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What Counts as Ethical Competence in the Health Professions? A Critical Review of Concepts, Measures, and Educational Assumptions

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Abstract

Ethical competence is widely invoked in health-professions education, yet the term encompasses heterogeneous claims about knowledge, moral reasoning, sensitivity, judgement, character, communication, action and professional conduct. Instruments intended to assess these capacities frequently operationalise narrower constructs, creating uncertainty about what particular scores establish and whether measured performance represents ethically desirable professional practice. This critical review used a transparent, interpretive design rather than an exhaustive effectiveness-review methodology. Literature published between 2017 and 2026 was identified through bibliographic and publisher-based searching focused on ethical and moral competence, professionalism, moral sensitivity and courage, professional resistance, ethics assessment, epistemic justice, patient participation, educational interventions and emerging artificial-intelligence ethics. Sources were compared for construct definitions, operationalisations, measures, validity claims, educational assumptions, contextual boundaries and normative implications. Analysis distinguished empirical findings from conceptual and normative reconstruction. The literature does not support a single settled conception of ethical competence. Existing approaches variously privilege ethical knowledge, reasoning, sensitivity, professional identity, dispositional qualities or action, while assessments often capture only selected components. Educational models may consequently embed assumptions that competence is individually located, measurable independently of context, transferable between situations and aligned with prevailing professional norms. Evidence concerning hidden curricula, professional resistance, epistemic injustice and patient partnership complicates those assumptions. The review therefore proposes a reconstructed account in which ethical competence includes contextual recognition, deliberation, epistemic responsiveness, justified moral agency and responsible action, while remaining sensitive to professional, cultural, institutional and technology-mediated conditions. Ethical competence should not be equated with conformity, a single psychometric construct or successful performance on one assessment format. The proposed reconstruction is a critical synthesis rather than a validated competency standard and requires cross-professional, cross-cultural, longitudinal and consequential validation.

Keywords: Ethical competence, Health professions education, Moral competence, Ethics assessment, Epistemic justice, Professional identity

Introduction

Ethical competence has become an increasingly important aspiration in health-professions education, but agreement about what the construct contains remains limited. Contemporary conceptual work describes ethical competence as encompassing knowledge and understanding, ethical sensitivity, personal qualities, judgement and the courage or ability to act, while broader healthcare literature documents substantial variation in how the construct is defined and operationalised [1, 2]. Heterogeneity is not merely terminological. Different

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definitions imply different educational aims, different forms of evidence and different conclusions about who should count as ethically competent.

The assumption that ethical competence naturally increases with educational progression is also uncertain. Recent work examining medical students' moral competence indicates that progression through training does not guarantee monotonically improving performance on established measures [3]. Such findings do not establish that education causes regression; they instead challenge a simple developmental model in which curricular exposure can be treated as equivalent to ethical growth.

The institutional environment further complicates individualised accounts. Research on moral injury and the hidden curriculum shows that learners may encounter morally troubling expectations and that such experiences may differ across socially positioned groups [4]. Ethical competence therefore cannot be evaluated solely by asking whether a learner correctly reproduces formal norms. The more difficult question is whether learners can recognise ethically salient problems, reason about conflicting obligations, respond to patients and colleagues as legitimate participants in moral deliberation, and act responsibly when institutional expectations themselves are contestable.

This review examines what contemporary health-professions education makes count as ethical competence, how those choices are operationalised, and what they exclude.

Review purpose and critical questions

The review adopts a critical orientation because competency language is not normatively neutral. Analyses of competency-based medical education have shown how competency discourse can acquire an appearance of technical certainty that obscures contestable assumptions about what counts as legitimate professional performance [5]. Applied to ethics, this creates a particular risk: constructs selected for educational convenience may be treated as though they were complete accounts of ethically good practice.

A central question is therefore whether ethical competence can be distinguished from moral conformity. Medical trainees describe professional resistance in forms that include actions, dispositions and ways of interpreting institutional demands [6]. Normative analysis further indicates that resistance may possess an ethical foundation when it responds to conflicts involving beneficence, non-maleficence, autonomy or justice [7]. This does not make dissent inherently ethical. Resistance may be ill-informed, self-serving or harmful. The critical distinction is that disagreement with authority cannot itself establish incompetence any more than compliance can establish ethical adequacy.

