Scientific Contribution

Gender in medical ethics: Re-examining the conceptual basis of empirical research

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Abstract:

Conducting empirical research on gender in medical ethics is a challenge from a theoretical as well as a practical point of view. It still has to be clarified how gender aspects can be integrated without sustaining gender stereotypes. The developmental psychologist Carol Gilligan was among the first to question ethics from a gendered point of view. The notion of care introduced by her challenged conventional developmental psychology as well as moral philosophy. Gilligan was criticised, however, because her concept of 'two different voices' may reinforce gender stereotypes. Moreover, although Gilligan stressed relatedness, this is not reflected in her own empirical approach, which still focuses on individual moral reflection. Concepts from social psychology can help overcome both problems. Social categories like gender shape moral identity and moral decisions. If morality is understood as being lived through actions of persons in social relationships, gender becomes a helpful category of moral analysis. Our findings will provide a conceptual basis for the question how empirical research in medical ethics can successfully embrace a gendered perspective.

Key words: empirical research – ethic of care – gender – Gilligan, Carol – moral philosophy – social psychology
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I. Introduction

Cultural studies have drawn attention to the fact that gender is an important factor in the explanation of cognitive and social behaviour. Today, gender studies, too, form an indispensable part of the social and literary sciences. Mainstream philosophy, ethics, and, in particular, medical ethics, however, apparently pass over this development in silence. The great majority of moral philosophers believe that ethics consists of a set of universalisable rules or principles independent of time and space and other conditional factors. According to this view, a gendered perspective, in fact, would limit the quality of moral reasoning. However, the empirical relevance of gender for the moral orientation of human beings should not be dismissed so easily. On the contrary, the implications of gender for ethical theory and related empirical research do merit intense discussion.

The established ethical discourses aim at universality and thus gender neutrality, which makes it hard to focus on gender differences in moral argumentation. However, a number of – mainly feminist – philosophers and ethicists have shown how the hidden category of gender can be made apparent in moral thinking, either in criticising implicit conceptions of 'normal' moral judgements or in contextualising moral arguments and thereby questioning their gender neutrality and universality. It should come as no surprise that moral philosophy, too, is not just simply pure theory but a cultural technique that is tacitly shaped by cultural distinctions of class, race and
gender. The ethics of care, in particular, was welcomed as an opportunity to make women's voices heard in moral theory. But the problem is that care ethics is very much in danger to enforce rather than to question gender stereotypes. This is particularly true for medical ethics where care is often identified with nursing and therefore with lower-status work predominantly performed by women.

Nevertheless, care ethics still provides us with the most promising concept for empirical research on gender in moral argumentation. First of all, it already encompasses empirical findings from developmental and social psychology. And, secondly, it offers a philosophical concept that pays attention to the moral agent, not just to arguments and decisions. In empirical research, the persons deciding and acting morally, their relationships and social identities are of interest, not just impersonal ideas or principles. However, still unresolved is the question how to supersede the common individualistic conception of ethics by one which takes into account social relations. Moreover, it is unclear whether such an approach can make reference to gender without enforcing gender differences. An interdisciplinary approach from moral philosophy, social psychology as well as feminist theory is necessary to answer these questions.

For this purpose, we will first analyse how the notion of care introduced by Carol Gilligan challenged conventional developmental psychology as well as moral philosophy, while at the same time running the risk to enforce essentialist gender differences. We will then demonstrate how theories in social psychology can help avoid the pitfalls of gender stereotypes. Our findings will provide a conceptual basis for the question how empirical research in medical ethics can successfully embrace a gendered perspective.
II. Theories of moral development

1. Empirical research in morality: Lawrence Kohlberg

The empirical research on cognitive moral development by Lawrence Kohlberg in the tradition of Erik H. Erikson and Jean Piaget is well known as one of the most extensive research programs on morality. Kohlberg's theory of cognitive moral development had an enormous impact on moral philosophy. It was adopted by Jürgen Habermas (1990, 1989/90) and Karl-Otto Apel (1988) in their discourse ethics – one of the famous theories in current continental practical philosophy (Wren et al. 1990, see also Benhabib 1992). It was, for example, also used in research on the moral development of medical students (Self et al. 1993).

