ETHICAL IDEOLOGY: AN INQUIRY INTO FACTORS AFFECTING THE ETHICAL POSITION OF SELECTED FUTURE HEALTH ADMINISTRATORS AND PRACTITIONERS

by

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(ABSTRACT)

Members of the health professions are being faced with a wide range of ethical dilemmas, the resolution of which will often be influenced by the ethical ideology of individuals in various health fields.

The purpose of this study was to measure the ethical position of junior and senior students in several health disciplines to determine if such factors as discipline, sex, ethnic membership, religious conviction, and locus of control were predictors of their ethical ideology.

Two hundred sixty-seven junior and senior students enrolled in allied health, nursing, and medicine programs at two universities completed questionnaire's used in the study. One university was predominantly black and the other was predominantly white. Subjects were administered the Ethics Position Questionnaire and Rotter I-E Locus of Control Scale. Subjects also completed a personal data sheet.

The results indicated that there was a significant difference in ethical ideology among health profession students as a function of type of health profession. Medical students tended to be subjectivist, nursing students, exceptionist; while allied health students were either situationist or absolutist. There were some evidence in the literature to support the results obtained for medical and nursing students. In addition, the literature would suggest that members of the same profession tend to share common values.

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"O Give Thanks Unto the Lord..."
Psalms 105; 1

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; ;

; ; ; and,

DEDICATION

This dissertation is dedicated to my family: my parents, for their love and support; my husband, , for his encouragement; my children, ., , and ; and, especially my grandchildren, , ., , , and in hopes it will encourage them to inspire to their greatest heights.

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TO..........All the Faculty, Administrators and Students who participated in this study, and

TO..........A group of Health Care Professionals who share in my recognition of the possibilities:

POSSIBILITIES**

THE MORE FAITH YOU HAVE,
THE MORE YOU BELIEVE,
THE MORE GOALS YOU SET
THE MORE YOU'LL ACHIEVE.
PICK A MOUNTAIN TO CLIMB,
DARE TO THINK BIG
BUT GIVE YOURSELF TIME.
REMEMBER, NO MATTER HOW
FUTILE THINGS SEEM,
WITH FAITH THERE IS
NO IMPOSSIBLE DREAM!

**Alice Joyce Davidson

*Posthumously

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CHAPTER I

Introduction

The past few decades have witnessed an increasing focus on and concerns about the ethical problems faced by health professionals and administrators. Many of thee issues are not new. What is new is the present scope and complexity of these issues. There are two major reasons for this: first, there is the development of highly sophisticated biomedical technology; and second, there is the growing complexity of the institutional setting in which medical and other health professions are practiced (Childress, 1981; Veatch, 1980, 1972; Ramsey, 1978; Pellegrino, 1969). Biomedical research has created new ethical problems and has provided a different perspective to the way in which the older ethical problems are approached. Mappes and Zembaty (1986) have made the following observations concerning this influence:

> Some developments, for example, those associated with in vitro fertilization and cloning, seems to present us with ethical problems that are genuinely unprecedented. More commonly, however, the advance of biomedical research has simply added complexity to old problems and created a sense of urgency with regard to their solution. Euthansia is not a new problem, but our ability to save the lives of severely defective newborns who would have died in the past, and our ability to sustain the biological process of irreversibly comatose individuals have added new dimensions and surely, a new urgency. . . . (p. 3).

With respect to the latter, Clouser (1976) has asked the following questions: "Is abortion the killing of the fetus or simply terminating an unwanted pregnancy?" "Is not treating a patient the same as killing?" "What rights do the fetus, the severely retarded, the terminally ill, or the senile have?" "What type of efforts should be applied to sustain life?" (p. 45).

The growing complexity of the institutional setting of health care also poses new and sometimes unprecedented problems for the health care professional. In the past, the health care system was a much more simplified process generally involving only the patient and his physician. Current health care systems are increasingly specialized. Patient care and treatment is often carried out by a team composed of physicians and other health professionals. These various groups often use very diverse methods to arrive at solutions for the patient. Because of the advances in biomedical technology and the complexities of the institutional settings, decisions arrived at by health professionals have come under greater scrutiny. In many instances, the health professions have received strong criticisms for practices which have been termed inhumane or ethically wrong. The Tuskegee syphillis experiment, and, more recently, the case of Baby Fae (1986) are some examples of those decisions that received adverse publicity.

Because of these concerns and the controversies surrounding some of the decisions made by health care professionals, there has been a growing interest in the need to examine the value systems of health professionals, the process by which judgments related to giving health care are arrived at, and the ways in which the value system of a health care professional may impact on his or her ethical decisions. Allen and Fowler (1986) concluded that it is essential to examine "the process as well as the context of bioethical decision-making by students and practitioners" (p. 19).

Background

The process by which individuals arrive at decisions are often complex and no models describing this process exists in the health professions literature. A review of selected literature on the decision making process, however, reveals that the way in which people arrive at a decision is dependent on many factors. Further, the literature appears to suggest that the predominance of a particular factor is often dependent on the situational context (Guillen, 1983; Frankena, 1973; Carlton, 1978; Janis & Mann, 1977; Midgely, 1981). Among the various factors cited in the literature which appear to affect an individual's decision making process are the value system of the individual and the antecedents of the process as well as the demographic and personality characteristics of the individual.

Research on moral and ethical issues would suggest that individuals differ significantly in ethical ideologies, and that such variances may be influenced by certain other salient characteristics of the individual (Sharp, 1898; Schlenker & Forsyth, 1977). Significant factors held to be responsible for variances observed in ethical stance include the stage of one's moral development, sex, religion, and locus of control.

Piaget (1965) and Kohlberg (1969) have suggested that people arrive at moral judgments in very dissimilar ways, and that such judgments are dependent on the developmental stage of the individual. Consequently, variations in moral judgments can be attributed to variation in levels of cognitive and moral development. Rest (1973) observed that there is a positive correlation between moral judgment and decision making. He has identified at least seven different variables which appear to intervene between an individual's moral judgment and actual decision. These variables include ego, situation, ethical orientation and steps of moral development. Voloshen (1980) has observed significant relationship between locus of control, sex, and moral judgment maturity.

Schlenker and Forsyth (1977) suggest that individual differences must be taken into account when examining moral judgment. They hypothesize that individuals have different ethical systems and make moral decisions based on their

system. They propose two basic factors underlying individual variations in ethical systems:

1. The extent to which individuals favor relative over absolute values. These individuals are at two extremes on a continuum. Some believe that no moral or universal rules can be relied on when making moral judgments. At the other end of the continuum are those individuals who believe that in some situations one can make use of moral rules.
2. The extent to which individuals favor idealism when making moral judgments. At one end of the idealism continuum are those who believe that good consequences can always be achieved if the actions are right or moral. At the other end are those who allow for both good and bad consequences from an action (p. 175-176).

They developed a questionnaire to measure individual ethical ideology and to test their hypothesis. The questionnaire consisted of 68 items designed to measure the extent to which individuals agreed or disagreed to the first 50 items based on a nine-point Likert-like scale. The authors claimed that many of the items were selected to "tap the major dimensions of ethical concern discussed by adherents to the three moral philosophies" they had previously discussed (p. 382); deontology, teleology, and skepticism. The authors conducted two experiments to

determine the degree to which "judgments of the ethicality of psychological research are affected by the consequences of the research and judges ethical ideology" (p. 369). Subjects judged experiments that investigated obedience to authority, and also were administered the Ethics Position Questionnaire. Factor Analysis were used to group items in the questionnaire into two categories. Two major factors emerged: Idealism-Pragmatism, and Rule-Universality. Each subject's average scores on the items that loaded heavily on each factor were then computed. A four-way classification table was then created by crossing the two factors.

Their model consists of two major dimensions, which are: (1) relativism, and (2) idealism. Each of these dimensions can be divided into high and low groups to yield four typologies: Situationists, Subjectivists, Absolutists, and Exceptionists. Figure 1 presents a taxonomy developed by Schlenker and Forsyth.

Forsyth (1980) used this model (Figure 1) to develop an instrument for measuring ethical ideology; labeled the Ethics Position Questionnaire (EPQ). He developed an instrument which was based partly on the initial questionnaire used by him and Schlenker (1977) to assess individual variations in ethical positions. Originally the instrument consisted of 55 items. The items were reworded so that they were not specific to psychological research as was the case with the initial Schlenker and Forsyth Questionnaire. In addition,

	Relativism	
Idealism	High	Low
High	Situationists Rejects moral rules; advocates individualistic analysis of each act in each situation; relativistic.	Absolutists Assumes that the best possible outcome can always be achieved by following univeral moral rules.
Low	Subjectivists Appraisals based on personal values and perspective rather than universal moral principles; relativistic.	Exceptionists Moral absolutes guide judgments open to exceptions to these standards; utilitarian.

Figure 1. Taxonomy of Ethical Ideologies*

*A brief description of the characteristics of individuals within each category; developed by Forsyth (1980).

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he included items extracted from the works of major philosophers of ethics.

Using the EPQ, Forsyth was able to empirically classify individuals along the two basic dimensions and further subdivide them into the four ethical typologies identified in the original study (Schlenker & Forsyth, 1977). In discussing the relationship of the four typologies to the major ethical theories, Forsyth described them as follows:

1. Situationism. The situationist believes that "people should make certain that their actions never intentionally harm another even to a small degree," but that "no ethical principles are so important that they should be a part of any code of ethics."

He observes that situationism "corresponds to skeptical philosophies such as situation ethics since this moral philosophy argues that morality should focus on a "contextual appropriateness" which is determined by the fit between the act and the circumstance."

2. Subjectivism. The subjectivist is skeptical of moral principle. Their stance corresponds to moral philosophies like ethical egosim. He states that "subjectivists agree with such statements as questions of what is ethical for everyone can never be resolved since what is moral or unmoral is up the individual" but they disagree with items like "if an action could harm an innocent other, then it should not be done."

3. Exceptionism. The exceptionist relies on moral absolutes when formulating judgments, but does not insist that all negative consequences be avoided. Forsyth states "this stance is consistent with a teleological moral philosophy." Such a viewpoint holds that the ultimate judgment of the morality of an action or set of actions depends upon the consequences that follow it.

4. Absolutism. The absolutist believes that the best possible outcome can be achieved if the moral rules regulating behavior are always followed. Forsyth (1980) states that, "in many respects, this ethical ideology is congruent with a system of ethics known as deontology" (pp. 175-176).

Several studies have been conducted using the EPQ (Forsyth, 1978, 1980, 1981a; Forsyth & Berger, 1982; Forsyth & Pope, 1984). However, only two of these investigated the relationship between ethical ideology and moral judgment (Schlenker & Forsyth, 1977; Forsyth, 1978). Further, while these studies used diverse populations ranging from high school to college students, only one focused on a particular profession (psychology). None have attempted to investigate the ethical ideology of health professionals or health professional students.

Forsyth (1980), in a study to measure the extent to which individuals adopt one of four ethical ideologies, concluded that there was a need for more research with the

EPQ to determine the ways in which differences in ethical ideology are related to the characteristics of different groups and the process by which ethical decisions are made.

One definition of group membership would include such factors as shared values, mores and codes of conduct. Given this definition, members of a particular health profession can be assigned to a group, sharing all the properties enumerated in the definition given. This assumption is supported by the fact that each health field has its own code of professional ethics. While there is a great deal of similarity among the codes of the various health professions, there are enough differences to render each code distinctive.

