Special Section:
Praxis: Ethical Issues in Medical Education and Training

# *The Moral Orientations of Justice and Care among Young Physicians*

DONNIE J. SELF, NANCY S. JECKER, and DEWITT C. BALDWIN, JR.

## Introduction

High moral standards and adherence to a moral code have long been strong tenets of the profession of medicine, even though there have been occasional lapses that have led to renewed calls for a revitalization of moral integrity in medicine.[1] Certainly, a moral component has generally been held to be an important aspect of the concept of a physician.[2]

There have been a number of studies in recent years describing the moral reasoning of medical students and healthcare professionals.[3,4] Some of the studies have assessed educational interventions designed to increase moral reasoning, and some have compared various methodologies for teaching medical ethics.[5,6] In contrast to the *moral reasoning* of medical students and healthcare professionals, there have been virtually no published reports on the *moral orientation* of medical students and healthcare professionals. The distinction between moral reasoning and moral orientation has been discussed elsewhere in a report on veterinarians[7] but is briefly described as follows.

As derived from the cognitive moral-development theory of Kohlberg, moral reasoning is the degree to which one employs the use of the principle of justice or relies on the concept of justice in resolving moral conflicts. Based on the pioneering work of Piaget and Dewey, Kohlberg devised a moral-development theory involving six stages of moral development.[8,9] His work has gained wide attention and has been validated by multiple studies substantiating his stage-theory claims.[10] These studies report evidence for the universality of moral reasoning across 26 Asian and Western cultures in both the Northern and Southern hemispheres.[11,12] Kohlberg's theory articulates a hierarchical sequence of moral reasoning, culminating with justice reasoning as the highest moral value.[13]

In response to Kohlberg's theory, which regards justice as the moral ideal, Gilligan formulated a moral-development stage theory that holds care as the moral ideal.[14] In Kohlberg's model, what is morally right is defined by justice, fairness, and independent principle guidedness, whereas in Gilligan's model, moral rightness is interpreted to mean care, relatedness, and refraining from doing harm or violence. Lacking comparable empirical support for her stage theory, Gilligan later moved away from the concept of moral stages. Rather, she began to emphasize the concept of moral orientation or moral voice, for which she does have empirical evidence.[15]

Moral orientation refers to the framework in which a moral dilemma is perceived and described. Gilligan has identified two moral voices or orienta-


*Cambridge Quarterly of Healthcare Ethics* (2003), **12**, 54–60. Printed in the USA.

tions that people employ in describing their experience of morality—namely, an orientation of justice and an orientation of care. These two orientations provide the framework by which one identifies an issue as a moral issue. Persons who exemplify a justice orientation view relationships in terms of inequality versus equality and in terms of mutuality and reciprocity. One who adopts this orientation asks what is fair for all involved in a situation. Justice thus connects vulnerability with oppression. A justice orientation is concerned with issues of fairness, individual rights, and adherence to standards and principles. From this framework, morality requires following the universal ethical principles of justice, autonomy, reciprocity, equality, and respect for all human beings.

By contrast, from the orientation of care, relationships are characterized not in terms of equality and inequality but attachment versus detachment. Care connects vulnerability with the moral issues of support versus abandonment, not with oppression and inequality. Here, the concern is not whether one will be oppressed or treated unfairly, but whether one will be deserted, alienated, isolated, or abandoned. A care orientation is concerned with the complexities of sustained attachments, compassion, forgiveness, and close personal relationships. From a care perspective, morality requires not hurting others, condemning all violence and exploitation, and nurturing relationships and connections between persons. Gilligan's research supports the claim that males, as a group, exhibit a justice orientation predominately and that females generally exhibit a care orientation predominately. However, members of both genders exhibit both orientations.

The current study specifically addressed the issue of moral orientation in young physicians graduating from medical school before beginning their residency specialty training. It provides initial baseline data on the moral orientation of members entering the medical profession.

