Partial and impartial ethical reasoning in health care professionals

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Abstract
Objectives – To determine the relationship between ethical reasoning and gender and occupation among a group of male and female nurses and doctors.
Design – Partialist and impartialist forms of ethical reasoning were defined and singled out as being central to the difference between what is known as the “care” moral orientation (Gilligan) and the “justice” orientation (Kohlberg). A structured questionnaire based on four hypothetical moral dilemmas involving combinations of (health care) professional, non-professional, life-threatening and non-life-threatening situations, was piloted and then mailed to a randomly selected sample of doctors and nurses.
Setting – 400 doctors from Victoria, and 200 doctors and 400 nurses from New South Wales.
Results – 178 doctors and 122 nurses returned completed questionnaires. 115 doctors were male, 61 female; 50 nurses were male and 72 were female. It was hypothesised that there would be an association between feminine subjects and partialist reasoning and masculine subjects and impartialist reasoning. It was also hypothesised that nurses would adopt a partialist approach to reasoning and doctors an impartialist approach. No relationship between any of these variables was observed.

Introduction
Recently, there has been considerable interest in the relationship between occupation and ethical reasoning. This is particularly so with the health care professions, where doctors and nurses deal with significant moral problems each day. A large body of work has developed in the wake of Lawrence Kohlberg’s, and later, Carol Gilligan’s research on modes of moral reasoning, and it is of interest here to investigate how those modes are distributed among doctors and nurses.

In keeping with Piaget’s model of cognitive development, Lawrence Kohlberg devised an influential six-staged developmental theory of moral reasoning. While the cognitive stages postulated by Piaget were intended to reflect advances in reasoning about logical relations, Kohlberg takes his moral stages to represent advances in reasoning about justice, arguing that justice is the fundamental principle of morality. Because Kohlberg conceived of moral thinking in terms of justice, his experimental measure for an individual’s level of moral reasoning – the Moral Judgement Interview – presented subjects with moral dilemmas that generally involved competing rights in order to elicit from them reasoning relating to fairness, duty, equality and justice. Kohlberg defined and ordered his developmental stages according to the idea that the more morally mature one is, the more one’s moral thinking will be informed by abstract, “rational”, objective, and universalisable considerations or principles. There were early indications, though, that women generally scored lower than men on Kohlberg’s measure, with fewer women developing beyond Kohlberg’s “conventionalist” Stage 3 of conformity to interpersonal expectations.2 Rather than taking this as a reflection of women’s lesser capacity for moral development, Carol Gilligan argued that women’s lower scores reflected a difference in the overall moral orientations of men and women.4,5,6 Gilligan based this view partly on interview data gained from women freely discussing their abortion decisions. It emerged from these interviews that women understood the moral problem confronting them not in terms of abstract considerations such as rights, duties and justice, but in the more concrete and contextual terms of their perceived responsibilities to care for and avoid hurting those in relationship with them. Gilligan theorised that this “care” orientation in moral thinking is gender related and that it also admits of developmental stages linked to the formation of women’s self-concept which centres on interpersonal connectedness and maintenance of relationships, rather than on separation, individuality and autonomy that is typical of mature male ego-identity. The care perspective is characterised by Gilligan in terms of a number of themes which are in direct opposition to Kohlberg’s ethic of justice. Where mature moral reasoning on the justice orientation is typified by reliance on principles,
abstract, universalisable, impartial and non-affective thinking, the care orientation involves an emotionally informed engagement with the concrete details of the particular situation at hand. Although there is now evidence that women do not consistently score lower than men on Kohlberg's test but sometimes higher, there has nevertheless been some support for Gilligan's proposal of a gender-related difference in moral orientation. So, even if women are just as capable of using justice concepts as men, they may still prefer a care-oriented approach to moral thinking. Overall, though, the evidence for Gilligan's proposal is inconsistent. While some studies show a significant gender difference in orientation, other researchers have observed little notable difference. There may be different explanations for this variability, some relating to the possibility that other variables are at work, and others focusing on the appropriateness of the particular reasoning contrasts being measured. Among the former is the view, advocated by Gilligan, that moral orientation is not simply determined by gender but by gender and experience combined. Experience-related factors such as education and occupation have been found by some to be relevant to level and orientation of moral reasoning. One occupational area of particular interest to the current study is the health care profession, where reasoning differences have been identified between doctors and nurses. There is evidence to suggest that the ethical reasoning of doctors is oriented towards the justice perspective, while that of nurses is much more aligned with care. This difference has been attributed not only to the traditional gender divisions between those occupations (with nurses predominantly female and doctors male), but also to the influence of established standards of practice and professional stereotypes: for example, doctors cure and nurses care; doctors are clinical, detached and justly administer healing, while nurses are responsive and sympathetic.

