
<td>-0.251</td>
<td>0.077</td>
<td>0.250</td>
<td>0.330</td>
<td>1.000</td>
<td>-0.072</td>
<td>0.167</td>
<td>0.172</td>
<td>0.071</td>
</tr>
<tr>
<td>One's individual conscience expresses society's values</td>
<td>0.102</td>
<td>0.100</td>
<td>0.203</td>
<td>0.078</td>
<td><strong>0.383</strong></td>
<td>0.306</td>
<td>0.117</td>
<td><strong>0.411</strong></td>
<td>0.036</td>
<td>0.215</td>
<td>-0.171</td>
<td>-0.072</td>
<td>1.000</td>
<td>0.136</td>
<td>0.312</td>
<td>0.325</td>
</tr>
<tr>
<td>God speaks through our conscience</td>
<td>-0.016</td>
<td>0.269</td>
<td>0.240</td>
<td>0.204</td>
<td>0.181</td>
<td>0.167</td>
<td>0.008</td>
<td>0.024</td>
<td>0.086</td>
<td>0.335</td>
<td>0.227</td>
<td>0.167</td>
<td>0.136</td>
<td>1.000</td>
<td>0.194</td>
<td>0.135</td>
</tr>
<tr>
<td>By obeying my conscience I develop as a human being</td>
<td>-0.153</td>
<td>0.172</td>
<td>-0.044</td>
<td>0.011</td>
<td>0.203</td>
<td>-0.030</td>
<td>0.241</td>
<td>0.023</td>
<td>0.121</td>
<td>-0.169</td>
<td>0.172</td>
<td>0.312</td>
<td>0.194</td>
<td>1.000</td>
<td><strong>0.401</strong></td>
<td></td>
</tr>
<tr>
<td>When I cannot meet my own demands on myself, I get a bad conscience</td>
<td>-0.045</td>
<td>-0.193</td>
<td>0.166</td>
<td>0.082</td>
<td>0.340</td>
<td><strong>0.385</strong></td>
<td><strong>0.397</strong></td>
<td><strong>0.529</strong></td>
<td>0.100</td>
<td>0.076</td>
<td>-0.193</td>
<td>0.071</td>
<td>0.325</td>
<td>0.135</td>
<td><strong>0.401</strong></td>
<td>1.000</td>
</tr>
</tbody>
</table>
1. *Very strongly typical, common and meaningful correlation* is the only one (positive) and it could be explained in a such way: more the health care professional has to silence the conscience in order to be able to continue working in the caring professions then more the conscience can give the false signals to her / him (rho = 0,666; p ≤ 0,01; P = 0,000).

2. *Strongly typical, common and meaningful correlations are the following:*

   - When the health care professional cannot meet the own demands on the self and she / he gets a bad conscience, thus more the health care professional is able to follow the personal conscience at work (rho = 0,529; p ≤ 0,01; P = 0,000). It means that the bad experience influences the health care professional to reflect and ‘go deeper’ into the self in order to ‘follow the own conscience’.

   - More the health care professional has to silence the individual conscience in order to be able to continue working in the caring profession, less she / he can express at work – place what the individual conscience tells to her / him (rho = 0,-0553; p ≤ 0,01; P = 0,001). It means that the emotional closeness is treated as self – sacrifice in activity process of caring.

   - More the health care professional listens to individual conscience, less the individual conscience is in silence, thus more tranquillity the professional needs in order to hear the voice of individual conscience (rho = 0,501; p ≤ 0,01; P = 0,000). It means that professional’s reflection on her / his personality that is related to spiritual and moral aspects and on experience that is got from caring practice is realized more meaningful and to depth in tranquillity.

3. *Intermediately typical, common and meaningful correlations are those:*

   - More the health care professional is able to follow the individual conscience at work, less she / he is able to escape the voice of conscience (rho = 0,463; p ≤ 0,05; P = 0,000). Thus professional’s ability to ‘follow’ the conscience is an inner process and in caring context could be related to her / his obligations and / or duties.

