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Moral Attention Before Moral Action: A Conceptual Framework for Healthcare Ethics Education

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Abstract

Health-professions ethics education often emphasizes reasoning, judgment, and action after an ethical problem has already been recognized. Yet ethically consequential features of clinical situations may never become objects of deliberate reflection because they are overlooked, trivialized, normalized, or interpreted through a narrowed perspective. This conceptual-framework article proposes moral attention as an educational construct situated upstream of, but interacting with, moral reasoning and action. Moral attention is defined as the educable capacity to notice potentially morally salient features, recognize their possible significance, widen the perspectives considered, test initial interpretations, and connect resulting reasons to an ethically responsive course of action. Drawing on scholarship in moral perception, moral sensitivity, compassion, metacognitive reflection, epistemic justice, perspective-taking, patient involvement, and health-professions education, the article develops a five-stage framework: Recognition, Moral significance, Perspective expansion, Interpretive testing, and Ethical response. Corresponding failure modes are non-recognition, trivialization, perspective narrowing, premature closure, and action–reason disconnect. The framework is intended to organize curriculum design, teaching, and assessment without treating agreement with a preferred ethical conclusion as evidence of competence. It also foregrounds structural and epistemic inequities that shape what learners are taught to notice and whose knowledge is treated as credible. The framework is a proposed conceptual synthesis rather than a validated cognitive sequence, competency model, or clinical intervention. Its stages, educational indicators, developmental progression, transfer assumptions, and equity consequences require empirical and consequential validation across professions, settings, and jurisdictions.

Keywords: Moral attention, Ethics education, Moral perception, Perspective-taking, Metacognition, Epistemic justice

Introduction

Why ethical action begins with noticing

Health-professions ethics education commonly begins once a dilemma has become visible: a learner identifies competing values, applies principles, weighs reasons, or justifies a decision. This sequence risks overlooking an earlier educational problem. Ethical reasoning can operate only on features that have entered awareness as potentially relevant. Recent work in nursing ethics argues that moral perception itself deserves cultivation rather than being treated as an automatic precursor to explicit reasoning [1]. The claim advanced here is therefore not that ethical action always follows a conscious linear sequence, but that education should examine how morally salient features become noticeable before learners are asked what they ought to do.

That upstream focus is supported indirectly by evidence that ethical and relational orientations are shaped within educational environments. A recent qualitative meta-aggregation describes compassion in medical education

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as something learners observe, receive, enact, and sometimes struggle to sustain within relationships and institutional cultures [2]. Clinical exposure can also produce divergent forms of engagement: in end-of-life learning, students have described patterns of connection and detachment that cannot be reduced to abstract knowledge of ethical principles [3]. Such evidence does not establish a distinct construct of moral attention, but it demonstrates that what learners register and how they orient toward patients are educationally conditioned.

The hidden curriculum sharpens the problem. Learners may encounter norms that conflict with declared professional values, and those experiences can be morally injurious or differently distributed across social groups. Studies of hidden curriculum and moral injury, together with qualitative synthesis on empathy and compassion, suggest that implicit norms, role modelling, and clinical culture can shape or erode ethical and relational orientations [4, 5]. Moral attention is proposed here to make this pre-decisional terrain educationally explicit: not as a replacement for moral reasoning, but as an account of what must become available for reasoning to engage.

Moral attention as an educational construct

Moral attention is proposed as the educable capacity to notice potentially morally salient features of a situation, recognize their possible ethical significance, widen the range of perspectives considered, test an initial interpretation against context and alternatives, and connect the resulting reasons to a clinically responsive course of action. The construct is deliberately broader than perception alone. Metacognitive-reflection scholarship emphasizes monitoring and evaluating one's thinking, including reconsideration when initial interpretations prove incomplete [6]. That process is especially relevant once a learner has noticed something but has not yet determined what it means.

