Relationship of Moral Sensitivity and Distress Among Physicians

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Background: Providing health services is described as an important moral measure, since its major aim is to ensure the welfare of the people who need treatment and care. Moral sensitivity is the ability to identify the existing moral problem and understand the moral consequences of the decisions made on the patient’s part. Physicians are always exposed to moral distress due to various circumstances.

Objectives: In this survey, we evaluated moral sensitivity and moral distress among physicians and the relationship of these ethical factors on them. Hence, we assessed the relationship between moral sensitivity and moral distress in physicians will facilitate their sound moral decision-making at an interpersonal level (2). Moral sensitivity is the ability to identify the existing moral problem and understand the moral consequences of the decisions made on the patient’s part (3). Moral decision-making involves being sensitive to patient’s vulnerability and expressing this sensitivity.

Physicians are always exposed to moral distress due to some circumstances, such as taking action despite one’s conscience, not providing full treatment due to the financial weakness of a patient, ineffective treatment, lack of time, patients on a long waiting list, lack of resource and organizational factors (4). Our previous study found moral distress among Iranian physicians (5); the consequences are anger, hopelessness, depression, shamefulness, distress, sadness, disappointment and feeling miserable (6, 7). Its long-term consequences emerge due to unresolved moral distresses, which are called moral residue. Moral residue is characterized by tolerance, compromise, silence and getting used to the situation (reconciliation) (7). Acting against professional values and interests destructs one’s moral integrity and brings about job dissatisfaction, leaving their job, and most importantly, not providing high-quality and safe health care to patients (8).

If moral decision making is faced with situations that cause moral distress, a therapist will not be able to recognize situations and moral issues, and make good decisions. Recognizing distressing and morally problematic situations is highly important in decision-making processes. Fulfilling this highly important task not only requires moral knowledge, but also requires moral sensitivity (9, 10). Individuals who possess moral sensitivity are capable of solving ethical conflicts. Moreover, they are capable of forming a sensory and intellectual perception of individuals’ vulnerable situations, and are aware of moral consequences that are important in making decisions for others (11). It is believed that in clinical contexts,
responding to morally distressing situations is related to criteria such as moral sensitivity (12). In healthcare, morality is an inter-related and dynamic process that is suggested by moral sensitivity (13).

2. Objectives

In this survey, we evaluated moral sensitivity and moral distress among physicians.

3. Materials and Methods

The present descriptive-cross-sectional study was performed on physicians practicing in hospitals affiliated to the Tehran University of Medical Sciences. The inclusion criteria were recruitment in the hospital, and at least one year of experience as a specialist. Two-stage random cluster sampling method was used. Participants were selected from hospitals based on all participants. The survey was kept open for four weeks. A total of 321 of 694 physicians were involved in this study.

Our tool consisted of a three-part questionnaire. The first part evaluated demographic features. The second part was a revised moral sensitivity questionnaire developed by Kim Lutzen (14, 15). The third part was a revised moral distress questionnaire developed by Hamric (16). Content validity Index (CVI) was used for this study. The agreement coefficient of researchers’ comments was 92%. The 25-item questionnaire was translated. Then, the reliability was determined. Its reliability was examined by test re-test method in 20 subjects with a one-week interval. The reliability coefficient was calculated to be 0.92 which signified an appropriate reliability. Its construct validity was tested through factor analysis.

For evaluating the questionnaires, Likert’s scaling was used. Cronbach alpha was estimated 0.78 and for all factors of the questionnaire was estimated between 0.74 to 0.78. Its grading varied from high disagreement = 1 to high agreement = 5.

Hamric’s MDS-R questionnaire was used to edit the moral distress questionnaire. This questionnaire took 3 factors into account in measuring moral distress. These factors were “individual responsibility”, “not in the patient’s best interest” and “deception”.