Professional identity adds another layer. Identity formation occurs through socialisation into professional communities and expectations [8]. Such socialisation can transmit valuable commitments, but it can also normalise assumptions that deserve ethical scrutiny. Accordingly, the review asks four linked questions: What conceptual families are used to define ethical competence? What do existing measures actually operationalise? Which educational, cultural and professional assumptions are embedded in those measures? And what additional capacities become visible when patient partnership, epistemic justice, justified contestation and context-sensitive judgement are taken seriously?

The purpose is not to replace existing frameworks with another purportedly universal standard. It is to clarify construct boundaries and develop a proposed reconstruction whose claims remain proportionate to the evidence.

Search and selection strategy

The review used a transparent critical-review strategy in which search and synthesis methods were chosen to serve conceptual comparison and reconstruction rather than exhaustive estimation of intervention effects. This approach is consistent with methodological guidance that review design should be aligned with the purpose and type of knowledge sought [9].

Searching was conducted on 9 August 2026 using PubMed-indexed records, publisher records and DOI-directed searches. Search concepts covered ethical competence, moral competence, ethical and moral sensitivity, moral courage, professionalism, professional identity, professional resistance, hidden curricula, ethics assessment, psychometrics, educational interventions, epistemic injustice, equity, shared decision-making, patient partnership and artificial-intelligence ethics competence. Searches also incorporated construct synonyms, opposing concepts, measurement terminology and contextual or cultural qualifiers.

Eligible sources were peer-reviewed journal articles published from 2017 through 2026 with verifiable DOIs and direct relevance to a planned conceptual, empirical, methodological or educational claim. Selection favoured

sources capable of supporting a precise claim rather than general background. Duplicate DOIs, alternative publication versions, sources without adequate journal eligibility, and adjacent articles whose interpretation would require overgeneralisation beyond their population or setting were excluded.

The resulting corpus was treated as an auditable interpretive evidence base, not as proof of exhaustive retrieval. No claim of systematic-review completeness or meta-analytic representativeness is made.

Critical interpretive approach

Analysis proceeded through structured extraction of each source's focal construct, definition or operationalisation, evidentiary basis, educational setting, reported finding or normative argument, limitation and transferability boundary. Interpretation remained reflexive because thematic analysis does not reveal a single neutral structure already contained in the literature; analytic categories depend on theoretically coherent choices about what differences and relationships matter [10]. Transparency was therefore treated as a methodological requirement rather than as a claim that interpretive judgement could be eliminated [11].

The comparison focused on four distinctions. First, concept definitions were separated from the instruments used to operationalise them. Second, evidence that a measure has defensible psychometric properties was separated from the normative question of whether its target should be treated as an educationally desirable account of ethical competence. Third, empirical associations and educational outcomes were distinguished from causal or clinical-transfer claims. Fourth, professional agreement or compliance was separated from ethical justification.

Thematic analysis was used as an organising strategy for comparing patterns across concept families, measures, educational assumptions and blind spots, while recognising that themes are analytic constructions rather than mechanically discovered facts [12]. The reconstruction developed later in the review is therefore explicitly interpretive. Evidence-supported components are identified as such, but their integration into a broader account of ethical competence is an original proposed synthesis whose validity remains to be tested across professions, cultures, institutions, educational stages and clinical contexts.

Conceptual families of ethical competence

The literature supports several overlapping rather than interchangeable families of ethical competence. An integrative review of nursing ethics described competence as a complex combination of perception, reflection, behaviour and personal capacities rather than a single cognitive skill [13]. This matters educationally because a learner may know ethical principles yet fail to recognise that a situation is ethically salient, may reason persuasively without acting, or may act decisively without adequate justification.

Context also belongs inside, rather than outside, the competence problem. A recent synthesis of factors contributing to moral competence identified both human and structural influences, indicating that ethical performance is shaped by environments as well as individual attributes [14]. A multi-professional ethical-practice model similarly frames competence through situated professional interaction rather than as an isolated possession of the individual [15]. These approaches do not negate knowledge or reasoning; they challenge accounts that detach those capacities from relationships, institutions and practice conditions.

