

A Research about the Ethical Sensitivity of Healthcare Professionals

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Abstract

Objective: The purpose of this study is to determine the approach of healthcare professionals in ethical dilemmas and to examine the level of ethical decision-making. **Methods:** As a means of collecting data, "Ethical Sensitivity Questionnaire" was used that was developed by Lutzen and adapted to Turkish by Tosun. The study population consists of healthcare professionals who work in the province of Sakarya and agreed to participate voluntarily. In data analysis, descriptive statistical methods, factor analysis, correlation analysis, one-way ANOVA analysis, Tukey test and t-test for independent samples were used. **Ethical considerations:** Permission to carry out the study was obtained from hospitals under investigation. Questionnaires were distributed to participants and completed ones were sent to the researcher in a sealed envelope. Anonymity and confidentiality of the participants were ensured. **Results:** According to the findings of the study, there was a positive correlation between the sub-dimensions of the scale. There was no significant difference in ethical behavior of healthcare professionals according to sex, marital status and receiving ethical education or not. It was found significant difference in sub-dimensions of scale according to age, having children or not, profession, working unit, years of service and monthly income. **Conclusion:** Making ethics committees functional, implementing ethical consultation system, revising ethics education at undergraduate and post graduate levels and giving practical in-service training are proposed to reduce ethical dilemmas of healthcare professionals.

Keywords: Ethics, health ethics, ethical dilemma, health professionals

1. Introduction

Ethics, encountered in management, law, politics, media and medical field and that is one of the concept that is difficult to conduct precise definition, has always been an important part of healthcare service provision from past to present. Ethical perspective is needed in protecting and promoting human health in uncertain, high degree of difficulty and risky situations due to the nature of healthcare services. In this context, some studies have been made to create ethical framework in healthcare and prepare codes of ethics until today. Developments in health care, especially in technology, communication and patients' rights, force to change information asymmetry between physician-patient in favor of patients and lead to potential ethical dilemmas in the provision of healthcare services. Ethical dilemmas, that health professionals face and could face in service delivery, arise as a result of conflicts in ethical values and obligations and are mostly experienced in the process of treatment and care. Indeed, the process of treatment and care is prone to be a milieu for conflict of the patient's values and expectations and physicians' and nurses' values and obligations. Ethical issues occur when there is conflict of values with one another or conflict with another interest.

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For example, a physician being afraid of patient's serious subversion of definition of hopeless case honestly, may experience conflict between loyalty to patient's best interest, the physician's financial interest or responsibility to tell the truth and the responsibility to protect the health of patients (Bankowski, 1991: 28). In this study about health ethics, general concept of ethics and ethics in healthcare are emphasized and ethical dilemmas that physicians and nurses' face in the delivery of healthcare services are discussed.

2. Ethics and Health Ethics

Ethics is derived from the word "ethos", that means "character". "Ethics", derived from "Ethos", has emerged as a result of examination of ethics and values, pointing to ideal and abstract for a particular situation (Svensson & Wood, 2004: 321; Thompson, 1985: 555). Ethics is a concept that refers to the behavioral rules; ethical values are a system of behavioral rules and generally systems of rules belong to a philosophical current or religion, professional group or a culture (Barkow, 2000: 95). Ethics, as a multidisciplinary concept, consider judgments behind moral attitudes and with this perspective is a behavioral science (Audi, 2004: 1; Badenhorst, 1994: 740; Frankena, 1973: 4). Ethics is a set of values that is proposing to humans things to do or should not do. These values can be examined in four groups as manners homework, virtues, principles and interest of society (Svara, 2007: 10). Ethics is both based on more abstract concepts and try to define what should be understood from these abstract concepts. It is expected that ethical rules include written rules related to a clear and specific field. For instance, some fields such as politics ethics, law ethics, medical ethics, media ethics, and management ethics include their own principles (Lamberton & Minor, 2009: 326). Approaches, that is expressed with concepts such as bioethics, medical ethics, health ethics and that generates ideas on ethical aspects of medical practice, has emerged as a sub-branch of ethics. In this framework, health ethics means philosophical justification of ethical behavior in the provision of healthcare services and is based on being aware of human health entrusted to healthcare professionals and values in service delivery (Yuksel, 2012: 9). Reasons such as equal distribution of information, public goods properties, properties of negative and positive externalities in healthcare services, lead to inability for efficient production in market conditions and intention of public authorities to provide justice in the provision of healthcare services constitute the source of ethical problems (Tepecik & Yazici, 2012: 382). In this context, information asymmetry and individual's authority in using good faith and information when providing health services generally illustrate the need for health ethics (Koslovski, 2009: 54-56).

