Moral Reasoning of Members of Hospital Ethics Committees: A Pilot Study

Arthur Dobrin

INTRODUCTION

The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), the American Hospital Association, and hospitals themselves have mandated the establishment of ethical review procedures to respond to the various moral dilemmas confronting all those in hospital settings.1

Committees are frequently multi-disciplinary, involving the various professions represented in the hospital. Typically membership includes physicians, social workers, nurses, and administrators. Committees may also include a resident ethicist and lay members from the community, who are often clergy, but not exclusively.

Hospital bioethics committees typically perform one or more of these three functions: case consultation and review, policy development and review, and education. Case consultation commonly deals with advance directives, withholding and dealing with life-sustaining treatments, informed consent, and organ procurement;2 and with resolving ethical dilemmas as they present themselves clinically and in relation to the patient and/or family. A fourth function recently has been added for consideration by hospital ethics committees: organizational/business ethics.3 This function focuses on institutional development and growth, including, for example, patient services, business and service plans, employee rights, and the organization's role in the community.4

There are few, if any, measures of success for hospital ethics committees, since criteria for success have not been systematically developed.5 Some studies have examined levels of moral reasoning and clinical performance. Rest and Narvaez note, "higher stages [of moral reasoning] are said to be better conceptual tools for making sense out of the world and deriving guides for decision making."6 Sheehan et al. found a consistent relationship between pediatric residents' levels of moral reasoning and the quality of their clinical performance, as judged by their residency supervisors.7 Similar findings have been reported for family medicine residents.8 There is also evidence that orthopedic surgeons who scored higher on evaluations of moral reasoning were less likely to be involved in malpractice claims than orthopedic surgeons with lower moral reasoning scores.9 These studies suggest that similar methods may be applied to members of hospital ethics committees—namely, that the higher the level of moral reasoning demonstrated by the members of a committee, the more successful the committee.

MORAL DEVELOPMENT THEORY

According to Piaget,10 fundamental knowledge regarding space, time, causality, and logic emerge in stages, as a result of the interaction between the person and the environment. Knowing is an active structuring process, whereby logical and moral norms move from an egocen-
tric point of view to an increasing ability to take a variety of perspectives. This increasing ability is characterized by stages that structure cognitive and moral responses to the environment. Piaget divided moral points of view into two categories: (1) the *heteronomous*, which assumes that rules are fixed and the same for everyone, and (2) the *autonomous*, which assumes that rules are cooperative arrangements among equals. Autonomous moral judgments are referred to as *principled ethical judgments*.

Kohlberg elaborated upon Piaget's work, proposing that moral principles can be understood as being either *mature* or *immature*. "Mature principles are neither rules (means) nor values (ends), but are guides to perceiving and integrating all the morally relevant elements in a concrete situation."12

Rest accepts the Piaget/Kohlberg cognitive developmentalist approach to moral development.12 He differs from Kohlberg's approach in two regards. First, he is skeptical of the claim that a linear relationship exists between moral reasoning and action. Second, Rest maintains that the issue and the content of a moral dilemma influences moral judgments. However, he accepts Kohlberg's general finding that the individual's developmental stage limits his or her possibilities of using the higher stages, when appropriate. In other words, a person with less-mature moral principles is incapable of conceptualizing higher level or more-mature moral principles. *Mature moral principles* are defined as those that are impartial, and are based on concepts of justice, fairness, and universal rights, rather than on partiality and favoritism.

In selecting an instrument to measure moral development for this study, I considered the work of Carol Gilligan, who challenged the cognitive developmentalist approach to moral development as male-biased.13 The thrust of her criticism is that women view morality through a lens of particularity, while men favor abstraction. Instruments intended to measure moral development, therefore, are biased toward males, and so are of limited use. In this study I use the Defining Issues Test (DIT), an instrument developed by Rest. A review of 56 studies involving thousands of respondents who used the DIT found there was little or no difference in DIT scores based on gender.14

**HYPOTHESIS**

The purpose of this study was to compare the scores on moral reasoning of members of hospital bioethics committees with DIT scores of the general adult population, to learn whether the level of moral reasoning of committee members differed from the general adult population. The assumption of this study was that higher scores by members of hospital ethics committees would indicate the competencies of the committee to consider ethical problems. I hypothesized that there would be a significant difference between the scores of members of hospital bioethics committees and those of the general adult population, with members of bioethics committees receiving higher scores on a measure of moral reasoning.