Action forms a further conceptual boundary. Moral courage has been analysed as involving ethically motivated action despite difficulty or risk [16]. Courage cannot itself certify that an action is right, but it identifies why ethical competence cannot end with correct recognition or judgement. The proposed synthesis in this review therefore treats knowledge, reasoning, sensitivity, judgement, character, communication, action, relational competence, reflexivity and contextual responsiveness as distinguishable domains whose importance varies with the ethical task.

Table 1 presents "Conceptual domains used to define ethical competence in the health professions" for "What Counts as Ethical Competence in the Health Professions? A Critical Review of Concepts, Measures, and Educational Assumptions."

Table 1. Conceptual domains used to define ethical competence in the health professions

Domain	What the domain asks of the learner or professional	Critical boundary
Knowledge	Understand ethical concepts, duties and relevant facts	Knowledge does not establish recognition or action.

Reasoning	Compare reasons, principles and competing considerations	Coherent reasoning can still begin from incomplete premises.
Sensitivity	Notice morally salient features of a situation	Recognition is narrower than justified judgement.
Judgment	Reach a defensible ethical conclusion in a particular case	A test response is not equivalent to workplace conduct.
Character	Bring ethically relevant qualities and dispositions to practice	Desirable traits remain contestable and context dependent.
Communication	Make ethical reasoning intelligible within professional interaction	Articulation alone does not ensure responsiveness to others.
Action	Translate judgement into conduct despite practical difficulty	Action requires justification; courage alone is insufficient.
Relational competence	Respond ethically within interprofessional and interpersonal relationships	Relationship quality cannot be inferred from individual scores.
Reflexivity	Examine one's assumptions, position and interpretive limits. **Proposed synthesis.**	Reflexivity requires more than self-report endorsement.
Responsiveness to context	Adapt ethical judgement to structural and situational conditions	Context sensitivity must not become uncritical relativism.

Measures and operational definitions

Measurement makes the construct problem visible because instruments necessarily select what will count as evidence. A scale developed to assess moral intelligence among healthcare professionals operationalised specific dimensions and provided psychometric evidence for that defined target [17]. Such evidence can justify interpretations about the measured construct within the validation context, but it cannot by itself establish that the instrument captures ethical competence as a whole.

The same boundary appears across other instruments. The Ethical Sensitivity Questionnaire for Nursing Students operationalises a narrower sensitivity construct in a student population [18]. A digital-professionalism self-assessment, by contrast, asks professionals to evaluate conduct associated with social-media practice [19]. Both may be useful, yet their scores represent different response demands and domains. They should not be interpreted as interchangeable evidence of one underlying ethical attribute.

Instrument appraisal reinforces this caution. A contemporary review of ethical-sensitivity measures found meaningful differences in measurement properties and suitability across instruments [20]. Measures targeting moral intelligence, digital professionalism and ethical sensitivity operationalise different constructs and therefore should not automatically be treated as interchangeable indicators of a single ethical-competence trait [17, 19, 20]. The critical issue is not whether measurement should be abandoned, but whether the inference drawn from an assessment is proportionate to what the task actually requires and what its validation evidence supports.

Table 2 presents “Measures of ethical competence and their principal construct limitations” for “What Counts as Ethical Competence in the Health Professions? A Critical Review of Concepts, Measures, and Educational Assumptions.”

Table 2. Measures of ethical competence and their principal construct limitations

Instrument or assessment format	Intended construct	Response demand	Assessment context	Interpretation	Principal limitation
Moral-intelligence scale	Moral sensitivity, commitment and courage	Self-report ratings	Healthcare professionals	Profile of specified moral-intelligence dimensions	Does not establish observed ethical action or total competence.
Ethical Sensitivity Questionnaire	Ethical sensitivity	Self-report responses	Nursing students	Evidence concerning recognition-oriented sensitivity	Student- and context-specific; sensitivity is only one domain.