Statement of the Problem

The research on moral and ethical issues suggests that individuals differ in ethical ideologies and that such variances may be influenced by certain other characteristics such as age, group membership, level of education, religious beliefs, race, and locus of control (Forsyth, 1980; Rest, 1976; Kohlberg, 1976; Erikson, 1968; Gilligan, 1982; Connery, 1977; Gustafson, 1978). Consequently, once individuals have been classified along the dimensions suggested by Forsyth and Schlenker, it may be possible to account for differences in ethical ideology.

The following research questions were, therefore, examined in the study:

1. Can health care professionals be classified into the four ethical types identified by Schlenker and Forsyth using the EPQ?
2. Are there differences in ethical ideology among selected health professions groups?
3. To what degree do the factors of sex, race, health profession field, religious preference, and locus of control predict the ideological system of the individuals in the selected health profession?

Purpose and Objectives

The purpose of this study was to determine if: (1) student health professionals in Allied Health, Nursing, and Medicine can be classified according to the four typologies developed by Forsyth, and (2) whether a relationship exists between selected characteristics and ethical ideology.

Specific Objectives. The specific objectives are as follows:

1. To determine the extent to which selected health professional groups (Allied Health, Nursing, and Medicine) differ in ethical ideology.
2. To determine if one or more of the following characteristics are associated with ethical

ideology: sex, race, health profession, level of education, religion, and locus of control.

Based on the objectives of the study, the following research hypotheses are posited:

General Hypotheses

1. There are differences in Ethical Ideology among students enrolled in selected health professions as a function of type of health profession.
2. There is a difference in ethical ideology among students enrolled in selected health professions as a function of race, sex, level of education, religion, exposure to ethics courses, and locus of control.

Definition of Terms

Ethical Ideology refers to the stance an individual takes when making a moral decision or judgment. Four stances are identified by Forsyth: Situationist, Absolutist, Subjectivist, and Exceptionist.

Health Professional Students refer to students currently enrolled in selected health fields: Medicine, Nursing, and Allied Health (i.e. Physical Therapy, Radiation Therapy, Physician Assistant).

Level of Education refers to the year of study in which the student is enrolled. Nursing and Allied Health students

were in the junior or senior year. First year medical students were classified as juniors, and second year medical students were classified as seniors taking into account prior years of undergraduate education.

Religion refers to the individual's religious conviction and was based on responses to the items on the personal data sheet.

Exposure to Ethics Course refers to whether or not the participant took a course in ethics while matriculating in the program.

Locus of Control refers to the extent an individual perceives that internal or external forces are in control of the outcomes of his actions.

Limitations of the Study

The research was limited to a survey of 267 black and white students enrolled in the health professions field of medicine, nursing, and allied health at two universities, one predominantly black, another predominantly white.

Significance

There is a critical need for an understanding and discussion of how individuals in the health professions arrive at decisions or judgments that may impact on the well-being of patients. One factor in such decision-making is the values of the individual. As Uustal (1978) observed, "Everything we do, every decision we make and course of

action we take is based on our consciously or unconsciously held beliefs, attitudes, and values" (p. 11). Bohm (1980) has argued "that national and global crises involve values or the misunderstanding of values." He suggested that often, all things being equal, decisions are based on values or more specifically on an "individual's misunderstanding of his value system which then becomes internalized as opinions or feelings" (p. 405).

If this is so, it would be advantageous if those delivering health services could understand their own and their peers' value systems.

This study is believed to be the first of its kind to attempt to examine differences in ethical ideologies among multidisciplinary health professional students (i.e. medical, nursing, and allied health) using the EPQ instrument.

Summary and Overview of Remaining Chapters

In Chapter 1, a discussion of the following was presented: Introduction, statement of the problem, purpose and objectives of the study, general hypotheses, definition of terms, limitations of the study, and significance of the study. Chapter 2 is a review of relevant literature in the areas under investigation. The methodology is presented in Chapter 3 and includes a discussion of subjects, instruments, null hypotheses, and data analysis. The findings of the

study are presented in Chapter 4. Chapter 5 contains the conclusions, implications for further research, and a summary of the investigation.

CHAPTER II

Review of Literature

Introduction

This study investigated the differences in ethical ideology among students enrolled in selected health professions (Medicine, Nursing, and Allied Health). The independent variables selected for investigation were type of health professions, race, sex, level of education, religious conviction, exposure to ethics courses, and locus of control.

The theoretical and empirical bases for this study are discussed in this chapter. The order of presentation proceeds in the following manner: (1) Cognitive and moral development as well as two contemporary ethical positions which are germane, and (2) studies addressing moral development, moral judgment and their relationship to selected demographic characteristics identified as explanatory variables in the study.

The study's theoretical framework is based on the premise that an understanding of the process by which health care professionals arrive at ethical decisions necessitates a primary investigation of their value system.

Consequently, this study uses as its theoretical base the cognitive developmental theories of moral functioning.

Following Piaget's lead in defining stages in intellectual development, Kohlberg (1969, 1971) proposed that moral reasoning is dependent on certain general criteria which constitutes an individual's understanding of morality, and that these criteria develop with age. Kohlberg also suggested that certain characteristics of the individual, in particular, membership in a group, will impinge on the way in which the individual forms his moral code. Consequently, a degree of consistency in moral reasoning is assumed for individuals with similar characteristics and background.

Moral Development and the Development of Ethical Systems

As early as 1909, Dewey advocated the need to approach the issue of moral development from a cognitive viewpoint. However, it was not until the 1950's that Kohlberg (1951), using the Piagetian concept of stages in intellectual development, defined stages of moral reasoning. He further refined and validated these stages in 1975.

Kohlberg identified three major constructs underlying these steps in moral development:

1. Moral development stages are organized systems of thought.
2. The stages are an invariant sequence in development.

3. The stages are hierarchical, and form an order of increasingly differentiatial and integrated structures (Kohlberg, 1969, pp. 97-99).

Kohlberg defined his moral stages as structures of moral judgment on reasoning. He emphasized that they are different from the content of moral judgment, which he explained is the choice made by an individual when faced with a moral dilemma. The reasoning used to arrive at a moral decision defines the structure of the moral judgment.

Kohlberg (1978) proposed ten distinct moral values on which an individual draws when faced with a moral dilemma. They included (1) punishment, (2) property, (3) roles and concerns for self, (4) roles and concern for authority, (5) law, (6) life, (7) liberty, (8) justice, (9) religious beliefs, and (1) sex of the individual (p. 39). He stated that a moral choice is dependent on selecting between two or more of these moral values. He further observed that underlying any moral judgment is the stage of moral development that the individual has reached.

Kohlberg's theory has been criticized, primarily for the following reasons:

First, he has not been able to support his "claim that the observed developmental sequence is in a strictly ascending order from a moral point of view" (Crittenden, 1975, p. 695). That is to say he gives no evidence to support

that Stage 6 is "any way morally superior to any of the lower stages" (p. 696).

Second, his theory can be classified as a deontological theory. Deontological ethical theory states that it is the intent of the act rather than its consequences which makes it morally right or wrong (Aron, 1980, p. 407). However, an analysis of Kohlberg's definition indicates that his theory encompasses both ethical systems: Deontology and Teleology.

Other cognitive theorists of moral development differ from Kohlberg in that they focus less on the ways in which moral values develop and more on the reasons behind moral judgments. Thus, for example, Scriven (1966) stated:

> There is an objectivity of fact -- not a perfect objectivity of knowledge on which ethics must be built or put away . . . . The objectivity of ethics depends not on any one stage of moral development. Ethics is an objective and as debatable and as emotional a matter as that of identifying the best soccer team in the World Cup before the final. (p. 694)

Similarly, Crittenden (1975) argued that moral beliefs and practices must be based on reason and be justifiable. However, unlike Scriven who had no place for affect, Crittenden (1975) observed that there is a "complex relationship between the affective and the conceptual in moral reasoning and action." He stated that in "certain circumstances other human values may override the importance of moral values in decision making" (p. 696).

Two contemporary ethical positions are also germane to the present study. These are Frankena's Theory of Obligation and Firth's Theory of the Ideal Observer.

Frankena (1973) proposes two principles in this theory: The Principle of Beneficence and the Principle of Justice. According to the former:

1. one ought not to inflict evil or harm
2. one ought to prevent evil or harm
3. One ought to remove evil
4. one ought to do or promote good (Davis & oskar, 1983, p. 35).

Davis and Aroskar observed that the Principle of Benefience is an attempt to "combine utilitarianism and deontology" (p. 36) for 'ought' would suggest that there are certain rules that humans must adhere to while Frankena's insistence on the need to consider consequences, and to promote good is a utilitarian viewpoint.

Frankena (1973) observed that ought no. 4: "To do or promote good" is the ideal; that is, the rule by which health professionals should be guided. This principle underlies most professional codes of the various health care professions; for example, the Code for Nurses and the Hippocratic Oath for doctors. However, he goes on to state that if this course of action is not possible in a given situation, then the health care professional should do what is possible. He concluded that:

> To espouse the Principles of Beneficence is to say not only that we have no obligations except when some improvement or impairment of someone's life is involved but also that we have a prima facie obligation whenever this is involved." (p. 43)

Firth's (1970) Ideal Observer Theory

Firth has focused on the cognitive processes and emphasizes the role of cognition in moral judgment. According to Firth, an individual who is an 'ideal observer' is dispassionate and disinterested when faced with an ethical dilemma. Consequently, he is an impartial judge. Because of this impartiality, equality in treatment is assumed for all. Further, because judgments are made dispassionately and not emotionally, there is a tendency to be consistent. Essentially Firth postulated that the qualities of the ideal observer ensures that any ideal observer would act in the same manner to a given act. The theory, thus, provides criteria for examining ethical dilemmas through ethical reasoning and reflective thinking. It has certain drawbacks, however, not the least being a failure to explain how and where the development of the moral omniscience of the ideal observer will occur.

Related Research on Moral Development, Ethical Ideology and Moral Judgment

Ketefian (1980) examined the relationship between critical thinking, educational preparation and development of moral judgment among selected groups of practicing nurses.

Seventy-nine practicing nurses were subjects. Critical thinking was measured by the Watson-Glaser Critical Thinking Appraisal Test. Rest's Defining Issues Test (DIT) was used to measure moral judgment; educational preparation was obtained from personal information. Pearson Product Moment Correlation was used to test this hypothesis. (The obtained coefficient was significant at the .001 level r = .53.) He also hypothesized that type of educational preparation (professional versus technical) would be related on moral judgment. This hypothesis was supported. The author found a significant difference in moral judgment between the groups, $F(1, 77) = 9.6$, $p < .001$. Multiple regression was used to determine whether critical thinking and educational preparation would predict most variance in moral judgment. The author found that these two variables accounted for almost 33% of the variance observed in moral judgment. The author concluded that the results are consistent with theory and the findings of the few empirical studies on moral development. He deplored the fact that little research had been conducted on the application of moral development theory in the preparation of professionals.

In a related study, Rotter (1982) investigated the relationship between level of moral development, level of education, and decision making of a group of nurses. Two groups of nurses were examined; a sample of graduate and undergraduate university educated nurses. It was

hypothesized that the level of moral development of nurses would have a significant effect on how decisions are made in situations that pose moral dilemmas. Significant differences were found in level of moral development. In addition, a significant difference was found in types of decisions made between the two groups. The findings were similar to those of Ketefian.

