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Original Article

Ethical Sensitivity and its Association with Caring Behavior among Healthcare Workers in Delta State, Nigeria: A Cross-Sectional Study

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ABSTRACT

Introduction: Caring behavior is a unique behavior that can promote patients' well-being, the performance of healthcare workers, and the general effectiveness of healthcare institutions. The mechanism and possible predictors of caring behavior are under-researched in health and organizational behavior literature. Based on the aforementioned, this study examined the predictive effect of ethical sensitivity (dimensions included) on caring behavior, and gender differences in caring behavior and ethical sensitivity among public healthcare workers in Delta State, Nigeria.

Methods: A cross-sectional research design and a quantitative approach for data collection were adopted. Simple random sampling was adopted for selecting the participating hospitals while the convenience sampling technique was utilized for selecting the healthcare workers. Two instruments with good psychometric properties were used for the data collection. The simple linear regression and independent sample t-test were used for testing the hypotheses via the IBM-SPSS v.25.

Results: The participants comprised 150 healthcare workers from public-owned hospitals consisting of 73(48.7%) males and 77(51.3%) females with a mean age of 40.60 years and a standard deviation of 9.30. The results of the study indicated that ethical sensitivity positively and significantly predicted caring behavior. Also, two dimensions of ethical sensitivity, moral strength, and moral responsibility positively and significantly predicted caring behavior while a sense of moral burden did not. Finally, there was no significant gender difference in caring behavior and ethical sensitivity.

Conclusion: This study highlights the role of ethical sensitivity, moral strength, and moral responsibility in predicting higher levels of caring behavior among healthcare workers. Thus, it was recommended that hospital administrators, health policymakers, and practitioners seeking to boost the caring behavior of healthcare workers should focus on enhancing factors such as sensitivity to ethical standards. Also, administrators of medical education can nurture intending healthcare workers (medical students) on the importance of ethics in the medical profession.

Keywords: Caring behavior, Ethical sensitivity, Gender, Healthcare workers, Moral responsibility, Moral strength, Sense of moral burden

Introduction

Healthcare workers are crucial to nations around the world and they represent about 12% of the working population worldwide.[1] Healthcare workers work long hours and their job is usually challenging since they have to deal with human suffering daily. Despite this, it is their professional duty to ensure that the health of a patient is well managed.[2] Caring behavior is regarded as an essential attribute in the healthcare profession because of the salient role it plays in the caregiver-patient relationship.

Achieving an efficient and optimum healthcare delivery largely relies on the service process and the interaction between healthcare workers and patients.[3] Caring behavior is crucial in establishing and maintaining a sound therapeutic alliance, and it fosters the efficacy of the treatment process.[4]

Therefore, the relevance of the interaction between healthcare workers and health seekers cannot be overemphasized because it has been observed to aid the treatment process.[5] This relationship is built on effective care, interpersonal communication, information disclosure, and caring behavior which are important in ensuring and maintaining quality therapeutic relationships between healthcare workers and health seekers.[6,7] At a minimum, quality healthcare is built on the availability of necessary resources as well as a health workforce that is capable and well-motivated. Caring behavior is an interpersonal process that is built on sensitivity to the need of others and involves highly practical behaviors such as assuring humanistic presence, general respect for patients' needs, positive communication, providing professional skill and knowledge where necessary, and most importantly paying attention to the need of the patient.[8]

Caring behavior in the healthcare profession conveys concern for the safety and well-being of the patient and ensures that significant attention is given to the patient's needs during the treatment process.[9] Caring behavior is very important largely because healthcare professionals are constantly in direct contact with patients. The absence of caring behavior in the healthcare profession has detrimental effects on health seekers. In the Nigerian public healthcare system, workplace attitude marked by emotional incompetence, reduced interpersonal communication, and caring behavior has been major contributors to the reported challenges within the health sector.[10,11] These attitudes (emotional incompetence, reduce interpersonal communication, and caring behavior) can impact the quality of healthcare services, hence, discouraging patients from seeking care in public-owned health institutions. However, caring behavior has not been given as much attention in health and organizational literature as it should be, especially in the Nigerian context where there exists evidence of reduced care among healthcare workers.[11] On reviewing various kinds of literature it shows that researchers are recognizing its perceived importance in quality healthcare delivery still its antecedents and predictors have not been fully established in the global workspace, especially in Nigerian health organizations. A few gaps in the literature necessitated this study.