Digital-professionalism self-assessment	Digital professional conduct	Self-appraisal	Social-media practice	Perceived conformity with digital-professionalism expectations	Self-report cannot substitute for observed behaviour or ethical justification.
Ethical-sensitivity instrument selection	Instrument-specific sensitivity constructs	Questionnaire responses	Nursing education	Interpretation depends on purpose and measurement properties	Measures are not automatically interchangeable across populations.
Moral-competence testing	Moral reasoning/competence as operationalised by the test	Judgement of moral arguments	Medical education	Performance on a defined assessment task	Educational progression or ethical action cannot be inferred directly from a score.

Educational assumptions embedded in existing measures

Measures also carry educational assumptions. Nursing students describe ethical development as involving experience, reflection and encounters with ethically difficult situations [21]. This situated account sits uneasily with assessments that locate competence entirely within an individual's decontextualised knowledge or self-report. A measurement model can therefore shape pedagogy indirectly by making certain forms of learning more visible than others.

Intervention evidence further cautions against treating assessed improvement as straightforward proof of comprehensive competence. Simulated problem learning in nursing ethics was associated with changes in selected outcomes including moral sensitivity, empathy and critical thinking in a quasi-experimental setting [22]. These outcomes are educationally relevant, but they do not establish transfer to all forms of ethical judgement or clinical action. Similarly, a brief ethics intervention among healthcare professionals caring for people with dementia did not produce uniform improvement in ethical self-efficacy across participants [23]. Baseline differences and design limitations constrain interpretation, but the study illustrates why exposure to ethics education should not be equated automatically with competence gain.

The proposed critical reading is therefore that prevailing measures may encode assumptions about universality, consensus, individualism, transfer, measurability, professional neutrality, cultural invariance and stability. These assumptions are not necessarily false. They become problematic when they remain invisible and are treated as properties already established by the instrument.

Table 3 presents “Educational assumptions embedded in prevailing models of ethical competence” for “What Counts as Ethical Competence in the Health Professions? A Critical Review of Concepts, Measures, and Educational Assumptions.”

Table 3. Educational assumptions embedded in prevailing models of ethical competence

Assumption	Embedded educational implication	Critical interpretation
Universality	The same competence structure applies across learners and settings.	**Proposed critique:** contextual evidence makes universality an empirical question.
Consensus	Correct professional responses substantially converge.	**Proposed critique:** justified disagreement may remain possible
Individualism	Ethical competence primarily resides within the learner.	Situated learning suggests environmental participation also matters.
Transfer	Classroom or simulated performance carries into practice.	Improvements in selected outcomes do not establish broad clinical transfer.
Measurability	A score can adequately represent the intended competence.	Instrument evidence supports bounded constructs rather than an unrestricted whole
Professional neutrality	Existing professional expectations are ethically non-contestable.	**Proposed critique:** professional norms may themselves require ethical scrutiny
Cultural invariance	Construct meanings and measures transfer without important cultural change.	**Proposed critique:** validation remains population and context dependent.
Stability across contexts	Competence expressed in one setting predicts expression elsewhere.	Variable educational responses caution against assuming stable manifestation.

Cultural, epistemic, and professional blind spots

An account of ethical competence can become exclusionary when it assumes that assessors and institutions possess neutral access to what competent conduct looks like. Analysis of epistemic injustice in medical education shows how judgements of the "underperforming learner" may be shaped by credibility and interpretive structures, not only by an individual's knowledge or skill [24]. The implication is not that performance standards should disappear, but that the conditions under which testimony and interpretation acquire authority are ethically relevant.

Narratives from remediated residents make this problem concrete. Residents described situations in which hierarchical authority affected whose account of events was treated as credible [25]. Such evidence remains context-specific, yet it exposes a difficult case for competence assessment: a learner who contests an institutional interpretation may be demonstrating defensiveness, justified moral agency, or some mixture of both. An assessment system must therefore avoid treating agreement itself as the criterion.

Equity also complicates claims of cultural or professional neutrality. A critical review of postgraduate medical education argues for intersectional approaches capable of examining how multiple structures and positions shape educational experience [26]. The implication proposed here is neither unrestricted cultural relativism nor abandonment of common professional expectations. Rather, claims that a competence framework is universal should remain open to evidence that apparently neutral standards distribute credibility, opportunity or interpretive authority unevenly.