2.1. Principles of Health Care Ethics

With general acceptance of concept of principle that is used extensively in health ethics and extension of the elements of this concept until Hippocrates, health ethics principles has been made in written by Thomas Pervical in 1803 for the first time (Pervical, 1803). Later in 1847, largely based on the Pervical's ethical principles, ethical guidelines are prepared by American Medical Association and revised in 2001 latest (Cobanoglu, 2009: 15; www.ama-assn.org, 2013). Although health ethics principles are systematically classified in different ways in the literature, these principles generally grouped as benefit, respect for autonomy, do no harm and fairness. (Beauchamp & Childress, 2012; Gillon, 1994). In addition, although sharing information, confidentiality, respect confidentiality, integrity, avoidance from discrimination, respectful and equal service delivery, communication and consent, decision-making process for incompetent patient and professional secrecy are not among the basic principles, they are considered as principles of health ethics (Williams, 2009: 37).

2.2. Ethical Dilemmas in Healthcare Services

Ethics is focused on discussion related to process of determination of principles that will resolve people's conflicting desires or desired goods (Aydin, 2010: 5). In any matter to be decided on a case, if there is a confusion between the two values, ethical dilemmas arise (Fry, 1996: 32). Ethical issues are complex issues left in a quandary, requiring moral judgment and choice and not simple and have exact solutions to be defined as absolute right or wrong (Dinc, 2009: 116). Ethical dilemma is defined as both situation of two or more options in any situation and conflict of ethical obligations (Tosun, 2005: 18-19). Especially in the provision of health services, it is possible to say that inability to decide between two values occurs frequently. In the case of two or more alternatives, ethical dilemmas are experienced at the point of deciding which one is better (Craven, Hirnle & Jensen, 2013: 40-41). Because there are no specific rules in resolution of ethical dilemmas, especially during the presentation of treatment and care, health care professionals mostly have difficulties (Noureddine, 2001: 3). In the provision of health services, ethical dilemmas arise in the case of professional actions and maintenance treatment decisions (Elcigil et al., 2011: 53).

When we define ethical sensitivity in healthcare services as consideration of patient's condition in making decisions on behalf of patients in the process of treatment and care decisions, the basic dimensions of ethical sensitivity are collected under the title of orientation, holistic approach, benefit, autonomy, conflict and practice. Ethical dilemmas in the provision of health services reveal in these fields (Lutzen, Evertzon & Nordin, 1997: 474).

3. Materials and Methods

3.1. Research Objectives

The purpose of the study is to determine the approach of health care professional in ethical dilemmas in the delivery of healthcare services and examine the level of ethical decision-making.

3.2. Population and Sample

The study population is consisted of health professionals working in hospitals in the province of Sakarya. Study is being applied to 606 doctors and nurses that is determined by simple sampling method and voluntarily accepted to participate in the research. Study is limited only to the data obtained from the study sample.

3.3. Ethical Considerations

Permission was obtained from hospitals under investigation in order to carry out this study. Questionnaires were distributed to participants for collecting data and then questionnaires completed were sent to the researcher in a sealed envelope. Health care professionals agreed to voluntarily participate in the study. Anonymity and confidentiality of the participants was ensured.

3.4. Data Collection Tool

As a means of data collection, 9 questions consisting of socio-demographic characteristics of health care professionals and a questionnaire consisting of the ethical sensitivity scale developed by Kim Lutzen (1997) was used. The scale consisted of thirty-expression has been designed in Likert-shaped structure as 1. Completely disagree - 5. Completely agree. Total score that could be taken ranged from 30 to 150, that 5 points meant higher sensitivity and 1 point meant low sensitivity. While higher scores showed higher ethical sensitivity, lower scores showed low ethical sensitivity. Questionnaire had six subscales including autonomy, benefit, holistic approach, conflict, practice and orientation (Lutzen, Evertzon & Nordin, 1997; Tosun, 2005).

3.5. Statistical Methods Used

In order to analyze the validity and reliability of data obtained from study, Cronbach's alpha coefficient and exploratory factor analysis was used. In data analysis, descriptive statistical methods, correlation analysis, independent samples t test and One-way analysis of variance were used. For determining which variables caused by differences in One-way analysis of variance, Tukey test was used. Analysis was performed within 95% ($p = 0.05$).

