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Justice sensitivity among nurses and physiotherapists in a Croatian rehabilitation hospital

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The aim of this study was to investigate and compare justice sensitivity between self-perceived beneficiaries, victims, and observers in a sample of 90 healthcare workers (nurses and physiotherapists) at the Varaždinske Toplice Special Medical Rehabilitation Hospital, Croatia. For this purpose we used a questionnaire consisting of demographic data and the Croatian version of the justice sensitivity inventory developed by Schmitt. Regardless of its limitations, our study clearly shows that healthcare professionals at Varaždinske Toplice are most sensitive to injustice from the beneficiary's perspective, that is, as persons who personally benefitted from injustice, although they may not have been instrumental to this effect. They are less sensitive to injustice perceived on the outside (observer's perspective) or to injustice suffered by themselves (victim's perspective). Another important finding is that participants of female gender, rural residence, and nurses (who are all women) are significantly more sensitive to injustice, whereas age and marital status do not seem to contribute to justice sensitivity. Future research should investigate the perception of injustice over a longer timeframe and involve all healthcare workers. It could also address different approaches to management, especially in terms of worker rewards and career advancement. Qualitative research among healthcare workers could provide a broader and clearer idea of social injustice at their workplace.

KEY WORDS: beneficiary; cross-sectional study; gender; observer; residence; social injustice; victim; work environment

General justice is defined as the demand that each person should receive what belongs to them and that all participants should have an equal initial chance of achieving their goals (1). However, this utopian ideal has hardly been achieved anywhere in the world, as the number of filings of discrimination as well as damage to mental and physical health has risen dramatically over the last two decades (2, 3). Self-assessment of injustice requires assessing a particular situation, relationship, and a system deemed to be unjust and an understanding of the consequences for an individual and the community (4).

Self-assessment of justice can be introspective, in which a person reflects on their experience and feelings of injustice, but it can also reflect the mindfulness and understanding of systemic injustice and its impact on society (5). An important step in researching the construct of injustice was made by Schmitt et al. (6), who developed a justice sensitivity scale. They established that the reaction of an individual to an unjust event much depends on the role of the individual in the event, that is, whether they are the victim of injustice, merely an observer, whether they benefit from the injustice committed to someone else, or whether they are the one committing the injustice to someone else. From this they constructed an instrument that facilitates the investigation of justice sensitivity from three different perspectives (6): that of the victim, the observer, and the beneficiary (4, 7). From the victim's perspective, the most likely emotional reaction to injustice is anger, whereas the observer most likely faces a moral dilemma and some anxiety. The role of the passive "beneficiary" or an active "perpetrator" of injustice can lead to feelings of shame with a tendency to self-blame and the desire to compensate the victim (7). Baumert et al. (8) highlighted another important difference. Sensitivity stemming from the observer's and beneficiary's role is more associated with the tendency of social comparison within a group where most people benefit from injustice and where injustice occurs more often, which may, in turn, lessen the need to react to perceived injustices. In turn, sensitivity from the victim's perspective correlates positively with neuroticism and negatively with interpersonal trust, self-efficacy, and an internal locus of control. However, from the observer's and beneficiary's standpoint, greater sensitivity to injustice is associated with upheld values and morality, individual's moral identity, and prosocial behaviour. Victim's sensitivity to injustice, in turn, does not guarantee compassion towards other persons suffering injustice (7). In fact, it is primarily associated with a series of constructs that include self-orientedness and a tendency to self-protection, even when this may imply certain antisocial behaviours, such as jealousy,

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suspiciousness, or vindictiveness (4). In other words, victim tend to car about justice for themselves alone.

Justice among healthcare workers

The perception of justice among healthcare workers does not much differ from other jobs, and generally refers to equal conditions and opportunities for all employees, as well as to fair working conditions and wages, safety, and the possibility of continuing education and career advancement (9). According to research conducted by Decety (10) and Cartabuke et al. (11), the perception of social injustice is closely linked to empathy, which is essential for effective action in the healthcare system. Empathy facilitates mutual trust and understanding and is considered fundamental for all healthcare professions (12).

Johnson et al. (13) have shown that 20–77 % of healthcare workers experience injustice in the form of discrimination, professional stress, and abuse. They further claim that female or black healthcare workers, as well as other minority workers are more exposed to social injustice.