   - Less the health care professional listens to individual conscience, more her / his conscience gives false signals (rho = 0,492; p ≤ 0,01; P = 0,002). It means that the professional’s inability to stop the self for comprehending in silence, i.e. contemplation results the superficial understanding, feelings, etc.
• Less the health care professional listens to individual conscience and it is silenced, then more the professional silences her / his conscience in order to be able to continue working in the caring profession ($\rho = 0,482; p \leq 0,05; P = 0,000$). It means, more the professional knows her / himself in depth, more ‘presses’ the self in order to be closed, i.e. less she / he is able to express openly the feelings and experiences striving to recognize and know the individual conscience.

4. **Weakly typical, common and meaningful correlations are these:**

• More the professional’s conscience admonishes her / him not to hurt others, then more she / he needs tranquillity in order to hear the voice of conscience ($\rho = 0,426; p \leq 0,01; P = 0,000$). Thus the health care professional’s self – reflection and self – evaluation are not detached from interaction with others and that is based on conscience.

• More the health care professional is able to follow the individual conscience at work, more it supports the notion that the professional’s individual conscience expresses society’s values ($\rho = 0,411; p \leq 0,05; P = 0,002$). It means that professional’s individual and society’s values are in positive relationship and those are connected by conscience.

• More the conscience admonishes the professional not to hurt others then more the professional’s conscience admonishes her / him not to hurt the self too ($\rho = 0,408; p \leq 0,01; P = 0,001$). It means that the health care professional’s relationships express the way in which she / he treats the self.

• More the health care professional obeys the individual conscience and together she / he develops the self as a human being, less the nurse is able to meet the own demands on her / himself that results a bad conscience ($\rho = 0,401; p \leq 0,05; P = 0,000$). Thus the professional’s deep self – knowing is a premise to prevent the feeling of bad conscience.

• More the health care professional gets a bad conscience when she / he cannot meet the own demands on her / himself, more the professional may express at work – place what her / his conscience tells ($\rho = 0,397; p \leq 0,05; P = 0,002$). It means that a bad / negative experience stipulates the open expression of what the professional feels at work, i.e. in the caring context.

• Less the professional can meet the own demands on her / himself (that results a bad conscience), then less the professional obeys the individual conscience of others’ opinions ($\rho = 0,385; p \leq 0,01; P = 0,000$). Thus the health care professional’s inability to satisfy
the personal demands results her / his inability to protect the personal standpoints that follows individual conscience.

- More the professional’s individual conscience expresses society’s values then more the conscience admonishes her / him not to hurt others (rho = 0.383; p ≤ 0.01; P = 0.002). That correlation supports the connection between personal and society’s values and their influence to behavior and interaction between each other.

- More the professional is able to follow the individual conscience at work, more she / he obeys the conscience irrespective of other’s opinions (rho = 0.397; p ≤ 0.01; P = 0.000). It means that stronger values has the health care professional and better knows the self (including the conscience), then more is able to stand on personal standpoint, which is adapted to working context.

- More the conscience admonishes the professional not to hurt others them more the conscience must be interpreted (rho = 0.391; p ≤ 0.01; P = 0.003). From that context is clear that the conscience is contextual and situational.

- Less the health care professional’s conscience can give her / him false signals, then more she / he can express what the professional’s conscience tells to her / him at work – place (rho =-0.379; p ≤ 0.05; P = 0.000). Thus more the professional knows the meaning / essence of individual conscience, then more she / he is objective in expressing standpoints, prejudices, etc.

- More the health care professional has to silence the individual conscience in order to be able to continue working in the caring profession, then more she / he needs tranquility in order to hear the voice of individual conscience (rho = 0.376; p ≤ 0.05; P = 0.003). It means that staying and being in caring profession demands from the professional strengths and knowing the inner part of the self.

- More the health care professional’s conscience admonishes her / him not to hurt the self, then more the professional has to silence the individual conscience in order to be able to continue working in the caring profession (rho = 0.368; p ≤ 0.01; P = 0.000). Thus the professional’s strong involvement into the self results the bigger pressure on personal feelings and emotions that probably could quit of her / him the caring profession.

- Less the professional listens the individual conscience and it is silenced because of that, then less the professional’s conscience admonishes her / him not to hurt the self (rho
It means that health care professional’s ignorance about the self, results bigger fragility and vulnerability.