First, with recent reports in the literature indicating a shift from the regular sample utilized for studying caring behavior in the population of healthcare workers,[12] it becomes pertinent to examine other core healthcare units and possible variables that contribute to caring behavior in a bid to promoting the health and well-being of health seekers. The extant literature indicates that a significant number of studies have been focused on the caring behavior of nurses and other nursing caregivers with less attention given to other core healthcare personnel that have direct contact with patients.[3,6,8] In most Nigerian hospitals, health seekers have to meet record personnel who takes their record on behalf of the hospital, medical doctors responsible for drug prescription, a pharmacist in charge of giving the prescribed drugs or medications, and nurses who administer the drugs.[12] These processes are likely the same all over the world as the healthcare professional is highly regulated and controlled because of its essence to humanity. The inclusiveness of other core professionals in the healthcare sector reflects the caring behavior within the hospital. Second, studies examining the dimensionality of the ethical sensitivity scale (moral burden, strength, and responsibility) and its effects on caring behavior are lacking in the literature. Finally, the impact of gender on ethical sensitivity and caring behavior is also lacking in the Nigerian healthcare literature. The existence of these gaps in knowledge, if unattended can disempower health and hospital administrators in taking the right proactive and reactive steps in promoting caring behavior and ethical sensitivity. Based on this, the present study assessed caring behavior among healthcare workers and how it was influenced by ethical sensitivity, and its dimensions (moral burden, moral strength, and moral responsibility). The study also examines the likely differential effect of gender on caring behavior and ethical sensitivity. Studies on caring behavior are lacking in Nigeria, especially concerning the selected individual and demographic variables.

Ethics are the foundation on which the medical profession is built providing the basis for ethical patient care.[13] Therefore, the role of ethical sensitivity in the management and delivery of quality healthcare services cannot be undermined. Ethical sensitivity refers to the attentiveness to the moral values involved in a conflict-laden situation and self-awareness of one's personal role and obligation in a given situation e.g., during patient care.[14] It is the personal predisposition that guides healthcare workers in making an ethical decision which entails using their skills, feelings, cognitive capacity, and ethical knowledge.[14] Healthcare professionals face a variety of challenges that require ethical knowledge and a critical step to

take in increasing the ethical sensitivity of healthcare professionals is to increase their awareness and recognition of ethical issues especially those that have direct implications for patient care. [13] It has also been observed that personal disposition can influence care-related behavior among healthcare workers. [15] Healthcare workers need to understand basic ethical principles related to healthcare and integrate these principles with their moral values to deal with ethical problems. Reduced ethical sensitivity may bring about ethically inappropriate behavior and conflicts with the obligations of the healthcare profession. Hence, the abundance of ethical sensitivity may promote favorable workplace behavior that may have a positive impact on patients and colleagues at work. Consequently, it is hypothesized that ethical sensitivity is likely to have a positive impact on caring behavior. Previous studies have reported that higher levels of ethical sensitivity significantly contribute to compassion levels,[16] perceptions and quality of nursing,[17] occupational professionalism,[18] and greater empathetic behavior.[19] Also, the literature indicates that incompetency in ethical sensitivity threatens patient care and desensitizes healthcare workers when they are confronted with ethical situations or challenges.[20,21] Thus, there is a strong ground to believe that ethical sensitivity and its dimensions have the potential of predicting caring behavior among healthcare workers.