3.6. Validity and Reliability Analysis

Factor analysis was applied to describe the factor structures of variables that affect ethical sensitivity in healthcare services in research or which groups can be classified under. Expressions of "To get a positive response from patients in every attempt is important for me", "I often encounter with unpleasant situations that I have to decide without the participation of the patients" and "When oral therapy is rejected by the patient, threatening patient with injection have sometimes valid reasons", that place in scale in factor analyze, were excluded from the scale because of mismatches. After removal of these expressions from the scale, result of Kaiser Olkin Meyer was found 0.901 and this result showed factor analysis could be applied to this data set. In addition, Barlett's Test of Sphericity test that is used in testing factor analysis of variance was meaningful. In the result of analysis, 27 variables that affect ethical sensitivity in healthcare services were grouped under 6 factors. Total variance of the scale was %58.820 and the variables forming factors and explained variance are shown in Table 1. As shown in detail in Table 1, the reliability analysis of scale used in the study was carried out and Cronbach's alpha value was found 0.883. Reliability analysis was studied previously in different studies made in Turkey and in these studies Cronbach alpha value was found as 0.84 (Tosun, 2005), 0.83 (Pekcan, 2007) and 0.80 (Basak, Uzun & Arslan, 2010). Both results obtained from this study and results obtained from other studies indicate that the scale is reliable.

Table 1: Results of Reliability and Validity Analysis of Ethical Sensitivity Scale

Kaiser-Meyer-Olkin Measure of Sampling Adequacy				0.901	
Bartlett's Test of Sphericity				Meaningful	
Approx. Chi-Square	5961.028	df	351	Sig.	0.000
Cronbach Alpha	0.883	The Total Variance Explained		58.820	
Ethical Sensitivity Dimensions				Cronbach Alpha	
		Factor Loadings	Explained Variance	S	
Autonomy					
If I do not have enough knowledge about patient's personal history, I trust the standards related to treatment.		0.747			
I believe it is important to have certain principles in the treatment of patients.		0.731			
Even if patient objects, I always act based on the information which I believe as best treatment.		0.723			
I believe that good treatment mostly comprise the patient's participation in decision-making processes.		0.654			
When a patient refuses treatment, watching set of rules is important.		0.646			
If the patient was hospitalized involuntarily, I have to be prepared to situation that patient do not accept treatment.		0.579			
I consult my colleagues in the case of struggling to decide in the treatment process.		0.568			
Holistic Approach			10.311	0.788	
I have to know what kind of treatment and care that patients should take.		0.705			
When I have to decide on a difficult issue, it is important to be always honest to patients.		0.698			
Even if I cannot give patient adequate information about the his/her illness, I find my professional role meaningful.		0.697			
The patient's response to treatment mostly determines whether I make the right decision or not in the process of treatment.		0.673			
My responsibility as physician / nurse is to have knowledge about the patient's general condition.		0.641			
Conflict			6.260	0.884	
I mostly experience contradictions how I should approach to the patient about treatment.		0.886			
I'm often confronted with situations in deciding what ethically correct implication in the process of treatment is.		0.880			
I frequently meet with the case of deciding about the patient himself/herself in the treatment process.		0.862			
Orientation			5.814	0.712	
I believe that physician/nurse-patient relationship is very important component during the treatment process.		0.715			
I believe that a good treatment process involves the participation of the patient to this process.		0.696			
I mostly reflect my professional standards and values on my treatment.		0.636			
I believe that a good treatment includes respect to patient's choice.		0.632			
Practice			5.101	0.753	
I mostly trust my feelings when it is needed to take difficult decision for patient.		0.745			
When I do not know what is ethically right or wrong, I use my own experiences rather than theoretical knowledge.		0.736			
When I feel the need to make a decision outside the patient's wishes, I do most beneficial thing for the patient.		0.654			
When I'm not sure what to do in the process of treatment, I mostly rely on other physicians/nurses' information about the patient.		0.586			
Benefit			4.252	0.660	
If I lose the confidence of the patient, I think that my job has lost its meaning as nurse / physician.		0.735			
If the patient rejects treatment, I think that a good treatment is difficult.		0.693			
If there is lack of information about the patient's illness, I believe that I can do things to have knowledge.		0.668			
If I do not see an improvement in my patients, I feel that my work has no meaning.		0.602			

4. Findings

59.2% were female and 56.3% were married, 51.8% did not have children, 24.3% were between 26-30 age, 39.9% had monthly 2001-3000 income, 35.8% worked 5 years and less time, 57.8% were physicians, 37.6% worked in the clinic and 69.6% received ethics education of health professionals who participated in the study (Table 2).