Moral attention also overlaps with moral sensitivity, but the two should not be collapsed. Moral sensitivity has been operationalized and compared among nursing and medical students, demonstrating that sensitivity to ethical aspects of practice is an identifiable educational construct [7]. Such measurements do not establish a causal pathway from sensitivity to action, nor do they show that sensitivity encompasses perspective expansion, interpretive testing, or reason–action coherence. The proposed construct therefore organizes several functions that existing literatures often study separately.

Nor is moral attention synonymous with empathy, compassion, reflection, professionalism, or moral reasoning. A learner may empathize with one person while failing to notice an excluded stakeholder; may produce an articulate reflection without revising a premature interpretation; or may reason coherently from an impoverished description of the situation. The educational value of the construct lies in making those distinctions visible. It treats attention as ethically structured but fallible: learners can notice too little, assign significance too quickly, privilege familiar perspectives, or recognize a problem yet fail to connect their reasons to a response.

Objects of moral attention in healthcare

What deserves moral attention cannot be limited to conspicuous dilemmas or explicit patient preferences. Healthcare encounters contain morally relevant information in persons' lived experience, relationships of dependence and trust, institutional arrangements, patterns of exclusion, and contextual constraints. A recent scoping review of lived experience in simulation-based health-professions education shows that experiential knowledge can be brought into educational encounters in multiple forms [8]. Such inclusion can widen what learners encounter, although participation alone does not guarantee epistemic justice or educational benefit.

The distinction between hearing and attending is crucial. Clinical communication may formally invite a patient's narrative while still discounting its epistemic significance. Work on epistemic injustice in person-centred care shows how patients' accounts can be elicited yet insufficiently recognized as knowledge that should shape understanding [9]. Moral attention therefore concerns not only whether information is present but whether its source, meaning, and possible ethical weight are seriously considered.

For this framework, morally salient objects include persons, relationships, power, institutional conditions, consequences, exclusion, absence, vulnerability, and contextual cues such as uncertainty or workflow pressure. These categories are proposed as a non-exhaustive educational map rather than a validated taxonomy. They direct learners to ask not simply, “What is the ethical issue?” but also, “Who or what has not yet entered my description of the situation?”, this is shown in **Table 1** clearly.

Table 1. Domains and failure modes of moral attention in healthcare practice

Proposed domain	Examples of what may require attention	Corresponding proposed failure risk
Persons and vulnerability	Distress, preferences, dependence, embodied experience, vulnerability	Non-recognition; trivialization
Relationships	Trust, testimony, dependence, disagreement, experiential knowledge	Non-recognition; perspective narrowing
Power and identity	Credibility, hierarchy, stereotype, marginalization	Perspective narrowing
Institutional conditions	Workflow, role modelling, hidden curriculum, resource constraints	Trivialization; action–reason disconnect
Consequences	Burdens, risks, competing goods, downstream effects	Premature closure
Exclusion and absence	Missing voices, absent stakeholders, unrepresented experience, curricular erasure	Non-recognition; perspective narrowing
Contextual cues	Uncertainty, incomplete information, changing facts, time pressure	Premature closure
Ethical response under constraint	Feasible action, authority, workflow tension, response rationale	Action–reason disconnect

Note: The domains and domain-to-failure pairings are an original proposed synthesis informed by the approved literature. They are non-exhaustive and are not validated categories or thresholds.

Failures of recognition, interpretation, and perspective

Failures of moral attention may occur before a learner reaches an explicit ethical judgment. Perspective narrowing is one example. A review of perspective-taking instruments in medical education shows substantial heterogeneity in how perspective-taking is conceptualized and measured [10]. This makes it inappropriate to assume that "considering another perspective" is a single transparent skill or that one instrument can establish adequate attentional breadth across contexts.