In another study, Hansen (1984) investigated the moral reasoning of occupational therapists and its implications for education and professional practice. The purpose of the study was to develop an Occupational Therapy Dilemma Test (OTDT) designed to measure the level of moral reasoning of occupational therapists when faced with practice dilemmas. The major hypotheses advanced was that there would be a positive correlation between the OTDT and Rest's Defining Issues Test. Although the hypothesis was not supported, Hansen listed several implications of the study for further research. Several respondents reported a conflict between their perception of what ought to be done in a dilemma, and the action they would actually take, which appeared contrary to Kohlberg's assertion that an individual's action when faced with a dilemma is related to his/her level of moral development. The author concluded by pointing out the paucity of research in this area as it pertains to health professionals. She recommended the need for further research

to provide data on moral reasoning among occupational therapists.

A similar finding of a dichotomy between "what ought to be" and "what is" was found in a study conducted by Copstead. Copstead (1984) examined the relationship between perceived normative ethical stance, perceived realistic choice and self-esteem among selected groups of registered nurses in Washington State. Three hundred and five registered nurses responded to a questionnaire, which was designed to determine ethical stance and realistic choice in a dilemma. The respondents' level of self-esteem was also measured. The results indicated that there was no significant relationship between ethical stance and such selected background variables as religious practice and course work in ethics. However, a significant relationship was obtained between ethical stance and self-esteem. No such relationship was observed, however, between realistic ethical choices and self-esteem. The author found a statistically significant difference between nurses' perceptions of their ethical values and their perceptions of realistic ethical choices. The author recognized the probability that such a dichotomy could lead to conflict and subsequent attrition from the nursing profession. She recommended the need for further research in this area. On the other hand, Turner (1984) observed no such dichotomy between 'ought' and 'is' in her study of the relationship between moral judgment and moral action among

professional nurses. Subjects were confronted with a simulated nursing dilemma in which they could: (1) do nothing, (2) provide indirect assistance, and (3) provide personal assistance.

Following the simulation, the subjects were administered a questionnaire with open-ended items in which they were asked to indicate why they had acted the way they did during the simulation. They were then administered Kohlberg's Moral Judgment Interview. The author found a significant relationship between levels of moral reasoning and the degree of consistency between what respondents felt they should do (ought) and what they were observed to do (is) during the simulation.

A fairly recent survey by a nursing purchasing company (Informed Communications, Inc.) confirmed the presence of conflicts between nurses' normative ethical stance and realistic choice. Eleven thousand (11,000) nurses were surveyed nationwide. The results indicated that nurses were frustrated by the moral dilemma situations they faced (Nursing Ethics, 1974).

Other variables which have been examined in relationship to moral judgment are sex, religious practice, and locus of control.

Rotter (1966) defined locus of control as follows:

> The degree to which the individual perceives that a reward follows form, or is contingent upon, his own behavior or attributes versus the degree

> to which he feels the reward is controlled by forces outside his own actions. When a reinforcement is perceived by the subject as following some action of his own, but not being entirely contingent upon his action, then in our culture, it is typically perceived as the result of luck, fate, as under the control of powerful others, or as unpredictable because of the great complexity of the forces surrounding him. When the event is interpreted in this way, by an individual, we have labeled this a belief in <u>external control</u>. If the person perceives that the event is contingent upon his own behavior or his own relatively permanent characteristics, we have termed this a belief in <u>internal control</u>. (p. 53)

Research would appear to support the hypothesis that locus of control is related to "conformity to authority," with external types being more ready to conform.

It is, therefore, an important variable to consider when investigating the ethical reasoning of health professionals who may find their moral values in conflict with that of those in higher authority. For example, nurses versus doctors; or doctors versus hospital administrators.

Several studies which investigated the relationship of this variable with moral judgment and decision making were examined.

Jones (1973) conducted a study using middle class teenagers. She tested them, using the written form of the Kohlberg interview and an internality-externality scale. She found that preconventional moral reasoners expressed greater belief in external control than conventional and post-conventional reasoners.

Snyder (1972) correlated the Modified I-E Scale and Rest's Defining Issues Test. Subjects were college students. He hypothesized that principled reasoners would be more internal than pre-conventional subjects. This hypothesis was not supported. Supplemental analysis, however, indicated a trend toward increased internality for principled subjects as compared to the less morally mature subjects (as defined by Kohlberg), but this relationship did not reach a significant level.

Charles Johnson and John Gormly (1972) investigated the relationship between locus of control and resistance to temptation. Fifty grade school boys and girls were classified as cheaters and noncheaters on the basis of their scores on a behavioral test. They were then administered Crandall's Intellectual Achievement Responsibility Scale (IAR). This scale is a measure of locus of control. The results indicated significant differences between cheaters and noncheaters on the IAR. Female students who had been classified as cheaters were more external than their noncheating counterparts. Male pupils had similar results. The magnitude of the difference between cheaters and noncheaters was decidedly less marked than among females.

Midlarski (1971) found that subjects classified as internals were more likely to help another individual than were externals. In this investigation, subjects were placed in a position where they could help a fellow subject (i.e.

fellow subject was confederate of the experimenter) to finish a task of sorting small objects lifted from a grid. As each item was lifted, subjects received a moderate electric shock. The confederate performed more slowly than the subject so that the latter could offer to help after completing his task. The results indicated a positive correlation between helping and Midlarski's shortened form of the Internal-External Scale ($r = .54$, $p < .001$).

The relationship between locus of control and another measure of moral behavior was tested by Miller and Minton (1969). They used the Mach V scale which measured the extent to which an individual agrees with such Machiavellian attitudes as opportunisticm, cynicism, and suspicion of others. A significant correlation was obtained between the Rotter Internal-External scale and Mach V scale. The results indicated that externals tended to agree more readily with Machiavellian positions than did internals.

Bloomberg and Soneson (1976) found that locus of control did not correlate with stage of moral reasoning when viewed alone. However, the interactions of locus of control and field independence-dependence on moral reasoning did yield some significant results. The authors suggested that internal control appears essential in moral reasoning because principled moralists feel a deep commitment to self-chosen values. Such values form the basis for moral decisions apart from an identification with emotionally important persons or

with the social order. The authors suggested that the effect of locus of control may not seem evident in moral reasoning until stage five is reached because the validity of society's definition of right and wrong does not come under question until the shift from stage four to stage five.

In a similar study, Valle and Koeske (1974) studied the relationship between self-actualization (using Shostrom's Personal Orientation Inventory), moral maturity (using the Kohlberg Scale), and locus of control (using Rotter's I-E Index). Their subjects were 69 undergraduate psychology students.

The results differed from the studies described above. The correlation between locus of control and moral maturity for males was -.07. The correlation for females was -.15. The direction of the correlations was in agreement with the authors' hypothesis. A negative relationship had been expected since the internal/external scores are reported in terms of how external individuals are. However, the authors did not perform any multiple correlations to determine whether there are any significant interactions among the variables.

Deflumeri (1982) investigated the effects of locus of control and interpersonal trust on teacher moral reasoning. His findings indicated a significant interaction between field dependence/independence and locus of control on moral reasoning. Locus of control on its own accounted for almost

80% of the variance in moral development. He recommended future research to identify variables which can account for variances in moral development and ethical ideology.

A few studies have investigated the relationship between ethical ideology and moral judgment. Schlenker and Forsyth (1977), using the Ethics Position Questionnaire, investigated the relationship of ethical ideology and moral judgment. College students were asked to rate the morality of an obedience experiment. They were later classified along the four typologies they endorsed. Consistent differences as a function of type of ethical ideology endorsed was obtained. The differences focussed on students' perceptions of the risks and benefits of the experiment. The authors found that for students who were exceptionists, moral judgment correlated with the benefits of the research but had almost no relationship to the threat to subjects, or possibility of harm for participants. For Absolutists, on the other hand, the cost factors of the research correlated significantly with moral judgment, but the benefit factors did not.

In a similar study, Forsyth (1978) investigated the relationship between ethical ideology and the consequences of a field study on altruism. The field study yielded both positive and negative consequences. The results indicated significant differences in judgment as a function of ethical ideology. Absolutists were harshest in their evaluation of negative consequences. Additionally, they attributed more

blame to the experimenter when negative consequences were considerable. They were also more likely to condemn the research in these circumstances. Situationists, on the other hand, reacted in a similar manner as in the previous study. Exceptionists were the most positive in their evaluations of the consequences of the study.

In a 1984 study, Forsyth and Berger examined the relationship between ethical ideology and moral action. Subjects were requested to complete a measure of social sensitivity. The experimenter made remarks designed to encourage subjects. Analysis of the incidence of cheating revealed no significant differences in cheating behavior among the different ideologies.

Similar results were obtained in a follow-up study by the two investigators.

They found that while situationists' reactions were not related to cheating behavior, absolutists' self-ratings of feelings of satisfaction, happiness, strength, and goodness correlated negatively with cheating behavior, rs = -.63, -.79, -.87, and -.63 respectively.

In contrast, subjectivists' feelings were positively correlated with cheating.

Forsyth, et al. (1984) also examined the relationship between ethical ideology and personal moral philosophies. Two hundred and sixteen undergraduate psychology students were used in this study. Subjects were administered the EPQ

and classified along the two dimensions of Idealism and Relativism. Subjects were also administered an instrument designed to measure the two ethical perspectives identified by Gilligan (1982) -- An Ethic of Caring and An Ethic of Rational Justice. It was hypothesized that Gilligan's Ethic of Caring and Justice would be related to the EPQ's Idealism and Relativism dimensions. It was further hypothesized that women would be higher in idealism and men in relativism.

The results indicated that there was a significant relationship between Gilligan's Ethic of Caring and the Ethics Position Questionnaire's Idealism dimension. It was further hypothesized that women would be higher in idealism and men in relativism.

The results indicated that there was a significant relationship between Gilligan's Ethic of Caring and the Ethics Position Questionnaire's Idealism dimension. However, no relation was observed between the relativism dimension and the ethic of justice. The authors suggested that the ethic of caring and the ethic of justice are not necessarily incompatible moral perspectives. No significant differences were observed between men and women in two dimensions of the EPQ or Gilligan's Ethics of Caring and of Justice. The authors observed that the absence of sex differences suggest that differences in moral thought between the sexes may not be as pervasive as previous research would suggest.

Summary

This chapter provided a review of the literature in the areas of cognitive theories of moral development, and research on moral development, ethical values and decisions, in particular as they relate to health care professionals. The literature provides evidence of a relationship between moral development normative ethical stance and various background variables. The review of the literature on the relationship between ethical stance, personality variables, and moral judgment among health professionals proved disappointing. Very little research exists in this area. This literature review underscores the need for more research activity to obtain baseline data on the ethical stance and moral judgment of health professionals.

CHAPTER III

Methodology

The preceding chapter presented and discussed a review of the relevant literature in the areas under investigation. This chapter includes the methods and procedures of the study. It is divided into five sections. The first section discusses the design, selection of the study population, and data collection procedures. The remaining section discusses the instrumentation, statement of the null hypothesis, and data analysis.

Study Design

The study employed a survey design using two tested instruments. These instruments are (1) the Ethics Position Questionnaire (EPQ), and (2) Rotter's Internal-External Locus of Control Scale. A supplemental demographic sheet developed by this author was also administered to all participants in the study.

Ethical orientation of students enrolled in selected health fields is the dependent measure in this study (see Figure 2). Ethical orientation was assessed as scores of each subject on the idealism and relativism dimensions of the EPQ. Subjects were classified along the four typologies based on their mean scores on idealism and their mean score on relativism.