Lawrence Kohlberg concluded from his empirical research with boys and young men that moral development is divided into stages. At the last and most superior stage, persons are able to embrace a personally detached, universalisable position of justice and equity. Kohlberg's stage theory is descriptive because it aims to provide facts about the moral development of individuals. At the same time his approach is also normative insofar as the higher stages, which represent the principle of justice, are supposed to be superior to the lower ones.¹

Kohlberg's approach, however, was criticised from a gender perspective. As Carol Gilligan, one of his colleagues, showed, Kohlberg had developed his theory on the moral intuitions of boys and had perceived girls' moral judgements as deviant from the 'normal' male point of view. The alternative care approach worked out by Carol Gilligan took into account that men and women may endorse different types of morality. But whereas Gilligan's theory profoundly challenged traditional perceptions
of ethics in philosophy as well as psychology, medical ethics did not yet thoroughly profit from her insights.

### 2. A gender perspective on morality: Carol Gilligan

Carol Gilligan criticised Lawrence Kohlberg's theory of moral development from a gendered point of view (Gilligan 1982, 1987). Kohlberg had conducted his basic interviews solely with males and had taken his interview material as an empirical basis for a generalised model of moral development in children and adolescents (Colby and Kohlberg 1984, Kohlberg 1981, 243-293). In later studies Kohlberg had interviewed girls and women as well. But he interpreted their answers to moral dilemmas as – according to his model – a lower stage of moral consciousness. That women should have a lower level of moral maturity was one of Gilligan's major criticisms and her main motive to conduct alternative research on the moral development of girls and young women (Gilligan et al. 1988, v). She also reinterpreted the empirical data collected by Kohlberg and his team. Gilligan found that a considerable number of girls and young women expressed their moral perspective 'in a different voice' than the one known by (principle oriented) philosophical ethics as well as developmental theory. Gilligan called this 'different voice' an 'ethic of care' which she contrasted with Kohlberg's approach and his notion of justice.

Kohlberg's notion of justice relies on the ethical thinking of Immanuel Kant (1997, 1998) and John Rawls (1971). The justice perspective is characterised by arguments referring to individual rights, general rules and obligations. In particular, Kohlberg focuses on the question how individuals justify the decision between two well-founded
normative principles, for example respect for human life as opposed to respect for ownership (see Döbert and Juranek 2000, 234). Principle-based ethics has traditionally been one of the predominant philosophical approaches in medical ethics (Beauchamp and Childress first ed. 1979).

In contrast to the justice perspective, the care perspective developed by Gilligan makes reference to relationship, communication and personal responsibilities. Morality as understood from a care perspective is no longer limited to the application and justification of principles or restricted to pondering individual rights and duties. Rather it acknowledges the complexity of moral conflicts. A care perspective takes into account that some conflicts cannot be completely resolved – which, indeed, Kohlberg assumed – and that it is often necessary to live with imperfect solutions. Sometimes, there may even be no acceptable solution at all (Maihofer 2000).

Gilligan did not only explore the care perspective as an alternative approach in ethics. She also tried to show that women or girls predominantly embrace a care perspective when confronted with moral conflicts. She found that men or boys, on the other hand, tend to argue from a perspective of justice, as described by Kohlberg.

3. The care versus justice debate in medical ethics

work in moral psychology and her 'ethic of care' met with an interested, albeit controversial reception (e.g. Fry 1989, Krol and Sevenhuijsen 1992, Sevenhuijsen 1998, Tronto 1993, Manschot and Verkerk 1994, Allmark 1995, 1996, Bradshaw 1996, Gordon 1996, van Hooft 1996). Its central tenet – that there is a different way of viewing and resolving moral conflicts than the dominant one and that women employ it more frequently than men and nurses more frequently than doctors – has provided an important perspective on gender in medical and nursing ethics.