Table 2: Socio-Demographic Characteristics of Participants (n=606)

Features	n	%	Features	n	%
Marital Status			Sex		
Married	341	56.3	Female	359	59.2
Single	265	43.7	Male	247	40.8
Profession			Children		
Physician	256	42.2	There is	292	48.2
Nurse	350	57.8	There is Not	314	51.8
Working Units			Number of Children		
Polyclinic	228	37.6	No Children	314	51.8
Clinic	115	19.0	1 Child	107	17.7
Intensive Care	42	6.9	2 Children	122	20.1
Operating Room	72	11.9	3 And More Children	63	10.4
Emergency Room	116	19.1	Monthly Income		
Diagnosis Unit	33	5.4	≤ 2000	121	20.0
Age			2001 – 3000	237	39.1
≤ 25	107	17.7	3001 - 4000	102	16.8
26 – 30	147	24.3	4001- 5000	85	14.0
31 – 35	116	19.1	≥5001	61	10.1
36 – 40	94	15.5	Professional Experience		
≥41	142	23.4	< 5 Years	217	35.8
Receiving Ethics Education			5 – 9 Years	144	23.8
Yes	422	69.6	10– 14 Years	108	17.8
No	184	30.4	≥15 Years	137	22.6

In the study, to determine the level of ethical sensitivity of health professional, overall total scores and dimensions were calculated. The level of ethical sensitivity increased closer to the 5 for each variable forming the scale and reduced closer to 1. Ethical sensitivity minimum and maximum values varied according to number of questions in dimensions. For instance, in the study after three questions were removed in validity analysis in the study, 27 questions remained in scale. Ethical sensitivity values ranged from 27 to 135 points for 27 questions. As seen in Table 3, general ethical sensitivity point of health professionals was 102.17. Compared average value with maximum scores, highest score of ethical sensitivity was in orientation dimension (16.40 ± 2.140); holistic approach followed this dimension (20.05 ± 2.631). Ethical sensitivity was lowest in conflict dimension (9.16 ± 2.517).

Table 3: Situation of Ethical Dilemma Experience According to Dimensions

Factors	Number of Questions	Potential Score Range		Findings In Study	
		Minimum	Maximum	Means	S. D.
Benefit	4	4	20	14.66	2.540
Holistic Approach	5	5	25	20.05	2.631
Practice	4	4	20	14.53	2.605
Orientation	4	4	20	16.40	2.140
Conflict	3	3	15	9.16	2.517
Autonomy	7	7	35	27.36	3.354
General Ethical Sensitivity	27	27	135	102.17	10.506

Results of Pearson correlation analysis, that is to determine the relationship between dimensions of ethical sensitivity, were shown in Table 4. Accordingly; only the relationship between conflict dimension and orientation dimension ($r = 0.032$, $p > 0.05$) was not statistically significant. Except these dimensions, there was statistically significant relationship in all dimensions ($p < 0.01$).

Table 4: Ethical Sensitivity Levels and Correlation of Dimensions of Health Professionals'

	1	2	3	4	5
Benefit (1)	1				
Holistic Approach (2)	0.250**	1			
Practice (3)	0.290**	0.393**	1		
Orientation (4)	0.254**	0.491**	0.275**	1	
Conflict (5)	0.271**	0.132**	0.325**	0.032	1
Autonomy (6)	0.323**	0.488**	0.514**	0.493**	0.244**