HEALTH CARE
Professional Students

Medicine
Nursing
Selected Allied Health
Professions

INDEPENDENT VARIABLES

I. Education Related
Junior
Senior
Ethics Course

HEALTH FIELD

II. Socio-Demographic
Sex
Race
Religion

Locus of Control

EPQ

Dependent Variable
Ethical Ideology

Figure 2

Design of the Study

The independent variables were: type of health professions, level of education, exposure to ethics courses, sex, race, locus of control, and religion. The review of the literature had indicated the latter variables may have an effect on an individual's ethical stance (Gore & Rotter, 1963).

Subjects

Subjects for the study were students enrolled in selected Allied Health fields, nursing, and medicine, at two types of research universities; namely, predominantly black and predominantly white institutions. Only students in their junior and senior years were selected. It was reasoned that students who had been enrolled in a professional program for longer than one year would have become more familiar with some of the ethical dilemmas faced by professionals in their fields of study. Exposure to such dilemmas may, therefore, have increased their awareness of a need to clarify their own value systems. Simon and Clark (1976), in stressing the need for values clarification, observe that knowing one's self narrows the gap between our words and actions, while Brody observes that "we will act better in the long run if we get into the habit of making our values explicit and of being ready to examine our values critically" (p. 294).

Data Collection

A letter requesting permission to administer the two questionnaires, and a personal data inventory was sent to each dean. Included with the request was the purpose of the study and expected significance. The deans were also informed of anonymity of the participants, and that only minimal risk was involved.

Once approval was received from each institution, a faculty member from each of the participating departments was contacted in reference to administering the questionnaires. Faculty members accepted the responsibility of administering and returning the completed instruments and personal data sheets. The instruments were administered by faculty members in charge of appropriate classes.

Selection of Subjects

Subjects for this study were selected by using an equal number of students (75) enrolled in classes in the three health disciplines: first and second year students in medical school; juniors and seniors in nursing and allied health at two separate universities, one predominantly black; the other predominantly white. Thus, a total of 225 questionnaires were sent to each institution. However, only 160 responses were received from the white university, and only 120 from the black institution. Participation in completing the study was voluntary.

Thirteen of the returned questionnaires were not useable because the students did not complete all of the questions on all of the instruments. The final sample consisted of a total of 267 students; 157 students were from the predominantly White institution, and 110 students from the predominantly Black institution. The sample was broken down as follows: From the predominantly White institution, 73 white students were enrolled in the School of Allied Health, 42 were enrolled in the School of Nursing, and 42 were enrolled in the School of Medicine. From the predominantly Black school, 43 were enrolled in Allied Health fields, 35 in Nursing, and 32 in Medical School. One hundred fifty-six students were in the junior year, 65 in Allied Health, 33 in Nursing, and 58 in Medical School. There were 111 senior respondents, 52 in Allied Health, 44 in Nursing and 15 in medical school.

Instruments

Two instruments and a personal data sheet were administered to participants. These were:

1. Ethics Position Questionnaire (EPQ) (Forsyth 1980).
2. Rotter's Internal-External Locus of Control (1966).

Ethics Position Questionnaire. The Ethics Position Questionnaire is a 20-item instrument which assesses degree of idealism and rejection of universal rules in favor of relativism. It was developed to measure the extent to which

individuals identify with one of four ethical ideologies; namely, situationism, absolutism, subjectivism, and objectionism. The EPQ is composed of two 10-item scales measuring idealism and relativism. The 10-item scale is comprised of a series of attitude statements. One scale contains attitude statements concerning idealism, and the other statements concerning relativism. Respondents are asked to indicate the extent to which they agree or disagree with each statement. The scales have a Likert-type format with a 9-point scale ranging from completely disagree to completely agree. The mean score of response to each scale is taken as an individual's two EPQ scores. These scores are then used to classify individuals as to ethical ideology. Respondents who score at or above the mean on both scales are classified as situationists; those who score at or above the mean on the idealism scale but below on the mean on the relativism scale are absolutists. Respondents scoring below the mean on idealism and at or above the mean on relativism are subjectivists, while those who score below the mean on both scales are classified as exceptionists.

Schlenker and Forsyth (1980) obtained reliability and validity data for the instrument from a subsample of 74 freshmen psychology students. The subsample was drawn from a larger sample of 241 students who had completed the EPQ. The authors completed three measures of reliability. Test-retest reliability estimates were .67 for the idealism

scale and .66 for the relativism scale. The significant result indicated that the EPQ was a stable instrument. Schlenker and Forsyth also assessed the internal consistency of the measure. Cronbach's Alpha of .80 for idealism and .73 for relativism were obtained. These indices, while not overwhelming, fall within the range of consistency coefficients of widely used measures of this type (Forsyth, 1980).

The data were also analyzed to determine both construct and predictive validity of the instrument. Subjects used in this analysis were 128 students selected from the larger sample mentioned earlier. Equal numbers of both sexes were used. Correlation techniques were used to determine whether other measures related to ethical judgment processes were similar to the EPQ. The authors used two such measures: Rest's DIT (1966) which is a measure of Kohlberg's Stages of Moral Maturity and Hogan's (1973) Survey of Ethical Attitudes.

Schlenker and Forsyth hypothesized that there would be no relationship between the EPQ and Rest's DIT. They argued that these two measures used different criteria for assessing an individual's ethical perspective. They suggest that the DIT which is based on Kohlberg's Stages of Moral Development "distinguishes between respondents by examining the extent to which they rely on self-generated ethical values that emphasize crucially important issues such as human rights..."

(p. 180). The EPQ on the other hand uses different criteria based on idealism in evaluating consequences and moral relativism when distinguishing variations in moral values. In addition, the authors claimed that the EPQ does not focus on the source of the values held by the individuals, i.e. whether they are or are not self-generated. The correlations between the EPQ and P scores of the DIT were $r = -.01$ for idealism and $r = .01$ for relativism. These correlations indicate that neither idealism nor relativism were related to P.

A second study by Forsyth, Lyle, and Kelley (1985) added further information on the reliability and validity of the EPQ. A re-analysis of the EPQ yielded internal consistency coefficients of .82 and .84 for the idealism and relativism scales respectively.

The Rotter Internal-External Locus of Control (1966). The Rotter instrument is a 23-item forced choice questionnaire adapted from an internal-external locus of control scale developed by James in 1957. The questionnaire has six filler items which are not included in the final score. The scale is scored in the external direction; that is, the higher the score, the more external the individual's locus of control. Norms for the scale have been obtained from several populations including Black and white college students, white high school students (1968), black and white

male addict patients (1973), male soldiers (1971), and administrators (1971).

The scale, which is derived from learning theory principles, proposes two generalized expectancies concerning reinforcement: Based on their past experiences, one group of individuals acquire the view that the locus of causality for reinforcement is external and that consequently they are helpless to change the course of events. A second group view events as a consequence of their own actions, capabilities or personality. Consequently, individuals are hypothesized to vary along a locus of control dimension with the end points labelled internal and external.

Extensive research on the I.E. has been reviewed by Lefcourt (1981) and Rotter (1975, 1971). Much of the research reviewed focused on the reliability of the scale. The review concludes that:

The test-retest reliability of the Rotter I-E scale is consistent and acceptable and varies between .49 and .83. The reliability and validity of the scale was assessed by Hersch and Scheiber (1967). Hersch and Scheiber administered the scale to three samples of college students who were volunteer workers in state mental institutions in 1964, 1965, and 1966.

The tests were administered within a seven-week interval to each sample. Test-retest reliability coefficients ranged from .43 to .84 for the 1966 sample, and .72 for the 1964 and

1965 samples. A test for the significance of the mean test-retest change scores using the studentized t were nonsignificant for all three samples, t = .56 for the 1964 and 1965 samples, and t = 1.17 for the 1966 sample.

The construct validity of the I-E scale was assessed by correlating scores on the I-E with various personality measures.

Significant relationship was obtained between the MMPI Anxiety Scale and the I-E Scale, r = .26. A significant relationship was also observed between the Rotter I-E Scale and the 24-item Adjective Checklist (ACL) (Cough & Heilburn, 1965). The data indicated that 23 adjectives were checked significantly more often by internal individuals ($p < .05$). These included adjectives such as egoistical, independent, and enthusiastic. In contrast, only one adjective was checked most frequently by externals--self-pitying.

Predictive validity of the Rotter I-E was assessed in this study by comparing the relationship between the effectiveness of volunteers with their I-E scores. A significant relationship was obtained between locus of control and effectiveness of volunteers for the 1964 and 1965 samples. Internals tended to be rated more effective than externals. The results for the 1966 sample were inconsistent. Consequently, the authors questioned the utility of the I-E scale for behavioral prediction. However, their findings suggest that it is possible to predict some

personality characteristics and social orientations of individuals based on their identified locus of control dimension.

Personal Data Sheet. A Personal Data Sheet was also completed by subjects. The data sheet requested information on such characteristics as race, age, sex, type of health professions, church membership, church attendance patterns, and type of community in which the respondent lived. These responses were assigned numerical codes and served as control or explanatory variables in the data analyses. For the religion code, subjects were classified as religious if they indicated: (1) that they were members of a church, (2) were able to identify a denomination to which they belong, e.g., Jewish, Episcopal, Catholic, etc., and (3) indicated that they attended church at least once a month. Subjects were classified as nonreligious if they did not meet the above three criteria even though they may have been church members and could identify a denomination. The attendance pattern was the dominant criterion for classification.

Statistical Hypotheses

The following hypotheses were tested:

Major Hypothesis #1. There is no significant difference in ethical ideology as measured by scores on the Idealism and Relativism dimensions of the Ethics Position Questionnaire

(EPQ) among students enrolled in selected health professions as a function of type of health profession.

Major Hypothesis #2. There is no difference in ethical ideology as a function of race, sex, level of education, religious conviction, exposure to ethics courses, and locus of control among students enrolled in the health professions of Allied Health, Nursing, and Medicine.

Data Analyses

The instruments were scored by the investigator in accordance with the instructions on each instrument's administration material. Data on the Personal Data Sheet were also scored numerically. The Statistical Package for the Social Sciences (SPSS) computer program was used to analyze the data.

The general design of the study was a 3 x 4 x 2 factorial design. The independent variables were health professions, ethical ideology, and race. Three levels of health professions were selected: Allied Health fields v Nursing v Medicine; 4 levels Situationism v Absolutism v Objectivism v Exceptionism; and 2 levels of race, black versus white.

Hypothesis #1 was tested using a three-way analyses of variance. Hypothesis #2 used an expanded version of the basic study design with the addition of four additional variables: sex, two levels - male v. female; educational level, two levels - juniors v. seniors; religion - two

levels, religious v. nonreligious; and, locus of control, two levels, internal v. external. Additional statistical procedures included multiple regression, descriptive statistics of the study population, and X^2 goodness of fit. The .05 level was used as the point of rejection of the null hypotheses.

CHAPTER IV

Results

The results of the study are presented in this chapter. Each statistical hypothesis is restated, and the statistical methods used are discussed. The acceptance or rejection of each hypothesis was at the .05 level of significance. Prior to all data analysis, students in each health profession were classified along the four ethical dimensions suggested by Schlenker and Forsyth, based on their mean scores on the idealism and relativism Scale of the Ethics Position Questionnaire.