Gender has also been shown to influence varieties of workplace variables in healthcare institutions. Although there are inconsistent findings regarding gender influence on caring behavior, the role it plays cannot be overlooked. Previous studies outside Nigeria have shown that gender influences the caring behavior of healthcare workers.[22] Individuals who reported higher masculinity and femininity have been shown to have higher caring behavior. [23] Shmilovitz, Itzhaki and Koton found a significant gender difference in caring behavior with females reporting more caring behavior than males. [24] Similarly, a study found that gender is not a significant factor in understanding and dealing with the need of patients in Nigerian public hospitals.[25] These inconsistencies necessitated further examination of the observed difference between gender and caring behavior. Sensitivity to ethical practices might also be influenced by gender. This is based on the notion that males are more prone to assertiveness and rule-breaking compared to their female counterparts using the gender role theory.[26] Males are usually pushier and hence more likely to break ethical standards. Hence, females are more likely to be ethically sensitive than their male counterparts. Recent literature gives support for this proposition.[27,28] Consequent to the salient literature reviewed and the bid to fill the gaps earlier identified in the literature, this study is guided by the following hypotheses:

H_1: Ethical sensitivity will positively and significantly predict caring behavior.

H_{1a}: Sense moral burden will positively and significantly predict caring behavior.

H_{1b}: Moral strength will positively and significantly predict caring behavior.

H_{1c}: Moral responsibility will positively and significantly predict caring behavior.

H_2: There will be a significant gender difference in caring behavior.

H_3: There will be a significant gender difference in ethical sensitivity.

Methods

A cross-sectional study was adopted using a quantitative approach to data collection. The cross-sectional research design is appropriate because the sample was drawn from all participating public-owned hospitals in Delta State, Nigeria. This design was also deemed appropriate because of its capacity and flexibility in measuring several variables and testing multiple research questions and hypotheses at a single point in time. Also, the time constraint, the size of the sample, and the resource available at the time led to the selection of this method. A required sample size to test for statistical power and inference was adopted. This was estimated using the G*power software.[29] Using the adequate number of predictors outlined in the research hypotheses, a standardized alpha of 0.01, with a medium effect size (f^2) of 0.15, and a power level of 0.97. The G*power analysis suggested a required sample size of 101 participants.

As recommended by Bartlett, Kotrlik, and Higgins, it is advisable to increase the required sample size by 50% to enhance statistical inference.[30] Based on this recommendation, an additional sixty (60) participants were added to the overall sample totaling 161. This was evenly distributed across all the participating public owned hospitals. After the data collection, the researchers discovered that some questionnaires were not properly filled out by some of the respondents. This was attributed to the unwillingness of the participants to continue participation after giving their consent or merely a lack of motivation to respond to the items on the questionnaires. As a result, 150 questionnaires

were used for the final statistical data analysis and test of hypotheses. The questionnaire contained two psychometrically standardized instruments and questions eliciting sociodemographic information from the participants. The socio-demographics include gender, age, marital status, medical experience, current organizational tenure, and educational qualification. Item coding and mean scores of the participants' responses were used for the data analysis.

Ethical clearance was obtained from the institutional ethical committee of Delta State University before the commencement of the study. Confidentiality was maintained throughout the process of data collection. The researchers sought the permission of the participating hospitals (through a formal written letter stating the essence of the research and why health workers should participate in it) before administering the questionnaires. Verbal consent was taken from healthcare workers for participating in the study. Considering the constraint of resources, probability sampling was used for selecting the participating public-owned institutions via the use of random numbers assigned to hospitals to give some form of randomization to the process. The hospitals assigned to the random numbers selected were utilized for the study. Also, the convenience sampling technique was used for selecting the healthcare workers from the selected hospitals. The researchers ensured that participants were selected from the core units of the healthcare profession. One hundred and seventy (170) questionnaires were distributed, and one hundred and sixty-two (162) questionnaires were retrieved. The return rate was 95.29% and among them, 150 responses were used for the analysis.