**METHODS**

The study consisted of collecting moral reasoning data for members of hospital ethics committees, analyzing results, and comparing the data with similar data from the general public. Participants were recruited in 2000. The study was limited to hospitals with established and functioning bioethics committees, as determined by a search on the internet and through personal knowledge of the researcher. The DIT was sent to the chair of each committee who distributed it to members. The DIT was either completed at a committee meeting or returned to the chair at a subsequent meeting.

While five hospitals initially agreed to participate, only four hospitals returned data for analysis. One hospital ultimately declined to participate because the chair of the committee could not get members to return the DIT once it had been distributed. The four hospitals that did participate are located in three states. Two are teaching hospitals, one is a community hospital, and one is a military hospital. See table 1 for a listing of the professions of committee members.

The DIT is a paper-and-pencil measure of moral judgment. It presents 12 issues after a hypothetical dilemma for a subject to rate and rank in terms of importance. The scores represent the degree to which a subject uses the following in making moral judgments.
The scores purport to show how people conceptualize how it is possible to organize cooperation in a society. In short, the DIT is a measure of the development of concepts of social justice.

Validity for the DIT has been assessed in terms of seven criteria.

1. Differentiation of various age/education groups
2. Longitudinal gains
3. Significant relations to cognitive capacity measures
4. Sensitivity to moral education interventions
5. Linkage to many pro-social behaviors and to desired professional decision making
6. Linkage to political attitudes and political choices
7. Adequacy of reliability

Cronbach's alpha is in the upper .70s - low .80s. Test-retest reliability is about the same. The DIT is equally valid for males and females. No other variable or construct predicts the pattern of results on the seven validity criteria (listed above) as well as moral judgment.

Scores for the DIT are reported as P%. This is interpreted as the relative importance a subject gives to item choices that represent principled thinking.

RESULTS

Five hospitals initially agreed to participate in this study. A total of 118 DITs were sent to the hospitals, the total number of members reported by the chairs. After receiving the DITs, one of the four hospitals, with 16 members, did not participate. In all, the hospitals distributed 77 questionnaires. All of the hospitals were secular institutions. Hospital #1 was a military facility.
ADDITIONAL CONSIDERATIONS

Tables 1 and 4 report the means of P% by profession and by gender. These results were greatly influenced by two facts present in the raw data. First, there was only one person in the professional group Clergy. Because any comparison of means among groups is affected by the variance within groups (and the group “Clergy” has no variance because it has only one member), I examined P% when the group “Clergy” was collapsed with group “Other,” and I examined P% when the group “Clergy” was removed (see tables 2 and 3).

Second, the comparison of gender was affected by the fact that one individual (female)

Table 3
Scores by Profession (Excluding Group Clergy)

<table>
<thead>
<tr>
<th>Profession</th>
<th>N</th>
<th>Mean Score (P%)</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>9</td>
<td>42.3</td>
<td>17.8800</td>
</tr>
<tr>
<td>RN</td>
<td>7</td>
<td>31.4</td>
<td>18.8225</td>
</tr>
<tr>
<td>Administrator</td>
<td>3</td>
<td>51.3</td>
<td>8.0829</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>26.0</td>
<td>16.0831</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>37.3</td>
<td>18.0351</td>
</tr>
</tbody>
</table>

Table 4
Scores by Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>N</th>
<th>Mean Score (P%)</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>12</td>
<td>39.4</td>
<td>13.8024</td>
</tr>
<tr>
<td>Female</td>
<td>12</td>
<td>35.7</td>
<td>21.3172</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>37.5</td>
<td>17.6644</td>
</tr>
</tbody>
</table>

Table 5
Scores by Gender, Removing Outlier

<table>
<thead>
<tr>
<th>Gender</th>
<th>N</th>
<th>Mean Score (P%)</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>12</td>
<td>39.4</td>
<td>13.8024</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>38.7</td>
<td>19.3963</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>39.1</td>
<td>16.3209</td>
</tr>
</tbody>
</table>

had an “abnormal” score, which greatly affected the variance within the group “Female.” In table 4, it is clearly visible that the standard deviation (SD) for females was almost twice that of males. To aid comparison of gender, I eliminated the outlier score.

Analysis of profession. Although the numerical scores for the professions differed considerably, the differences in means among the professions as far as P% was concerned are not statistically significant. Table 1 shows the means of P% for the various professions.