Reasoning dimensions
Besides experience-based influences such as these, the overall variability in findings concerning moral orientation might be related to the particular reasoning dimensions being measured. One interesting suggestion arising from a recent study conducted by Galotti et al is that the simple "justice/rights" and "care/responsibility" distinction is not sensitive enough consistently to reflect gender differences in moral thinking. Their study indicated that more fine-grained differences than the simple "justice/rights" and "care/responsibility" distinction were at work in people's moral reasoning. It could be, then, that the varying evidence for gender-related differences in moral orientation is related to the fact that studies are measuring reasoning contrasts associated with the justice and care perspectives that are either not specific enough, or else, are not the most ethically or philosophically salient contrasts between the two perspectives. It is the latter view that motivates the present study.

The ethics of justice and care are often characterised in terms of their ostensibly opposed elements. While moral reasoning on the justice perspective is taken, for example, to be rule-based, universalistic, abstract, and to concern rights and fairness, such reasoning is, on the care perspective, seen as inductive, responsive, contextual and concerned with preventing harm. If real differences in people's moral thinking are to be measured, though, it is crucial that the contrasts relied on to distinguish the two perspectives be sound and pertinent. Some of those contrasts appear to be philosophically more central than others in distinguishing the two ethics. In the case of some, the extent to which they locate a real difference between the perspectives is unclear, either because a perspective does, in fact, implicitly subscribe to some contrasted element it is deemed not to (this might be so with the justice perspective and the goal of non-violence and avoidance of harm that is thought to be distinctive of the care ethic), or because a contrasted element attributed to a perspective does not necessarily apply to it (this might be so with the legalism and strict adherence to rules supposed essential to the justice ethic). There are also broader philosophical reasons for questioning some of the contrasts that have been emphasised, particularly when the care perspective is viewed as a critique of standard ethical reasoning. Kohlberg took himself to be measuring the fundamental aspects of genuine moral thinking, and Gilligan understood herself to have uncovered a distinct (female) moral alternative to that standard (Kohlbergian and male) ethic. There are, however, sound philosophical grounds for supposing that both are mistaken in identifying standard ethical reasoning exclusively with the Kantian tradition, where the concern for rightness, as opposed to personal or social good, defines genuine moral requirements and mature moral judgment. Some of those properties that Gilligan attributes to the standard or traditional conception of ethics no longer apply once that tradition is construed more broadly to include defensible candidates other than the purely Kantian one. Once this is done, a narrower set of contrasts becomes relevant when distinguishing the care ethic from standard views.

The view taken here is that these residual and salient contrasts can be expressed in terms of the general distinction between partial and impartial moral reasoning. The former, which characterises a central aspect of the care orientation, involves judgments that emphasise personal attachments and favour those with whom one is personally connected in situations where their interests compete with others'. Impartial reasoning, on the other hand, involves judgments that are detached and do not favour personal attachments, but reflect
a concern for what equal consideration and wider impersonal responsibilities require. For example, when posed with a choice between, say, rewarding my own son or another more deserving child, if I believe that my son should be rewarded then I am judging partially, and if I judge that the deserving child should win, this is impartialist. Different sorts of reasons will underlie my judgment in each case. I might favour my son because I value my attachment to him, or am compelled by a special responsibility to him, or believe that loved ones come first, etc. I might reward the other child because I believe that the only objectively relevant moral factor in the situation is desert, or because I believe that I must treat people equally and without favour, and so on.

It would be reasonable to expect that if there is any difference in people's moral orientation, that difference will be most apparent with respect to the contrast in moral reasoning that most sharply and deeply reflects the division between the care ethic and the traditional moral views it opposes. In other words, we should expect it to be most apparent in relation to partial and impartial ethical reasoning. Furthermore, if the partial/impartial distinction does underlie the difference in orientation represented by the care ethic and traditional moral views, then we should expect this to be especially apparent in the ethical reasoning of nurses and doctors, which would typically be aligned with the care ethic and the traditional orientation, respectively. In line with these expectations, the present study seeks to explore the distribution of partial and impartial ethical reasoning in a sample of nurses and doctors. It was suggested earlier that moral orientation is influenced by the experience of being male or female. This experience, though, is not simply based on biological sex, but is gender based. We understand ourselves and others through the medium of gender-based roles and characteristics, and develop our ego-identity in the light of them. We thought it appropriate, therefore, to seek also to measure the relationship between gender-identification and moral orientation in our sample.