** Correlation is significant at the 0.01 level (2-tailed).

Comparison of ethical sensitivity level and socio-demographic characteristics of health care professionals involved in research was shown in Table 5. There was no statistically significant difference between mean values in terms of gender, marital status and ethical education received ($p > 0.05$). When analyzed means according to the age; it was found higher level of ethical sensitivity in 26-30, 36-40 and ≥ 41 age groups compared to the 31-35 age group in practice dimension; ≥ 41 age group compared to 26-30 and 31-35 age groups in orientation dimension; 36-40 and ≥ 41 age groups compared to 31-35 age group in autonomy dimension; generally 36-40 age group compared to 31-35 age group in ethical sensitivity ($p < 0.05$). When examined mean values according to whether participants' have children or not, ethical sensitivity levels were found higher participants' having children than participants' not having children in only holistic approach dimension ($p < 0.01$). With respect to the number of children, ethical sensitivity was in higher levels for those who have one child than those who have three children ($p < 0.05$). When analyzed mean values according to participants' profession, physicians' ethical sensitivity was found higher than nurses' ethical sensitivity in holistic approach dimension and autonomy dimension ($p < 0.05$). According to working units of participants, ethical sensitivity level of those working in intensive care unit and operating room was higher than those working in polyclinics. According to total working time of participants, ethical sensitivity was higher in those working ≥ 15 years than < 5 years in orientation dimension; < 5 years than 10-14 years and ≥ 15 years ($p < 0.05$) in conflict dimension. With respect to monthly income of participants, ethical sensitivity level was found higher in those have ≥ 5001 TL, 4001-5000 TL and 3001-4000 TL monthly income than ≤ 2000 TL monthly income in practice dimension ($p < 0.05$).

Table 5: Comparison of Ethical Sensitivity and Socio-Demographic Characteristics of Participants