## Methods

The study involved analysis of the moral orientation of 20 graduating medical students, 41.7% of the student body for that cohort. The subjects were recruited as unpaid volunteers with appropriate informed consent. Data were gathered by administration of the Gilligan Real-Life Conflict and Choice Interview.[16] The interview is an oral tape-recorded interview of approximately 30–45 minutes with a standard set of probe questions designed to elucidate the degree of the subject's use of the concepts of justice or care in discussing a real-life moral conflict that the subject has experienced in the past. The systematic set of open-ended probe questions is designed to enable subjects to reveal the structure of their moral orientation in terms of the presence, predominance, and alignment with justice and/or care. Although these concepts have been elaborated in detail by Gilligan and her colleagues, briefly their meanings are as follows. Presence simply means whether or not the person takes into account, recognizes, or employs the concepts of justice and/or care in describing their real-life moral conflicts—that is, whether or not the concepts are present in their descriptions of moral dilemmas. Predominance means whether one of the concepts is used exclusively or to a significantly larger extent than the other concept. And alignment means whether or not the person accepts, personally

owns, endorses, and employs the concept of justice or care as their preferred mode of resolution of their conflict.

After transcription, the interviews were interpreted for moral orientation by one of the authors (N. J.), who had been trained by Gilligan's research team at Harvard University with the methodology described in Gilligan's manual for determining moral orientation or moral voice. All transcripts were interpreted by one reader, thus eliminating problems of interrater reliability.

## Results

A total of 20 subjects were initially enrolled in the study. Complete moral orientation data were obtained on all 20 subjects, as well as additional demographic data including gender, age, Medical College Admission Test (MCAT) scores, and grade point average (GPA). There were 7 male and 13 female subjects in the study. As shown in Tables 1–3, analysis of the data revealed that, although the presence of justice issues were recognized in 95% of the moral conflicts of the young physicians, the predominance of justice as the organizing principle or framework for resolution of the conflict occurred in less than one-third (30%) of the participants. Alignment with justice as the preferred mode of resolution of the conflict occurred in 20% of the cases. Conversely, the presence of care issues was recognized in 90% of the moral conflicts, with the predominance of care as the organizing principle or framework for resolution of the conflict occurring in 55% of the dilemmas. Alignment with care as the preferred mode of resolution of the conflict occurred in 25% of the cases. As shown in Table 2, statistical analysis revealed that there were no significant correlations between moral orientation components and age, gender, MCAT scores, or GPAs at the $p \leq .05$ level, except for gender by presence and GPA by alignment. In the first case, there were no females who recognized only justice or only care as present in their dilemmas. All females recognized the presence of both justice and care in their moral conflicts. In the second case, there was a significant relationship between alignment and GPA, but of the groups personally accepting only justice, only care, neither or both, no two groups were significantly different.

**Table 1.** Justice and Care Moral Orientation Data of Young Physicians

| | | |
|---|---|---|
| Presence | | |
| Justice only | 2 | (10%) |
| Care only | 1 | (5%) |
| Both justice and care | 17 | (85%) |
| Predominance | | |
| Justice | 6 | (30%) |
| Care | 11 | (55%) |
| Neither | 3 | (15%) |
| Alignment | | |
| Justice only | 4 | (20%) |
| Care only | 5 | (25%) |
| Both justice and care | 10 | (50%) |
| Neither | 1 | (5%) |

**Table 2.** Probability Levels Obtained from One-Way Analysis of Variance of Selected Demographic Characteristics of Young Physicians by Moral Orientation Components

| Demographic characteristics | Moral orientation components | | |
|---|---|---|---|
| | Presence | Predominance | Alignment |
| Age | 0.1520 | 0.1446 | 0.2231 |
| Gender | 0.0342 | 0.1115 | 0.4680 |
| MCAT | 0.4011 | 0.3826 | 0.9299 |
| GPA | 0.7166 | 0.7725 | 0.0271 |

MCAT = Medical College Admission Test; GPA = grade point average

## Discussion

Although this study did not present a random sample of graduating senior medical students, the participants represented 41.7% of the student body for that cohort, and there was no reason to think that they were not comparable to their other colleagues. The small sample size was a result of the study being done at a school with a very small student body. Although this small sample size makes it difficult to make broad generalizations, the results obtained here nevertheless indicate or suggest trends to be expected in a larger study. Such a small sample size has statistical power to detect only extremely strong relationships, so an important relationship may be there yet still be missed because of the limited sample size. Clearly, additional research needs to be done to investigate, characterize, and more fully understand the relationship between medical education and moral orientation.