3.1. Data Analysis

Appropriate correlational statistics were used to examine relationships among variables. Also, multiple linear regression analysis was used to assess the association between the several variables simultaneously. Quantitative variables were compared between groups using the Student’s t-test or Kruskal-Wallis and Mann-Whitney U-test, depending on whether normal or non-normally distributed variables were used, respectively. We checked all data for a normal distribution using the Kolmogorov-Smirnov test, and then data were analyzed using SPSS 20 software (SPSS, Chicago, IL, USA). P-values less than 0.05 were considered statistically significant. Additionally, a principal axis factor analysis with varimax rotation was conducted to assess the construct validity of the scale. The number of factors was decided by the Eigen value of the factor over 1.0. Items with first factor loadings of more than 0.4 were selected for configuration. Also, Cronbach’s alpha was calculated for the items of each factor to examine internal consistency.

3.2. Ethical Consideration

The study proposal was approved by the ethics committee of Shahid Beheshti University of medical sciences (Ethics code N-153) and legal permissions were obtained prior to collection of data. The participants were briefed on the voluntary nature of their participation in the study and were provided with all the necessary information on study objectives and how to complete the questionnaires before beginning to do so. Furthermore, participants were asked not to write their name on questionnaires.

4. Results

4.1. Demographic Characteristics

321 physicians completed the questionnaire; 114 surgeons, 110 internists, 28 anesthesiologists, 38 podiatrists, 14 specialists in emergency medicine and 17 others. The mean ± SD age of the participants was 41.31 ± 7.00 years, and 138 (43.0%) were male. The mean ± SD years of experience working as a physician was 12.39 (6.83%). The 264 (82.2%) of participants were married and 162 (50.5%) of them had participated in medical ethics training courses.

4.2. Moral Sensitivity

Five factors had been identified which described 58.75% of the variance. Bartlett’s adequacy ratio of the test was 0.88 which was significant (P < 0.001). With respect to the subjectivity of the items, named “ethical competency” referred to knowing and understanding responsibilities, professional moral codes, and taking responsible action in solving moral issues at bedside. The second factor as with Kim Lutzen’s work in 1995, was called “structuring moral meaning” that referred to the ways in which moral meanings are extracted from made decisions and taken actions. Factor 3 included “experiencing moral conflict,” it referred to experiencing potential moral conflicts in different situations. Factor 4 was called “expressing benevolence.” It referred to the moral motivation to do “good work” or doing actions in the patient’s favor. Factor 5 included the subjectivity of its items, called “patient-centered therapeutic relationships.” It referred to the quality of patient-doctor therapeutic relationships with respect to patient-centered behaviors.

4.3. Moral Distress

Mean scores for items on the moral distress intensity score ranged from 0.85 to 3.42, with an overall mean total
score of 2.17 ± 0.80. Mean scores for items on the moral distress frequency score ranged from 0.1 to 2.59, with
an overall mean total score of 1.24 ± 0.64. The highest-scoring items for moral distress frequency score was "wit-
ness diminished patient care quality due to poor team communication" (mean ± SD; 2.59 ± 1.40). The highest-
scoring items for moral distress intensity score was "due to the shortage of drugs and medical equipment, I could
not provide the appropriate treatment for the patient" (mean ± SD, 3.41 ± 1.06).

4.4. The Relationship of Moral Sensitivity and Demo-
graphic Characteristics

There was a positive and significant relationship between the overall moral sensitivity score and age (P = 0.02
and r = 0.140). Mean (standard deviation) of moral sensi-
tivity among individuals who had participated in medi-
cal ethics courses was 91.87 (10.85), and for the individuals
who had not participated in medical ethics courses was
85.17 (15.42), and their difference was also significant (P
< 0.001). Moreover, according individuals who had par-
ticipated in the course scored higher on “therapeutic
patient-centered relationships,” “ethical competency,”
and “structuring moral meaning” (P < 0.001). The over-
all mean (standard deviation) in female and male physi-
cians was different (P = 0.048). Moral sensitivity among
specialists in emergency medicine was the lowest and
its difference with other specialists was significant (P
< 0.001) and pediatricians showed the highest mean on
moral sensitivity. They showed a high mean difference
with specialists in emergency medicine and anesthesiol-
gists (P < 0.001). The highest mean ± SD of 17.11 ± 3.73 in meaning
factor was observed in internists. It showed a significant
difference among surgeons, anesthesiologists, and pe-
diatricians (P < 0.001).