Features	n	Benefit	Holistic Approach	Practice	Orientation	Conflict	Autonomy	Ethical Sensitivity
Sex								
Female	359	3,67±0,604	3,99±0,525	3,61±0,652	4,12±0,519	3,04±0,809	3,89±0,453	3,78±0,364
Male	247	3,65±0,679	4,04±0,527	3,66±0,651	4,07±0,556	3,08±0,882	3,93±0,515	3,80±0,423
p*		p>0,05	p>0,05	p>0,05	p>0,05	p>0,05	p>0,05	p>0,05
Age								
≤25 ¹	107	3,67±0,527	4,04±0,499	3,65±0,599	4,14±0,499	3,17±0,831	3,93±0,416	3,82±0,334
26-30 ²	147	3,65±0,643	3,96±0,558	3,68±0,629	4,00±0,607	3,09±0,814	3,88±0,546	3,76±0,430
31-35 ³	116	3,66±0,668	3,94±0,592	3,44±0,760	3,98±0,544	3,00±0,846	3,79±0,547	3,69±0,459
36-40 ⁴	94	3,77±0,637	4,06±0,495	3,73±0,621	4,16±0,531	3,06±0,855	3,99±0,377	3,85±0,331
≥41 ⁵	142	3,61±0,671	4,06±0,469	3,67±0,611	4,23±0,437	2,97±0,854	3,97±0,433	3,81±0,342
p**		p>0,05	p>0,05	p<0,05	p<0,05	p>0,05	p<0,05	p<0,05
Post Hoc***				3<2,4,5	5>2,3		3<4,5	3<4
Marital Status								
Married	341	3,67±0,652	4,02±0,504	3,64±0,661	4,12±0,529	3,00±0,845	3,93±0,466	3,79±0,385
Single	265	3,66±0,614	3,99±0,554	3,62±0,640	4,08±0,543	3,13±0,828	3,89±0,495	3,78±0,395
p*		p>0,05	p>0,05	p>0,05	p>0,05	p>0,05	p>0,05	p>0,05
Children								
There is	292	3,67±0,647	4,03±0,473	3,66±0,637	4,13±0,518	2,99±0,806	3,94±0,452	3,79±0,369
There is Not	314	3,66±0,625	4,00±0,572	3,61±0,665	4,08±0,550	3,12±0,865	3,88±0,502	3,77±0,407
p*		p>0,05	p<0,05	p>0,05	p>0,05	p>0,05	p>0,05	p>0,05
Number of Children								
No Child ¹	314	3,66±0,625	4,00±0,572	3,61±0,665	4,08±0,550	3,12±0,865	3,88±0,502	3,77±0,407
1 Child ²	107	3,77±0,594	4,01±0,501	3,61±0,614	4,11±0,565	3,08±0,789	3,88±0,500	3,79±0,395
2 Children ³	122	3,58±0,668	4,04±0,467	3,64±0,683	4,14±0,525	2,84±0,779	3,96±0,404	3,77±0,346
≥3 Children ⁴	63	3,69±0,675	4,03±0,441	3,77±0,577	4,13±0,419	3,10±0,859	3,99±0,454	3,84±0,369
p**		p>0,05	p>0,05	p>0,05	p>0,05	p<0,05	p>0,05	p>0,05
Post Hoc***						1>3		
Profession								
Physician	256	3,70±0,649	4,08±0,494	3,71±0,634	4,12±0,485	3,10±0,858	4,02±0,408	3,85±0,354
Nurse	350	3,64±0,624	3,96±0,545	3,63±0,658	4,08±0,569	3,02±0,825	3,83±0,512	3,74±0,407
p*		p>0,05	p<0,05	p>0,05	p>0,05	p>0,05	P<0,05	p>0,05
Working Unit								
Polyclinic ¹	228	3,65±0,644	4,01±0,494	3,64±0,629	4,11±0,507	2,94±0,800	3,94±0,457	3,78±0,358
Clinic ²	115	3,68±0,525	4,00±0,505	3,55±0,630	4,06±0,578	3,00±0,749	3,87±0,448	3,75±0,343
Intensive Care ³	42	3,66±0,641	4,16±0,388	3,82±0,542	4,25±0,345	3,33±0,849	4,01±0,345	3,92±0,306
Operating Room ⁴	72	3,81±0,610	3,98±0,628	3,64±0,745	4,10±0,590	3,34±0,892	3,91±0,559	3,83±0,473
Emergency Room ⁵	116	3,66±0,691	3,95±0,550	3,62±0,625	4,01±0,564	3,10±0,850	3,85±0,542	3,75±0,425
Diagnosis Unit ⁶	33	3,42±0,725	4,12±0,619	3,71±0,843	4,28±0,483	2,90±1,032	3,97±0,449	3,80±0,478
p**		p>0,05	p>0,05	p>0,05	p>0,05	p<0,05	p>0,05	p>0,05
Post Hoc***						1<3,4		
Total Working Time								
<5 years ¹	217	3,70±0,590	3,98±0,555	3,64±0,665	4,05±0,574	3,16±0,828	3,88±0,523	3,78±0,417
5-9 years ²	144	3,69±0,620	3,98±0,563	3,57±0,669	4,05±0,538	3,10±0,879	3,92±0,457	3,77±0,393
10-14 years ³	108	3,62±0,691	4,07±0,495	3,66±0,675	4,14±0,525	2,91±0,806	3,91±0,472	3,78±0,399
≥15 years ⁴	137	3,61±0,673	4,04±0,460	3,67±0,592	4,21±0,457	2,96±0,822	3,94±0,436	3,80±0,331
p**		p>0,05	p>0,05	p>0,05	p<0,05	p<0,05	p>0,05	p>0,05
Post Hoc***					1<4	1>3,4		
Monthly Income								
≤2000 ¹	121	3,56±0,660	3,93±0,624	3,52±0,668	3,99±0,693	2,86±0,807	3,80±0,616	3,67±0,480
2001-3000 ²	237	3,72±0,574	4,00±0,509	3,61±0,614	4,15±0,490	3,09±0,790	3,88±0,435	3,79±0,346
3001-4000 ³	102	3,68±0,634	4,05±0,520	3,69±0,603	4,06±0,454	3,14±0,983	3,98±0,449	3,82±0,368
4001-5000 ⁴	85	3,74±0,666	4,12±0,471	3,70±0,733	4,13±0,486	3,11±0,804	3,99±0,387	3,85±0,367
≥5001 ⁵	61	3,54±0,736	4,00±0,442	3,78±0,691	4,16±0,518	3,09±0,843	3,99±0,459	3,82±0,376
p**		p>0,05	p>0,05		p>0,05	p>0,05	p>0,05	p>0,05
Post Hoc***				1<4, 5>2<5				
Ethics Education								
Received	422	3,68±0,636	4,04±0,518	3,63±0,654	4,13±0,555	3,05±0,830	3,92±0,488	3,80±0,392
Not Received	184	3,63±0,633	3,95±0,543	3,64±0,646	4,04±0,483	3,06±0,862	3,88±0,459	3,76±0,382
p*		p>0,05	p>0,05	p>0,05	p>0,05	p>0,05	p>0,05	p>0,05