Epistemic injustice offers a second lens. Shared decision-making depends not only on exchanging information but also on recognizing patients as legitimate contributors to knowledge about their own circumstances [11]. A clinician can therefore hear a patient's account while treating it as less credible, less relevant, or less authoritative than it warrants. In the proposed framework, this is not simply a communication failure; it is an attentional failure because the epistemic standing of the speaker affects what is allowed to count as morally significant.

Five failure modes are proposed as analytic counterparts to the framework's five stages: non-recognition, trivialization, perspective narrowing, premature closure, and action–reason disconnect. They should not be treated as mutually exclusive, exhaustive, or psychometrically distinct. A single episode may involve several at once. Nor does widening attention guarantee a uniquely correct moral conclusion. More perspectives can reveal genuine disagreement rather than resolve it. The educational aim is therefore not maximal inclusiveness without judgment, but disciplined resistance to avoidable blindness, unjustified narrowing, and closure before relevant alternatives have been considered.

The moral attention framework

The framework organizes moral attention into five proposed stages. Recognition asks what potentially salient feature has entered awareness. Moral significance asks why that feature might matter ethically. Perspective expansion asks whose standpoint, knowledge, interests, or vulnerability may be missing. Interpretive testing asks whether an initial reading survives alternative explanations, contextual information, and uncertainty. Ethical response asks whether the reasons now judged relevant are connected to a defensible clinical response. Recent work on metacognitive reflection supports inquiry, adaptive action, and reconsideration as educational processes that can resist premature closure [12], but it does not validate this five-stage order.

Conceptual caution is essential. Reflection in medical education is heterogeneous rather than a single settled construct [13], and competence itself is multilayered and context dependent rather than reducible to an underlying trait expressed uniformly in performance [14]. Moral attention should therefore not be presented as a newly discovered competency with a stable score. Its value is organizational: it makes separable educational questions

visible and permits targeted analysis of where ethical responsiveness may fail.

A further risk is performativity. Reflection can become ritualized when learners learn to display expected language rather than genuinely interrogate their assumptions [15]. The same danger would arise if moral attention were taught as a checklist in which learners merely name the "right" stakeholder or approved ethical concern. The framework instead requires reasons for noticing, perspective expansion, reinterpretation when warranted, and an intelligible link between reasons and response.

Figure 1 synthesizes the proposed Moral Attention Framework as a staged form of ethical inquiry, showing how recognition, moral significance, perspective expansion, interpretive testing, and ethical response are linked to characteristic failure points while remaining conceptually directional rather than empirically validated as a fixed cognitive sequence.

