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DEVELOPING THE CONCEPT OF MORAL SENSITIVITY IN HEALTH CARE PRACTICE

Kim Lützén, Vera Dahlqvist, Sture Eriksson and Astrid Norberg

Key words: ethics; health care; instrument construction; moral sensitivity

The aim of this Swedish study was to develop the concept of moral sensitivity in health care practice. This process began with an overview of relevant theories and perspectives on ethics with a focus on moral sensitivity and related concepts, in order to generate a theoretical framework. The second step was to construct a questionnaire based on this framework by generating a list of items from the theoretical framework. Nine items were finally selected as most appropriate and consistent with the research team’s understanding of the concept of moral sensitivity. The items were worded as assumptions related to patient care. The questionnaire was distributed to two groups of health care personnel on two separate occasions and a total of 278 completed questionnaires were returned. A factor analysis identified three factors: sense of moral burden, moral strength and moral responsibility. These seem to be conceptually interrelated yet indicate that moral sensitivity may involve more dimensions than simply a cognitive capacity, particularly, feelings, sentiments, moral knowledge and skills.

Introduction

Health care practice is often described as a moral enterprise because the overarching aim is to ensure the wellbeing of persons who are in need of medical treatment and nursing care. Gastmans,1 for example, characterizes nursing as an ‘ethically laden practice’ because of the decisions and choices involved in providing comfort and preserving the human dignity of persons who are in need of professional care and treatment.

However, there are many situational factors that make these decisions emotionally difficult, such as incompatible (conflicting) values or: feelings that one has not done enough, or that one is duty bound to carry out actions that are not consistent with one’s own conscience.2–5

The psychological consequence of being aware of what ‘should be done’ and not having the power or the resources to act on this awareness, as well as doing something...
that one regrets, can cause a troubled conscience. Interviews with health care personnel in Northern Sweden have shown that physicians and nurses sometimes refer to their conscience when asked to narrate the meaning of being in ethically difficult care situations. Jansson and Norberg, Åström et al., Rasmussen et al., Söderberg, Strandberg and Jansson, and Sørlie et al. have described how conscience has forbidden and ordered certain actions, and requested individuals to examine their self, their actions, and their thoughts. Strandberg et al. report that nurses have feelings of guilt and inadequacy when falling short of what they think they should do. This feeling of ‘not having done enough’ seems to indicate awareness of the moral nature of a situation or recognizing the morally relevant features of it. Moral sensitivity may be said to have a theoretical and cognitive foundation. Conceptually, it may help us to understand how some health care professionals seem to be able to see and reflect on the vulnerability of patients from the patients’ perspectives, as the above studies demonstrate.

Thus, the aim of the present study was to develop an understanding of the concept of moral sensitivity in health care practice. In order to achieve this aim, an overview of variations of the philosophical concept of moral sensitivity was first conducted. This resulted in a theoretical framework that was used to construct a questionnaire, which was then distributed to two groups of health care workers in Sweden. The process is described in the following section.

**Theoretical framework**

The philosophical concept of moral sensitivity can be traced historically to the idea of a moral sense, first introduced by Anthony Ashley Cooper, the Earl of Shaftesbury, in the seventeenth century, as the faculty by which a person distinguishes between right and wrong. Justifying reason, according to Shaftesbury, demands the sense of the right and wrong, and it is by the working of the moral sense that the ‘benevolent sentiment’ is applied in a conflict-laden situation. Shaftesbury believed that the moral sense existed in the same way as a person’s other senses, such as sight. Hutcheson, and to some extent Hume, developed the theory of the moral sense as the capacity to experience feelings of approval and disapproval, thereby opposing rationalist theories of ethics. The feeling of approval is what Hutcheson believed was the moral sense. The benevolent motive, to act for the ‘sake of the good of others and not merely for one’s own advantage’, is approved by the moral sense.

Although it is difficult to provide evidence by scientific means of the existence of moral sense as an ‘intuitive’ faculty of the human mind, there is reason to believe that a type of benevolent sentiment is a vital component in a person’s moral motivation to act on that which he or she believes to be ‘good’. In health care practice, moral motivation is not the sole determinant of action. For example, personal prestige may motivate a physician to perform delicate surgery or a nurse skilfully to take care of the patient after surgery. Good intentions do not necessarily guarantee ethically justifiable outcomes.