Two instruments were used for assessing the two major variables in the study. One for caring behavior and the other for ethical sensitivity. Caring behavior was assessed with the instrument developed by Wu et al.[31] The inventory measures healthcare workers caring behavior toward patients. The caring behavior inventory was adapted to accommodate all participating healthcare workers such as doctors, nurses, and others within the field with direct contact with patient care. The inventory comprises 24 items that yielded four factors with each constituting a specific and significant domain of caring behavior: assurance (measured with 8 items), knowledge and skill (measured with 5 items), respectfulness (measured with 6 items), and connectedness (measured with 5 items). According to Nwanzu and Babalola, the assurance domain entails giving time to the need and security of patients, knowledge, and skill has to do with information and proficiency in the healthcare profession, with regard to patient's well-being, respectfulness entails the act of having courteous regard for patients, while connectedness covered optimistic and constant readiness on the part of the healthcare worker to help patients. [9] Examples of the items include: "I attentively listen to my patient"; "I allow the patients to express feelings about his/her disease and treatment"; "I am usually patient and tireless with the patients". The scale was measured on a five-point Likert format ranging from strongly disagree (1), disagree (2), neutral (3), agree (4), and strongly agree (5). The overall scores for each of the dimensions represent the composite construct of caring behavior. A reliability coefficient alpha of .96 was reported for the overall scale.

Ethical sensitivity was assessed with the index of ethical sensitivity questionnaire developed by Lutzen et al.[14] The scale was specifically developed for measuring ethical sensitivity during ethical decision-making among healthcare professionals working in a variety of healthcare settings. The ethical/moral sensitivity questionnaire comprises 9-item that yielded three factors each constituting a specific and significant domain of ethical sensitivity in healthcare settings: sense of moral burden (measured with 4 items), moral strength (measured by 3 items), and moral responsibility (measured with 2 items). Examples of the items include: "I always feel a responsibility that the patient receives good care even if the resources are inadequate"; "I have a very good ability to sense when the patient is not receiving good care"; "my ability to sense a patient's needs means that I often find myself in a situation in which I feel inadequate", representing each of the significant domain respectively. A Likert-type response was adopted for the instrument. Specifically, a 5-point Likert format was adopted ranging from strongly disagree (1) to strongly agree (5). Since the present study was focused on ethical sensitivity as a composite and the specifics, the mean scores reflecting the whole and the dimensional construct were utilized such that higher scores indicate high ethical sensitivity and lower scores indicate low ethical sensitivity. The same applies to the dimensions. The scale has been found to possess good psychometric properties.

Preliminary statistical analyses such as the normality test, Cronbach's alpha, correlation, and common method bias tests were conducted to

check the suitability of the data and see if it meets the assumptions of the parametric statistical test. The first groups of hypotheses (H_1, H_{1a}, H_{2b}, and H_{1c}) were tested with the simple linear regression analysis while Hypotheses two (H_2) and three (H_3) were tested with the independent sample t-test. The decision rule to be used in testing the hypotheses is, if the critical value (p) > 0.05 for a two-tailed test, reject the null hypothesis, if not accept the null hypothesis. The data were analyzed with the IBM-SPSS Statistics v.25.

Results

The sociodemographic profiles of the respondents are given in Table 1. The participants had a mean age of 40.60 years (*SD*= ±9.30). The study sample comprised 77(51.3%) females and 73(48.7%) males and a majority of the participants were married.

Table 1.: Sociodemographic characteristics of the respondents

	n	Frequency	Percent
Gender	150		
Male		73	48.7
Female		77	51.3
Age	150		
Under 31years		22	14.7
31-40years		61	40.7
41-50years		53	35.3
51 years and above		14	9.3
Marital Status	150		
Married		88	58.6
Single		51	34.0
Separated/Divorced		7	4.7
Widowed		4	2.7
Medical Experience	145		
Less than 5years		40	27.5
6-10years		49	33.8
11-20years		31	21.4
21-30years		11	7.6
31 years and above		14	9.7
Organizational Tenure	150		
Under 12years		100	66.7
12-22years		29	19.3
23 years and above		21	14.0
Educational Qualification	149		
Bachelor's degree/Equivalent Certificate		115	77.1
Postgraduate		34	22.9

Participants between 31-40, 60(40.7%) years of age, and those who have spent below 12 years (66.7%) in their various hospitals made up a significant proportion of the research sample. All the participants reported that they have received formal education with most of them having bachelor's degrees or an equivalent certificate at a descriptive value of 115(77.1%). The correlation analysis shown in Table 2 indicates that age (r = .284, p <.01), organizational tenure (r = .174, p <.05), and educational qualification (r = .288, p <.01) were all associated with the caring behavior of healthcare workers. The demographic characteristics of the participants have no association with ethical sensitivity.