Reconstructing ethical competence

The literature permits a reconstruction that is broader than any single instrument but remains explicitly provisional. Shared decision-making models reveal that clinical decisions embody relational values and forms of participation, not merely private professional reasoning [27]. Ethical competence should therefore include the capacity to deliberate with others rather than simply to produce a defensible answer about them.

Epistemic justice adds a second element. Critical healthcare literature supports taking patients seriously as contributors of knowledge whose credibility and interpretive resources can be enhanced or diminished within care relationships [28]. The proposed competence is thus epistemically responsive: it includes recognising when professional expertise is relevant while also recognising when institutional or professional authority unjustifiably displaces another person's knowledge.

A third element is adaptability. Research with early-career doctors has proposed a clinical artificial-intelligence ethics competence framework derived from experiences of digital-age practice [29]. Its context does not justify universalisation, but it shows why competence must be capable of recalibration as technologies redistribute information, judgement and responsibility.

The reconstruction proposed here consequently links six capacities: ethically salient recognition, reasoned deliberation, relevant normative and factual understanding, epistemic responsiveness, justified moral agency and responsible action. Contextual reflexivity connects these capacities by asking whether their expression remains appropriate across relationships, institutions, professions, cultures and technologies. This is a proposed organising account, not a validated competency standard.

Figure 1 translates the proposed reconstruction of ethical competence into an educational alignment framework, showing how claims about ethical recognition, deliberation, epistemic responsiveness, justified moral agency and responsible action depend on correspondence among the competence being defined, the learning opportunity provided, the assessment evidence collected and the interpretation ultimately made.

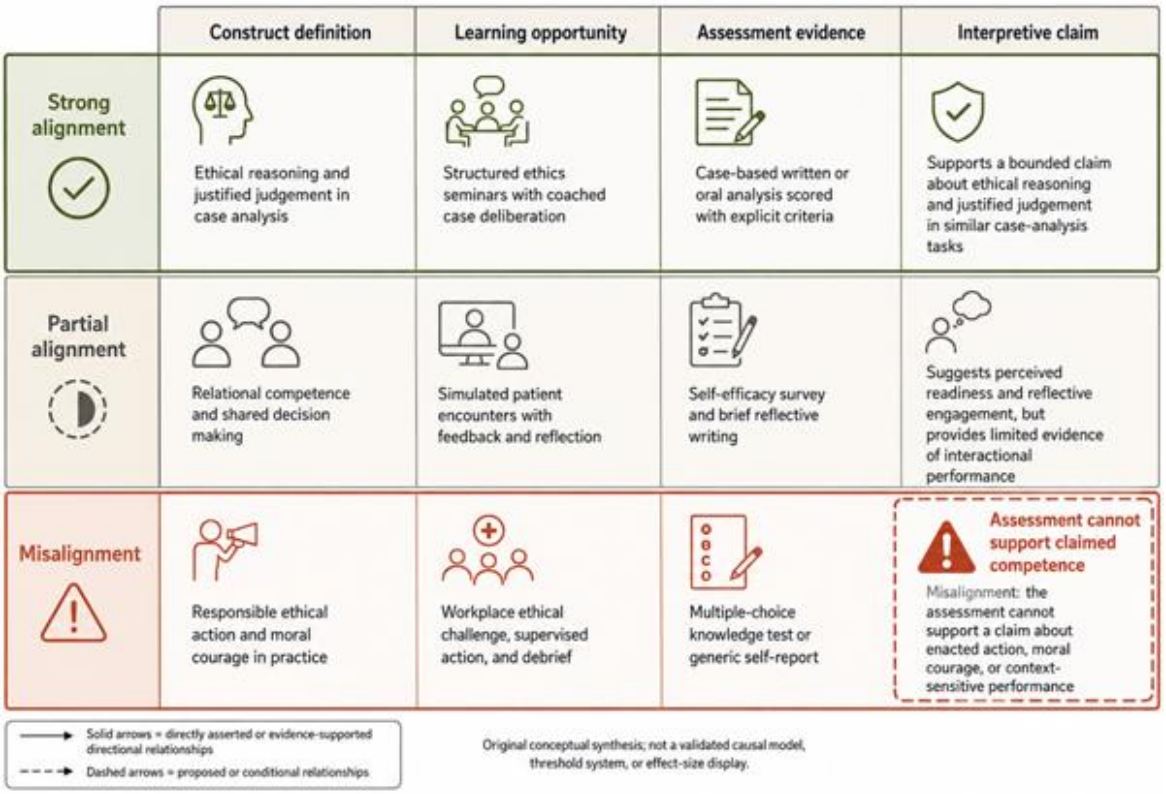

Figure 1. Alignment of ethical-competence constructs, learning activities, assessment, and interpretation