The idea of the benevolent sentiment, central to moral sense, was later illuminated by Tymieniecka as a main theme in the ontological conception of the human person according to the life-world perspective. Tymieniecka emphasizes the intersubjective component of moral sense, the ‘decisive factor in man’s specificity, the meaning of his...
life and of his destiny’ (p. 8). The intersubjectively shared and communicable life-world becomes the communal life-world. The moral sense, Tymieniecka suggests, brings ‘into the natural unity of a life, a benevolent sentiment toward all living things’ (p. 44) and gives moral meaning to life. Bishop and Scudder specifically link the ‘practice’ of caring to the moral sense, meaning that the ‘benevolent sentiment’ functions as the moral motivation to ‘do good’.

Thus, the phenomenological conception of the moral sense stands in contrast to traditional ethics theory that assumes that moral deliberation of right and wrong is primarily a function of intellectual rationalism based on a priori values. As Tymieniecka points out, the intellect cannot account for the emergence of the benevolent sentiment, therefore the explanation must be found within the transactional experience of shared moral meaning in the life-world. According to Tymieniecka it is the benevolent sentiment that comprises the axis of right and wrong that establishes the ‘intersubjective life-sharing’ (p. 37). This axis originates in the moral sense.

Moral sensitivity can be described, as an ‘attention’ to the moral values involved in a conflict-laden situation and a self-awareness of one’s own role and responsibility in the situation. Moral sensitivity is not only a matter of ‘feeling’ (ie relying on emotions to identify a moral conflict) but a personal capacity, acquired by personal experience, to ‘sense’ the moral significance in a situation. According to Tymieniecka, moral sensitivity as a personal capacity is necessary in order for the process of moral deliberation to begin. The capacity to be able to distinguish moral problems from other problems is not only a matter of having theoretical knowledge. To be able to distinguish between feelings, facts and values, and to reflect on these, is a cognitive capacity, preconditioned by a moral motivation to ‘do good’ and, specifically related to health care professionals, ‘to care’. This means that moral sensitivity and moral motivation are linked together if we assume that care is the core of health care practice, and thereby a motivational factor.

In the literature, both ethical sensitivity and moral sensitivity can be found, at times interchangeably. A distinction could feasibly be made between the two concepts: ethical sensitivity referring to knowledge of ethics theory and principles, and moral sensitivity relating to personal agency within the interpersonal relationship.

Moral sensitivity can be expressed as a genuine concern for the welfare of the other, which we experience as ‘caring’ about the other. For example, in an empirical study by Ersoy and Gündoğmuş, ethical sensitivity is described as a process by which a person becomes aware of the existence of ethical problems, interprets a situation, and decides what options are viable. Jaeger argues that moral sensitivity is more than putting oneself in another person’s shoes; it is a ‘capacity for relatedness indispensable to moral theorizing that can be either cultivated or undermined and therefore ought not to be ignored by educators nor those responsible for ethically weighted decision-making situations’ (p. 132).

Rest and colleagues, whose original work is based on Kohlberg’s theory of moral development, argue that moral decision making consists of four components: (1) moral sensitivity; (2) moral judgement; (3) moral motivation; and (4) moral character. Moral sensitivity, according to Rest, is an awareness of how our actions affect others and thus influence how we interpret the situation. Thus, Rest’s four components form a more integrated view of ethics compared with the cognitive paradigm of ethics on which Kohlberg’s theory of moral development is based.
In some of the literature, moral sensitivity is used synonymously with conscience. Davis, for example, suggests that ‘moral values are known by a unique and irreducible intuition’, referred to as a ‘moral sense or conscience’ (p. 115).\textsuperscript{24} In philosophical, theological and psychological literature there are many conceptualizations of conscience. Freud\textsuperscript{25} saw conscience (superego) as an integration of parents’ and other authorities’ values. Frankl\textsuperscript{26} differentiated between genuine conscience and superego, and between individual and social conscience. There are theologians who consider conscience related to natural law, conscience being God’s voice on the human being.\textsuperscript{27} Heidegger\textsuperscript{28} described conscience as \textit{Dasein’s} call of itself. Ricoeur\textsuperscript{29} argued that conscience is felt as if coming from within the human being at the same time as coming from a higher authority, a type of practical wisdom.

This overview of the literature indicates that moral sensitivity is a complex phenomenon and involves more than a cognitive capacity.

**Method**

**Construction of the questionnaire**

A previous instrument, the Moral Sensitivity Questionnaire,\textsuperscript{30,31} was used as a basic model for developing a measure that would be relevant for health care professionals employed in various settings. The original Moral Sensitivity Questionnaire, a Likert-type scale containing 30 assumptions about patient care with seven alternative answers, was developed from the qualitative analysis of interviews and observations of nurses in psychiatric practice.\textsuperscript{32} This instrument has been used in several studies involving nurses and physicians, mainly in psychiatric practice.\textsuperscript{33} Since there was an apparent need to update this instrument and adapt it to present day practice, several modifications were necessary.