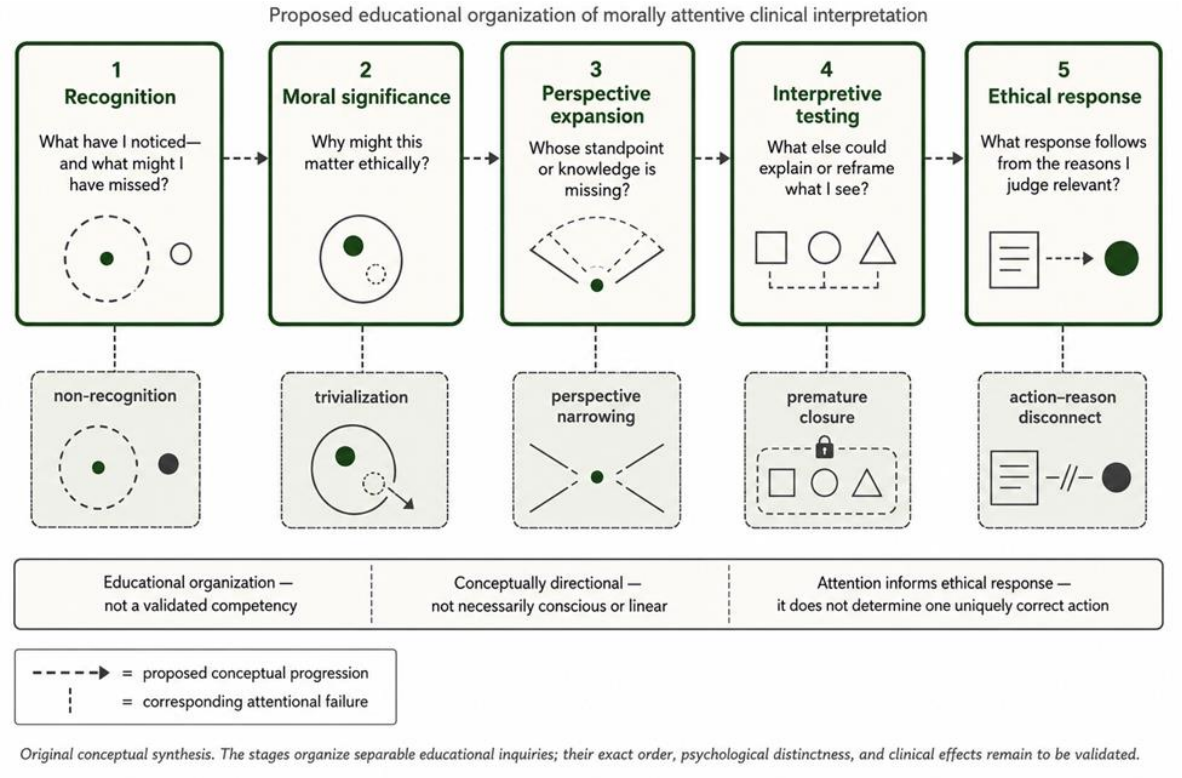

Figure 1. From moral attention to ethically responsive clinical action

Development across the health-professions curriculum

Moral attention should be developed longitudinally rather than confined to a single ethics course. Work on social accountability in health-professions curricula shows that contextual and community-oriented learning can be distributed across programs rather than treated as an isolated curricular event [16]. For moral attention, the implication is not that learners pass through invariant psychological stages, but that educational demands can be deliberately scaffolded: early learners can practice recognizing salient features, while later learners confront more ambiguous interactions among patient experience, institutional conditions, professional roles, and competing obligations.

Development also continues as learners enter workplace participation. Phenomenographic evidence on the transition from student to doctor describes learning as occurring through the work itself, with clinical participation reshaping how new doctors understand and perform their roles [17]. This makes the workplace an essential developmental environment for moral attention, because pressures that are largely simulated in classrooms become embedded in actual responsibility, workflow, hierarchy, and uncertainty. Progression should consequently concern the complexity of the

learner's task rather than an assumed moral maturity attached to year of training. An advanced learner may still overlook an obvious vulnerability, whereas a novice may recognize structural or relational features because of prior experience.

Patient involvement provides another route for progressive complexity. A theoretical systematic review identifies multiple forms and rationales for patient involvement in health and social care education [18]. The framework therefore proposes a progression from guided noticing toward interpretation with patients and other stakeholders, then toward ethically responsive action under real constraints. Patient participation should not be treated as exposure to a corrective perspective that automatically improves learners. **Table 2** presents educational value that depends on how authority, preparation, feedback, and participation are structured. The sequence is curricular, not maturational: learners may enter with uneven strengths, develop nonlinearly, or regress when clinical environments narrow what they are able or willing to notice.

Table 2. Developmental progression of moral-attention learning across the health-professions curriculum