There are several ways to interpret these data. On the one hand, if the concept of justice is considered the moral ideal, one might conclude that it is encouraging that almost all (95%) of the young physicians recognized the

**Table 3.** Presence, Predominance, and Alignment of Moral Orientation in Young Physicians by Gender

| Gender | Only justice orientation | Only care orientation | Both justice and care orientation | Neither justice nor care orientation | Totals |
|---|---|---|---|---|---|
| Presence | | | | | |
| Male | 2 (100%) | 1 (100%) | 4 (23.5%) | N/A | 7 (35%) |
| Female | 0 (0%) | 0 (0%) | 13 (76.5%) | N/A | 13 (65%) |
| Totals | 2 (100%) | 1 (100%) | 17 (100%) | N/A | 20 (100%) |
| Predominance | | | | | |
| Male | 4 (66.7%) | 3 (27.3%) | 0 (0%) | N/A | 7 (35%) |
| Female | 2 (33.3%) | 8 (72.7%) | 3 (100%) | N/A | 13 (65%) |
| Totals | 6 (100%) | 11 (100%) | 3 (100%) | N/A | 20 (100%) |
| Alignment | | | | | |
| Male | 2 (50.0%) | 1 (20%) | 3 (30.0%) | 1 (100%) | 7 (35%) |
| Female | 2 (50.0%) | 4 (80%) | 7 (70.0%) | 0 (0%) | 13 (65%) |
| Totals | 4 (100%) | 5 (100%) | 10 (100%) | 1 (100%) | 20 (100%) |

presence of justice concerns in the conflicts. However, less than one-third (30%) of them relied predominately on justice in the resolution of the conflicts, and even fewer (20%) actually aligned with or personally accepted and owned the justice orientation as their preferred mode of resolution of moral conflicts. This would seem to reflect rather poorly on young physicians if the concept of justice is considered the moral ideal.

On the other hand, if the concept of care is considered the moral ideal, one might conclude that it is encouraging that almost all (90%) of the participants recognized the presence of care issues in the conflicts. However, only 55% of them relied predominately on care in the resolution of the conflicts. Even fewer (25%) actually aligned with care and personally owned a care orientation as their preferred mode of resolution of moral conflicts. From these data, neither care nor justice appears to emerge as a moral ideal.

An alternative viewpoint might build a rationale for combining justice and care and for considering both constituents as components of a moral ideal. However, if that is the case, matters get even worse. Although 85% of the young physicians recognized the presence of both justice and care in the moral conflicts, only 15% of them exhibited a balanced approach where neither justice nor care were in predominance. Nevertheless, 50% of them gave evidence of a personal alignment with a combined approach of justice and care as their preferred mode of resolution of moral conflicts.

It is interesting to note that, although statistical analysis showed no significant correlations between gender and predominance in moral orientation, these limited data tend to support Gilligan's claim of males being predominately justice oriented and females being predominately care oriented. These data reveal that 66.7% of the time the justice orientation was exhibited as predominant by males and only 33.3% of the time predominant by females. Conversely, the care orientation was exhibited as predominant 72.7% of the time by females and only 27.3% of the time by males.

## Conclusion

These are the first data reported on the moral orientations of graduating senior medical students entering the profession. They contain small numbers, thus limiting their generalization to all young physicians. Nevertheless, even such a preliminary study suggests that it is better to be generally informed and incomplete rather than to be precisely ignorant. These data fit in well with other data gathered on non–medical students. Clearly, further research needs to be conducted on the moral reasoning and moral orientations of young physicians. This study needs to be replicated in other places and under different circumstances to strengthen the conclusions.

One conclusion that could be drawn from this study is that there may be other moral aspects beside justice and care that form the structure of moral reasoning in young physicians. This is supported by the fact that combining those who aligned with justice (20%) as the preferred mode of resolution of the conflict and those who aligned with care (25%) for resolution would still only account for less than one-half of the preferred ways of resolution of moral conflicts. Over one-half (55%) of the participants preferred another mode of resolution for the conflicts, which was unidentified by the bipolar analysis for justice and care. Other possible moral ideals need to be explored, identified,

and researched thoroughly to account better for the moral reasoning and moral orientation of young physicians. Other potential moral ideals in contrast to justice and care could include benevolence, following authority, adherence to religious teachings, and so forth.

