

Debate

Philosophy and teaching medical ethics

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Author's reply – introduction

Commentaries on the cognitive-developmental approach to ethical or moral education most often focus on one or both of two concerns:

- a) the philosophical basis of the claim to moral adequacy of the higher reasoning stages, and
- b) the empirical support for cognitive-developmental theory in general, and as it applies to the development of moral reasoning in particular.

Not unpredictably, Raanon Gillon's reactions to *Teaching medical ethics: The cognitive-developmental view*¹ included both. While these general concerns have been addressed in other contexts²⁻⁷, a brief specific response to Gillon's comments is appropriate for the readers of this Journal.

Gillon's philosophical concerns appear to be that the cognitive-developmental approach to moral education is philosophically irrelevant and that there is no basis for claiming the greater logical and philosophical adequacy of higher stages. These are not uncommon nor unimportant misconceptions of the cognitive-developmental approach. While space limitations prohibit comprehensive responses to these issues, I shall briefly address them, urging the interested reader to consult the sources cited earlier, or to correspond directly with me.

A psychological approach

The cognitive-developmental approach to moral development and moral education is primarily a psychological one in that it deals with the cognitive skills brought to bear on moral issues. To say that it has no philosophical relevance, however, is to fail to recognise the inherent relationships among psychology, epistemology, and philosophy. The reasoner at each stage employs a logic or philosophy in resolving a moral dilemma. The quality of reasoning increases in a very real and measurable fashion as one advances through the stages. Further, the social perspective employed by higher stage reasoners is less egocentric and increasingly oriented to the rights of the individual as determined

by principles of justice and fairness (as opposed to arbitrary authority, egocentrism, or convention). Thus, it is not posited that higher stages are more adequate merely because they succeed earlier ones (as Gillon supposes, with an analogy to age). Rather, the sequence of stages represents a qualitative, hierarchical growth in cognitive development. One can say, then, that higher stage reasoning is more adequate and, hence, more desirable. Let us examine a specific example to help clarify this point. Stage 5 reasoning is attained only after having sequentially passed through each of the prior stages (as supported by ample empirical evidence), and is not usually achieved before early adulthood (and, unfortunately, by only a relatively small percentage of the population). In what logical and philosophical sense can we say that Stage 5 reasoning is superior to Stage 4 reasoning? Cognitively, it is better differentiated, better integrated, and more inclusive (*ie*, it includes elements of Stage 4 reasoning but is more sophisticated). The social perspective of the Stage 5 reasoner is prior to society (a law-making perspective) while that of the Stage 4 reasoner is as a member of society (a law-maintaining perspective). To the Stage 5 reasoner, the authority of law derives from freely accepted contracts with society, while for the Stage 4 reasoner the authority of law resides in divine, natural, or societal authority. For the Stage 5 reasoner, laws are maintained to maximise public utility and the greater good of society, while for the Stage 4 reasoner laws are maintained to prevent disorder. Furthermore, we have considerable evidence indicating that Piaget's⁸ stages of cognitive development (general logical abilities) and Selman's⁹ stages of social perspective taking are necessary (but not sufficient) for higher stages of moral reasoning. This clearly implies the greater logical adequacy of the higher stages. In addition, research shows that respondents prefer higher stage reasoning, even when they cannot generate it themselves.

Higher stage reasoning and morality

Morally, the higher stages are more adequate in that they are characterised to a greater extent by the formal criteria which distinguish moral from non-moral behaviours (see *eg*, Frankena, Hare, Kant, Raphael, and Rawls). These include prescriptivity (having a definite sense or concept of internal duty),

universalisability (having a sense that a moral or ethical judgment should be such that all rational persons could agree and act upon it), primacy (of ethical over non-ethical considerations), and reversibility (that a decision would be deemed fair from any participant's perspective; ideal role taking; the veil of ignorance).

Gillon's contention, then, that Stage 2 instrumental egoism can be considered to be as morally adequate and logically sophisticated as Stage 5 or Stage 6 principled reasoning is not tenable, unless we agree that egocentric considerations will produce a solution which is more fair and just than will social utilitarian or universal ethical principled reasoning. The former would maximise the benefits of the individual and would be in conflict with the self-maximised interests of others. The latter, on the other hand, would consider equally the rights of all participants in a formally just and impartial fashion and would seek to maximise the outcomes for all without disregard for or disrespect of others. Furthermore, the Stage 2 reasoner would be limited to an egocentric relativistic view of the situation, whereas the Stage 5 and 6 reasoners could view the situation non-relativistically from a universal perspective (research supports the principle of inclusivity—due to cognitive limitations, the Stage 2 reasoner cannot argue from a Stage 5 perspective, whereas the reverse is possible). No doubt the 'sophisticated' reasoners whom Gillon suggests might defend Stage 1 or 2 morality (eg, Kalin) would employ a logic and social perspective far beyond the capabilities of the actual Stage 1 or 2 reasoner.

An elitist theory?