5. Very weakly typical, common and meaningful correlations are the following:

- More the conscience admonishes the professional not to hurt others then more she/he is able to meet the own demands and that not results a bad conscience ($\rho = 0.340; p \leq 0.05; P = 0.002$). It means that professional’s knowing the self, influences ability to meet the individual demands on the basis of ‘good’ conscience.

- Less the professional listens to individual conscience, then less she/he believes that god speaks through her/his conscience ($\rho = 0.335; p \leq 0.01; P = 0.000$). Thus the health care professional’s self – knowing correlates with the believing into God’s power, which is connected to person’s conscience.

- More strict is professional’s conscience then more she/he should silence the individual conscience in order to be able to work in caring profession ($\rho = 0.330; p \leq 0.05; P = 0.003$). Thus less the professional relates the individual qualities, behavior, etc. to conscience, then less she/he has a strong internal background that would ‘keep’ the professional in caring profession.

- More the professional obeys the individual conscience through what she/he develops the self as human being, then more health care professional’s individual conscience expresses society’s values ($\rho = 0.312; p \leq 0.01; P = 0.000$). It means that professional’s ability to obey is connected to expression of society’s values.

- Less the health care professional silences the individual conscience (in order to be able to continue working in the caring profession), then more the professional’s conscience should be interpreted ($\rho = -0.312; p \leq 0.01; P = 0.000$). The correlation supports the
notion that the superficial and subjective knowing the internal world of professional’s personality is more dependent on external peculiarities.

- More the professional is able to follow the individual conscience at work, then more the health care professional is able to express what the individual conscience tells to her/him at work – place (\( \rho = 0.322; p \leq 0.05; P = 0.002 \)). It means that the professional’s self – knowing results the ability to express feelings, experience, i.e. spiritual aspects.

- More the professional should obey the individual conscience irrespective of others’ opinions, and then more the nurse’s individual conscience expresses society’s values (\( \rho = 0.306; p \leq 0.05; P = 0.003 \)). That correlation supports the notion that professional’s conscience is not detached from personal and societal values.

- More the health care professional should obey the individual conscience irrespective of other’s opinions, then less she/he can escape the voice of conscience (\( \rho = 0.305; p \leq 0.05; P = 0.003 \)). Thus the professional’s behavior is connected to ‘inner’ of the self.

**Factor analysis**. Factor 1 ‘Silent conscience’ consists of four items and three of them satisfy the rule of factorial weight \( L \geq 0.6 \) and one item is equal to 0.599 that could be approximated to 0.6. Thus Factor 1 could be named as ‘pure’, typical and meaningful to health care professionals’ sample. The Factor 1 invokes the content, which could be divided into two parts: 1) relations between listening and expressing the silence; 2) false signals and silenced conscience that could be interpreted in such way: if the health care professional does not listen the individual conscience, then she/he is not able to express it and because of that the professional has to silence her/his conscience. All that results the false signals of conscience in the context of caring (see Table 6).

**Table 6. Factor 1: results of rotated Component Matrix (a)**

<table>
<thead>
<tr>
<th>Explained Dispersion of a factor (%)</th>
<th>Title and content of the factor</th>
<th>Factorial weights (L)</th>
<th>Factorial No</th>
</tr>
</thead>
<tbody>
<tr>
<td>60.00%</td>
<td><strong>SILENT CONSCIENCE</strong></td>
<td>0.829</td>
<td><strong>F1</strong></td>
</tr>
<tr>
<td></td>
<td>Our conscience can give us false signals</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>I have to silence my conscience in order to be able to continue working in the caring profession</td>
<td>0.780</td>
<td></td>
</tr>
<tr>
<td></td>
<td>At my work-place, I can express what my conscience tells me</td>
<td>0.753</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Our conscience is silenced if we do not listen to it</td>
<td>0.599</td>
<td></td>
</tr>
</tbody>
</table>

**Rotation converged in 16 iterations.**

3 Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization. Cronbach alpha = 0.8549 that shows the strong validity of questionnaire ‘Conscience’.
Factor 2 ‘Expressions of individual conscience’ consists of three items and every of them weights more than 0.6. Thus the Factor 2 is ‘pure’, typical and meaningful to health care professionals. The main idea, which is expressed in this factor includes such content: the professional’s obeying to personal conscience, which expresses society’s values, develops her / him as a human being and that is a premise to professional’s ability to meet the own demands (see Table 7).