Proposed stage	Learning objective	Educational activities	Expected forms of noticing	Interpretive complexity	Clinical application
Novice	Distinguish potentially salient cues from background detail	Paired cases; guided noticing; short narrative contrasts	Explicit vulnerability, preferences, distress, exclusion	Separate observation from inference; consider one or two perspectives	Structured cases and early simulation
Intermediate	Expand perspective and question first interpretations	Patient narratives; simulation; patient involvement; reflective explanation	Relational, contextual, institutional cues	Compare multiple perspectives and alternative explanations	Simulation and early clinical encounters
Advanced	Detect hidden norms, power, uncertainty, and downstream consequences	Clerkship debriefing; direct observation; comparative cases	Absence, hierarchy, structural conditions, workflow pressures	Revise interpretations under ambiguity and conflicting obligations	Supervised patient care
Workplace	Sustain and repair attention under real constraints	Team reflection; feedback; patient participation; metacognitive review	Interaction of person-level and system-level cues	Adaptive reinterpretation, calibrated uncertainty, reason–action coherence	Everyday clinical practice

Note: The progression is an original proposed curricular scaffold informed by the literature discussed in the text. It is not a validated developmental sequence, universal learner trajectory, or readiness threshold.

Teaching moral attention in classroom and clinical settings

Teaching should make noticing inspectable without reducing it to a checklist. Lived-experience storytelling offers one route. A pilot intervention with medical students suggests that stories grounded in women's lived experience can support empathy-related learning [19]. In this framework, storytelling is used more narrowly: learners can be asked what they noticed first, which details changed the moral description of the case, what assumptions they made, and whose standpoint remained absent. The evidence supports educational feasibility, not durable transfer or clinical effectiveness.

Patient and service-user involvement can move learners beyond treating patients as objects of ethical analysis. A BEME systematic review documents multiple forms of patient and service-user participation in medical education [20]. Moral-attention teaching can therefore include patients as contributors to case construction, simulation, feedback, or debriefing, while recognizing that poorly designed participation may become tokenistic or burdensome. Educators should also distinguish perspective expansion from compulsory agreement with a patient's interpretation. The educational task is to understand what a standpoint contributes to the moral description, where disagreement remains, and whether the learner's original account requires revision.

Clinical teaching must expose conflicts between ethically valued attention and workplace demands. Clerkship learners have described tensions between caring and efficiency [21]. This makes idealized dilemma discussion insufficient on its own: a learner may identify an ethical concern in seminar yet fail to register it when competing tasks redefine what appears urgent. Comparative cases can vary one morally salient feature while holding clinical facts relatively stable; simulation can reveal what

cues attract attention; and debriefing can reconstruct what disappeared under pressure. Brief questions during rounds—"What might we be missing?" or "What would change this interpretation?"—can integrate the framework without converting every encounter into a formal ethics exercise.

No single method is proposed as superior. The educational mechanism proposed here is repeated practice in recognition, significance attribution, perspective expansion, interpretive testing, and revision under progressively less controlled conditions. Teaching should sometimes preserve ambiguity rather than resolve it for learners. If every exercise culminates in a model answer, learners may learn to search for curricular approval rather than remain attentive to uncertainty, conflict, and incomplete knowledge.

Assessing moral attention without rewarding agreement

Assessment should ask what a learner noticed and how the learner handled significance, perspective, uncertainty, and revision—not whether the learner reproduced an examiner's preferred moral conclusion. Argumentation theory applied to assessment validity emphasizes that interpretations of performance require explicit claims, warrants, and evidence rather than being assumed from a score [22]. A moral-attention assessment should therefore specify what observable behavior is intended to indicate and what inference the educator is entitled to draw from it. Recognition in one standardized case, for example, cannot by itself warrant claims about stable workplace attentiveness across patients and settings.

Reflective writing may contribute evidence, but it should not become the sole window onto the construct. A systematic scoping review shows substantial heterogeneity in how reflective writing is used and assessed in medical education [23]. Written fluency, familiarity with reflective conventions, or willingness to disclose personal experience should not be mistaken for attentional quality. Reflection can instead be treated as one evidentiary source alongside comparative cases, simulation, direct observation, reinterpretation tasks, and responses to new information.