4.5. The Relationship of Moral Distress and Demo-
graphics

The relationship between the frequency of moral dis-
tress and age was significant (r = 0.189, P < 0.01). More-
over, “individual responsibility” and “not in the patient’s
best interest” had a negative significant relationship
with age and moral distress (r = -0.189, P < 0.01, r = -0.191,
P < 0.01). The relationship between overall moral distress
frequency and job experience was negatively significant
(r = -0.139, P < 0.01). “Ethical competency” and “not in the
patient’s best interest” had a negative significant rela-
tionship with job experience.

The relationship between intensity and frequency of
moral distress in the specialist in emergency medicine
51.35 ± 2.92 was the highest compared to other specialist,
this difference was significant (P < 0.001). Mean ± SD fre-
quency of moral distress in pediatricians (16.5 ± 7.35) had
the lowest relative to other professionals and this differ-
ence was significant.

Their relationship between moral distress frequency
and moral sensitivity was negatively significant (r =
-0.512, P < 0.001). The relationship between moral distress
intensity and moral sensitivity was positively significant
(r = 0.309, P < 0.001). The frequency of “individual respon-
sibility” of moral distress and “ethical competency”
of moral sensitivity showed the highest correlation coeffi-
cient. It was negatively significant (r = -0.637, P < 0.001).
“Ethical competence,” “patient-centered therapeutic
relationship,” and “structuring moral meaning” factors
from moral sensitivity questionnaire had a positive sig-
nificant relationship with the intensity of “individual re-
sponsibility” and moral distress (P < 0.01). Moreover, the
frequency of “individual responsibility” of moral distress
had a positive significant relationship with the overall
score of moral sensitivity (r = 0.236, P < 0.01).

The intensity of “not in patient’s best interest” factor of
moral distress had a positively significant relationship
with all moral sensitivity factors (P < 0.01). Also, its rela-
tionship with the overall score on moral sensitivity was
positively significant (r = 0.345, P < 0.01).

“Experiencing moral conflict” and “expressing benevo-
ence” from moral sensitivity, and “deception” factor from
moral distress were not significant (P > 0.05), while other
factors from moral sensitivity had a positive significant
relationship with the intensity of “deception” factor (P
< 0.01). The relationship between “individual responsibil-
ity” from moral sensitivity and the overall score of moral
distress intensity was positively significant (r = 0.603, P
< 0.01). The relationship between the overall moral distress
intensity and the overall moral sensitivity was also posi-
tive and significant (r = 0.309, P < 0.001).

4.6. Multi-Variable Analysis of the Relationship of
Moral Sensitivity, Moral Distress, and Demo-
graphic Characteristics

The relationship between moral sensitivity, intensity,
and the frequency of moral distress and demographic
characteristics was investigated simultaneously using
multi-variable regression. It was shown that 38.2% of the
frequency of moral distress was described by moral sen-
sitivity with the variables, such as age, sex, and participa-
tion in medical ethics course (R-Square = 0.382, P < 0.001, F
= 39.63). Age coefficient was a significant predictor for the
frequency of moral distress (P = 0.016, -0.245). Moreover,
this negative coefficient shows the negative relationship
between age and the frequency of moral distress. Moral
sensitivity was a significant predictor for the frequency
of moral distress (P < 0.001, -0.512), Participation in medi-
cal ethics courses was also a significant predictor for the
frequency of moral distress (P < 0.001, -5.877). Moreover,
using a linear multi-variable regression, the relationship
between moral distress intensity and moral sensitivity
and participation in medical ethics courses showed that
31.6% of moral distress intensity was described by moral
sensitivity variables, such as age, sex, and participation
in medical ethics courses (R-Square = 0.316, F = 7.12, P < 0.001). Among variables, the only positive and significant one was moral sensitivity coefficient. With an increase in moral sensitivity, moral distress increased, providing that all other variables are fixed, including age, sex, and participation in medical ethics classes (B = 0.4, P < 0.001).