**Method**

**PARTICIPANTS**

One thousand questionnaires were mailed to 400 doctors in Victoria, 200 doctors and 400 nurses in New South Wales. These doctors and nurses were randomly selected from databases from the Victorian and NSW Medical Boards, and the Australian Nursing Federation. Three hundred doctors and nurses (178 doctors and 122 nurses) of mixed sex (115 male and 61 female doctors; 50 male and 72 female nurses) returned completed questionnaires. More than half were between 31 and 50 years of age, and 88% are currently employed within the health care field, with 78% of participants having more than 10 years experience. Thirty-eight per cent of the nurses have, or were in the process of acquiring, a tertiary qualification. Because respondents were presented with ethical problems involving their mothers, respondents' perceptions of the nature of that relationship were relevant. A large majority (77%) describe the relationship with their mother as being either "good" or "excellent", 15% claim it to be "average", and only 8% of respondents spoke of the relationship as "below average" or "poor".

**PROCEDURE**

Unlike Gilligan's care conception of morality which was derived empirically from women's reported experience, the difference in moral reasoning investigated here is antecedently defined, and this will influence how it is best measured. Moral dilemmas were used to focus subjects' moral reasoning, and because the interest is in subjects' orientation to predefined types of moral reasons, standardised and hypothetical, as opposed to actual and self-selected, dilemmas were chosen. The former allow for much greater control over content, and are more suited to use in quantitative tests than the latter, whose variable content and subjective importance have been seen by some as an influence on reasoning orientation. 26 14 15

An open-ended interview or questionnaire that elicits free response was seen as a less efficient means of testing for orientation to predefined types of reasons than a structured questionnaire with predetermined standardised responses which allow for quantitative analysis. Such a questionnaire was derived from two focus groups and a pilot study. The focus groups were each composed of male and female doctors and nurses, and the relevant dilemmas asked participants to choose, in various situations, between aiding their mother (partialist) and aiding someone else who is either very worthy from an impartial point of view or whose being aided would have better overall consequences. The person-types depicted in these situations as representing impartial worth or merit were a judge, a medical practitioner, a saintly nun, and a sportswoman. It was recognised that there was no plausible way of presenting an impartial choice alternative in these situations without resorting to person-types of these sorts.

Given that the central concern of the study is the relationship between profession and ethical approach, it was considered important to set dilemmas in both health care professional and non-professional contexts. Also, because our interest is in the approach to ethical reasoning that people might consistently take, the dilemma situations were varied in another significant respect - in terms of the seriousness or urgency of the problems involved. Some dilemmas presented a problem where lives were under threat, and others where mere comfort was at stake. Focus group responses also strongly supported the view that reactions to dilemmas might be influenced by whether they were posed in a health care professional context or not, and whether they involved a life-threatening situation or not. So, for
the main study, four dilemmas were presented to cover the possible combinations of these factors. The first dilemma (A1), where the choice is between aiding the respondent's mother and a judge, involved a non-life-threatening situation in a non-professional context; the second (A2), posed a choice between saving the respondent's mother and a medical specialist, and was a life-threatening situation in a non-professional context; the third (A3) was a life-threatening situation in a professional context where the life of the respondent's mother and that of a saintly nun are in danger; and the fourth (A4) involved a non-life-threatening situation in a professional context, where the choice is whether to benefit the respondent's mother or an accomplished sportswoman. After further refinement through the pilot study, the final questionnaire presented subjects with ten statements following each dilemma. The statements either expressed a choice and a particular reason for it, for example, "I should rescue the medical specialist first, because the medical specialist has an important commitment on which others depend", or else stated a general attitude or consideration, for example, "I need to look at the situation from an impersonal perspective". Five statements represented a partialist moral orientation and cited considerations such as being attached to one's mother, having a special responsibility to one's mother, and loved ones coming first. The other five represented the impartial orientation and cited considerations such as having a wider responsibility to society, not having a right to favour one's mother, and one's mother and x having equally valid reasons to be aided. Subjects were asked to rate their level of agreement with each of the ten statements on the following four-point scale: "agree", "somewhat agree", "somewhat disagree", and "disagree". On the basis of their overall levels of agreement with the ten reason statements for each dilemma, subjects were asked to indicate finally if they believed they should aid their mother (partialist overall), or aid the other worthy person represented in the dilemma (impartialist overall). Subjects' responses were classified as partialist or impartialist in accordance with this indication. An example of one of the dilemmas has been included as an appendix.