The first step in the construction of the revised questionnaire, according to psychometric theory,\textsuperscript{34} was to obtain items that adequately represent the phenomenon to be studied. This process consisted of a selection of original items that were assessed to be most valid in relation to the literature reviewed and recent empirical research on moral sensitivity. Some items were added and others were re-worded until nine items were agreed upon as the most consistent by the research team. The revised instrument had nine items/assumptions with six possible responses, with anchor 1 indicating total disagreement with an assumption and anchor 6 total agreement.

**Procedure and selection of respondents**

The questionnaire was distributed to two groups of health care workers on different occasions. The only inclusion criterion was willingness to participate in the study. All questionnaires were returned anonymously. The first convenience sample (group A) consisted of respondents ($n = 123$) at a health care conference. A number of questionnaires were left at one of the information booths by which all persons attending the conference would pass. However, since it was not known how many persons would be attending the conference on the day of distribution of the questionnaire, it was impossible to know the number who refrained from completing it. Thus the response rate cannot be calculated for sample A. The second sample
Table 1  Demographic details of participants

<table>
<thead>
<tr>
<th>Group</th>
<th>Age (years)</th>
<th>Years in health care profession</th>
<th>Profession</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group A:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>health care conference (n = 123)</td>
<td>Range 24–61 (mean = 44, SD = 9.9)</td>
<td>Range 0–40 (mean = 21.5, SD = 10.5)</td>
<td>Nurse 89.9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Physician 0.7%</td>
<td>Not known</td>
</tr>
<tr>
<td>Group B:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hospital setting (n = 155)</td>
<td>Range 24–64 (mean = 44.8, SD = 10)</td>
<td>Range 0.2–27.3 (mean = 18.8, SD = 13.9)</td>
<td>Nurse n = 50</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Physician n = 9</td>
<td>84%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nurse assistant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>n = 96</td>
<td></td>
</tr>
</tbody>
</table>

SD, standard deviation.

(group B) included physicians, nurses and nursing assistants (n = 155) in a hospital setting (see Table 1 for demographic details). For this group, the response rate was 84%. The total number of returned completed questionnaires was 278.

Statistical analysis

In questionnaires of the type constructed for this study, there are reliability limitations. Test-retest was not considered appropriate because the type of questions used may have stimulated the respondents to reflect on the topic. This (reflection) could in turn have led to new perspectives or attitudes towards a subject and thus to an inconsistency in responses in the two test situations. Moreover, correlations that are found in this type of research are not considered to be stable over time.

The split-half technique was also not considered appropriate because different scores of reliability can be obtained depending on how the items are divided into the two groups.

Frequency of response to each item is shown in Table 2.

Table 2  Frequency (%) of response on a scale of 1–6, where 1 = total disagreement and 6 = total agreement with an assumption, together with the mean score for each item

<table>
<thead>
<tr>
<th>Item</th>
<th>Missing</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Feel responsibility</td>
<td>1.0</td>
<td>1.0</td>
<td>1.4</td>
<td>5.2</td>
<td>13.8</td>
<td>28.6</td>
<td>50.0</td>
</tr>
<tr>
<td>2) Ability to sense</td>
<td>1.0</td>
<td>0.0</td>
<td>0.3</td>
<td>1.7</td>
<td>5.5</td>
<td>34.1</td>
<td>58.3</td>
</tr>
<tr>
<td>3) Ability to talk</td>
<td>1.0</td>
<td>0.3</td>
<td>2.4</td>
<td>9.3</td>
<td>23.8</td>
<td>39.3</td>
<td>24.8</td>
</tr>
<tr>
<td>4) Sense need</td>
<td>1.4</td>
<td>2.8</td>
<td>10.7</td>
<td>13.5</td>
<td>24.9</td>
<td>29.8</td>
<td>18.3</td>
</tr>
<tr>
<td>5) Sense not good care</td>
<td>1.0</td>
<td>0.7</td>
<td>0.0</td>
<td>5.2</td>
<td>16.6</td>
<td>45.5</td>
<td>32.1</td>
</tr>
<tr>
<td>6) Suffering</td>
<td>1.0</td>
<td>7.9</td>
<td>24.1</td>
<td>22.4</td>
<td>20.0</td>
<td>17.2</td>
<td>8.3</td>
</tr>
<tr>
<td>7) Balance between</td>
<td>3.8</td>
<td>1.1</td>
<td>3.9</td>
<td>8.9</td>
<td>20.6</td>
<td>43.3</td>
<td>22.3</td>
</tr>
<tr>
<td>good and harm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8) Feel inadequate</td>
<td>2.4</td>
<td>4.5</td>
<td>15.0</td>
<td>15.0</td>
<td>9.9</td>
<td>31.5</td>
<td>14.0</td>
</tr>
<tr>
<td>9) Rules and regulations</td>
<td>3.8</td>
<td>11.7</td>
<td>20.6</td>
<td>20.2</td>
<td>20.6</td>
<td>18.4</td>
<td>8.5</td>
</tr>
</tbody>
</table>