5. Discussion

5.1. Theoretical Framework

5.1.1. Moral Distress

The term moral distress was first used by Jameton to refer to a phenomenon which occurred when nurses failed to carry out actions that they believed to be morally appropriate (17-20). Later, Jameton divided moral distress into two categories of initial and reactive moral distress. The former is due to organizational barriers and conflicts with another's values and is characterized by hopelessness, anger, and anxiety. The latter is due to leaving the former type of moral distress unresolved and is characterized by tolerance, compromise, silence, and getting used to the situations (21). Later, Hamric and Epstein stressed the importance of moral residue and reactive moral distress (7, 8). Kalvemark considered moral distress as “traditional negative stress symptoms that occur due to situations that involve ethical dimensions and where the healthcare provider feels she/he is not able to preserve all interests and values at stake” (19).

5.1.2. Moral Sensitivity

Historically, the philosophical notion of moral sensitivity could be traced back to the idea of “moral sense” (13). The “moral sense” was thought to close the gap between moral knowledge and moral behavior by providing a motive for action (11). Lutzen defined moral sensitivity as the “inner voice” that leads to decision-making (11). He considered it as the immediate understanding of a patient’s vulnerability and awareness of the moral notions underlying his/her decisions. Later, he defined moral sensitivity as one’s awareness of his/her own sense of responsibility, moral load, and moral capability (1). Rest defined sensitivity as one’s awareness of the way his/her actions affect others (22). He described four psychological processes regarding moral behavior (11, 14). The first being moral sensitivity (22).

In a previous study, we investigated moral distress among Iranian physicians and compared the results to those of similar studies in other countries (5). It was found out that the physicians under study showed a high moral sensitivity, a moderate to high moral distress intensity and a low to moderate frequency of moral distress. These results show that although Iranian physicians did not face many distressing situations, they experience a high intensity moral distress in dealing with such situations. This could be due to the high moral sensitivity of Iranian physicians, since identifying morally distressing and problematic situations in clinical decision-making, not only requires moral knowledge, but also requires moral sensitivity. No similar study showing the relationship between moral sensitivity and moral distress was found. However, many investigated moral sensitivity or moral distress alone, or their relationships to other moral components.

Our study showed that there is a relationship between moral sensitivity and moral distress. This emphasizes Lutzen’s position, which claims moral sensitivity and moral distress have a relationship due to their relationship to moral agent (11). On one hand, moral sensitivity originates from an individual’s unpleasant feelings, including moral distress when he/she cannot act upon (11). On the other hand, when due to moral sensitivity, an individual becomes aware of a moral issue and his/her moral responsibility, and makes the morally correct choice, but when is unable to put it into action, he/she experiences moral distress.

Clinical physicians with an underdeveloped moral sensitivity may fail in identifying the existing situations, and in turn, fail in fulfilling the necessity of taking moral action or dealing with taking immoral action (12).

We found a negative relationship between moral sensitivity and the frequency of moral distress. This result may be because the moral sensitivity is a requirement for having a clear understanding of what is really moral (22). Hence, what a physician feels may not necessarily be a moral distress, especially since with an increase in ethical competency factor in moral sensitivity, moral distress frequency of “individual responsibility” showed the highest decrease. It signifies that when a physician is highly capable of identifying his personal and professional responsibilities with respect to the existing situations, due to his/her moral competency, he/she carries out all his/her activities based on moral principles, codes, and rules appropriate to the situation (23). Hence, he/she experiences a lower moral distress.

It was also concluded that intensity of moral distress increases by an increase in moral sensitivity. Moral sensitivity, as a trait, makes the individual capable of identifying and choosing the moral action correctly in a given situation (11, 24). Hence, if an individual is not capable of putting his/her moral decision into action, despite his/her moral sensitivity, he/she will experience a more intense moral distress (11). Hence, individuals in the same situation will experience various levels of moral distress based on their moral sensitivity.

Our study showed that with an increase in moral sensitivity, excluding “Experiencing moral conflict”, “expressing benevolence” factors increases the intensity of “deception” factor of moral distress. However with increasing all moral sensitivity factors, the intensity of “not in patient’s best interest” factor of moral distress increases. This shows that compared to other physicians, Iranian physicians have a higher moral sensitivity in taking action in patient’s
interests, with a sense of responsibility, they avoid carrying out actions against the patient's interests.