Table 7. Factor 2: results of rotated Component Matrix (a)

<table>
<thead>
<tr>
<th>Explained Dispersion of a factor (%)</th>
<th>Title and content of the factor</th>
<th>Factorial weights (L)</th>
<th>Factorial No</th>
</tr>
</thead>
<tbody>
<tr>
<td>74.69%</td>
<td><strong>Title: EXPRESSIONS OF INDIVIDUAL CONSCIENCE</strong></td>
<td>L2 0.774</td>
<td><strong>F2</strong></td>
</tr>
<tr>
<td></td>
<td>By obeying my conscience I develop as a human being</td>
<td>0.774</td>
<td></td>
</tr>
<tr>
<td></td>
<td>When I cannot meet my own demands on myself, I get a bad conscience</td>
<td>0.727</td>
<td></td>
</tr>
<tr>
<td></td>
<td>One's individual conscience expresses society's values</td>
<td>0.643</td>
<td></td>
</tr>
</tbody>
</table>

Factor 3 ‘Inner voice of conscience’ consists of two items and only one is adequate to rule $L \geq 0.6$. This factor is not ‘pure’ and cannot be treated as typical and meaningful to health care professionals (see Table 8).

Table 8. Factor 3: results of rotated Component Matrix (a)

<table>
<thead>
<tr>
<th>Explained Dispersion of a factor (%)</th>
<th>Title and content of the factor</th>
<th>Factorial weights (L)</th>
<th>Factorial No</th>
</tr>
</thead>
<tbody>
<tr>
<td>45.01%</td>
<td><strong>Title: INNER VOICE OF CONSCIENCE</strong></td>
<td>L3 0.832</td>
<td><strong>F3</strong></td>
</tr>
<tr>
<td></td>
<td>Our conscience admonishes us not to hurt ourselves</td>
<td>0.832</td>
<td></td>
</tr>
<tr>
<td></td>
<td>God speaks through our conscience</td>
<td>0.433</td>
<td></td>
</tr>
</tbody>
</table>

Factor 4 ‘Following the individual conscience’ consists of three items and tow of them are adequate to the rule $L \geq 0.6$ perfectly. The one item with weight $L = 0.579$ could be approximated to $L = 0.6$. Then the Factor 4 is ‘pure’ and typical for health care professionals. The content of this factor illuminates that the professional obeys the conscience irrespective of others’ opinions and follows it so why she / he cannot escape the individual conscience (see Table 9).

Table 9. Factor 4: results of rotated Component Matrix (a)

<table>
<thead>
<tr>
<th>Explained Dispersion of a factor (%)</th>
<th>Title and content of the factor</th>
<th>Factorial weights (L)</th>
<th>Factorial No</th>
</tr>
</thead>
<tbody>
<tr>
<td>57.60%</td>
<td><strong>Title: FOLLOWING THE INDIVIDUAL CONSCIENCE</strong></td>
<td>L4 0.853</td>
<td><strong>F4</strong></td>
</tr>
<tr>
<td></td>
<td>We cannot escape the voice of conscience</td>
<td>0.853</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I am able to follow my conscience in my work</td>
<td>0.642</td>
<td></td>
</tr>
<tr>
<td></td>
<td>We should obey our conscience irrespective of others' opinions</td>
<td>0.575</td>
<td></td>
</tr>
</tbody>
</table>
Factor 5 ‘Interpretation of conscience’ consists of three items when two are adequate to rule $L \geq 0.6$ and one item is with weight $L = 0.579$ that could be approximated to $L = 0.6$. Then the Factor 5 is treated as ‘pure’, typical and meaningful to health care professionals. The content of such factor illuminates why the conscience should be interpreted. The health care professional’s individual conscience is too strict and admonishes the professional not to hurt others, i.e. the individual professional’s conscience is contextual and / or situational thus it should be interpreted in the light of concrete context / situation (see Table 10).