Results

The main concern of the survey was to discover whether gender or occupation (doctor or nurse) impacted on the approach (partialist or impartialist) that participants took to various moral dilemmas. To address this question, we looked at the distribution of partial/impartial approaches in each of the four dilemmas for the whole group. The results are presented in table 1.

From these results it seems that in situations in which lives are at stake, whether they are set in a professional context or not, responses are overwhelmingly in favour of a partial approach. For the situations in which no lives are at stake, and the outcome is merely discomfort, there appears to be a difference between the professional and the non-professional situations. In the relevant professional situation (fourth dilemma), more respondents think they should adopt an impartial approach, whereas, in the situation set outside a professional context the matter seems to be less clear-cut. Although a majority of respondents lean towards an impartial approach, the difference between those in favour of an impartial approach and those that favour a partial approach is not as big as in any of the other situations.

Statistical analysis

To investigate whether thinking one should choose partially or impartially in either of the four dilemmas was dependent on (i) the sex of the respondents, (ii) their occupation, and (iii) their gender classification, cross-tabulations were generated and several measures of association calculated. The Chi-square-based measures (Pearson, Phi and Cramer's V) are problematic in the sense that they are difficult to interpret. For samples that are too small, it won't be possible to detect even large differences, while for large samples, even small differences can be statistically significant. An alternative measure is the Lambda statistic, based on the idea of proportional reduction in error (PRE). The Lambda statistic indicates the proportion by which error can be reduced in predicting the dependent variable if the independent variable is known. Lambda ranges from 0 to 1, for example, a Lambda of 0.142 means that by knowing the independent variable (for instance,
knowing the sex of the respondents), the error in predicting the dependent variable (for instance, partial/impartial approach to the dilemmas) can be reduced by 14.2%. However, even when Lambda is 0, other measures of association may find relationships of a different kind.

Several Lambda measures were utilised. Symmetric Lambda assumes that there is no reason to consider one of the variables dependent and the other independent. In our case, sex, occupation and gender-classification were assumed to be the independent variables. Subjects were classified as conforming to either a masculine or feminine gender identity according to the BEM Sex Role Inventory questionnaire. This questionnaire asked respondents to classify themselves (on a seven-point scale ranging from “Never or almost never true” to “Always or almost always true”) with respect to 30 personality characteristics, such as “willing to take risks”, “eager to soothe hurt feelings”. Each personality characteristic has a predefined association (based on social stereotypes) with one of four gender role descriptions: masculine, feminine, androgynous and undifferentiated. So, if a subject rates herself highly overall with respect to typically feminine characteristics, and lowly on masculine characteristics, she is classified as in the “feminine” group.

We looked at the appropriate Lambda to see how much we could reduce our error in predicting the approach of doctors’ and nurses’ to the four dilemmas when knowing the values of the independent variables, sex, occupation and gender-classification. Subjects’ responses classified according to occupation and gender are presented in table 2, and table 3 respectively. Our results showed that the approach doctors and nurses adopt in all four dilemmas is independent of either their sex, occupation or gender classification. So, knowing the sex, occupation, or gender of the respondents does not help predict the reasoning approach they adopt with the dilemmas. In addition, no relationship was observed between participants’ approach to

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<th>Table 2</th>
<th>Responses to dilemmas: occupation (doctor/nurse)</th>
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<td></td>
<td><strong>Dilemma A1</strong></td>
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<tr>
<td></td>
<td>Doctors</td>
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<tr>
<td>Partial</td>
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<td>Table 3</td>
<td>Responses to dilemmas: gender classification (according to BSRI)</td>
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<tr>
<td></td>
<td><strong>Dilemma A1</strong></td>
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dilemmas and several other variables (age, income, education, religion and respondent/mother relationship).