Our study showed that moral distress frequency decreases with an increase in age. It was also found out that with an increase in age, moral sensitivity also increases. It is due to the fact that with an increase in age, other than recognizing and calling the information appropriate to the situations, other capabilities also increase, including social recognition in understanding behavior and situations and infer intents and causes of behavior. Results showed that as Iranian physicians became older, they showed a higher tendency to express benevolence, however Lutzen et al. also showed in a study that as age increases, autonomy factor in moral sensitivity increases (15).

Participating in medical ethics courses decreased moral distress frequency. Results showed that people who had participated in the courses showed a higher moral sensitivity, especially in “therapeutic patient-centered relationships,” “ethical competency” and “structuring moral meaning.” In other words, we can improve some factors through training, including communication skills with patients, paying more attention to patient’s autonomy in treatment process, sense of responsibility based on professional codes and rules, and the ability to identify and understand ethical implications of decisions.

Park et al. (25) showed that senior students scored a higher moral score in “conflict” and “patient-oriented care conflict” factors, compared to freshmen. They showed that training can improve moral sensitivity of students.

In a study on nurses, Abduo et al. (26) observed a significant difference in moral sensitivity, expressing benevolence factor in particular, with marital status, age-group, educational competency, and academic status.

Our study did not show a significant relationship between moral sensitivity with years of work experience. In a study on nurses, however, Lutzen et al. showed that moral sensitivity increases by experience and is not fixed and independent from the context (3).

Women scored higher than men in moral sensitivity and it was evident in dimensions such as “ethical competency” and “structuring moral meaning”. It was also shown that moral distress frequency in men was higher than women. It shows that although men dealt with more instances of morally distressing situations, women experienced a higher moral distress (2).

Lutzen et al. (3) showed that with respect to “meaning”, “relationship”, and “benevolence” dimensions, female physicians scored higher than male physicians. Male physicians, however, scored higher on “experiencing conflict” and “rules”. While most studies show that women pay more attention to expressing benevolence among moral sensitivity dimensions, men emphasized the sense of responsibility and understanding professional codes and rules. We found that moral sensitivity was the highest among pediatricians, while it was the lowest among emergency medicine specialists. While this difference among pediatricians was significantly higher than emergency medicine specialists and anesthesiologists with respect to moral sensitivity, internists scored higher on structuring moral meaning than surgeons, anesthesiologists, and pediatricians. Results showed that pediatricians showed the least frequency and the highest intensity in moral distress, while emergency medicine specialists showed the highest frequency and the least intensity. This difference can imply the dominant moral atmosphere in different healthcare units (11, 27), and that an individual's perception of the dominant moral atmosphere affects their approach and behavior. Hence, from an organizational ethics perspective, there should be a shift of attention from individuals to system with respect to ethics. A positive perception of the moral atmosphere of workplace affects individual’s motivation and approach, and in turn balances moral distress. Different specialist sections affect other moral components with their different moral atmospheres. Hence, any step that needs to be taken for changing moral behavior must focus on moral and social structure of organizations (11).

Cetin et al. reported the effect of workplace on moral sensitivity (27). As in our study, they emphasized the effect of organization and moral atmosphere on moral components.

Therefore, further interventional studies must be carried out regarding the effect of training and moral atmosphere on moral sensitivity and moral distress among Iranian physicians.

Although the response rate was not high in this survey, this study had a response rate of 46.2% and shows that moral distress in the studied physicians in this study is not only affected by external factors and experience, but that personal factors such as moral sensitivity also play a role in their occurrence and intensity.

Therefore, promoting one’s moral sensitivity leads into their moral competency, and in turn, he/she will experience less moral distress. Therefore both of them are proportionally required.

Participation in medical ethics courses increased moral sensitivity. Hence, health policymakers should hold medical ethics courses in order to increase moral competency and sensitivity, and prevent the repetition of moral distress in providing safe and high-quality treatment.

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Authors’ Contributions

Nasrin Nejadsarvari: doing research and writing article; Mahmoud Abbasi: supervising research process; Fariba Borhani: consultant of research process; Ali Ebrahimi: article writing; Hamidreza Rasooli: methodology of research;
Kalantar Motamedi MH: language editing of article; Mehrzad Kiani: supervising research process; Shabnam Bazmi: consultant of research process.

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