Table 2.: Association between sociodemographic characteristics and the scores on caring behavior and ethical sensitivity

	Descriptive statistics		**Caring behavior**		**Ethical sensitivity**	
	Mean	SD	correlation	p-value	Correlation	p-value
Gender	1.513	.501	.033	.689	.004	.959
Age	40.606	9.302	.284**	.000	.009	.917
Marital status	1.513	.711	.060	.465	-.035	.670
Medical experience	2.379	1.236	.148	.075	.109	.191
Organizational tenure	1.460	9.126	.174*	.033	.104	.206
Educational qualification	2.973	.993	.288**	.000	-.096	.243

Note: *Correlation is significant at .05 level (2-tailed); **correlation is significant at .01 level (2-tailed); Gender, marital status, and educational qualification were collected at nominal levels while age, medical experience, and organizational tenure were coded in years (continuous level) and later categorized.

The Cronbach's alpha, a test of normality, and multicollinearity (for the predictors) for the pre-statistical tests were all within the normal range. The internal consistency of the instruments was largely satisfactory as they met the literature requirement for a reliable scale. Specifically, Cronbach's alpha values for the sense of moral burden, moral strength, moral responsibility, and caring behavior were .65, .74, .70, .67, and .91 which were considered satisfactory. The values for the variance inflation factor (<10) and tolerance (>0.40) were also within normal range. The descriptive statistics and normality test were within the acceptable range for a regression-based model. Table 3 also shows the descriptive statistics and the correlation coefficient of the research variables. A modest value was attained for the mean and standard deviation of all the variables. The table also shows a significant relationship for most of the key study variables. Specifically, moral strength ($r = .20$, $p < .05$), moral responsibility ($r = .19$, $p < .05$), and the composite value for ethical sensitivity ($r = .21$, $p < .05$) were significantly related to caring behavior among healthcare workers while the sense of moral burden did not ($r = .10$, $p > .05$). It is also important to know that the observed correlation values were below .80 indicating that common method variance and multicollinearity did not affect the results of the analysis.

Table 3.: Mean, standard deviation, and correlation coefficient of research variables

		M	**SD**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
1	Sense of moral burden	3.94	.81	[.65]								
2	Moral strength	4.59	.59	.15	[.74]							
3	Moral responsibility	4.60	.67	.17*	.67**	[.70]						
4	Ethical sensitivity	4.30	.52	.80*	.68**	.66**	[.67]					
5	Assurance	4.39	.60	.10	.13	.15	.16*	[.87]				
6	knowledge and skill	4.50	.49	-.04	.16*	.13	.07	.36**	[.86]			
7	Respectfulness	4.50	.57	.10	.14	.10	.16	.26**	.47**	[.85]		
8	Connectedness	4.53	.46	.09	.19*	.18*	.19*	.24**	.41**	.50**	[.73]	
9	Caring behavior	4.47	.39	.10	.20*	.19*	.21*	.76**	.71**	.73**	.65**	[.91]

Note: *Correlation is significant at .05 level (2-tailed); **correlation is significant at .01 level (2-tailed); The Cronbach's alpha for each variable is placed in parentheses.