According to Molina et al. (14), the perception of injustice can lead to psychosocial stress, which affects the perceiver's quality of life and mental and/or physical well-being. A study conducted by Mohamed in 2022 (15) shows that a sense of procedural injustice is closely tied to workplace alienation, including a sense of self-alienation and meaninglessness.

The feeling of safety is key to the sense of social justice among healthcare workers. This implies the sense of being protected from physical and verbal abuse, infections, and injuries, and of working fair hours and enjoying fair working conditions (16). This also implies equality and fairness in wages. Fair wages empower healthcare workers, increase their motivation, and improve work satisfaction, all of which reduces the sense of inequality or injustice (17). Research conducted by Aman et al. (18) shows that nearly half of the health extension workers in Ethiopia experience job dissatisfaction, most notably with supportive supervision and remuneration.

In the times of revolutionary technological developments in biomedical sciences and healthcare, another important aspect is lifelong or continuing education (19). Along with the opportunity for career advancement it encourages healthcare workers to develop skills and deepen their knowledge (20).

Promoting social justice among healthcare workers creates an environment in which their work is appreciated, their well-being supported, and high-quality healthcare ensured for all patients (21). It further improves key communication skills in a clinical environment (22).

Sociodemographic differences in the perception of (in)justice

Prior studies have often shown that various sociodemographic factors, such as age (23–25), gender (26–28), marital status (29–31), and work experience can influence the perception of (in)justice. Rai and Fiske (32) identified higher justice sensitivity in women. According to Družić Ljubotina (33), this sensitivity stems in large part from the fact that women are disadvantaged in a traditional society that imposes numerous stereotypes on women, their position, and role. Muench et al. (34) point to a large disparity in salaries between male and female nurses and call for greater transparency in promotions, hiring, and salaries. Jia et al. (35) report a positive correlation between income levels and an individual perception of social justice. Radin (36), in turn, suggest that the difficulty in achieving a life-work balance, gender stereotypes, and lacking institutional support in career are the main factors hindering the advancement of women workers in the healthcare system. In terms of marital status, single people express slightly greater justice sensitivity as victims than couples and the divorced. The same is true for the unemployed as opposed to the employed. The sensitivity of the victim decreases with age, whereas those under the age of 18 express significantly lower sensitivity as perpetrators and beneficiaries than all older groups (7).

Study aim

Research into the perception of social justice is relatively rare in Croatia and mostly focused on the general perception of injustice and mistrust among young people and adults (1). Furthermore, such research has never been conducted among Croatian healthcare workers. Instead, most research is focused on professional stress and burnout (37–40), which does not address justice perception or sensitivity.

Therefore, the main objective of our study was to fill that gap by establishing justice sensitivity in this population and to determine how it relates to victims, observers, and beneficiaries, as well as to sociodemographic characteristics (age, gender, marital status, level of education, job performed, place of residence) of our study group.

Our first hypothesis (H1) was that justice sensitivities from the perspectives of the beneficiary, the victim, and the observer should correlate significantly. The second hypothesis (H2) was that gender, age, marital status, place of residence, and job should be significant predictors of justice sensitivity.

PARTICIPANTS AND METHODS

Participants

The study was conducted between 13 and 20 March 2023 and included a convenience sample of 90 Croatian healthcare workers (nurses and physiotherapists) at the Varaždinske Toplice Special Medical Rehabilitation Hospital who gave their informed consent to participation with the completed questionnaire (on paper).

The study was approved by the Ethics Committee of the Varaždinske Toplice Special Medical Rehabilitation Hospital (approval No. 01-1628/3-2022).

The first part of the questionnaire gathers sociodemographic data, as follows: gender (female/male), age (years), place of residence, level of education (secondary or higher), job (medical nurse or physiotherapist), duration of employment in health care (0–5, 6–10 years, 11–20, 21–30, or 31 years or more), and marital status (married/single, common-law union, separated/divorced, widow/widower).

The second part includes the Croatian version of the Justice Sensitivity Inventory or scale, developed by Schmitt et al. (6) and translated by Ćubela Adorić and Jurkin (4). It was first applied in a group of 155 Zadar University students, and yielded Cronbach's alpha for justice sensitivity of 0.86 from the victim's perspective, 0.94 from the observer's perspective, and 0.93 from the beneficiary's perspective (4).