A defensible approach is multimethod and process-focused. Learners may reach different ethically defensible conclusions while showing comparable attentional breadth and interpretive discipline. Conversely, agreement with an examiner can coexist with superficial noticing or untested assumptions. The framework therefore proposes observable indicators such as detecting a changed salient cue, identifying an absent standpoint, distinguishing observation from inference, generating a plausible alternative interpretation, and revising reasons when relevant information changes.

This pluralism has limits. "Do not reward agreement" does not mean that every conclusion becomes acceptable if a learner can narrate a process. Discriminatory, coercive, clinically reckless, or otherwise indefensible responses may remain unacceptable for reasons external to the proposed attention construct. Assessment should separate that ethical or professional judgment from the narrower question of whether moral-attentional processes were demonstrated.

Table 3 presents "Assessment methods and observable indicators of moral attention" for "Moral Attention Before Moral Action: A Conceptual Framework for Healthcare Ethics Education."

Table 3. Assessment methods and observable indicators of moral attention

Proposed method	Observable indicator	What it may evidence	What should not be rewarded
Comparative cases	Detects ethically relevant differences across similar cases	Recognition and contextual sensitivity	Guessing the examiner's intended issue
Reflective explanation	Explains what was noticed, why it mattered, and what remains uncertain	Moral significance and metacognitive monitoring	Length, eloquence, or compelled disclosure
Simulation	Responds to standardized interpersonal and contextual cues	Situated recognition and perspective expansion	Performative empathy alone
Direct observation	Notices concerns, asks clarifying questions, responds to new information	Workplace enactment	Checklist completion without interpretation
Perspective expansion	Identifies absent or underrepresented standpoints	Breadth of perspective	Mechanical stakeholder listing
Reinterpretation	Generates and tests a plausible alternative explanation	Interpretive testing	Changing an answer merely to appear reflective

Revision after new information	Updates interpretation and rationale when relevant facts change	Responsiveness and resistance to premature closure	Consistency with the original answer at all costs

Note: These indicators are an original proposed assessment synthesis. They require purpose-specific validity evidence and should not be interpreted as established scores, thresholds, or measures of moral correctness.

Supporting transfer into clinical practice

Classroom performance is not equivalent to clinical transfer. A comparative study of self-reflection within online clinical-skills training shows that reflection-related educational processes can influence training outcomes [24], but such findings do not demonstrate that a learner will notice or respond similarly in an unscripted clinical environment. Transfer must therefore be treated as an empirical question rather than assumed from curriculum completion. The relevant outcome is not whether learners remember the five labels; it is whether attentional practices remain available when information is incomplete, priorities compete, and consequences are real.

Clinical communication illustrates why context matters. Medical students describe effective communication as situated within relationships, patient responses, supervision, and clinical circumstances rather than as a decontextualized technique [25]. Moral attention is likely to face the same problem: what can be recognized in a protected exercise may be obscured by time pressure, hierarchy, competing tasks, emotional load, or uncertainty in practice. Transfer may also be asymmetric. A learner might reliably notice patient distress yet fail to identify how organizational policy, language barriers, or credibility judgments shape that distress.

Uncertainty is especially important. A scoping review across undergraduate health-professions education describes uncertainty as pervasive and variably encountered by learners [26]. The framework therefore proposes transfer supports that preserve inquiry under pressure: repeated workplace enactment, supervision that asks what may have been missed, feedback on interpretation rather than outcome alone, and opportunities to revise judgments after new information. Workplace debriefing can examine not only "Was the decision correct?" but "Which features became visible too late?" and "What made another interpretation difficult to entertain?"

These are plausible educational strategies, not proven implementation requirements. Transfer can fail despite excellent classroom performance, and recognition can be adequate while ethically responsive action remains constrained by authority, staffing, resources, or institutional policy. The framework therefore separates noticing from capacity to act. Clinical transfer would require evidence that educationally observed processes generalize across cases and contribute meaningfully within real practice without assuming that attention alone can overcome structural constraints.