Discussions
The failure to find a significant relation between partial/impartial moral reasoning and occupation or gender might be due to a number of factors. It is possible that, because of the detail needed to convey the desired ethical context for each dilemma, some confusion may have arisen on the part of some participants, and responses may not have been as determinate as they could have been. Another possibility relates to the hypothetical manner in which the ethical problems were presented. It may have been that this introduced an element of personal distance into the choice situation, which prevented genuine and immediate feelings of attachment that can motivate a partialist response, from being effectively engaged with on the part of respondents. So, those who we would most expect to choose partially, for example, nurses, may not have been given the appropriate opportunity to demonstrate this. This suggestion, though, does not account for the results concerning doctors, who were expected to respond significantly more impartially. The same hypothetical nature of the dilemmas that supposedly suppresses a partial response in nurses, would also be expected to facilitate an impartial response in those disposed to it. There are, however, other possible explanations for the present results. In the case of occupation and orientation, the fact that no significant reasoning difference was observed between doctors and nurses might be an indication of the weakening grip that stereotypes and ingrained standards are having on nurses’ and doctors’ conceptions of their professional roles. This might be so particularly with nurses who are now, more than ever, consciously and critically reflecting on the nature of their professional status and activities. So, our findings, here, fail to support the views of those who see a specifically partialist “ethic of care” as characteristic of nurses, and an impartialist “justice ethic” as being characteristic of the medical profession.

There is also another possible explanation for our results. The fact that a substantial majority of subjects, regardless of gender, occupation, etc., respond partially when lives are at stake indicates that there might be a relationship between the seriousness to subjects of the potential personal loss involved and their orientation to a partialist response. This tends to suggest that the disposition to partialist and impartialist approaches might, in that respect, be “problem” sensitive rather than gender or occupation related. In other words, it might be that most people’s ethical reasoning includes both partialist and impartialist dimensions, and the one that dominates depends on the level of personal costs involved in the problem situation.

The current study can be seen within a broader theoretical context. The debate in many academic disciplines over the care ethic versus standard ethical views has gained a lot of its momentum from being embedded in a wider set of issues concerning gender relations. Although this association has added to the prominence and immediacy of that debate, it has, to some extent, also served to distract from some important philosophical issues about the relative merits of these perspectives as ethical approaches and about where they overlap and differ. Such questions about the philosophical status of the two approaches are of primary interest independently of their proposed associations with gender. Indeed, some of those questions had been on the philosophical agenda for some time before Gilligan proposed a gender connection.28 The fact that the present study finds no gender difference in moral orientation adds to the reasons for maintaining a degree of conceptual separation between the two sets of questions.

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Appendix
DILEMMA A2 (NON-PROFESSIONAL, LIFE-THREATENING)
Person overboard
It is very late, and you are on the bow of an ocean liner far out at sea. Suddenly, on one side of the boat you hear cries of “help” and “rescue me” and realise someone has fallen off the ship and is drowning. You recognise the cries as coming from a woman to whom you were briefly introduced the other night. She is a universally well-regarded medical specialist who has dedicated her life to health-issues in disadvantaged and indigenous communities. As you are about to rush to the woman’s aid, you hear cries of “help” and “rescue me” from the other side of the boat and realise someone else has fallen off the boat and is drowning. You recognise these cries as coming from your mother, who you had believed was safely in her cabin. Both your mother and the medical specialist are about the same age, and both appear to be in extreme distress. They are both approximately 20 metres from the ship. You realise that
you will probably only be able to rescue one of them. Who should you attempt to rescue first?

References
27 This measurement technique was originally described in Goodman L, Kruskal WH. Measures of association for cross-classifications, part 1. Journal of the American Statistical Association 1954; 49: 732–64.

News and notes
Medical Ethics at the end of the 20th Century

The Ministry of Science in Israel is to sponsor an international conference on Medical Ethics at the Close of the 20th Century. The conference will be held at The Van Leer Jerusalem Institute, 5–8 January 1998, Israel.

Speakers will include: Baruch Brody, Baylor College of Medicine; Tom Beauchamp, Georgetown; Raphael Cohen-Almagor, Haifa; Bernard Dickens, Toronto; Justice Dalia Dorner, The Supreme Court of Israel; Shimon Glick, Ben-Gurion; John Harris, Manchester; Goverdt den Hartog, Amsterdam; Jan C Joerden, Europa-Universitat Viadrina; Eike-Henner Kluge, Victoria; John Lantos, Chicago; Evert van Leeuwen, Vrije; Frederick Lowy, Concordia; John Robertson, Texas; Charles Sprung, Jerusalem; Avraham Steinberg, Jerusalem; Antonella Sumbone, Memorial Sloan-Kettering Cancer Center, and Robert D Truog, Harvard.

For more information please contact Ms Beki Shimoni, Head, Conference Unit, The Israeli Ministry of Science, Building C, PO Box 18195, Jerusalem 91181, Israel. Fax: 972-2-5824022. Phone: 972-2-5811220; 5847783.