Table 10. Factor 5: results of rotated Component Matrix (a)

<table>
<thead>
<tr>
<th>Explained Dispersion of a factor (%)</th>
<th>Title and content of the factor</th>
<th>Factorial weights (L)</th>
<th>Factorial No</th>
</tr>
</thead>
<tbody>
<tr>
<td>47.42%</td>
<td>Title: INTERPRETATION OF CONSCIENCE L5</td>
<td>0.782</td>
<td>F5</td>
</tr>
<tr>
<td></td>
<td>Conscience must be interpreted</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The conscience admonishes us not to hurt others</td>
<td>0.642</td>
<td></td>
</tr>
<tr>
<td></td>
<td>My conscience is too strict</td>
<td>0.579</td>
<td></td>
</tr>
</tbody>
</table>

Factor 6 ‘Hearing the conscience’ consists only of one item with the factorial weight $L = 0.790$ and this is not ‘pure’ factor thus it cannot be treated as typical and meaningful to health care professionals (see Table 11).

Table 11. Factor 6: results of rotated Component Matrix (a)

<table>
<thead>
<tr>
<th>Explained Dispersion of a factor (%)</th>
<th>Title and content of the factor</th>
<th>Factorial weights (L)</th>
<th>Factorial No</th>
</tr>
</thead>
<tbody>
<tr>
<td>33.71%</td>
<td>Title: HEARING THE CONSCIENCE L6</td>
<td>0.790</td>
<td>F6</td>
</tr>
<tr>
<td></td>
<td>We need tranquility in order to hear the voice of conscience</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DISCUSSION

In correlation analysis statistical relationships vary from very weak (e.g., 0.194) until mediate (e.g., 0.66), but the established ranks by the author of the Master thesis illuminated the core aspects that are essential for health care professionals, e.g., connection between individual conscience and society’s values; contextuality and situativity of individual conscience, etc. As notes Zydziunaite (2004), individual nurse’s existence has external and internal sides thus external is expressed by professional behavior (which is demonstrated in concrete working situation), and internal is also expressed by emotions and feelings that not rarely express the values carried out from family roots and society.

Sixteen items were retained in the factor analysis, and they loaded in six factors. The entries under each factor are the weights on that factor, which are called factor loadings. Factor
loadings express the correlations between individual variables and factors (underlying dimensions) (Polit and Hungler, 1995).

The factors were entitled ‘Silent conscience’, ‘Expression of individual conscience’, ‘Inner ‘voice’ of conscience’, ‘Following the individual conscience’, ‘Interpretation of conscience’, and ‘Hearing the conscience’ all areas of understanding concept of conscience among health care professionals.

The statements from this questionnaire were divided into six factors:

- **Silent conscience**: conscience gives signals to us in silence and we have to listen to it and it is possible to express the conscience.
- **Expression of individual conscience**: we should obey, because it influences the personal development and individual conscience expresses society’s values.
- **Inner ‘voice’ of conscience**: God speaks through our conscience and admonishes us not to hurt ourselves.
- **Following the individual conscience**: we cannot escape from conscience and it is important to follow the conscience at work and obey the conscience irrespective of others’ opinions.
- **Interpretation of conscience**: conscience must be interpreted in order to be understood, because of it could be too strict and the interpretation admonishes us not to hurt others.
- **Hearing the conscience**: even in tranquility the caring professional may hear the voice of conscience.

In Webster’s Revised Unabridged Dictionary (1998) conscience is described as: 1) motivation deriving logically from ethical or moral principles that govern a person’s thoughts and actions (syn: scruples, moral sense, sense of right and wrong); 2) conformity to one’s own sense of right conduct; 3) a feeling of shame when you do something immoral.

**GENERAL DISCUSSION**

The overall aim of the thesis was to describe the essence of the concept of conscience reflected by the care professionals in primary health care. It is a two parts study: literature review and empirical study.
Description of the concept of conscience from philosophical, psychological and theological prospective was presented in the background of the thesis.

Past research about conscience of care professionals was reviewed and summarized in the literature study part. 12 articles (8 empirical and 4 theoretical articles) were selected and reviewed using Matrix Method. According to Garrard (1999) review of articles takes 3 steps: organizing the documents, choosing topics and abstracting the documents.