Findings for Analyses of Variance

As shown in Chapter 3, two separate analytical techniques were employed. First, analysis of variance was used to test the hypothesis of no difference between the groups on each of the independent variables. Second, stepwise multiple regression was used to determine which of the independent variables contributed most to the variance observed in ethical ideology. The findings from each of these tests are presented below.

Statistical Hypothesis #1

There is no significant difference in ethical ideology as measured by scores on the idealism and relativism scale of the EPQ among the three groups enrolled in selected health

professions (selected allied health fields, nursing, and medicine).

Three separate analyses of variance were run to test this hypothesis.

The first analysis of variance was run to determine if there was a significant difference in the idealism dimension among the three health profession student groups. The hypothesis of no difference was rejected, $F(2.264) = 12.8$, $p > .01$ (Table 1).

The second analysis of variance was to test for significant difference on the relativism dimension. No significant difference was observed on this dimension among students in the different health professions, $F(2.264) = 0.39$ ns (Table 2).

The third analysis of variance was run to determine if there was a significant difference in ethical ideology as measured by combined scores of the idealism and relativism dimensions among the groups. The hypothesis of no difference was rejected. A significant difference in ideology was observed, $F(2.264) = 3.39$, $p < .05$ (Table 3).

Statistical Hypothesis #2

There is no significant difference in ethical ideology as measured by scores on the idealism and relativism dimensions of the EPQ among the three groups in health

Table 1

Analysis of Variance Summary Table for Main Effect of Type Health Professions on Measure of Idealism

Source	Sum of Squares	df	Mean Squares	F
Between Groups	32.99	2	16.49	12.8**
Within Groups	341.13	264	1.29	

**p < .01

Table 2

Analysis of Variance Summary Table for Main Effect of Health on Measure of Relativism

Source	Sum of Squares	df	Mean Squares	F
Between Groups	1.51	2	0.75	0.39 ns
Within Groups	504.51	264	1.91	

ns = not significant

Table 3

Analysis of Variance Summary Table for Main Effect of Type Health Professions on Measure of Ethical Ideology

Source	Sum of Squares	df	Mean Squares	F
Between Groups	6.08	2	3.041	3.39*
Within Groups	236.57	264	0.89	

*$p < .05$

professions (selected allied health fields, nursing, and medicine) as a function of race, sex, level of education, religious convictions, locus of control, and exposure to ethics courses. This major hypothesis was broken down into the following subhypotheses to be tested.

Subhypothesis #2a. There is no difference on the idealism dimension among health profession groups as a function of sex. This hypothesis was rejected, $F(1.265) = 11.57$, $p < .01$. Sex of respondents had a decided effect on idealism, with female respondents appearing to be more idealistic than male respondents (Table 4).

Subhypothesis #2b. There is no significant difference on the relativism scale as a function of sex. This was not rejected. A nonsignificant $F(1.265) = 0.51$ was obtained (Table 5).

Subhypothesis #2c. There is no significant difference in ethical ideology as measured by combined scores on the idealism and relativism scales of the EPQ among health profession groups as a function of sex. This hypothesis was not rejected, $F(1.265) = 2.65$ (Table 6).

Subhypothesis #2d. There is no significant difference on the idealism scale of the EPQ among health profession groups as a function of race. This hypothesis was not rejected, $F(1.265) = .04$ (Table 7).

Subhypothesis #2e. There is no significant difference on the relativism scale of the EPQ as a function of race.

Table 4

Analysis of Variance Summary Table for Main Effect of Sex on Measure of Idealism

Source	Sum of Squares	df	Mean Squares	F
Between Groups	15.65	1	15.65	11.57**
Within Groups	358.49	265	1.35	

**p < .01

Table 5

Analysis of Variance Summary Table of
Main Effect of Sex on Measure of Relativism

Source	Sum of Squares	df	Mean Squares	F
Between Groups	0.97	1	0.97	0.51 ns
Within Groups	505.04	265	1.90	

ns = not significant

Table 6

Analysis of Variance Summary Table of Main Effect of Sex on Measure of Ethical Ideology

Source	Sum of Squares	df	Mean Squares	F
Between Groups	2.41	1	2.41	2.65 ns
Within Groups	240.24	265	0.91	

ns = not significant

Table 7

Analysis of Variance for Main Effect of Race on Measure of Idealism

Source	Sum of Squares	df	Mean Squares	F
Between Groups	0.05	1	0.05	0.04 ns
Within Groups	374.08	265	1.41	

ns = not significant

This subhypothesis was rejected. A significant difference was observed in the direction of white health professional students, $F(1.265) = 3.86$, p .05 (Table 8).

Subhypothesis #2f. There is no difference in ethical ideology as measured by combined scores on the idealism and relativism scales of the EPQ as a function of race. This was not rejected. A nonsignificant $F(1.265) = 1.75$ was obtained (Table 9).

Subhypothesis #2g. There is no significant difference in ethical ideology as measured by scores on the idealism scale of the EPQ among health professions students as a function of strength of religious conviction. This hypothesis was accepted with a nonsignificant $F(1.265)$ of 1.98 (Table 10).

Subhypothesis #2h. There is no significant difference in ethical ideology as measured by scores on the relativism scale among health profession students as a function of strength of religious conviction. This was rejected, $F(1.265) = 4.94$, $p < .05$ (Table 11).

Subhypothesis #2i. There is no significant difference in ethical ideology as measured by combined scores on the idealism and relativism scales of the EPQ as a function of strength of religious conviction. This was accepted, $F(1.265) = 0.70$ (Table 12).

Subhypothesis #2j. There is no significant difference on the idealism scale of the EPQ among health professions

Table 8

Analysis of Variance Summary Table for Main Effect of Race on Measure of Relativism

Source	Sum of Squares	df	Mean Squares	F
Between Groups	7.27	1	7.27	3.86*
Within Groups	498.74	265	1.89	

*$p < .05$

Table 9

Analysis of Variance Summary Table for Main Effect of Race on Measure of Ethical Ideology

Source	Sum of Squares	df	Mean Squares	F
Between Groups	1.58	1	1.58	1.76 ns
Within Groups	241.07	265	0.91	

ns = not significant

Table 10

<u>Analysis of Variance Summary Table for Main Effect of Religious Conviction on Measure of Idealism</u>

Source	Sum of Squares	df	Mean Squares	F
Between Groups	1.68	1	1.68	1.98 ns
Within Groups	372.45	265	1.41	

ns = not significant

Table 11

Analysis of Variance Summary Table for Main Effect of Religious Conviction on Measure of Relativism

Source	Sum of Squares	df	Mean Squares	F
Between Groups	9.25	1	9.25	4.94*
Within Groups	496.76	265	1.88	

*$p < .05$

Table 12

Analysis of Variance Summary Table for Main Effect of Religious Conviction on Measure of Ethical Ideology

Source	Sum of Squares	df	Mean Squares	F
Between Groups	0.64	1	0.64	0.70 ns
Within Groups	242.01	265	0.91	

ns = not significant

students as a function of Internal-External locus of control. This was rejected, with a significant $F(1.265) = 6.07$, p .01 (Table 13).

Subhypothesis #2k. There is no significant difference on the relativism scale of the EPQ as a function of Internal-External locus of control among health profession students. This was accepted $F(1.265) = .30$ (Table 14).

Subhypothesis #2l. There is no significant difference in ethical ideology as measured by combined scores on the idealism and relativism scales of the EPQ as a function of Internal-External locus of control among health professions students. This was accepted, $F(1.265) = 1.40$ (Table 15).

Subhypothesis #2m. There is no significant difference on the relativism scale of the EPQ among health professions students as a function of exposure of ethnic courses. This was accepted with a nonsignificant $F(1.265) = 0.04$ (Table 16).

Subhypothesis #2n. There is no significant difference on the relativism scale of the EPQ among health professions students as a function of exposure to ethic courses. This was accepted $F(1.265) = 1.94$ (Table 17).

Subhyphothesis #2p. There is no significant difference in ethical ideology as measured by combined scores on the idealism and relativism scales of the EPQ among health professions students as a function of exposure to ethics.

Table 13

Analysis of Variance Summary Table for Main Effect of Locus of Control on Measure of Idealism

Source	Sum of Squares	df	Mean Squares	F
Between Groups	8.44	1	8.38	6.07**
Within Groups	365.75	265	1.38	

**p < .01

Table 14

<u>Analysis of Variance Summary Table for Main Effect of Locus of Control on Measure of Relativism</u>

Source	Sum of Squares	df	Mean Squares	F
Between Groups	0.57	1	0.57	0.30 ns
Within Groups	505.44	265	1.91	

ns = not significant

Table 15

Analysis of Variance Summary Table for Main Effect of Locus of Control on Measure of Ethical Ideology

Source	Sum of Squares	df	Mean Squares	F
Between Groups	1.28	1	1.28	1.40 ns
Within Groups	241.37	265	1.91	

ns = not significant

Table 16

Analysis of Variance Summary Table for Main Effect of Exposure to Ethics Course on Measure of Idealism

Source	Sum of Squares	df	Mean Squares	F
Between Groups	0.05	1	0.05	0.04 ns
Within Groups	374.07	265	1.41	

ns = not significant

Table 17

Analysis of Variance Summary Table for Main Effect of Exposure to Ethics Course on Measure of Relativism

Source	Sum of Squares	df	Mean Squares	F
Between Groups	3.68	1	3.68	1.94 ns
Within Groups	502.33	265	1.89	

ns = not significant

This was accepted. A nonsignificant $\underline{F}(1.265) = 1.38$ was obtained (Table 18).

Subhypothesis #2q. There are no significant interactions between the independent variables of (1) type of health professions, (2) sex, (3) race, (4) strength of religious conviction, and (5) Internal-External locus of control on the idealism and relativism scales of the Ethics Position Questionnaire and on Ethical Ideology.

The null hypothesis was tested by a four-way analysis of variance. The results showed a significant two-way interaction between type of health professions and race, and a significant three-way interaction between sex, race, and internal-external locus of control on the idealism scale (Table 19). All other interactions on this scale were nonsignificant.

On the relativism scale, significant two-way interactions were obtained between type of health professions and locus of control. No other two-way interactions was significant. There was a significant three-way interaction between sex, race, and locus of control. No other three-way interaction was significant (Table 20).

Significant two-way interactions were obtained between type of health professions and religious conviction and between sex and religious conviction on the total EPQ scale. There were significant three-way interactions between type of health professions, race, and locus of control; sex, race,

Table 18

Analysis of Variance Summary Table for Main Effect of Exposure to Ethics Course on Measure of Ideology

Source	Sum of Squares	df	Mean Squares	F
Between Groups	1.26	1	1.26	1.38 ns
Within Groups	241.39	265	0.91	

ns = not significant

Table 19

Analysis of Variance Summary Table for Effects of Health Profession, Race, Sex, Religious Conviction and Locus of Control on Measures of Idealism

Source	Sum of Squares	df	Mean Squares	F
Main Effects				
Health Profession	6.99	2	3.49	2.74**
Sex	0.79	1	0.79	0.62
Race	0.13	1	0.13	0.08
Religious Conviction	0.08	1	0.88	0.69
Locus of Control	2.18	1	2.19	1.78
Two-Way Interactions				
Health Profession x Sex	0.67	2	0.34	0.27
Health Profession x Race	6.27	2	3.14	2.46
Health Profession x Religious Conviction	0.10	2	0.05	0.04
Health Profession x Locus of Control	0.85	2	0.42	0.12
Three-Way Interactions				
Sex x Race x Religious Conviction	4.55	1	4.55	5.05*

$^{**}p = .001$

$^{*}p = .05$

Table 20

<u>Analysis of Variance Summary Table for Effects of Health Profession, Race, Sex, Religious Conviction and Locus of Control on Measures of Realitivism</u>

Source	Sum of Squares	df	Mean Squares	F
<u>Main Effects</u>				
Health Profession	161.94	2	80.97	0.43
Sex	47.74	1	47.74	0.25
Race	909.67	1	909.67	4.87*
Religious Conviction	947.02	1	947.02	5.07*
Locus of Control	527.91	1	527.91	2.83
<u>Two-Way Interactions</u>				
Health Profession x Religious Conviction	2539.3		1269.65	6.79**
<u>Three-Way Interactions</u>				
Sex x Race x Religious Conviction	980.28	1	980.28	5.25*

**p = .001

*p = .02

and locus of control; and sex, religious conviction, and locus of control. All other interactions were not significant (Table 21).