A simple linear regression was performed to examine the effect of ethical sensitivity on caring behavior among healthcare workers and the results are presented in table 4. The statistics in the table offered support for the hypothesis: ethical sensitivity positively and significantly predicted caring behavior, (B= .20, 95% CI [.03, .27], t = 2.58, p= .011). The observed B value suggests that for every unit increase in ethical sensitivity, a .20 increase in caring behavior is expected and the R^2 of .04 indicates that ethical sensitivity accounts for 4% of the variation in caring behavior. The analysis of variance (ANOVA) test, $F(1, 148) = 6.68$, $p= .011$, indicates that the regression was statistically significant, meaning caring behavior can be predicted from ethical sensitivity. Hence, the first hypothesis was accepted. There was no

support for hypothesis H_{1a} as the regression analysis indicates that a sense of moral burden did not significantly predict caring behavior (B= .10, 95% CI [-.02, .13], t = 1.29, p > .05).

The results also indicated that moral strength significantly predicts caring behavior (B= .21, 95% CI [.03, .24], t = 2.60, p= .010). The B value suggests that for every unit increase in moral strength, a .21 increase in caring behavior occurs while the R^2 of .04 indicates that moral strength accounts for 4% of the variation in caring behavior. The test for ANOVA, F(1, 148) = 6.77, p= .010, indicates that the regression is statistically significant, meaning caring behavior can be predicted from the moral strength of healthcare workers. Therefore, we did not fail to accept hypothesis H_{1b}.

Finally, the results in Table 4 showed that the moral responsibility of healthcare workers significantly predicts caring behavior (B= .19, 95% CI [.02, .20], t = 2.40, p= .018). The B value suggests that every unit's increase in moral responsibility leads to a .19 increase in caring behavior. Also, the R^2 of .03 indicates that moral responsibility accounts for 3% of the variation in caring behavior. The test for ANOVA, F(1, 148) = 5.75, p= .018, indicates that the regression is statistically significant, meaning that the caring behavior of healthcare workers can be predicted from moral responsibility. Therefore, hypothesis H_{1c} was accepted.

Table 4.: Simple regression analysis showing ethical sensitivity, and its dimensions predicting caring behavior

	B	SE	t	R^2	Adj R^2	F	P	95% CI	
								Lower	Upper
Ethical sensitivity	.20*	.06	2.58	.043	.037	6.68	.011	.03	.27
Sense of moral burden	.10	.04	1.29	.011	.005	1.68	.196	-.02	.13
Moral strength	.21*	.05	2.60	.044	.038	6.77	.010	.03	.24
Moral responsibility	.19*	.05	2.40	.037	.031	5.75	.018	.02	.20

Note: *p < .05 level (2-tailed).

An independent sample t-test was conducted to check for gender differences in the caring behavior and ethical sensitivity of healthcare workers. For the first condition (gender difference in caring behavior) as seen in Table 5, there was no significant difference in the scores for males (M = 4.461, SD = 0.405) and the scores for females (M = 4.488, SD = .392) on caring behavior, t(148) = -.405, p = .686. Hence, the hypothesis (H_2) which stated that there will be a significant gender difference in caring behavior was rejected. For the second test of difference (gender difference in ethical sensitivity) as displayed in Table 5, there was no significant difference in the scores for males (M = 4.304, SD = .523) and females (M = 4.309, SD =.528) on ethical sensitivity, t(148) = -.051, p = .959. Therefore, the hypothesis (H_3) which stated that there will be a significant gender difference in ethical sensitivity was rejected.

Table 5.: Independent sample t-test for gender difference in caring behavior and ethical sensitivity

	N	M	SD	t-value	p-value	Mean difference	95% CI		Cohen's d
							Lower	Upper	
Caring Behavior									
Male	73	4.461	.405	-.405	.686	-.027	-.155	.102	-.066
Female	77	4.488	.392						
Ethical Sensitivity									
Male	73	4.304	.523	-.051	.959	-.005	-.174	.165	-.008
Female	77	4.309	.528						

Discussion

This study examined the predictive relationship between ethical sensitivity and caring behavior among public healthcare workers in Delta State, Nigeria. Specifically, the study explored the composite concept of ethical sensitivity, its dimensions which include a sense of moral burden, moral strength, and moral responsibility,

and how they impact the caring behavior of healthcare workers. Also, the study examined gender differences in caring behavior and ethical sensitivity. Three research hypotheses were developed (with the first having three other hypothetical statements to further explore the dimensions of ethical sensitivity). The descriptive statistics, normality and reliability tests were within the normal range for a regression-based model.[32,33] The correlation analysis of the demographic variables on caring behavior and ethical sensitivity revealed that the age, number of years spent in the hospital (organizational tenure), and educational qualification of a healthcare worker were all associated with the caring behavior while the demographic characteristics of the participants have no association with ethical sensitivity.