Table 2 shows the means of P% of professions when the group “Clergy” was collapsed into the group “Other” (see discussion in section above). A one-way ANOVA (analysis of variance) resulted in an F-value of 1.59 (with 3 and 20 d.f. p-value = .223). The small sizes of the samples of the various professional groups probably is the main reason these mean differences are not statistically significant.

A one-way ANOVA conducted on the data shown in table 3 (analysis of data without the group “Clergy”) produces similar results. Therefore, there is no statistically significant difference among the professions as far as P% is concerned.

Analysis of gender. The results are not statistically significant. I tabulated scores by gender both with the “abnormal” score described above (see table 4) and without it (see table 5). The results are not statistically significant. There are differences in variance in both the “Male” group and the “Female” group, and they are quite large. This suggests that the groups overlap as far as P% is concerned, reducing the chance that small differences in mean are significant.

DISCUSSION

The major finding of this study is that the scores for moral reasoning of members of hospital ethics committees on the DIT are somewhat higher than that of the general adult population on the DIT (hospital ethics committee members, P% = 45.6, versus scores of the general adult population, P% = 40.0).

The conclusion changes when the hospital with the lowest score is dropped from consid-
eration (as discussed below). Without this score, the DIT scores of members of hospital ethics committees is better than the DIT scores of the general population (45.7 versus 40.0).

The moral reasoning scores of hospital ethics committees fare even worse when compared to the mean scores of the medical professions at-large. When the mean scores of the professions on the hospital ethics committees are examined, they, too, are worse than that of professions at-large.

Hospital #1 deserves comment, as it is an anomaly. A DIT score in the 20s is typical of junior high school students. At least two explanations are possible: (1) Hospital #1 is a military hospital, where following orders is prized more than independent judgment, and (2) the mean age of committee members at Hospital #1 was considerably younger than the mean age of members at the other hospitals in the study: 37 years versus 46.8 years.

The first explanation may be more likely. The military mind-set may mimic that found in religious orders. There is a consistent inverse relationship between DIT scores and religious beliefs. Reliance upon an external authority, as found in some religious traditions in which adherents abandon independent thinking in order to conform to tradition and/or religious authority, is correlated with lower than expected P% scores. I suggest that the same factor of relying upon external authority is often found in military settings, and may thereby inhibit moral reasoning at a high level. Since Hospital #1 is the only military hospital in this study, any conclusions must be extremely tentative.

CONCLUSION

This study is limited by the small number of responses. Further, the sample was not random, and the administration of the instrument was not under the supervision of the investigator. Other limitations include a lack of data regarding (1) whether the committees included professional ethicists and (2) whether committee members received training in ethics. Therefore, this must be viewed as a pilot study. Nevertheless, it indicates areas worth further study.

The strength of the study is its suggestion that the moral reasoning of members of hospital ethics committees may be no better than that of the general adult population, and that it may, in fact, be worse than the moral reasoning of other physicians, social workers, and nurses at-large. This bears further investigation and may indicate the need for additional education to improve levels of moral reasoning among members of hospital ethics committees.

It cannot be assumed that members of committees are any better at moral reasoning than the average person. If committee members are in fact not better at moral reasoning than the average person, hospitals must address this, as this undermines the efficacy of such committees to negotiate the difficult terrain between clinical care and ethical issues on the one side, and health care workers, the hospital as an institution, and patients and families on the other. The power of an ethics committee rests upon its implied ability to reach good ethical decisions. If this is not the case, committees cannot perform their assigned tasks.

In the future, investigators may want to do pre-test, post-test observations to see the impact, if any, of serving on an ethics committee.

The “abnormal” score of the one military hospital points to the need to further understand whether this was an anomaly or whether this hospital is typical of military hospitals in general. If it is the latter, then the impact of the military on the development of moral reasoning requires further examination. A concern for poor levels of moral reasoning is particularly relevant in settings such as hospital ethics committees, where good reasoning is a requisite for making good ethical decisions.

A further avenue of investigation would be to determine whether ethics education programs affect the DIT scores of committee members.

ACKNOWLEDGMENT

The author wishes to thank Ivo Antoniazzi, PhD, for his assistance with the data analysis.

NOTES

14. Rest et al., see note 12 above.
15. Ibid.
16. Ibid.
19. See note 12 above.