The scale consists of three theoretical dimensions (subscales), each consisting of 10 items measuring the level of justice sensitivity from three different perspectives: the victim's (items 1–10; e.g., it upsets me when someone else gets the reward I deserved), observer's (items 11–20; e.g., "It bothers me when someone gets something that shouldn't have been theirs"), and the beneficiary's (items 21–30; e.g., "It bothers me when I get something others should have gotten"). The respondents rate their agreement or disagreement with each statement on a six-level assessment scale (from 1 – I completely disagree to 6 – I fully agree). The total subscale score is calculated as the average of the ten scores. A higher score indicates greater justice sensitivity from a given perspective.

The authors and charge nurses distributed the questionnaire to the participants, informed them that participation was voluntary and anonymous, explained its purpose, and instructed them how to complete it. The average time needed to complete the questionnaire was about six minutes. The respondents placed the completed survey into a designated envelope and handed to their department head, who handed them to us.

Statistical analysis

The collected data were processed and analysed using the statistical program package SPSS 21 (IBM, Armonk, NY, USA). For descriptive statistics we used the univariate model to describe variable distribution , means, modal values, medians, standard deviations, asymmetry, and kurtosis).

Bivariate analysis was used to test differences and correlations between variables. Depending on variable type and data distribution, either parametric or non-parametric methods were applied.

For factor analysis, we used multivariate tests to evaluate justice sensitivity. They were also used to test specific sociodemographic characteristics of healthcare workers as possible predictors of justice sensitivity using multiple regression analysis.

RESULTS AND DISCUSSION

Table 1 shows sociodemographic details of the studied population. Our findings confirm both hypotheses of significant correlation between justice sensitivity scores and all three perspectives and of demographics being significant predictors of justice sensitivity (Table 2). However, if we take a more detailed look, only the female gender, rural residence, and the job of medical nurses are statistically significant predictors of justice sensitivity, whereas age and marital status are not. Follow the specific outcomes and their detailed interpretation.

Table 3 shows descriptive statistics of the selected injustice sensitivity indices. Judging by their mean values, our healthcare workers show the highest justice sensitivity from the beneficiary's perspective (mean±SD=3.51±0.98). Furthermore, the beneficiaries of the perceived injustice show the lowest variation in responses (CV=27.87), whereas the observer show the highest (CV=22.68). This may indicate a need for additional education and discussion within healthcare teams to align perspectives and ensure that equity is applied consistently across all aspects of their work.

Furthermore, individuals with high justice sensitivity from one perspective seem to be more sensitive to injustice from the other two perspectives. These results are consistent with those reported by similar studies (6, 41), which show that, regardless of perspective, justice sensitivity entails considering injustice to be a violation of a moral principle or code. These results are not surprising, given that prosocial behaviour of healthcare professionals is motivated by an underlying altruism and reciprocity (42). Furthermore, empathy is regarded as a fundamental virtue in patient care, since it helps to understand patients' feelings and establishes the framework for appropriate response to various circumstances (43). Taking an active or passive part in committed injustice may trigger the feelings of guilt, a propensity for self-blame, and the desire to make amends with the victim (7). Moreover, the above mentioned studies purport that greater sensitivity exhibited by beneficiaries and observers is associated with moral values and prosocial behaviour, but that the reverse is true for victims. Injustice-sensitive victims are not necessarily compassionate about injustices suffered by others.

To establish the relationship between justice sensitivity and gender, age, marital status, place of residence and job, a unique indicator was used that combines all scores from the three different perspectives. According to the Kolmogorov-Smirnov test, this unique indicator had normal distribution (0.078; P=0.2). After having confirmed the adequacy of the data for regression analysis using the tolerance coefficient and the variance inflation factor (VIF), we ran a standard multiple regression analysis with gender, age, marital status, place of residence, and job taken as independent predictor variables and justice sensitivity as (dependent) criterion variable.

Table 4 shows the results of descriptive statistics as the first step in data analysis. The respondents gave the highest possible score to the item "I cannot easily bear it when I realise that someone has taken advantage of me" and the lowest possible score to "It bothers me when I have to work hard to get what others can get more easily".