The integrative research review was used for the literature review. Cooper (1989) states, that integrative review summarizes past research by drawing overall conclusions from many separate studies that are believed to address related or identical hypotheses. The integrative review hopes to present the state of knowledge concerning the relations of interest and to highlight important issues that research has left unresolved.

The main conclusions of different empirical and theoretical studies were fixed as titles of the results. These themes were: Call of conscience, Individual conscience, Professional conscience and Bad conscience and feelings of guilt, shame and emotional pain.

The aim of the empirical study was to examine the validity of the questionnaire of ‘Conscience’ among care professionals in primary health care. A modified validation process has been used for the questionnaire: face and content validity.

Polit and Hungler (1995) state, that face validity refers to whether the instrument looks as though it is measuring the appropriate construct. Although face validity should not be considered as acceptable evidence for the quality of an instrument, it may be helpful for a measure to have face validity if other types of validity have also been demonstrated.

Polit, Beck and Hungler (2001) suggest without face validity to have three other aspects of validity whose are of greater importance in assessments of an instrument: content validity, criterion-related validity, and construct validity.

Pilot study has been performed with the revised and final version of the questionnaire. 40 health care professionals from Klaipeda primary health care center have completed the questionnaire.

Factor analysis was used to test the structures of the items of questionnaire. Researches widely use factor analysis seeking to develop, refine, or validate complex instrument. The major purpose of factor analysis according to the Polit and Hungler (1995) is to reduce a large set of variables into a smaller, more manageable set of measures. Factor analysis disentangles
complex interrelationships among variables go together as unified concepts. The underlying dimensions thus identified are called factors.

Sixteen items were retained in the factor analysis, and they were loaded in six factors. The factors were entitled ‘Individual conscience’, ‘Inner voice (God)’, ‘Silent conscience’, ‘Interpretation of conscience’, ‘Listening to the conscience’ and, ‘Conscience and human development’.

The results from literature review and empirical study excluded the similar themes about the conscience of health care professionals. Conscience is ethical concept, but it is basic significance for religion.

Individual and professional conscience was discussed May (2001), McCullough (2004) and Childress (1997). Individual conscience, according to McCullough (2004) concerns boundaries of behavior by the integrity of physicians from sources other than professional medical ethics, e.g., religious belief and other core personal values that pertain to the individual physician but not his or her professional role. According the Lederman (2003) conscience is personal. It relies on the freedom of existence. He states that man reflects on himself.

Kierkegaard, Newman & Barth state that the individuality of conscience is one’s personal responsibility before God (Costigane, 1999).

Kissling (2001) claims that an individual answers personally to God for what that individual has done. Since individuals answer for their behavior, then those individuals must have the freedom to act on their deeply held, reflected beliefs.

One of the loaded factors item was named ‘Individual conscience’- we should obey, cannot escape the conscience and be able to follow the own conscience. Variable3 (We cannot escape the voice of conscience) showed the highest correlation with factor four.

Conscience and human development was other loaded items of factor analysis. It is consist of statements ‘By obeying my conscience I develop as a human being’ and ‘One’s individual conscience express society’ values’.

According to Tillich (1966) conscience has many different functions; it is good or bad, commanding or warning, elevating or condemning, battling or indifferenting.
Professional conscience may be seen as social conscience. According to the Virt (1987) the personal conscience can come in conflict with ideologies, norms or practices of society that, increasingly, is shifting the responsibility of moral decisions onto individuals.

Areas of conscientious conflict may concern the dissonance between person and society, person and person but also a dissonance with a person. This dissonance may lead to moral distress and an experience of inadequacy (Alden, 2002).

Health care professionals experience distress when they either face a situation with contradictory demands or are hindered to take actions as ethically demanded. Like Piaget Zecha & Weingartner (1987) assume the motivation for the development of making judgments themselves is largely based on the internal cognitive moral conflict, and to adapt to the world by role-taking or taking into account the moral or social perspective of others, that this a taken-for-granted tendency, to take point of view of others and it’s also, there’s a need to resolve ‘disequilibrium’ as Piaget would call it, within conflict one’s own point of view.

Other defined items of factor loading were ‘Inner voice’ and ‘Listening to the conscience’.