Findings for the Stepwise Multiple Regression Analyses

Three separate multiple regression analyses were run on the data using those independent variables which had been shown to have a significant effect on scores of one or other of the two EPQ scales and on the EPQ as a whole. This was done to determine the contribution that each of these variables might have in predicting the ethical ideology of students in the health professions. In each case, the dependent variables were scores on the idealism and relativism and total EPQ scale. Using a stepwise approach, all variables were entered into the equation. This was done to ensure that the variable which contributed most to any observed variations would be forced out first. On the idealism scale, the variable to enter the equation first was type of health profession. This was significant when related to scores on idealism ($r = 29$, $f = 25.1$, $p = .001$). Next to enter the equation was Internal-External locus of control with an $r = .03$. This was not significant. The other independent variables entered the equation simultaneously and together obtained a nonsignificant r of .03 (Table 22).

On the relativism scale, strength of religious conviction entered the equation first with an r of .13. This

Table 21

<u>Analysis of Variance Summary Table for Effects of Health Profession, Race, Sex, Religious Conviction and Locus of Control on Measures of Ideology</u>

Source	Sum of Squares	df	Mean Squares	F
<u>Main Effects</u>				
Health Profession	2029	2	1014.7	2.81*
Sex	668	1	468.6	1.44 ns
Race	103	1	668.5	1.84 ns
Religious Conviction	103	1	668.5	1.84 ns
Locus of Control	448	1		
<u>Two-Way Interactions</u>				
Health Profession x Locus of Control	547.7	2	273.8	0.7 ns
Health Profession x Race	1129.4	1	564.7	1.55 ns
Locus of Control x Race	44.2	1	44.2	1.41 ns
<u>Three-Way Interactions</u>				
Health Profession x Locus of Control x Race	1029.9	2	514.9	1.42 ns

*p = .05

ns = not significant

Table 22

Summary Table of Contribution of Independent Variables Type of Health Profession, Locus of Control, Religious Conviction, Race and Sex of Measure of Idealism

	R	R^2	r	Beta
Health Profession	.29	.08	.29	-.24*
Locus of Control	.32	.10	.14	-.13*
Religious Conviction	.35	.11	.06	.05
Race			.01	.05
Sex			.20	.11

*p < .001

was significant $F(1.265) = 4.9$, $p = .05$ Race entered the equation next, $r = .05$. The correlation between idealism and race combined with strength of religious conviction was significant, $F = 6.67$, $p = .01$ (Table 23).

A final stepwise multiple regression was performed to determine the relationship between ethical ideology as measured by total scores on the combined relativism and idealism scales and all of the independent variables of interest. Health profession entered the equation first with a low but significant r of -.15, $F(1.265) = 6.66$, $p = .01$. Religious conviction, race, internal and external control, and sex entered next in that order and together obtained an r of .01 which was not significant (Table 24). Because of the conflicting results contained in these analyses, a series of cross tabulations were run to examine patterns of association between the various independent variables and the dependent variable.

Table 25 shows the association between type of health profession and ethical ideology. The data indicate that students in the allied health field were more likely to be either situationists or absolutists; nursing students were more likely to be exceptionists; and medical students, subjectivists. A chi square test of significance run on the data indicated that these differences were significant and not due to chance alone ($X^2 = 26.1$, df = 3, $p < .001$).

Table 23

Summary Table of Contribution of Independent Variables Type of Health Profession, Locus of Control, Religious Conviction, Race and Sex of Measure of Relativism

	R	R^2	r	Beta
Religious Conviction	.13	.02	.13	.13*
Health Profession	.18	.03	.04	.03
Race	.19	.004	-.11	-.13*
Sex			-.04	-.03
Locus of Control			.04	.04

*$p < .05$

Table 24

Summary Table of Contribution of Independent Variables Type of Health Profession, Locus of Control, Religious Conviction, Race and Sex of Measure of Ethical Ideology

	R	R^2	r	Beta
Health Profession	.15	.02	-.15	-.13*
Locus of Control	.19	.03	-.07	.06
Religious Conviction			.05	.06
Race			.08	.07
Sex			.07	.06

*$p < .05$

Table 25

<u>Relation Between Health Profession Field and Ethical Ideology</u>

	Ethical Ideology			
Health Profession	Situationist	Absolutist	Subjectivist	Exceptionist
Allied Health	35.9%	32.5%	17.1%	14.5%
Nursing	26.0%	23.4%	19.5%	31.2%
Medicine	20.5%	15.3%	39.3%	24.8%

$X^2 = 26.1$, df = 3, $p < .001$**

N = 267

**Indicates significance at the .01 level

Conversely, no association was observed between level of education and ethical ideology. Juniors and seniors were equally distributed among the four Ideologies indicating that for these students, level of education bore little relation to the ethical position to which they subscribed (Table 26).

There appeared to be some relationship between sex of students and ethical ideology. Male students tended to be subjectivists while female students tended to be situationists. The observed relationship was significant beyond the .01 level, ($X^2 = 15.2$, df = 3). (See Table 27.) This finding validated earlier studies that medical students tended to be subjectivists, while students in the allied health fields tended to be situationists. The majority of medical students were male, while the majority of allied health students were female. While strength of religious conviction did not appear to have any relationship with ethical ideology, there was a marked deviation in the pattern for students who had been identified as strongly religious. Among these students, a greater percentage were situationists. On the other three typologies, whether a student was religious or not seemed to be independent of his/her ethical position (Table 28).

Students' race also appeared to be independent of ethical ideology, with the exception of white students who were slightly more likely to be situationists (Table 29).

Table 26

Relation Between Level of Education and Ethical Ideology

	Ethical Ideology			
Level of Education	Situationist	Absolutist	Subjectivist	Exceptionist
Junior	28.8%	26.3%	23.1%	21.8%
Senior	28.8%	23.4%	25.2%	22.5%

N = 267

Table 27

Relation Between Sex and Ethical Ideology

	Ethical Ideology			
Sex	Situationist	Absolutist	Subjectivist	Exceptionist
Male	24.4%	15.1%	37.2%	23.3%
Female	30.9%	29.8%	17.7%	21.5%

$X^2 = 15.2$, df = 3, $p = .001$**

N = 267

**Indicates significance at the .01 level

Table 28

Relation Between Religious Strength and Ethical Ideology

	Ethical Ideology			
Religious Strength	Situationist	Absolutist	Subjectivist	Exceptionist
Religious	28.3%	26.7%	21.7%	23.3%
Not Religious	29.9%	21.8%	28.7%	19.5%

N = 267

Table 29

Relation Between Race and Ethical Ideology

	Ethical Ideology			
Race	Situationist	Absolutist	Subjectivist	Exceptionist
White	31.2%	22.3%	27.4%	19.1%
Black	25.5%	29.1%	19.1%	26.4%

N = 267

A similar pattern emerged when the relationship between internal-external locus of control and ethical ideology was examined. No significant relationship was observed; however, internals were slightly more likely to be situationists (Table 30). Finally, the analysis of crossbreaks revealed no relationship between ethical ideology and prior exposure to ethics courses. Here again, however, health profession students who had such an exposure were more likely to be situationists (Table 31).

The analysis of crossbreaks helped clarify the conflicting results obtained in the earlier analysis. It also helped to explain the dominance of the idealism scale when analysis of variance and multiple regression techniques were performed on the data.

The results from these analyses, implications, and recommendations for further research are discussed in Chapter 5.

Table 30

Relation Between Locus of Control and Ethical Ideology

Locus of Control	Ethical Ideology			
	Situationist	Absolutist	Subjectivist	Exceptionist
Internal	30.6%	27.4%	22.6%	19.4%
External	27.3%	23.1%	25.2%	24.5%

N = 267

Table 31

<u>Relation Between Ethics Course and Ethical Ideology</u>

	Ethical Ideology			
Ethics Course	Situationist	Absolutist	Subjectivist	Exceptionist
Yes	30.8%	22.5%	25.8%	20.8%
No	27.2%	27.2%	22.4%	23.1%

N = 267

CHAPTER V

Discussion & Conclusion

This chapter contains a summary of the study, a discussion of the results, as well as conclusions from the analysis. The results are discussed in relation to specific hypothesis, and then in terms of the implications for development of ethics courses for students in the health professions. Particular care was taken to address the findings to the philosophical and cognitive perspectives on ethical systems and moral development. The order of presentation of the contents of this chapter is as follows: (a) overview of the purpose, (b) summary of literature findings, (c) restatement of hypothesis and methodology used, (d) discussion of findings, (e) implications for training of students in the health professions, in particular, the development of ethics courses for such students, (f) recommendations, and (g) conclusions.

Purpose and Objectives

The major purpose of the study was to determine whether there was a difference in ethical ideology among students enrolled in selected health professions as a function of type of health profession. More specifically, the objectives of the study were (1) to determine the extent to which selected health professional groups (Allied Health, Nursing, and

Medicine) differ in ethical ideology, and (2) to determine the extent to which characteristics of health profession students are related to their ethical ideology.

Hypothesis

The major null hypotheses which were tested in this study are as follows:

1. There is no significant differences in ethical ideology as measured by scores on the idealism and relativism scales of the Ethics Position Questionnaire among students enrolled in selected health professions (Allied Health, Nursing, and Medicine) as a function of type of health profession.
2. There is no significant difference in ethical ideology among students enrolled in selected health professions as a function of race, sex, level of education, religious conviction, exposure to ethics courses, and locus of control.

Discussion of the Findings

The first null hypothesis was that there would be no significant difference in ethical ideology as measured by (a) scores on the idealism scale, (b) scores on the relativism scale, and (c) scores on the EPQ among students in selected health professions (Allied Health, Nursing, and Medicine) as

a function of type of health profession. Significant differences in ethical ideology among the three health professions were obtained for the idealism scale of the EPQ and for the EPQ as a whole. No significant differences were observed when student groups in the various health professions were compared on the relativism scale.

Analysis of crossbreaks revealed that medical students were more likely to be subjectivists, nursing students were more likely to be exceptionists, while Allied Health students were either situationists or absolutists. Schlenker and Forsyth (1977) observed that subjectivists tend to be low in idealism and high in relativism. In this respect, they appear to endorse an ideology based on ethical skepticism. They recognize that there are "many different ways to look at morality" (p. 176) and that a pragmatic approach should be taken when evaluating actions. While few studies were found in the literature which examined the ethical ideology of health professionals or health professions students, a study by Wakeford and Allery (1986) appeared to confirm the results of this study in respect to medical students. They found that male surgeons tended to be mostly subjectionists while women doctors were more likely to be situationists. They surveyed 200 practicing physicians and psychiatrists in this study.