The 'care perspective', which differs from the 'justice perspective' in its emphasis on the situational context, the particular other, and the preservation of relationships rather than on general rules, a generalised other, and conflicting rights, has been criticised on several grounds. For one, Gilligan's empirical research as well as her interpretation of the data basis has been questioned. A strong criticism contests her assumption that the care perspective is embraced primarily by women and girls because such a claim tends to reinforce conservative notions of gender.

Critical voices also pointed to the dangers of a polarisation between justice and care that might lead to an inappropriate either-or-thinking (Nelson 1992, Biller-Andorno 2001). Others warned against the construction of an ethics 'for women only' and argued for a 'de-moralisation' of gender, meaning that moral arguments should be discussed independently from possible empirical correlation with one gender or another (Tronto 1987, Friedman 1995). Still others questioned the theoretical status of the "ethics of care", perceiving it as an "invitation to do theory" (Little 1998, 204) rather than a complete theory in and of itself (Loewy 1995). It was also been questioned whether women and men can indeed be distinguished by their moral perceptions (Nicholson 1983). Gertrud Nunner-Winkler (1984), for example,
suggested that, instead, both women and men perceive and deal with moral conflicts similarly when they are personally affected.

Because of these criticisms, it is still unclear how to integrate the ethics of care into a comprehensive theory of medical ethics. Furthermore it has to be clarified how empirical research in medical ethics can integrate gender aspects without sustaining gender stereotypes.

III. Morality as individual decision versus morality as social cognition and interpersonal action

Some of the above-mentioned problems of an ethics of care, however, can be solved when morality is no longer perceived as independent from social relationships. Traditionally, ethics – and empirical research on morality – focuses on individual decision making. For a long time, cognitive psychological empirical research on morality, deontological ethics\(^2\), and medical ethics, too, has tended to see morality as something inherent to an individual. They have interpreted morality as a capacity which allows an individual to arrive at moral judgements along a set of rules or principles and to justify these principles.

To some extent, Gilligan holds a different view. She envisions moral judgement as embedded in particular ways of life and tries to inscribe the interdependency of human beings into the concept of morality. Moreover, she interprets the genesis of moral conflicts as well as the way to cope with ethical dilemmas as questions of how people establish social connections and initiate teamwork (Conradi 2001, 2002). Nevertheless, Gilligan locates these processes predominantly at the level of con-
sciousness and sees them as a particular type of reflection. She describes care
morality as "ways of viewing the world" (Gilligan 1988, 8) and portrays it as a form of
perception, like "seeing a world comprised of relationships rather than of people stand-
ing alone, a world that coheres through human connection" (Gilligan 1982, 29).

The fact that Gilligan stresses relatedness but locates it predominantly at the level of
consciousness increases a methodological problem: Gilligan does not reflect
relatedness methodologically. She still focuses on the decision of an individual. Mo-
rality is conceived as an argumentation about whether this or that option might be the
'right' solution to a specific dilemma. This argumentation focuses on the foundation
and clarification of the validity of ethical principles. Her research – as most of the em-
pirical research about morality – is based on questionnaires and interviews,
confronting individual participants with moral dilemmas, asking them to decide and
give arguments for their decision. Although Gilligan focuses on relationship and
communication instead of individual rights and obligations, this method nevertheless
leads to an individualistic and cognitivistic 'purification' of morality and forces
participants into a reflective relationship to their everyday practice (Bergmann and
Luckmann 1999, 17).

In order to improve Gilligan's thesis about relationship and communication in morality
on the methodological level, it is necessary to focus on social groups and interpersonal
action. These elements are addressed by two theoretical approaches dealing with the
dynamic notion of the socially constructed self. Both are social psychological per-
spectives on the social basis of the self but they differ in their disciplinary roots: The
social identity approach, namely the social identity theory (SIT) by Tajfel (1978) and
the self-categorisation theory by Turner and Oakes (Turner 1982; Turner and Oakes
sociocognitive processes of ingroup-outgroup categorisation and individual self-enhancement by comparisons favouring the ingroup. The other perspective – identity theory (Burke 1980, McCall and Simmons 1978, Stryker 1968, Turner 1978) – stems from the sociological branch of social psychology and is rooted in symbolic interactionism (Mead 1934, Blumer 1969). Identity theory (IT) sets out to explain individual behaviour as mediated by role identities (Hogg, Terry and White 1995, 266). Both perspectives look at the same problem from different angles. From the perspective of SIT/SCT, an individual shapes his or her moral behaviour according to the optimal distinction between ingroup and outgroup. From the perspective of IT, an individual shapes his or her moral behaviour according to role expectations within a network of interpersonal relations.