Table 1 Sociodemographic information about healthcare workers at the Varaždinske Toplice hospital, Croatia

Variable	Category	N	%
Gender	Men	21	23.3
	Women	69	76.7
Age	<29 years	24	26.7
	30–39 years	17	18.9
	40–49 years	22	24.4
	50–59 years	27	30.0
Education	Secondary education	52	57.8
	Advanced specialist training	27	30.0
	University degree	11	12.2
Marital status	Not married	20	22.2
	Married	60	66.7
	Common-law marriage	4	4.4
	Separated/Divorced	6	6.7
	Widower/Widow	0	0.0
Household members	Parents	7	7.8
	Alone	9	10.0
	Spouse	17	18.9
	Spouse and child/children	44	48.9
	Spouse, child/children, child's spouse and grandchild/grandchildren	4	4.4
	Other	9	9.9
Residence area	Rural	37	41.1
	Urban	53	58.9
Current work position in the hospital	Nurse	51	56.7
	Physiotherapist	39	43.3
Total years of service (work experience) in healthcare	Up to 5 years	17	18.9
	6 to 10 years	15	16.7
	11 to 20 years	21	23.3
	21 to 30 years	19	21.1
	31 years and more	18	20.0

Table 5 shows that the prediction model (which combines the set of independent variables) significantly predicts the justice sensitivity score ($F_{(5.82)}$=3.766: P<0.01) and accounts for 14 % of its variance, whereas 86 % of the variance remains under the influence of other factors that are not included in this model. Furthermore, it singles out gender, place of residence, and the job of healthcare workers as statistically significant individual predictors of justice sensitivity. Age and marital status of our healthcare workers, in turn, are not significant predictors of justice sensitivity. This is in agreement with an earlier report that justice sensitivity decreases with age (8), yet another study reports even lower sensitivity in adolescents (6), which may be owed to a ten-year span between the two studies and different social characteristics of the respondents.

Considering the beta weight of statistically significant predictors (Table 5), women (ß=0.26), rural residents (ß=-0.21), and female nurses (ß=-0.25) seem more sensitive to injustice than men, urban residents, and physiotherapists. Higher sensitivity in women has also been reported by other similar studies (6, 33, 34, 37, 44), probably due to the still disadvantaged position of women in the society (34) but also to the higher demand to balance work and life.

As for rural residents, we did not find a single study to compare with our findings. However, we can assume that rural respondents do not share the same opportunities as the urban ones, considering that living and working in post-war transitional Croatia is marked by increasing poverty or risk thereof, economic and social stratification, especially along the rural-urban line, existential fear,

Table 2 Regression analysis and ANOVA of the first and second hypothesis

Hypothesis 1: The level of justice sensitivity from the beneficiary's perspective, the level of justice sensitivity from the victim's perspective, and the level of justice sensitivity from the observer's perspective are statistically significantly related		Hypothesis accepted? (yes/no)
Regression statistics		
Multiple R	0.7268	
R-squared	0.5282	
Standard error	0.6111	
Observations	148	Yes
ANOVA		
F	163.4759	
Significance F	0.0000	
Standard Error	0.1714	
Hypothesis H2: Gender structure, age structure, marital status, place of residence, and workplace are statistically significant predictors of the level of justice sensitivity		Hypothesis accepted? (yes/no)
Regression Statistics		
Multiple R	0.6227	
R-squared	0.3878	
Standard error	0.7122	
Observations	148	Yes
ANOVA		
F	92.4782	
Significance F	0.0000	
Standard error	0.1245	

Table 3 Justice sensitivity scores among healthcare workers by perspective

	justice sensitivity score from the beneficiary's perspective	**justice sensitivity score from the victim's perspective**	**justice sensitivity score from the observer's perspective**
Valid answers	89	89	90
Missing answers	1	1	0
The theoretical range of the results	0–6	0–6	0–6
The empirical range of the results	1.05–4.99	1.20–4.56	0.97–4.59
Mean	3.51	3.33	3.38
Median	3.44	3.45	3.46
Modal value	4.99	4.56	2.91 and 3.46
Standard deviation	0.98	0.82	0.77
Variations' coefficient (CV)	27.87	24.51	22.68
Skewness	-0.34	-0.53	-0.73
Kurtosis	-0.52	-0.32	0.46
Kolmogorov-Smirnov test	0.066	0.107*	0.138*