A study conducted by Schwartz, et al. (1978) gives further support to this study's findings that medical

students tend to be subjectionists, that is, low in idealism and high in relativism. In a survey of medical students, they found that these students tended to become less idealistic as they progress through medical school. They concluded that there was a pattern of discontent with both the process of medical education and medicine in general, which occurs in the last few years of medical school.

However, a study by Self (1983) appears to contradict this study's findings that medical students were more likely to be subjectivists. Self conducted a survey of medical students and physicians to determine the various philosophical positions they held with respect to ethical decision-making. He observed that physicians tended to be inconsistent in the philosophical foundations of their medical ethical decision-making. He also observed that they simultaneously hold some subjective and some objective beliefs which are philosophically incompatible with each other. One reason for the difference in the two studies may be because Self's study used items that focused solely on medical issues, while the EPQ, which was used in the present study, posed dilemmas that were more general in nature. However, this study's findings are not completely incompatible with Self's results. For while the largest percentage of medical students tended to be subjectionists, the second largest number were exceptionists. In this regard, it should be noted that Self's definition of

objectivists suggests that they are somewhat similar in philosophical orientation to exceptionists, as defined by Schlenker and Forsyth.

The conflicting results obtained when student groups in the three health professions were compared on the idealism and relativism scale is puzzling. It is not clear why no differences could be observed on the relativism scale. One explanation can be found in Self's findings of a subjective-objective dichotomy in the philosophical basis of medical students' and physicians' ethical decision-making. This is further substantiated (Erde, 1983; Marcus, 1980; and Nagel, 1977) who observed that professionals often tend to become moral schizophrenics. Thus, Erde (1983) observed:

> People enter the professions for what may be termed personal reasons at all three levels of value -- ego-level, prudence (self, health or finances, id-level reactions (anger, fear, or hatred of death); - as wounded healer, trickster (Erde forthcoming) and at the super-ego-level missions (ideal of helping). Once entered, individuals are forced by the ethic of being professionals to sever much of their ties to central aspects of these values so that they may act upon other values; for example, they are supposed to contribute some of their skills without charge, and they are encouraged to work so hard that it is to the detriment of their own health. Further, they are supposed to pursue cure and to accept a patient's choice of death or rejection of best care; they are required not to help in all possible ways - not to co-opt the sick into being their patient. They are also obliged to please the patient, but not to use unorthodox therapies. (p. 23)

Self (1983) in noting this dichotomy concluded that physicians may not be inconsistent in their actual medical

decisions but only in the responses they give to questions about how medical ethical decisions are to be determined, and these responses may require inconsistent philosophical stances. He warned that one should:

> "be careful not to confuse medical ethical decisions with questions about medical ethical decision-making, i.e., with the methodology for determining the response to a medical ethical question. Basically, the difference is in asking what to do as opposed to asking how to determine what to do. Medical ethical questions are "what" questions. Methodological questions about medical ethical decision-making are "how" questions. (p. 68)

Few studies were found which examined the ethical ideology of Allied Health and Nursing professions or students. However, there was one such study which looked at the ethical stance of nurses. The study appeared to confirm this study's findings that nursing students tend to be exceptionists. Kohnke (1973) surveyed a group of hospital and college trained nurses. She found that, on the whole, nurses did not practice what they verbalized. This relates to Schlenker and Forsyth's definition of exceptionists as those who confirm to moral rules but feel that exceptions to these principles are permissible.

The second hypothesis of no difference in ethical ideology among health professions as a function of race, sex, locus of control, religious beliefs, level of education, and exposure to ethics courses was partly rejected.

Significant main effects were obtained for sex and locus of control on the idealism scale, and for race and religious conviction on the relativism scale. Significant two-way interactions between health professions and race, and three-way interactions between sex, race, and locus of control were obtained for the idealism scale.

On the relativism scale, significant two-way interactions were obtained for health professions and locus of control and for sex and locus of control. Significant three-way interactions were obtained for sex, race, and locus of control.

On the total scale which represents the ethical ideology endorsed by an individual, significant two-way interactions were obtained between health professions and religious conviction, and between sex and religious conviction. Significant three-way interactions were obtained for health professions, race, and locus of control, and for sex, religious conviction, and locus of control.

The significant main effects observed for sex on the idealism scale was in the direction of females. An examination of the crossbreaks indicated that females tended to be more idealistic than males. This finding is in keeping with Gilligan's observation that females are higher on the Ethic of Caring Scale. However, Forsyth, et al. (1984) obtained results that contradicted both this study's and Gilligan's result. They found that there was no difference

in idealism as a function of sex. However, they did obtain a significant relationship between the idealism dimension of the EPQ and Gilligan's Ethic of Caring. One possible explanation for the sex difference observed in the idealism scale in the present study may be because the majority of respondents in the nursing sample were female.

A significant main effect was also observed for locus of control, with internally controlled subjects more idealistic than externals. When the interactions of these variables were examined, however, no significant interactions were observed between type of health profession, sex, and locus of control, although a main effect for health profession was observed on the idealism scale.

The converse was true for performance on the relativism scale. On this scale, significant main effects were observed for race and religious conviction. White health professional students who had been designated as religious tended to be more relativistic. On this scale, significant two-way interactions were obtained between type of health professions and locus of control.

On the total scale, which represented the individual's ethical ideology based on the four typologies, significant two-way interactions were obtained between type of health profession and religious conviction, and a significant three-way interaction between type of health profession, race, and locus of control. These conflicting results

underscored the need for further analysis to determine which of the independent variables contributed most to the differences observed in ethical ideology. The results of the multiple regression analysis yielded similar patterns. However, the regression analysis showed more clearly that the type of health profession in which the student was enrolled best predicted his/her ethical ideology. Characteristics such as race, religious conviction, and internality-externality added little to the prediction. They did, however, help to explain the relationship that existed between these variables as was evident when an analysis of the crossbreaks was conducted.

Several findings in the study are confirmed by evidence in the literature. The finding that black students tended to be more externally controlled has been well documented (Lefcourt, 1982; Strickland, 1977). The main effect of locus of control on the idealism scale in supported by the few studies found examining the relationship between moral judgment and locus of control. Thus, Alker and Poppin (1973) found that internals were more likely to use principled reasoning in Kohlberg's moral judgment interviews than were externals. While Bloomberg (1974), in a study which examined the relationship between locus of control and moral judgment, found no evidence of such a relationship, he did find that internals choose a significantly greater number of items characterized as principled than did externals.

A more recent study examined the relationship between ethical ideology and judgment of social psychological research. The findings of this study help to explain the conflicting findings obtained in this study. Forsyth and Pope (1984) examined the relationship between ethical ideology and three key factors in social science research: potential subject harm, use of illegitimate procedures, and the ratio between benefits and risks. Their results indicated that situationists tended to focus on the positive outcomes of the research while absolutists focused more on the cost benefits. Subjectivists were more likely to focus on the scientific legitimacy of the procedures and the invasiveness of the methods, while exceptionists were more concerned with the justification for the research, but would allow for violation of moral standards if proper safeguards were used.

These results helped in part to explain the type of interactions obtained in the study; for example, the significant interactions obtained between health professions and locus of control on the idealism scale, and between health professions, race, and locus of control on the total EPQ. Because of the lack of research in this area, little evidence was available in the literature to support the findings of this study. However, one important factor has emerged. There does appear to be a difference in ethical ideology among students in the different health professions

observed, which is a function of type of health profession. The various characteristics examined, while significant in themselves, did not appear to be strongly related to the type of health professions in which the students were enrolled. However, some interactions were observed in particular between health professions, locus of control, and religious conviction.

What does not seem clear is why students who embrace a specific ideology are more likely to be found enrolled in a particular health profession. Erde (1983) hints a possible answer to this question when he makes the following observation:

> A profession can be considered a community, an institution or even a cooperative social practice aimed at producing social benefits (MacIntyre, 1981), but each profession takes on an orientation of its own. Each is defined by certain fundamental ends or goals that serve it as super-ego ideals. For medicine, these include health, cure pallitation, and patient education - all of which constitute patient care. But the mental and social nature of human rights require that practitioners of medicine be shaped and molded by medical education so that medicine's fundamental ends may be realized. Through socialization, neophytes are, in effect, domesticated -- changed in the direction of accepting the domestic rules which lead to fulfilling the fundamental goals of the practice (p. 12).

In a similar vein, Schwartz, et al. have found that the stress of medical school selects for a certain student type rather than for a variety of types (p. 183).

Implications

The results of this study would seem to emphasize the need for more research on the ethical positions of health professions. The significant differences found between the three professions studied is a promising start. If there are in fact differences in ethical viewpoints among health professionals, who often have to work as a team to give health care to a patient, the potential for conflict is enormous. Erde has pointed out that in ethical decision-making, the professional brings not only his professional values but also his personal values. In this respect, he observed "how pervasively people are influenced by their values; how holding or adopting values affects one's construction of the world as well as the action and options one chooses among" (p. 23). He argued that if everyone agreed, there would be less interpersonal conflict and little need for ethics; but this homogeneity does not pertain. It is this potential for conflict which underscores the need for knowledge of the ethical stances of various health professionals. In this respect, Pellegrino, et al. (1985) surveyed 3,000 practicing physicians who had graduated between 1974 and 1978. They found that among all respondents with and without ethics training, 99.4% indicated that the most powerful factors influencing their approaches to ethical issues were personal values and beliefs (p. 50). An understanding of the fact that health professionals can and

do have differing ethical stances, and that such stances are in some way related to the type of health profession chosen, is of tremendous value to those in charge of developing ethics courses for students in the health professions. The differences observed would form a basis for the development of such courses to enable students to understand the type of value conflicts they may encounter, both as health professionals and later as administrators. The need for such an approach to the development of ethics courses is emphasized by Self (1983) when he observed:

> Lastly, the large affirmative response to question 10 (83.07%) concerning the need for more emphasis to be placed upon medical ethics in medical education indicates that the medical profession perceives the need for more instruction in medical ethics. Since conceptual clarification and consistency in logical reasoning are major aims of philosophy, perhaps an increase in exposure to medical ethics would give physicians a better understanding of the philosophical foundations of medical ethical decision-making and help eliminate some of the inconsistency in their philosophical stances concerning medical ethical issues (p. 68).

Pellegrino, et al., emphasize this need when they concluded:

> Not surprisingly, factors other than course work were perceived to have the strongest influence on the respondent's values and beliefs. It is to be expected that persons in their 20s would arrive in medical school with some well-developed moral beliefs. What a study of ethics can add is the skill for systematic analysis of these beliefs and a capacity to handle the conflicts in values that can arise between physicians, families, and society in actual clinical decisions.
>
> Clearly, the physician must understand both his own and the patient's moral values if he is to deal with decisions about truth telling, obtaining morally valid

> consent, respecting the patient's autonomy, keeping promises, making just decisions, starting or stopping life-support measures, treating congenitally defective infants, or the myriad other issues common to medical practice today. The differences in fundamental beliefs in our society about the value of human life, the conflict of responsibility to the patient and to society, even the nature and meaning of human life, are such that the physician must be able to analyze ethical decisions with as much care and confidence as he does clinical decisions.
>
> Courses in ethics can help to define and clarify ethical issues so that physicians and others can know when they can or cannot cooperate with the patient's wishes (pp. 52-53).