With the help of social psychological theories as SIT/SCT and IT, it is possible to operationalize the idea of the social construction of morality within a specific situational context. These approaches allow for specifying conditions under which individual moral attitudes or decisions are influenced by the actual social context. These conditions refer to characteristics of the social situation rendering salient the membership or the role of an individual within certain groups or social categories, e.g. gender.

1. Social identity approach

The social identity approach focuses on the group-membership of an individual. In this theory, a group exists when "two or more individuals who share a common identification or, which is more or less the same thing, perceive themselves to be members of
the same social category" (Turner 1982, 15). That means that physicians act differently depending on the social category that becomes particularly relevant for them in the specific situation.

Human beings tend to categorise themselves and others in distinguishable social categories (e.g. gender or profession). This social categorisation can be understood as a sociocognitive process that provides a self-definition for the individual as part of his or her self concept. This self concept is a combination of a personal and a social identity. The personal identity represents the uniqueness of an individual. The social identity is conceptualised as an aspect of the self concept based on a person's group memberships. According to these theories people strive to form a positive social identity. If possible, they choose a self-categorisation that is more favourable for their social identity and that elevates their self-esteem. Such a self-enhancement can be achieved in groups by making social comparisons between the ingroup and relevant outgroups in ways that favour the ingroup, maximise the intercategory differences and minimise the intracategory differences (meta-contrast principle). With salient social identity, an individual acts in an intergroup context (Turner and Oakes 1989, Turner 1999) and his or her behaviour is orientated to group norms, stereotypes etc. of the salient category. For example, people tend to perceive themselves and others more in terms of their nationality when interacting with foreigners than when interacting with compatriots (Bochner and Perks 1971).

From the point of view of SIT and SCT, gender identities as part of the multifaceted social identity are categories with a high dynamic fluctuation in content and over time mediating sociocognitively between individual behaviour and social structure. The responsiveness of social identity to immediate contextual factors is a central feature of
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this dynamic construct. The salience of gender and the resulting intergroup behavior
form the basis for expressing gender.

2. Identity theory

The social identity approach focuses on intergroup differentiation and elaborates the
operation of this categorisation process as the cognitive basis of an individual's group
behaviour (Hogg et al. 1995, 260). These groups have to be seen as evolved and
structured by social systems. SIT and SCT do not fully address intragroup
differentiation, they pay for example not attention to roles (Hogg 1996, 235). The
demand for a more differentiated view of the internal structure of groups that exceeds
the distinction between personal and social identity is carried out by identity theory
(Stryker 1985). Additionally to the situationally fluid, intergroup aspect of social
identity within SIT and SCT, identity theory stresses the continual and interpersonal
side of social identity. Identities are "internalized positional designations existing inso-
far as persons participate in structured role relationships" and persons own "as many
identities as they have different sets of structured relationships with others" (Stryker
1985, 345). Identity theory conceptualises the self as a hierarchical ordering of
identities. These identities are sets of role expectations that are organised in a
hierarchy of salience defined by the probability of invoking an identity in a given
situation or across situations. The relationship between identity salience and role
behaviour is reciprocal. The more salient an identity, the more likely is the opportunity
to be used to perform behaviours associated with the role on which the identity is
based. The identity salience is a consequence of the commitment, defined as the de-
gree to which a relationship with particular others depends on acting according to a specific social role. In this way commitment reflects the relevance of society for interaction (Stryker 1985).