Implications for curriculum and assessment

Curriculum design should begin by specifying what kind of ethical capability an activity is intended to develop and what evidence could reasonably demonstrate it. Analysis of ethics and law assessment in medical schools argues against assuming that there is one universally best answer format for all intended outcomes [30]. Knowledge tests may be appropriate for some objectives; complex judgement, communication, reflexivity and ethically justified action require different evidence.

Pedagogical alignment should likewise resist broad claims that an "ethics intervention" produces ethical competence. A systematic review of educational interventions to enhance ethical sensitivity among nursing students in Asia and the Middle East found heterogeneous approaches and outcomes across contexts [31]. The practical implication is to link teaching activities to explicitly defined components, then interpret measured change only at the level supported by the assessment. Simulation, facilitated case discussion, reflective work and workplace learning may therefore be complementary rather than competing solutions when they target different capabilities.

Technology introduces another assessment boundary. An entrustment framework for artificial intelligence in health-professions education proposes evaluating AI-mediated tasks through dimensions including ability, integrity and benevolence and calibrating supervision to task-specific trustworthiness [32]. This framework should not be treated as validated proof of safe AI use. It nonetheless illustrates a useful educational principle: ethical competence may need to be assessed through the person's capacity to recognise when tools, institutions or delegated systems change the conditions of responsible judgement.

For curriculum designers, the central recommendation is alignment rather than standardisation for its own sake. Construct definition, learning opportunity, assessment evidence and interpretive claim should form an explicit chain. Where one link is missing, the educational conclusion should be narrowed rather than the evidence stretched.

Consequently, a curriculum map should identify whether each learning event develops recognition, reasoning, relational deliberation, reflexivity or action; whether assessment samples that same capability; and what inference is warranted. Misalignment occurs when, for

example, a written knowledge response is used to certify interpersonal responsiveness or courageous action. Partial alignment may still be useful if the claim is correspondingly limited. This approach preserves measurement value without allowing technical precision to conceal construct underrepresentation.

Review limitations

This critical review is interpretive rather than exhaustive, and its reconstruction inherits the heterogeneity of the underlying constructs, professions and assessment traditions. Assessment conditions themselves can complicate interpretation: research comparing online and paper-based moral-competence testing shows that mode and test-taking conditions are legitimate empirical considerations rather than neutral background [33].

Transferability is also limited. Cross-sectional findings among healthcare students in Slovakia illustrate that moral-competence results are situated within particular educational and national contexts and cannot establish universal developmental norms [34]. Mixed-method research among dental students likewise demonstrates the value of combining quantitative and qualitative explanations while remaining bounded by profession and institutional setting [35].

The proposed reconstruction therefore requires prospective testing across professions, cultures and stages of training, including behavioural and patient-partnered evidence. Its usefulness should be judged partly by whether it clarifies interpretation and reveals misalignment, not by assuming in advance that its components form a single measurable latent trait.

Conclusion

Ethical competence in the health professions is not adequately captured by one score, one behavioural ideal or conformity with prevailing professional expectations. Existing literature supports multiple legitimate domains but also exposes gaps between definitions, educational opportunities, assessment evidence and the conclusions drawn from them.

This review proposes reconstructing ethical competence as context-responsive recognition, deliberation, understanding, epistemic responsiveness, justified moral agency and responsible action, connected through reflexivity. The reconstruction is intended as a critical organising framework rather than a universal standard. Its educational value lies in making claims more disciplined: assessment should establish only what its task and evidence can support, while curricula should remain attentive to patients, institutions, culture, professional power and changing technologies. Whether this account improves assessment or practice remains an empirical and normative question for future research.

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