* $p<0.01$

Table 4 Descriptive statistics of indicators of justice sensitivity

	N	Range	Min	Max	Sum	Mean±SE		SD	Variance
It bothers me when others get something that should have been mine.	90	5	1	6	379	4.21	0.152	0.642	1.079
It upsets me when someone else gets an award that I deserve.	91	5	1	6	395	4.34	0.157	0.760	1.249
I can't take it easily when I realise that someone has taken advantage of me.	91	5	1	6	419	4.60	0.132	0.655	1.075
It takes me a long time to forget the situations in which I had to correct someone else's negligence.	91	5	1	6	355	3.90	0.140	0.634	1.179
It bothers me when I am given less chance to achieve something than others.	91	5	1	6	393	4.32	0.145	0.881	1.208
It bothers me when others are better off than me for no good reason.	91	5	1	6	309	3.40	0.170	0.625	1.042
It bothers me when I have to work hard to get what others get easily.	91	5	1	6	354	3.89	0.157	0.501	1.054
It bothers me when others are treated better than me for no real reason.	91	5	1	6	411	4.52	0.157	0.501	1.053
Valid N (listwise)	90								

SD – standard deviation; SE – standard error

Table 5 Gender, age, marital status, place of residence, and job as predictors of justice sensitivity

Predictors of justice sensitivity		Standard error	Beta weight	T-ratio	Tolerance coefficient	VIF
Gender	1.19	0.47	0.26	**2.53***	0.92	1.09
Marital status	-0.57	0.49	-0.13	-1.16	0.76	1.32
Place of residence	-0.83	0.40	-0.21	**-2.06***	0.94	1.07
Workplace	-0.97	0.41	-0.25	**-2.39***	0.89	1.12
Age	0.01	0.02	0.05	0.45	0.79	1.27
R			0.43			
R^2			0.19			
Corrected R^2			0.14			
Standard error			1.80			
F-ratio			$\mathbf{F_{(5.82)}=3.766**}$			

*P<0.05; **P<0.01; VIF – variance inflation factor

Table 6 Statistical significance of the difference in gender structure between nurses and physiotherapy technicians

Variable			Gender		Statistical significance of the test
			Men	Women	
Workplace	Nurses	EF	8	43	$\chi^2_{(1)}=3.847*$
		TF	12	39	
	Physiotherapy technicians	EF	13	26	$\chi^2_{(1)}*=2.924$
		TF	9	30	

EF – empirical frequencies; TF – theoretical frequencies; $\chi^2_{(df)}$ – Pearson's chi-squared test with the pertaining degrees of freedom; $\chi^2_{(1)}$ – Pearson's chi-squared test with the pertaining degrees of freedom with Yates' correction. * p<0.05

Table 7 Significance of differences in justice sensitivity between healthcare workers of different education

		Secondary education (n=51)	Advanced specialist training (n=26)	University degree (n=11)
Levene's test for homogeneity of variances	Statistical significance of the differences in the average	Mean±SD	Mean±SD	Mean±SD
$F_{(2.85)}=0.325$	$F_{(2.85)}=0.830$	10.35±1.99	10.17±1.76	9.52±2.08

social insecurity, multidimensional deprivation, and a pronounced sense of injustice (45).

In terms of job differences, a comparison between nurses and physiotherapists (Table 6) confirms our initial assumption that nurses are more sensitive to injustice. However, there are many more female than male nurses in our sample, while the opposite is true for physiotherapists. Even though the chi-squared test with Yates' correction shows no significant differences (2.924; P=0.087), the risk level is 5 %, and we believe that a chi-squared test on a bigger sample would show statistical significance. The social division of female and male roles is perhaps nowhere else more evident than in nursing. This is why we believe that it is not the job of the healthcare workers that is predictive of justice sensitivity but the prevalent gender associated with the job (46).

Table 7 shows no significant differences in justice sensitivity scores between healthcare workers with completed secondary education, advanced specialist training, and university degree.

We also found no significant correlation between years of work in healthcare profession and justice sensitivity (Spearman's rho=0.11; P=0.29).

Table 8 shows a significant positive correlation between justice sensitivity scores from the victim's, beneficiary's, and observer's perspective for each query item: the greater the justice sensitivity of one individual from the beneficiary's perspective, the greater it is from the victim's and, in turn, observer's perspective. Considering that all *t* values are significant, we believe that all respondents are evenly sensitive to injustice, regardless of the perspective.

Even so, the highest sensitivity scores are those from the beneficiary's perspective (mean±SD=3.51±0.98), followed by those from the observer's (mean±SD=3.38±0.77) and victim's perspective (mean±SD=3.33±0.82). This finding is supported by the Kaiser-Meyer-Olkin test, with a satisfactory closed interval from 0 to 1 for all perspectives (Table 9).