Conclusions

The major purpose of this study was to determine whether there was a significant difference in ethical ideology among students in different health professions as a function of type of health profession. The results indicated that there was a significant difference in ethical ideology among health professionals. However, when students in the various health professions were compared on the scales that make up the EPQ, no significant differences were observed on the relativism scale. Significant differences were obtained on the idealism and the total scales.

Significant interactions were obtained for some characteristics on both the idealism and the relativism scales. The lack of significant interactions between type of health profession and other characteristics of the students pointed to the predominance of type of health professions in predicting ethical ideology.

The study is of an exploratory nature, and therefore it would be premature to arrive at a final conclusion. However, the results obtained appear to confirm the investigator's intuitive belief that ethical ideology and group membership are related. The study makes a valuable contribution to the scant literature on ethical ideology and health professions. It demonstrates clearly that members of different health professions hold different ethical stances.

Recommendations for Further Research

1. The findings of this study emphasize the need for further research on the extent to which differences in ethical ideology is related to types of health professions. In particular, more research needs to be conducted to determine if differences observed in ethical ideology among the health professions holds true for other health professions.

2. Research is needed to determine the extent to which type of ethical ideology is related to decision-making among health professionals. In particular, research needs to be conducted to determine the extent to which health professionals perceive conflict in the decision-making process.

3. This study is regarded as exploratory in nature. There is need for replication, using larger samples of institutions and students.

4. Finally, the implications of the study highlights the need for more research that focuses on the socio-demographic characteristics of health professions students. This may help to further explain the type of ethical ideology they endorse.

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APPENDIX A

Table A1

Ethical Ideology of Health Profession Students, N = 267

ETHICAL POSITION	N	%
Situationist	77	28.8
Absolutist	67	25.1
Subjectivist	64	24.0
Exceptionist	59	22.1
Total	267	100.0

Table A2

Health Profession of Participants N = 267

ETHICAL POSITION	N	%
Allied Health	117	43.8
Nursing	77	28.8
Medicine	73	27.3
Total	267	100.0

Table A3

Sex of Health Professional Students, N = 267

SEX	N	%
Male	86	32.2
Female	181	67.8
Total	267	100.0

Table A4

Race of Health Professional Students, N = 267

RACE	N	%
White	157	58.8
Black	110	41.2
Total	267	100.0

Table A5

Exposure to Ethics Course of Health Professional Students,
N = 267

ETHICS COURSE	N	%
Yes	120	44.9
No	147	100.0
Total	267	100.0

Table A6

Educational Level of Health Professional Students, N = 267

EDUCATIONAL LEVEL	N	%
Junior	156	58.4
Senior	111	41.6
Total	267	100.0

Table A7

Locus of Control of Health Professional Students, N = 267

LOCUS OF CONTROL	N	%
Internal	124	46.4
External	143	53.6
Total	267	100.0

Table A8

Religious Strength of Health Professional Students

RELIGIOUS STRENGTH	N	%
Religious	180	67.4
Non Religious	87	32.6
Total	267	100.0

APPENDIX B

SOCIO-DEMOGRAPHIC DATA QUESTIONAIRE

1. Please indicate your sex. (Circle One)
   a. Male
   b. Female

2. Please indicate the year you were born.

   ____

3. What is your health care discipline? (Circle One)
   a. Allied Health (Please specify OT, PT, RAD Tech, etc.)
   b. Nursing
   c. Medicine

4. Please indicate your classification. (Circle One)
   a. Freshman
   b. Sophomore
   c. Junior
   d. Senior
   e. Medical School (Please specify 1st yr., 2nd yr., etc.) _____

5. What is your racial or ethnic group? (Circle One)
   a. Caucasian/White
   b. Black/Afro-American
   c. Hispanic
   d. Native American/American Indian
   e. Asian/Oriental
   f. Other (Please Specify) ______________

6. Are you a member of an established church? (Circle One)
   a. Yes
   b. No

7. If the answer to number 6 is no, do you ever go to church, Synagoge or Temple? (Circle One)
   a. Yes
   b. No

8. What is your religious preference? (Circle One)
   a. Baptist
   b. Born Again Christian
   c. Christian Scientist
   d. Jehovah Witness
   e. Jewish
   f. Morman (Later Day Saints)
   g. Protestant (Please specify Episcopals, Presbyterian, Methodist, Unitarian)
   h. Roman Catholic
   i. Seventh Day Adventist
   j. Other (Please specify) _______________

9. How often do you go to church? (Circle One)
   a. Every Sunday or Saturday
   b. Once every 2 weeks
   c. Once a month
   d. Two times a year
   e. Only on Holy Days (e.g., Christmas, Easter Passover, etc.)

10. Have you taken a course in Ethics? (Circle One)
   a. Yes
   b. No

11. How would you classify the community where you spent most of your youth? (Circle One)
   a. rural
   b. small town/village
   c. small city
   d. large city
   e. suburb of large city

The Ethics Position Questionnaire*

Instructions: You will find a series of general statements listed below. Each represents a commonly held opinion and there are no right or wrong answers. You will probably disagree with some items and agree with others. We are interested in the extent to which you agree or disagree with such matters of opinion.

Please read each statement carefully. Then indicate the extent to which you agree or disagree by placing in front of the statement the number corresponding to your feelings, where:

1 = Completely disagree	4 = Slightly disagree	7 = Moderately agree
2 = Largely disagree	5 = Neither agree or agree	8 = Largely agree
3 = Moderately disagree	6 = Slightly agree	9 = Completely agree

1. A person should make certain that their actions never intentionally harm another even to a small degree.

2. Risks to another should never be tolerated, irrespective of how small the risks might be.

3. The existence of potential harm to others is always wrong, irrespective of the benefits to be gained.

4. One should never psychologically or physically harm another person.

5. One should not perform an action which might in any way threaten the dignity and welfare of another individual.

6. If an action could harm an innocent other, then it should not be done.

7. Deciding whether or not to perform an act by balancing the positive consequences of the act against the negative consequences of the act is immoral.

8. The dignity and welfare of people should be the most important concern in any society.

9. It is never necessary to sacrifice the welfare of others.

10. Moral actions are those which closely match ideals of the most "perfect" action.

11. There are no ethical principles that are so important that they should be a part of any code of ethics.

12. What is ethical varies from one situation and society to another.

13. Moral standards should be seen as being individualistic: What one person considers to be moral may be judged to be immoral by another person.

14. Different types of moralities cannot be compared as to "rightness."

15. Questions of what is ethical for everyone can never be resolved since what is moral or immoral is up to the individual.

16. Moral standards are simply personal roles which indicate how a person should behave, and are not be applied in making judgments of others.

17. Ethical considerations in interpersonal relations are so complex that individuals should be allowed to formulate their own individual codes.

18. Rigidly codifying an ethical position that prevents certain types of actions could stand in the way of better human relations and adjustment.

19. No rule concerning lying can be formulated; whether a lie is permissible or not permissible totally depends upon the situation.

20. Whether a lie is judged to be moral or immoral depends upon the circumstances surrounding the action.

*Developed by Forsyth (1980)

THE ROTTER
INTERNAL-EXTERNAL LOCUS OF CONTROL SCALE

This is a questionnaire to find out the way in which certain important events in our society affect different people. Each item consists of a pair of alternatives lettered a or b. Please select the one statement of each pair (and only one) which you more strongly believe to be the case as far as you're concerned. Be sure to select the one you actually believe to be more true rather than the one you think you should choose or the one you would like to be true. This is a measure of personal belief; obviously there are no right or wrong answers.

Your answer, either a or b to each question on this inventory, is to be reported beside the question. Print your name and any other information requested by the examiner on the bottom of the questionnaire.

Please answer these items carefully but do not spend too much time on any one item. Be sure to find an answer for every choice. For each numbered question make an X on the line beside either the a or b, whichever you choose as the statement most true.

In some instances you may discover that you believe both statements or neither one. In such cases, be sure to select the one you more strongly believe to be the case as far as you're concerned. Also try to respond to each item independently when making your choice; do not be influenced by your previous choices.

REMEMBER

Select the alternative which you personally believe to be more true.

I more strongly believe that:

1.___a. Children get into trouble because their parents punish them too much.
___b. The trouble with most children nowadays is that their parents are too easy with them.

2.___a. Many of the unhappy things in people's lives are partly due to bad luck.
___b. People's misfortunes result from the mistakes they make.

3.___a. One of the major reasons why we have wars is because people don't take enough interest in politics.
___b. There will always be wars, no matter how hard people try to prevent them.

4.___a. In the long run people get the respect they deserve in this world.
___b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5. ___a. The idea that teachers are unfair to students is nonsense.
___b. Most students don't realize the extent to which their graces are influenced by accidental happenings.

6. ___a. Without the right breaks one cannot be an effective leader.
___b. Capable people who fail to become leaders have not taken advantage of their opportunities.

7. ___a. No matter how hard you try some people just don't like you.
___b. People who can't get others to like them don't understand how to get along with others.

8. ___a. Heredity plays the major role in determining one's personality.
___b. It is one's experiences in life which determine what they're like.

9. ___a. I have often found that what is going to happen will happen.
___b. Trusting to fate has never turned out as well for as making a decision to take a definite course of action.

10. ___a. In the case of the well prepared student there is rarely if ever such a thing as an unfair test.
___b. Many times exam questions tend to be so unrelated to course work that studying is really useless.

11. ___a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
___b. Getting a good job depends mainly on being in the right place at the right time.

12. ___a. The average citizen can have an influence in government decisions.
___b. This world is run by the few people in power, and there is not much the little guy can do about it.

13. ___a. When I make plans, I am almost certain that I can make them work.
___b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14. ___a. There are certain people who are just no good.
___b. There is some good in everybody.

15. ___a. In my case getting what I want has little or

nothing to do with luck.

___b. Many times we might just as well decide what to do by flipping a coin.

16. ___a. Who get to be the boss often depends on who was lucky enough to be in the right place first.

___b. Getting people to do the right thing depends upon ability; luck has little or nothing to do with it.

17. ___a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control.

___b. By taking an active role in political and social affairs the people can control world events.

18. ___a. Most people can't realize the extent to which their lives are controlled by accidental happenings.

___b. There really is no such thing as "luck."

19. ___a. One should always be willing to admit his mistakes.

___b. It is usually best to cover up one's mistakes.

20. ___a. It is hard to know whether or not a person really likes you.

___b. How many friends you have depends upon how nice a person you are.

21. ___a. In the long run the bad things that happen to us are balanced by the good ones.

___b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22. ___a. With enough effort we can wipe out political corruption.

___b. It is difficult for people to have much control over the things politicians do in office.

23. ___a. Sometimes I can't understand how teachers arrive at the grades they give.

___b. There is a direct connection between how hard I study and the grades I get.

24. ___a. A good leader expects people to decide for themselves what they should do.

___b. A good leader makes it clear to everybody what their jobs are.

25. ___a. Many times I feel that I have little influence over the things that happen to me.

___b. It is impossible for me to believe that chance or luck plays an important role in my life.

26. ___a. People are lonely because they don't try to be friendly.

    ___b. There's not much use in trying too hard to please people, if they like you, they like you.

27. ___a. There is too much emphasis on athletics in high school.

    ___b. Team sports are an excellent way to build character.

28. ___a. What happens to me is my own doing.

    ___b. Sometimes I feel that I don't have enough control over the direction my life is taking.

29. ___a. Most of the time I can't understand why politicians behave the way they do.

    ___b. In the long run the people are responsible for bad government on a national as well as on a local level.

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