Of a less central nature are Gillon's concerns that the cognitive-developmental approach ignores emotivism and intuitivism, and that the theory is elitist since not all persons are capable of attaining the highest stages of reasoning. First, affect, or emotion, is not a separate phenomenon from cognition in this view; parallel structural changes are observable in both. Cognitive theorists do not deny that moral dilemmas often include strong emotional components, and that, indeed, behavioural choices are often influenced in an overriding fashion by emotional factors. However, this does not negate the cognitive basis by which one rationally determines the moral or ethical 'ought' in a situation. Second, a theory is not necessarily elitist because it recognises individual differences in cognitive (or other) capacities. Ample evidence indicates that:

- a) not all adults achieve full formal operational thought (due to genetic and/or environmental limitations), and
- b) such a level of reasoning is necessary for principled moral reasoning.

Thus, until such general reasoning skills are acquired, advances to the highest moral reasoning stages is not possible. Indeed, a theory which failed to acknowledge such individual differences would be inferior. Elitism becomes an issue only if one were to equate human worth with reasoning ability, a posture adamantly opposed by cognitive-developmental theorists, and one which we assume Gillon would oppose, as well.

Regarding of the sample

Gillon's empirical concerns include the sample size and the possible atypicality of medical students and the attendant non-generalisability of research in this area to medical school settings. Most moral education projects usually do not employ large samples, both because they are not statistically necessary (as in the case of survey research) and because the research is extremely demanding of the time and energies of both researchers and participants. Moreover, the individual moral education project should not be viewed as an isolated experience. Rather, it is part of a larger set of such projects, employing similar techniques, conducted with a variety of subject populations, and providing mutually supportive outcomes. Were the data obtained in any one project found to be divergent from previously conducted research, both would be subject to close scrutiny in terms of methodology and theoretical adequacy. As it was, our techniques and data were highly typical of the extant literature; in fact, our results were more impressive than most. The point of divergence of our study was not a technique or outcome, but rather in the focus of medical-ethical dilemmas. The purpose of the study, furthermore, was not to test the theory, but rather to demonstrate the applicability of the approach to medical ethics education.

Second, it may or may not be the case that medical school students are more disposed than other students to finding 'practical or clinical' solutions to dilemmas, as Gillon claims, or that they may be more emotional and intuitive and less rational in their judgments. These statements appear to be internally inconsistent, the comparison groups are not specified, and no supportive evidence is cited. It seems unlikely that medical students are indeed more 'practical' in problem solving situations than are students of business, engineering, clinical psychology, criminal justice, or, for that matter, sculpture. In addition, whether or not they are really quite irrelevant to the task of ethical education in the cognitive-developmental view. The goals of such education are to enhance reasoning skills, promote logical sophistication, and to enable more abstract, comprehensive, and integrated resolution of ethical dilemmas. As such, the starting point of reasoning skills is a factor to be taken into account in the design of a program, but it requires

alteration of either the theory or technique of moral education, and no limitation of results to specific occupational or other non-cognitive characteristics of participants. The cognitive-developmental approach is suitable for anyone who is functioning at a stage below that maximally attainable given the individual's more general cognitive (Piagetian) and social perspective taking stage. Further, one might argue that MDs would do well to suspend their emotions and 'intuition' in dealing with medical ethical problems, given the arbitrary, inconsistent, and non-rational bases of these perspectives. In this light, training in the use of comprehensive logic, an encompassing social perspective, and a profound respect for the rights and dignity of the individual would seem to be highly desirable for medical students.

Conclusion

Gillon's final comment, that in medical ethical training we should concentrate on impartial analysis of a broad range of practical alternatives and encourage the student to 'develop his own informed but autonomous decisions', is not greatly disparate from our own position. Indeed, a major component of the Blatt and Kohlberg technique of moral education is to promote critical analysis of alternate solutions, leading to autonomous moral decisions. The cognitive-developmental approach assiduously avoids preaching specific solutions (the content of moral reasoning), focusing on the structure of reasoning employed in arriving at solutions. What this approach does that many others do not is to enhance the student's ability to deal with the moral principles involved in a medical-ethical dilemma as opposed to inculcating merely expedient, utilitarian, or conventionally popular solutions.

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Kidney transplants: a reply to Sells

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I read very carefully Robert Sells' reply to my paper on the supply of kidneys for transplantation. I readily concede that the attitude of the medical profession towards kidney transplantation is a factor in inhibiting the supply of kidneys, indeed I gave considerable weight to the point myself. I persist in the view, however, that there are other factors principle among which are the framework, wording and policy of the Human Tissue Act. Sells makes four points. The first is that the present supply of kidneys for transplantation is approximately one third of those required each year. This appears almost as an afterthought in the last sentence of the penultimate paragraph. I made it my starting point. It is, after all, the crucial issue. The second point Sells makes is that the Human Tissue Act is unimportant or 'non-problematical' in inhibiting the supply of organs. Third, Sells identifies as 'the single most important impediment' the reluctance of the medical profession to refer dead patients with functioning kidneys as donors. Finally, Sells states categorically at the outset that the supply of organs would not be significantly increased by changing the law to an opting out principle. The posture adopted by Sells is, in other words, that which I discussed under the heading of, retain the existing law with increased publicity and education, and dismissed as unlikely to produce significant improvement in the foreseeable future.

The lack of kidneys

May I comment briefly upon these points made by Sells? As regards the first, the lack of kidneys, I took and take the view that we ought to be giving prominence to this fact and asking why it comes to pass. This is particularly so in light of the fact that it is now nineteen years since Parliament passed the law, the express purpose of which was to facilitate transplantation surgery and that kidney transplants have been an available form of therapy for some thirteen or so years. By relegating this