3. Social identity approach, identity theory, and gender

Both the social identity approach and identity theory view a person's behaviour (cognition, emotion, motivation, perception) as influenced by his or her short-term reaction to specific situational factors. A problem of the social identity approach is that it conceives of social categories as relatively homogeneous and monolithic entities. It does not consider differences in interpersonal interaction within groups. Identity theory overcomes this deficit, but is rarely used for empirical research.

Moskowitz, Suh and Desaulniers (1994), for example, explored role-based variations in agentic (i.e. frequently dominant, infrequently submissive) and communal (i.e. cooperative, solidly united, frequently agreeable) behaviour. They found that both men and women were more submissive in the role of supervisees and more dominant in supervisory roles. In a leader position, women acted in an agentic way, but combined their behaviour with a communal manner according to their expected social role as a woman. Thus, the degree of dominant and submissive behaviour was dependent on current interactions and actual social roles.

Identity theory thus helps to envision these interactions and actual social situations. For empirical research, it is important to deal with gender not as "a single membership category but rather a set of categories" (Deaux and Lafrance 1998, 798). Gender is part of other social identities because of its ubiquity in social relations. As master category,
it evokes a multiplicity of gendered identities. Identity theory offers an opportunity to describe and analyze these identities in moral argumentation.

It is, however, important to notice that women and men do not morally argue differently because of their sex. On the contrary, they activate, produce and construct gender depending on situational factors like the composition of the group, the distribution of roles and status or gender belief systems that are lively within the specific group situation (Deaux and Major 1987). Future research in medical ethics will have to consider the intragroup as well as the intergroup differentiation. This can be achieved through a combination of IT and SIT/SCT. To examine whether physicians or nurses tend to offer care or justice perspectives according to their professional or gendered identities, one could ask them to discuss ethical dilemmas in different groups (heterogenously/homogenously structured). The diversity of gender-related identities could then be analysed by exploring intergroup or ingroup differentiation of behaviour. Regarding differences within a group, one could examine how group members attribute gender-related characteristics to themselves and whether they define them as 'male' or 'female'.

IV. Conclusions

The relevance of gender on the level of moral theory is controversial, as reflected in the philosophical debate on universalism. However, on the level of moral psychology it has been shown that gender might be an important category for describing common morality. Gilligan's 'ethic of care' with its focus on relationships and contextual details might help to give a more comprehensive description of common morality. As such it provides important incentives for moral theory to search for possible conceptual
imbalances or blind spots. Medical ethics and nursing ethics, too, can profit from the care-justice debate: If there are different – possibly gender related – modes of moral argumentation, are they adequately represented in the medical ethics literature as well as in the teaching and practice of medicine?

There is, however, a concern that the concept of 'two different voices' may reinforce gender stereotypes. Secondly, although Gilligan stresses relatedness, this is not reflected in her empirical approach, which still focuses on individual moral reflection. As we have shown in the paper, social psychology can help overcome both problems. Only if morality is detached from its roots in every-day life, it appears to be a purely cognitive phenomenon. However, if morality is understood as being lived through actions of persons in social relationships, gender becomes an important category of moral analysis. Identity theories help to understand how gender shapes moral identity and moral decisions.

An empirical approach towards common medical morality would thus profit from a combination of a gendered perspective and sensitivity to social relationships. This way, the pitfalls of repeating gender stereotypes can be avoided without glossing over important differences in moral argumentation. For health care ethics in particular it is of crucial relevance to have a good understanding of different modes of moral perception and judgment as well as of the role of relationships and social processes.

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1 Gilligan's as well as Kohlberg's theoretical approach was based on empirical research but made claims for moral theory as such. The problem of the normativity of facts is not explored in detail in this paper. For a more thorough discussion see Lawrence Kohlberg: 'From *is* to *ought*: how to commit the naturalistic falacy and get away with it in the study of moral development'. In: Kohlberg 1981, pp. 101-189.

2 "Deontological ethics" means an approach which is built around principles, duties and rules. Its most famous representative is Immanuel Kant.

3 Characteristics as for example developed in the sex-role inventory designed by Sandra Bem 1974, German adaptation by Schneider-Düker and Kohler 1988.