Finally, the factor analysis of the main components singles out ten variables (items) as characteristic of justice sensitivity. From the observer's perspective these are: "It bothers me when someone is criticized for things for which others are given a free pass" (0.80163), "It makes me angry when someone is treated worse than others" (0.70325), and "It upsets me when I see that someone else doesn't get the award they deserve" (0.82431).

From the victim's perspective these are: "It makes me angry when I am treated worse than others" (0.79211), "It bothers me when I am criticised for things for which others get a free pass" (0.70148), "I can't bear it easily when I realise that someone has taken advantage of me" (0.65981),and "It bothers me when others are treated better than me for no real reason at all" (0.69971).

From beneficiary's perspective these are: "It takes me a long time to forget situations in which others had to correct my negligence" (0.81245), "I can't bear it easily when I realize that I used someone" (0.80193), and "It makes me angry when others are treated worse than me" (0.79115).

Previous research (6, 42) shows that sensitivity from the observer's and beneficiary's perspective involves an intrinsic concern for "justice for all", that is, primary concern for others, and prosocial tendencies (empathy and social responsibility), which are certainly important qualities in healthcare professionals. Of course, some people easily accept being rewarded more than others *(so-called worthies*), whereas some easily accept being rewarded less than others, because they are primarily concerned with what and how much they invest and not with their own gains (so-called *benevolents*). People encounter some form of injustice in their everyday lives, be it distributive (e.g., the principle of merit, equality, need), procedural, interactional, or retributive, but individuals react differently to injustices (6). These issues can be addressed by interventions aimed at increasing perceived job control and social support in the workplace (47).

Practical implications of the research

Our findings provide an insight into the current situation of self-assessing social injustice, but reveal no dynamics or trends over a longer period of time. Studies such as ours are important inasmuch as they encourage healthcare professionals to reflect upon and assess potential situations of social injustice. In addition to healthcare professionals, this research can also help teachers to prepare students of nursing and related professions for the clinical environment and future challenges. Minimising social injustice at work is possible through training and well-planned action to enhance the quality of work, motivation, and productivity of healthcare workers, all of which improves overall job satisfaction. Training can help to promptly identify and respond to injustice to create a fairer working environment and minimise dissatisfaction and potential conflict, emotional exhaustion, anger, underperformance, employee turnover, and the risk of jeopardising patient health and safety.

Our findings can also help to shape policies and provide guidelines to healthcare facilities as to how to address issues of social injustice and establish support and counselling for healthcare workers experiencing or witnessing injustices. Such support can include psychological counselling and legal assistance.

Study limitations and suggestions for further research

One of the obvious limitations of our study is the small sample, which certainly limits the interpretation and generalisation of our results.

Furthermore, it is not a longitudinal study that could provide a dynamic analysis or establish a trend in the perception of social injustice among healthcare workers over time.

Future research should therefore address these limitations by investigating injustice perception over a longer timeframe at regular intervals, involve all healthcare workers, and perhaps compare private and public healthcare facilities and even whole systems. Besides investigating individual perception of social injustice, future studies could address different approaches to management, especially in

Table 8 *T*-test comparison of mean justice sensitivity scores from the perspective of the beneficiary, victim, and the observer

One-Sample Test							
	Test Value=0						
	t	P	df	Significant (2-tailed)	Mean difference	95 % confidence interval of the difference	
						Lower	Upper
I can't take it easy when I realise that someone has taken advantage of others.	-4.2	**<0.001**	90	.000	4.648	4.39	4.91
It takes me a long time to forget situations where someone has to correct someone else's negligence.	-4.8	**<0.001**	90	.000	4.022	3.73	4.31
It bothers me when someone is given less chance to achieve something than others.	-4.3	**<0.001**	90	.000	4.560	4.33	4.80
It bothers me when someone has it worse than others for no good reason.	-3.9	**<0.001**	90	.000	4.505	4.26	4.75
It bothers me when someone has to work hard for what others get easily.	-4.6	**<0.001**	90	.000	4.011	3.77	4.25
It bothers me when someone is treated better than others for no real reason.	-4.5	**<0.001**	90	.000	4.407	4.14	4.68
It bothers me when someone is criticised for things for which others get a free pass.	-5	**<0.001**	90	.000	4.198	3.94	4.46
It makes me angry when someone is treated worse than others.	-4.3	**<0.001**	90	.000	4.407	4.14	4.67
It bothers me when I get something that others should have gotten.	-4.8	**<0.001**	90	.000	4.429	4.18	4.68
It upsets me when I get an award that someone else deserves.	-4.9	**<0.001**	90	.000	4.681	4.44	4.92
I can't take it easy when I realise I've taken advantage of someone.	-5.2	**<0.001**	90	.000	4.615	4.37	4.86
It takes me a long time to forget situations where others had to correct my negligence.	-5.3	**<0.001**	90	.000	4.330	4.06	4.60
It bothers me when I am given a better chance to achieve something than others.	-5	**<0.001**	90	.000	4.242	3.97	4.51
I feel guilty when I am better off than others for no good reason.	-4.2	**<0.001**	90	.000	4.418	4.14	4.70
It bothers me when I easily get what others have to work hard for.	-4.3	**<0.001**	90	.000	4.505	4.25	4.76
It bothers me when I am treated better than others for no real reason.	-4.6	**<0.001**	89	.000	4.111	3.85	4.37
It bothers me when things for which others are criticised "see through my fingers".	-4.3	**<0.001**	90	.000	4.110	3.82	4.40