For health care professionals is important to hear the voice of conscience. Heidegger discovered the path to describe conscience in phenomenological terms, namely, as the silent call of care (Schalow, 1995). According to the Crowell (2001) Heidegger’s analysis of the two sides of conscience-‘what is talked about’ and ‘what is said’- elucidates the positive role of first- person self-awareness. By ‘what is talked about’ Heidegger means that ‘to which the appeal is made’; by ‘what is said’ he means what conscience ‘gives to understand’ about that to which the appeal is made.

Nurses present stories about common meanings of living a caring presence in nursing. Themes were the timelessness and spacelessness of caring, creating home, and calls to care as common meanings of living a caring presence in nursing the call of conscience. All nurses in this study heard and heeded this call, a wordless, silent call. The call is precisely something we ourselves have neither planned nor prepared for nor voluntarily perform. It calls against our expectations and against our wills (Nelms, 1995).

In theology the emphasis has been laid on the obect-orationation of the conscience. Often it is considered as being ‘the Voice of God’. The formulation ‘follow your conscience’, often heard in connection with morality and pastoral matters is basically subject-related (Fuchs, 1987). Other theologians consider conscience related to natural law, conscience is God’s voice on the human being (Hoose, 1999).
Ricoeur (1992) argues that conscience is felt as coming from within the human being at the same time as coming a higher instance.

‘Silent conscience’ and ‘Interpretation of conscience’ was the last defined items of factors loading. According to Heidegger, the call of conscience says ‘nothing’. By saying nothing, the call provides the necessary provocation to awaken the self to its own possibilities (Schalow, 1995).

How the care provides may understand the conscience if she says ‘nothing’? The call of conscience, if understood through resoluteness, recalls us to an authentic openness, which in turn transforms our awareness of the ‘world’ and others (Nelms, 1996).

Interpretation of conscience reveal of individual (personal) conscience. Rose (1999) argues that conscience development, which includes ethical and moral development, requires some degree of intellectual development. The growth of conscience involves the gradual increase in impulse control, the incorporation of parental moral standards, the development of shame and guilt, learning of the consciousness and practice of rules, and the maturation of sense of justice.

Barker (1995) defined the conscience as a person’s system of moral values, standards of behavior and sense of right and wrong. Its elements consist of a sense of accountability, including both responsibility for past actions and feelings and obligation in regard to future ones, a capacity for self-criticism, and standards and ideals (Loevinger, 1994).

Health care professionals encounter with ethically difficult care situations, value conflicts and ethical dilemmas. They experience moral distress, emotional pain, bad consciences, and feelings of shame and guilt.

Post (1998) states that an inner conflict may arise when a nurse is unable to defend her ideals, allowing her colleagues’ demands for effectiveness to control the care. This conflict gives for nurses a bad conscience and takes on the guilt and the responsibility for what happened to the patient. According to the Crowell (2001) Heidegger’s description of ‘what is said’ in the call, namely, the accusation ‘Guilty!’ Heidegger formalizes the everyday notion of guilt in such a way that those ordinary phenomena of ‘guilt’ which are related to our concernful being with others will drop out – phenomena related to everyday ‘reckoning’ as well as ‘any law or ought’.

Sorlie, Jansson & Norberg (2003) found that nurses were regarded as good providers but at the same time, their conscience reminded them of not taking care of all the ‘uninteresting’
patients. The emotional pain nurses felt was about remembering the children they overlooked, about bad conscience and lack of self-confirmation. Nurses felt lonely because of lack of open dialogue about ethically difficulties, between colleagues and about their feelings that the wrong things were prioritized in the clinics.

Sometimes health care providers experience the moral distress as a consequence from the conflict between the time and work spent on patients in relation to time for administrative tasks. Care providers talk about “a constantly bad conscience” and hold that they “would feel better” if they had more time with the patients. According to their conscience their prime task is to be there for the patients (Kalvemark et al., 2003).

Zecha & Weingartner (1987) discussed the compromise between different values, rights, etc.: ‘If I know in my conscience, this is really what I have to do and I decide against it in order to avoid difficulty – this would be in the strict sense a moral compromise’ (p. 51).