Moral sensitivity in health care 191
Nursing Ethics 2006 13 (2)
A principal component analysis, varimax rotation, was computed, which resulted in three components as shown in Table 3. All factor loadings \( > 0.55 \) were regarded as relevant. Eigenvalues were: component 1 = 2.849, component 2 = 2.184 and component 3 = 1.368.

### Findings

The three factors identified by the principal component analysis were: sense of moral burden, moral strength and moral responsibility. They consisted of the following items:

- **Sense of moral burden:**
  4) My ability to sense the patient’s needs means that I do more than I have the strength for.
  6) I find it very difficult to deal with my feelings that are aroused when a patient is suffering.
  7) When caring for patients, I am always aware of the balance between the potential for doing good and the risk of causing harm to them.
  8) My ability to sense a patient’s needs means that I often find myself in situations in which I feel inadequate.

<table>
<thead>
<tr>
<th>Item</th>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) I always feel a responsibility that the patient receives good care even if the resources are inadequate</td>
<td>0.250</td>
</tr>
<tr>
<td>2) My ability to sense the patient’s needs is always helpful in my work</td>
<td>0.657</td>
</tr>
<tr>
<td>3) I have a very good ability to feel how I should talk about difficult things with the patient</td>
<td>0.814</td>
</tr>
<tr>
<td>4) My ability to sense the patient’s needs means that I do more than I have the strength for</td>
<td>0.785</td>
</tr>
<tr>
<td>5) I have a very good ability to sense when a patient is not receiving good care</td>
<td>0.206</td>
</tr>
<tr>
<td>6) I find it very difficult to deal with my feelings that are aroused when a patient is suffering</td>
<td>0.719</td>
</tr>
<tr>
<td>7) When caring for patients, I am always aware of the balance between the potential for doing good and the risk of causing harm to them</td>
<td>0.550</td>
</tr>
<tr>
<td>8) My ability to sense a patient’s needs means that I often find myself in situations in which I feel inadequate</td>
<td>0.795</td>
</tr>
<tr>
<td>9) It helps me to know what is good or bad for the patient when I can follow rules and regulations</td>
<td>0.100</td>
</tr>
</tbody>
</table>
Moral strength
2) My ability to sense the patient’s needs is always helpful in my work.
3) I have a very good ability to feel how I should talk about difficult things with the patient.
5) I have a very good ability to sense when a patient is not receiving good care.

Moral responsibility
1) I always feel a responsibility for the patient receiving good care even if the resources are inadequate.
9) It helps me to know what is good or bad for the patient when I can follow rules and regulations.

Discussion

The main conclusion of this study is that the revised questionnaire is a valid instrument for assessing moral sensitivity, yet there are some specific methodological considerations that should be noted.

For practical reasons it is unknown how many persons at the health care conference looked at a questionnaire but decided not to complete it. Thus, the response rate cannot be calculated accurately. There were few missing values, which indicates that the instrument was perceived as positive and could possibly be used in practice. One question that arises is whether the instrument measures moral sensitivity as one dimension or as three components of moral sensitivity. The Eigenvalues for the three components can give support for both interpretations: if all three have approximately the same Eigenvalue, the latter interpretation would seem feasible; if, however, one is dominant and the other two contribute to a smaller degree, this would support the existence of moral sensitivity as a one-dimensional concept. The results show that the Eigenvalues for components one and two are approximately the same, and the value for component three is slightly lower. The difference is small, which suggests that moral sensitivity as presented here is unidimensional.

The factor analysis identified three factors: moral burden, moral strength and moral responsibility. These seem consistent with the theoretical construct of moral sensitivity and thus reflect both the psychological and moral dimensions of moral sensitivity that are described in the literature. An interpretation of the interrelationship of these factors is that moral sensitivity is preconditioned by an awareness of the moral significance of one’s actions, yet this can become a burdensome responsibility, requiring resilience and endurance (i.e., moral strength).