The first hypothesis which stated that ethical sensitivity will positively and significantly predict caring behavior was supported. Ethical sensitivity was found to be a positive and significant predictor of caring behavior among healthcare workers. This implies that an increase in ethical sensitivity will necessitate an increase in the caring behavior of healthcare workers. The finding is in line with similar studies in the literature. Previous studies have reported that sensitivity to ethical practices is significantly related to empathy, general compassion levels, and the occupational professionalism of healthcare workers.[16,18,19] Thus, ethical sensitivity fosters the caring behavior of healthcare workers. Further analysis of the dimensions of ethical sensitivity showed that of the three dimensions, two significantly predicted caring behavior. Specifically, moral strength and moral responsibility showed predictive abilities i.e., they both predicted caring behavior. This indicates that moral strength and moral responsibility are two defining factors in ethical sensitivity. Hence, the feeling of responsibility to the patient and the moral capacity to carry out assigned tasks, especially those that deal primarily with patient care are necessary factors for caring behavior.

The second hypothesis which stated that there will be a significant gender difference in caring behavior was not supported as the results of the study did not offer support for this proposition. Male and female healthcare workers do not differ in their levels of caring behavior. The finding is consistent and also inconsistent with previous literature. Consistent with the current finding is the work of Onuoha and Idemudia who found that gender is not a significant factor when it comes to comprehending and handling the need of patients in the hospital. [25] The current finding is not consistent with previous literature such as the work carried out by Liu et al. on gender role orientation and its impact on caring behavior and the ability to think critically. [23] The researchers reported a significant gender difference in caring behavior. The finding is in line with that of Talebian et al. and Shmilovitz, Itzhaki and Koton.[22, 24] The researchers reported a significant gender difference in caring behavior with females reporting more caring behavior than males. The third hypothesis which stated that there will be a significant gender difference in ethical sensitivity was also not supported as the results were not in line with the research hypothesis. The finding was not consistent with studies outside the current context (Nigeria). Studies show that gender could be a factor in sensitivity to ethical practices.[27,28] The reason for the current findings can be attributed to individual and organizational factors, and possibly issues prevalent in the Nigerian healthcare sector. Hence, factors such as uniform education and training for male and female healthcare workers, support from their supervisors, workload, job satisfaction levels, and cultural and emotional intelligence are to be considered. These factors should be investigated alongside the current variable to get more stable and robust results on gender differences in caring behavior.

This study provides valuable insight into the circumstances under which healthcare workers will care more for their patients which will further inform policies developed by hospital administrators, medical educators, and healthcare practitioners. Like many studies of this nature, this study has some limitations. First, the cross-sectional nature of the study restricted the findings to correlation rather than the establishment of causal relationships. Perhaps, longitudinal studies to test the causal direction between the various dimensions of ethical sensitivity and caring behavior are needed. Second, all the variables were obtained through self-report measures. Data on a variable like caring behavior can be obtained via supervisor rating or possibly through coworker reports in order to have a true picture of the behavior.

Conclusion

This study has successfully examined the empirical link between the ethical sensitivity of healthcare workers and their caring behavior toward patients. In conclusion, ethical sensitivity fosters caring behavior. Also, the dimensions of

ethical sensitivity (moral strength and moral responsibility) promote caring behavior. Through this study, new knowledge has been added to the healthcare literature on caring behavior and ethical sensitivity which are the foundations of treatment and professionalism.

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