Identifying tools and techniques for teaching justice and care will be valuable in accomplishing the task of teaching medical ethics. Rest has shown that, contrary to popular belief, it is not developmentally too late to effect significant changes in moral reasoning in young adults.[17] Certainly in medicine and dentistry it has been clearly demonstrated that teaching ethics improves moral reasoning.[18,19]

The current study is an attempt to further our understanding of moral orientation and moral development among members of the health professions. This is considered important because there is emerging evidence in the field of medicine that levels of moral reasoning and moral development are affected by educational experiences and are significantly related to clinical competence and incompetence.[20,21,22] An interesting additional area for future research and discussion would be to consider what implications the moral orientation of women have for an increasingly feminized medical profession, whose student trainees are increasingly women. It is hoped that these and continuing studies will serve to expand our understanding of the possible role of moral reasoning and moral development in medical education and practice.

## Notes


1. Petersdorf RG. A matter of integrity. *Academic Medicine* 1989;64:119–23.
2. Pellegrino ED, Thomasma DC. *The Virtues in Medical Practice*. London: Oxford University Press; 1993.
3. Baldwin DC Jr, Daugherty SF, Self DJ. Changes in moral reasoning during medical school. *Academic Medicine* 1991;66(9S):1–3.
4. Self DJ, Olivarez M. Retention of moral reasoning skills over the four years of medical education. *Teaching and Learning in Medicine* 1996;8(4):195–9.
5. Self DJ, Baldwin DC Jr, Olivarez M. Teaching medical ethics to first-year students by using film discussion to develop their moral reasoning. *Academic Medicine* 1993;68(5):383–5.
6. Self DJ, Wolinsky FD, Baldwin DC Jr. The effect of teaching medical ethics on medical students' moral reasoning. *Academic Medicine* 1989;64:755–9.
7. Self DJ, Jecker NS, Baldwin DC Jr, Shadduck JA. Moral orientations of justice and care among veterinarians entering veterinary practice. *Journal of the American Veterinary Medicine Association* 1991;199:569–73.
8. Kohlberg L. *Essays on Moral Development: Vol. 2. The Psychology of Moral Development*. New York: Harper & Row; 1994:640–51.
9. Kohlberg L. Moral stages and moralization: the cognitive-developmental approach. In: Lickona T, ed. *Moral Development and Moral Behavior*. New York: Holt, Rinehart, Winston; 1976:31–53.
10. Rest JR. *Moral Development: Advances in Research and Theory*. New York: Praeger; 1986.
11. Snarey JR. Cross-cultural universality of social-moral development: a critical review of Kohlbergian research. *Psychological Bulletin* 1985;97:202–32.
12. Snarey JR, Reimer J, Kohlberg L. The development of social-moral reasoning among kibbutz adolescents: a longitudinal cross-sectional study. *Developmental Psychology* 1985;21:3–17.
13. The theory is described in detail and in summary elsewhere with multiple references available on request from the authors.
14. Gilligan C. *In a Different Voice: Psychological Theory and Women's Development*. Cambridge, Mass.: Harvard University Press; 1982:1–184.
15. Gilligan C, Attanucci J. Two moral orientations: gender differences and similarities. *Merrill-Palmer Quarterly* 1988;34:223–37.

16. Brown LM, Argyris D, Attanucci J, Bardige B, Gilligan C, Johnston D, et al. *A Guide to Reading Narratives of Moral Conflict and Choice for Self and Moral Voice*. Cambridge, Mass.: Center for the Study of Gender, Education, and Human Development of the Harvard Graduate School of Education; 1987:1–141.
17. Rest JR. Can ethics be taught in professional schools? the psychological research. *Ethics: Easier Said Than Done* 1988;1:22–6.
18. Self DJ, Baldwin DC Jr, Wolinsky FD. Evaluation of teaching medical ethics by an assessment of moral reasoning. *Medical Education* 1992;26:178–84.
19. Bebeau MJ, Thoma SJ. The impact of a dental ethics curriculum on moral reasoning. *Journal of Dental Education* 1994;58(9):684–92.
20. Sheehan TJ, Husted S, Candee D, Cook CD, Bargen M. Moral judgment as a predictor of clinical performance. *Evaluation and the Health Professions* 1980;3:393–404.
21. Sheehan TJ, Candee D, Willms J, Donnelly JC, Husted SR. Structural equation models of moral reasoning and physician performance. *Evaluation and the Health Professions* 1985;8:379–400.
22. Baldwin DC Jr, Adamson TE, Sheehan JT, Self DJ, Oppenberg AA. Moral reasoning and malpractice: a pilot study of orthopedic surgeons. *The American Journal of Orthopedics* 1996;25(7):481–4.