*Independent Sample t Test **One-Way ANOVA, ***Tukey Test

5. Evaluation and Conclusion

According to the results of the study, ethical sensitivity of health professionals was generally moderate level. It was found that orientation and holistic approach dimension were highest ethical sensitivity between dimensions. In contrast, the lowest sensitivity was in conflict dimension. Except conflict and orientation dimensions, there was relationship between all ethical sensitivity dimensions. Thus, change in any dimension of ethical sensitivity affected other dimensions. Gender, marital status and receiving ethical education of health workers did not cause any change in ethical sensitivity. In contrast, in a study conducted by Tosun (2005), it was found that there was a significant difference in gender within physicians in *conflict and orientation dimension* and nurses in *benefit and orientation dimensions*. Similar to the results of this study, in the study of Basak, Uzun and Arslan (2010: 78), there was no statistically significant relationship between marital status and ethical sensitivity levels and sub-dimensions. However, there were opposite studies showing that those who are married were higher ethical sensitivity levels (Tosun, 2005). Results obtained from other studies showed that ethics education did not affect developing ethical sensitivity. In the study of Basak, Uzun and Arslan (2010: 78), there was no meaningful relationship between receiving ethics education and ethical sensitivity level in intensive care nurses. In another study, ethical dilemma was emphasized, that ethics education caused failure in practice (Tadd et al., 2006). Age of health professionals caused significant differences in *practice, orientation and autonomy dimensions* and ethical sensitivity level. In the literature, there were also studies that age caused some differences in ethical sensitivity; especially ethical sensitivity was evolved with increasing age (Ozturk, Hindistan, Kasım & Candas, 2009: 81; González-de Paz, Kostov, Sisó-Almirall & Zabalegui-Yárnoz, 2012: 2756; Ersoy & Goz, 2001: 309; Basak, Uzun & Arslan, 2010: 78; Tosun, 2005; Ersoy & Gundogmus, 2003).

Having children or not caused differences in holistic approach dimension and number of children in conflict dimension. In the study of Tosun (2005), ethical sensitivity level of health professionals, who have children, was found higher in autonomy and practice dimensions. Physicians' ethical sensitivity level was higher than nurses in holistic approach and autonomy dimensions. In the study of Tosun (2005), it was found that nurses had higher ethical sensitivity level in autonomy and practice dimensions and physicians have in orientation dimension. Indeed, Oberle and Hughes (2000: 709) put forward those differences of physicians' and nurses' ethical sensitivity levels were associated with task perceived and title. Because physician gave decisions and ordered and nurses implemented the decisions given by someone else, perspectives on ethical dilemmas varied. Similarly, Joudrey and Gough (1999: 1157) argued that there were differences on ethical sensitivity of physicians and nurses. Ethical sensitivity of health professionals working in the operating room and intensive care units was higher than those working in polyclinics. It was suggested in other studies that working units of health professionals caused differences in ethical sensitivity. For example, in the study of Tosun (2005), ethical sensitivity level of nurses in was found higher than nurses working in psychiatric units. According to the results of another study, ethical sensitivity of nurses working in primary health care was found higher than nurses working in hospitals (González-de Paz, Kostov, Sisó-Almirall & Zabalegui-Yárnoz, 2012: 2756).

Weaver, Morse and Mitcham (2008, p. 610) argued that ethical behavior and critical thinking tendency and knowledge of ethical codes of conduct increased as professional experience of health professionals increased. In this study, it had seen differences between those who have ≤ 5 years work experience and those who have ≥ 15 years. This result confirmed the above assertion. In a study by Ozturk, Hindistan, Kasım and Candas (2009: 81), it was found that as professional experience and year of study increased, ethical sensitivity increased in benefit dimension. In another study, ethical sensitivity of nurses with 1-5 years experience was less than those with 6-10 years of experience (Lutzen, Blom, Ewalds-Kvist & Winch, and 2010: 219). In another study conducted on this issue, it was emphasized that experience facilitates their work when nurses faced with ethical dilemmas (Ersoy & Goz, 2001: 309). In addition, it was found that there were some differences according to participants' monthly income in practice dimension. Especially, ethical sensitivity of those who have high monthly income was found high. As a result, ethical sensitivity of health professionals was higher than mid-level in sample. However, when considering ethical dilemmas in the provision of healthcare services and the need to raise the level of ethical sensitivity of health professionals, it is expected that these steps will not be limited to ethical sensitivity dimension, enable more efficient and effective healthcare service provision, affect patient satisfaction positively, solve conflict and violence cases because of various reasons, especially lack of communication. By making the ethics committees functional in hospitals, providing consultation services for physicians and nurses who have ethical dilemmas in the provision of health services and giving practical training to physicians and nurses in the areas of ethics and ethical decision-making will contribute to development of ethical values.

6. References

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