Sorlie, Kihlgren & Kihlgren (2004) found that a lack of time could lead to a bad conscience over the ‘little bit extra’ being omitted. This lack of time could also lead to tiredness and even burnout, but the system did not allow for more time.

**METHODOLOGICAL CONSIDERATIONS**

The aim for the thesis was to describe the essence of the concept of conscience reflected by the care professionals in primary health care. In the first part of study was summarized past research about the conscience of care professionals.

It was difficult to find empirical studies about conscience of care professionals. Eight qualitative empirical studies were found relevant to the aim of the study. Articles about study of conscience among care professionals in primary health care not have been finding.

The goal of empirical part of this study was to examine the validity of the questionnaire of ‘Conscience’ among care professionals in primary health care. Validation of questionnaire was examined by face validity and content validity. Only pilot study was performed with the revised and final version of the questionnaire. Health care professionals in primary health care centre completed 29 questionnaires. The results have been analysed by using factor analysis (factor loading). The sample of questioned persons was too small which is a limitation. A sample size of at least 200-300 subjects is recommended in order to minimize the risk of false results based on chance (Ferketich, 1991).
One more possible limitation was that it was unacceptable and uncommon questions for the respondents. The general practice doctors completed questionnaires more carefully than community nurses and midwives and the relation between choose similar statements was seen.

CONCLUSIONS

- This study consisted of survey past research about conscience among health care professionals and examine the questionnaire ‘Conscience’ among care professionals in primary health care.

- Individual conscience and professional conscience have been discussed in few studies. Conscience is personal and it relies on the freedom of existence. Individuality of conscience is one’s personal responsibility before God. The personal conscience can come in conflict with ideologies, norms or practices of society that, increasingly, is shifting the responsibility of moral decisions onto individuals. Integrity of conscience can be explained as integrity between professional and individual conscience.

- Nurses heard the call of conscience and heeded this call, a wordless, silent call. The call is precisely something we ourselves have neither planned nor prepared for nor voluntarily perform. The call of conscience, if understood through resoluteness, recalls us to an authentic openness, which in turn transforms our awareness of the ‘world’ and others. Conscience is felt as coming from within the human being at the same time as coming a higher instance.

- Health care professionals encounter with ethically difficult care situations, value conflicts and ethical dilemmas experience moral distress, emotional pain, bad consciences, and feelings of shame and guilt. Care providers talk about ‘a constantly bad conscience’ and hold that they ‘would feel better’ if they had more time with the patients. Lack of time could lead to a bad conscience over the ‘little bit extra’ being omitted. This lack of time could also lead to tiredness and even burnout, but the system did not allow for more time. The emotional pain nurses felt was about remembering the children they overlooked, about bad conscience and lack of self-confirmation. Nurses felt lonely because of lack of open dialogue about ethically difficulties, between colleagues and about their feelings that the wrong things were prioritized in the clinics.
The performed correlation and factor analyses support the correct validity of the questionnaire.

From correlation analysis emerged those aspects:

- Health care professional’s behavior at work expresses the personal and societal values.
- More the health care professional knows the self, then more she / he can express the individual standpoints, prejudices, etc. that are related to work situations and is a premise to feel the depth of individual conscience.
- The health care professional’s conscience is contextual.
- The professional’s self – knowing is connected to strengths that ‘keep’ her / him in caring profession.
- Better the health care professional knows the self, less false signals she / he gets and expresses that are related to individual conscience, and less subjectively she / he interprets the work situations.

From factor analysis emerged that:

- Health care professionals get the false signals form conscience if they do not listen and presses the self to silence the individual conscience (at work). It means that health care professionals’ self – reflection and self – evaluation are important in knowing and recognizing the individual conscience.
- The professional’s ability to meet the individual demands on the self and obeying the conscience results influences her / his development as human being and that process us bit detached from society’s values. It means that conscience educates and develops the health care professional.
- The health care professional should obey the conscience even it is not acceptable to others and should follow it at work. It means that conscience cultivates the professionals that results her / his self – knowing.
- The conscience in every context and / or situation is interpreted by the nurse and it is in some way as ‘prevention; of hurting / breaking the dignity of the self and others.
REFERENCES


REFERENCES