Equity considerations and educational risks

Moral attention is not neutral with respect to power. What curricula repeatedly present as salient, ordinary, exceptional, or irrelevant can reproduce structural exclusions. Recent analysis of curricular violence in medical education argues that racism, colonization, and Indigenous erasure can be produced through curriculum rather than merely appearing as missing content [27]. An attention framework that focuses only on interpersonal sensitivity would therefore risk individualizing harms whose production is institutional and historical. Structural conditions must remain objects of attention in their own right, not background variables appended after the learner has analyzed a patient encounter.

Epistemic structure matters as well. Critical scholarship in health-professions education has argued that dominant ways of knowing can reproduce inequity by determining which knowledge, methods, and voices are treated as legitimate [28]. Moral attention should consequently include attention to absence: whose account is not present, whose interpretation is routinely downgraded, which experiences have been made difficult to articulate, and which institutional conditions have become normalized. Perspective expansion is thus not simply adding more viewpoints; it includes examining how credibility and interpretive authority are distributed.

The educational risks are symmetrical. Expanding perspective can become tokenism; asking learners or patients for lived experience can impose unwanted representational labor; assessors can mistake culturally familiar emotional expression for ethical depth; and rubrics can penalize learners who preserve warranted uncertainty. A curriculum can also make marginalized learners repeatedly responsible for correcting their peers' blindness, thereby reproducing the burden it intends to address.

The framework therefore proposes safeguards against coerced disclosure, majority-norm scoring, and reduction

of structural injustice to individual empathy. Patient and learner participation should include meaningful choice about role and disclosure, and assessment should permit multiple defensible interpretive paths where ethical pluralism is genuine. These safeguards themselves require evaluation, especially across professions, cultures, and jurisdictions; they should not be presented as sufficient protections merely because they are normatively attractive.

Limitations and validation requirements

The framework remains conceptual. Its stages may overlap, occur recursively, or prove reducible to existing constructs such as moral sensitivity, perspective-taking, metacognition, or practical wisdom. Any assessment derived from it requires an explicit interpretation-use argument specifying what performances mean and what decisions may reasonably follow from them [29]. Face plausibility, educator agreement, or reliable scoring would not by themselves establish that a task measures moral attention as proposed.

Validation should also examine generalization, extrapolation, decisions, and consequences rather than stopping at internal scoring properties [30]. Appropriate research would include cognitive interviews, think-aloud studies, contrasting cases, simulation, direct observation, longitudinal transfer studies, cross-professional and cross-cultural comparisons, and consequential analyses of inequitable scoring. Construct research should test whether the proposed stages are empirically distinguishable from adjacent constructs and whether the sequence adds explanatory or educational value beyond simpler models.

The framework should also be falsifiable in practice. Evidence that learners routinely skip, combine, reverse, or replace stages without loss of ethically responsive performance should count against the proposed sequence rather than be treated as error. Likewise, evidence of systematic cultural bias, coercive educational effects, or poor clinical extrapolation should trigger revision or rejection rather than implementation refinement alone.

Conclusion

Moral attention names an educational problem that precedes, accompanies, and constrains ethical reasoning: morally important features cannot shape deliberate judgment when they remain unseen, trivialized, epistemically discounted, or prematurely interpreted. This article has proposed a five-stage framework linking recognition, moral significance, perspective expansion, interpretive testing, and ethical response, together with corresponding failure modes and educational implications.

Its contribution is organizational rather than evidentiary proof. The framework does not establish a universal cognitive sequence, a validated competency, a scoring instrument, or a clinically effective intervention. Its value will depend on whether it helps educators distinguish failures of noticing from failures of reasoning, teach learners to reconsider what enters their moral field, and assess interpretive quality without rewarding conformity. Future work should test whether the stages are distinct, transferable, equitable, and educationally useful across professions and settings. The framework should remain revisable where learners' actual reasoning processes, workplace conditions, or consequential-validity evidence show that its proposed distinctions do not hold.

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