A sense of moral burden can be distinguished from other types of burden such as economic, social or psychological burdens in that the moral burden is caused by a problem or situation that involves moral values. An example of a moral burden is not being able to give blood to a patient who, because of religious beliefs, refuses transfusion of blood products, or, more commonly, attempting to feed a patient with dementia who refuses to eat. The conceptualization of a ‘moral burden’ is similar to the experience of moral stress that intensive care nurses in Swedish hospitals are reported to have experienced. These nurses described situations in which they ‘knew’ what morally should be done, but lacked the resources or the authority to act accordingly.
Not to be able to ‘care’ in the way they felt the patients wanted left the nurses feeling troubled.\textsuperscript{36}

Feeling a sense of moral burden seems to be the ‘negative’ dimension of moral sensitivity, which indicates that the questionnaire tapped into something other than moral sensitivity as a positive dimension. If moral sensitivity is a cognitive dimension, then it seems reasonable that this includes the ability to deal with moral problems. Instead, nurses’ awareness of competing or contradicting moral imperatives but not being able to resolve them leaves them feeling burdened, perhaps with a troubled conscience. Johnstone\textsuperscript{37} points out that nurses who are not ‘prepared’ to deal with troublesome moral situations may be at risk of moral distress but may also fail to act in the best interest of the patient. Thus moral sensitivity must be complemented with a preparedness to deal with moral problems in a justifiable manner. According to Rest,\textsuperscript{21} moral sensitivity is not only an awareness of how our actions affect others, it also involves interpretation of the ‘ethical dilemma’ and making decisions that can be justified. It would therefore be of interest to investigate the relationship between moral sensitivity and how effectively health care professionals deal with moral problems without feeling a sense of burden.

Moral strength may be expressed by having the courage to act and the ability to provide arguments with the intention to justify these actions on behalf of another (ie the patient) instead of defending oneself. Thus, moral strength is necessary. However, moral weakness could lead to a shift in focus to oneself instead of the patient, and in self-defensive actions and arguments (ie ‘covering up the tracks’). Frankena\textsuperscript{38} describes this as ethical egoism because self-interest is placed before a certain moral duty. For example, a nurse who ignores a patient’s call for help would view leaving work on time as a greater good than going to the patient. Moral strength may be reflected in taking a moral position in a conflict situation, but also strength in the sense of showing resilience and endurance. For example, in a similar study, mental health nurses who were employed at a psychiatric facility in Canada implicitly expressed the significance of having moral strength.\textsuperscript{39} The mental health nurses who spoke out on behalf of patients thought that this was an act of moral survival (ie doing what they judged to be good).

Moral strength of character can also be described as a personal attribute that aids recovery from an unfortunate situation and has protective strength.\textsuperscript{40}

The two items composing moral responsibility indicate primarily a moral obligation to work according to rules and regulations, and insight into their purpose. In addition, moral responsibility is to ‘know’ what is a moral problem from the perspective of the individual patient. Johnstone\textsuperscript{37} refers to not being able to see a problem as a moral problem as ‘moral blindness’ (p. 165) or ‘moral indifference’ (p. 169). Similarly, not to be able to foresee limitations of rules and regulations from the perspective of the patient is also a form of moral blindness and an unconcerned attitude about the consequences. The absence of rules and regulations can lead to situations in which health care professionals misinterpret their moral responsibility or feel inadequately prepared to take action (eg lack moral strength). In other words, moral rules and regulations play an important role in guiding moral behaviour, but it is uncertain whether these are prescriptive action guides (p. 87).\textsuperscript{37}
Conclusions

The three factors identified in this study – a sense of moral burden, moral strength and moral responsibility – appear to be conceptually interrelated, yet indicate that moral sensitivity involves more dimensions than simply a cognitive capacity, especially feelings, sentiments, moral knowledge and skills. Of specific interest is the role of moral experience. Yet, even if the findings indicate this connection, there are questions concerning the legitimacy of moral sensitivity as a moral authority in health care practice (or in any context for that matter). Although moral sensitivity may certainly attune a person to the moral nature of a situation, it is uncertain in what way it is linked to either a good or a troubled conscience. The question is, where does the boundary lie for what moral sensitivity can achieve? Another question is whether moral burden is needed to challenge our moral judgements and if in that way it can indeed be looked on as a positive dimension. Whether moral sensitivity encourages moral agency in practice needs to be further explored in specific health care contexts.

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