Table 9 Kaiser-Meyer-Olkinove measures

Variables	Kaiser-Meyer-Olkinove measures
The level of justice sensitivity from the observer's perspective	0.86263
The level of justice sensitivity from the victim's perspective	0.78543
The level of justice sensitivity from the beneficiary's perspective	0.90013

terms of worker rewards and career advancement. Furthermore, it would be useful and interesting to conduct qualitative research among healthcare workers to get a broader and clearer idea of social injustice at their workplace.

CONCLUSION

Regardless of its limitations, our study clearly shows that healthcare professionals at the Varaždinske Toplice hospital are most sensitive to injustice from the beneficiary's perspective, that is, as persons who personally benefitted from injustice, although they may not have been instrumental to this effect. They are less sensitive to injustice perceived on the outside (observer's perspective) or to injustice suffered by themselves (victim's perspective). Another important finding is that participants of female gender, rural residence, and nurses (who are women) are significantly more sensitive to injustice, whereas age and marital status do not seem to contribute to justice sensitivity.

This research provides important insights into how different socio-demographic factors shape the perception of justice among healthcare professionals, which may help to better manage human resources and to create a fairer work environment.

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Conflict of interests

None to declare.

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Osjetljivost na nepravdu među medicinskim sestrama i fizioterapeutima u jednoj od specijalnih bolnica za medicinsku rehabilitaciju u Hrvatskoj

Cilj ovog rada bio je istražiti i usporediti samopercepciju osjetljivosti na nepravdu iz perspektive profitera, žrtve i promatrača na uzorku od 90 zdravstvenih radnika (medicinskih sestara i fizioterapeuta) u jednoj od specijalnih bolnica za medicinsku rehabilitaciju u Hrvatskoj. U tu svrhu korišten je upitnik koji se sastojao od demografskih podataka i hrvatske inačice skale osjetljivosti na nepravdu. Bez obzira na postojeća ograničenja, rezultati istraživanja jasno pokazuju da su zdravstveni djelatnici u predmetnoj specijalnoj bolnici za medicinsku rehabilitaciju u Hrvatskoj najosjetljiviji na nepravdu iz perspektive profitera, odnosno kao osobe koje su se osobno okoristile nepravdom. Manje su osjetljivi na nepravdu koju percipiraju izvana (perspektiva promatrača) ili na nepravdu koju sami trpe (perspektiva žrtve). Drugi je važan nalaz da su sudionici ženskog spola, ruralnog prebivališta i medicinske sestre znatno osjetljiviji na nepravdu, a dob i bračni status nisu pokazali značajnu povezanost s osjetljivošću na nepravdu. Buduća istraživanja trebala bi istražiti percepciju nepravde kroz dulji vremenski okvir i uključiti u istraživanje zdravstvene djelatnike svih struka. Također, bilo bi preporučljivo istražiti različite stilove upravljanja u zdravstvenim sustavima, posebice u smislu nagrađivanja radnika i napredovanja u karijeri. Kvalitativno istraživanje među zdravstvenim radnicima moglo bi pružiti širu i jasniju predodžbu o socijalnoj nepravdi na njihovu radnom mjestu.

KLJUČNE RIJEČI: prebivalište; presječno ispitivanje; profiter; promatrač; radno okružje; rod; socijalna nepravda; žrtva