Journal of Medical Ethics, 1996; **22: 259–260**

Editorial

Ethnography, medical practice and moral reflective equilibrium

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In this issue of the journal a Canadian sociologist and medical student, David Robertson, describes studies he carried out in an English old-age psychiatry ward of the moral concepts and values used by doctors and nurses in their everyday work.[1]

Mr Robertson joined the doctors as a medical student and the nurses as an honorary nursing assistant. He noted examples of ethically laden discussion or actions and then analysed them in terms of some contemporary ethical theoretical concepts that seemed relevant. Having encountered some "scepticism among health practitioners and academics that ethical theory, especially the principles-based mainstream, can usefully describe the approaches of doctors and nurses to patient care", he was particularly interested to see which – if any – of three current types of approach to health care ethics – principles-based, virtue-based and feminist – seemed best to fit the ethical discourse and action he actually observed on the ward.

In brief, he found first that what he calls "mainstream, principles-based health care ethics" of the Beauchamp and Childress four principles type, when supplemented by both "feminist", relationship-orientated, ethical theory and by character-orientated virtue theory, were together helpful in describing the ethical talk and actions of the doctors and nurses whom he observed on the ward.

He also discovered some differences in their underlying professional objectives. Doctors tended to be more concerned than nurses to solve clinical problems, to optimise patients' organic functioning, and to do research. Nurses tended to be more concerned than doctors to maintain daily care of patients and foster their normal functioning and independence. Such professional differences, believes Mr Robertson, help to explain some differences he found in the ethical perspectives of the doctors and nurses.

Thus although both doctors and nurses were strongly committed to beneficence, in the sense of utility of outcomes for patients, nurses were much more often also concerned with beneficence in the sense of the need for "*being* a benevolent practitioner (an idea better described by virtue theory) and [in] fostering good *relationships* with patients (a concept elaborated in feminist relationship theory)".

Nurses and doctors also shared a strong commitment to respect for patients' autonomy, both in the sense of respecting their autonomy rights and in the sense of autonomy as based on rationality. Nurses, however, were also more inclined to see autonomy also manifested by independent abilities falling short of rational decision-making (for example, independent eating, shaving and washing in patients with dementia); and to see autonomy as manifested in the ability to relate to other people (for example in a patient with dementia being able to "reach out towards the other", expressing tenderness and humour, despite the dementia and dysphasia).

Both nurses and doctors were committed to just distribution of scarce resources and in the context of day-to-day resource allocation they seemed to share a similar egalitarian conception of such justice, whereby patients were regarded as having equal worth and equal entitlements and were to be allocated resources in proportion to their needs.

In practice the moral principles may of course conflict and the most frequently observed such conflict, hardly surprising in the context, was between respect for autonomy and beneficence, particularly in the sense of respect for patients' autonomy rights conflicting with beneficence in the sense of patient utility. Although there were differences within each professional group in resolving these conflicts Mr Robertson discovered a marked difference between the two groups with nurses being more likely to support respect for patients' autonomy at the expense of beneficence, while doctors were more likely to support beneficence at the cost of respect for autonomy.

Mr Robertson suggests that the different professional goals and daily tasks of the doctors and nurses he observed were quite likely to account for at least some of the differences in ethical perspective. For example, nurses' observed preference for respect for patients' autonomy over beneficence when these conflicted might be explicable, he suggests, by nurses' closer relationships and greater identification with the patients.

Two types of question arise from such studies. First, even if the methodology is sociologically sound and the results are accurate, what is the ethical

significance of empirical findings? Second, even if differences between doctors' and nurses' ethical reasoning and behaviour genuinely exist, what is the ethical significance of that?

So far as the first question is concerned there is a fundamental philosophical criticism of such empirical studies, which is that even if 100 per cent of a sample of people studied were found to think and act in a particular way this would not necessarily help one to decide whether their thoughts and actions were morally justifiable or unjustifiable. A klu klux klan lynch mob might all be found to think and act in the same way and still be properly judged to be thinking and behaving in a morally indefensible way.

However, while it is true that the mere empirical facts about people's thoughts and actions are insufficient to ground moral judgments, none the less it is by reflection on people's considered actions, attitudes and judgments, and the moral justifications they give for these, that moral theory can and, it is widely acknowledged, should be developed. Such theory may then turn out to be inconsistent with *some* of the considered judgments and so prompt us to review even these. As a result of such review we may revise those judgments so as to be consistent with the theory; alternatively the judgments may withstand such review despite their conflict with the theory, in which case it is the theory that will require modification to accommodate them.

This process of dynamic moral "reflective equilibrium", described by Rawls[2] and by Beauchamp and Childress[3] requires both philosophical reflection and theory on the one hand, and empirical observation of the facts – the facts of people's considered moral judgments, attitudes and actions – on the other. Neither is supreme, both are essential. In the pursuit of such reflective equilibrium empirical studies into what people's considered moral attitudes, actions and judgments are and their justifications for them, are of importance not just to health care ethics but to ethics in general.

What about the differences in moral reasoning discovered between the nurses and the doctors? The first point to note is that the study discovered major agreements between the two groups concerning the importance of the Beauchamp and Childress four principles. Since these are claimed to be compatible with a wide range of moral theories and perspectives, and to be widely acceptable, it is agreeable (though hardly surprising) to those who advocate use of these principles for moral analysis, to find that they are indeed used in practice.

So far as the differences are concerned, it is important to recognise that, despite protestations by some critics to the contrary, the four principles approach is in no way incompatible with or antagonistic to either virtue approaches to ethics or the importance of good relationships. On the contrary these approaches are complementary to principle-based ethics, and an adequate practical ethics has always been recognised by proponents of the four principles approach to require them all.

When it comes to differences in the way conflicting principles are "weighted" or otherwise prioritised in particular cases, it is important to recognise that the principles approach is entirely compatible with different approaches to, and results of, such prioritisation. While Mr Robertson offers a psychologically plausible explanation of such differences, it would have been interesting to have had the views of the doctors and nurses themselves on why they gave priority to one rather than another principle when they conflicted in particular cases. The whole issue of how to "balance" or "harmonise" or otherwise prioritise conflicting moral principles or values in particular cases – the moral meat of casuistry – is one that requires far more study than it is currently obtaining, either philosophically or empirically.

The differences perceived between the nurses and doctors over the concept of autonomy also deserve further study. It may be, as Mr Robertson suggests, that the nurses he studied thought that being able to eat, wash and shave oneself manifested autonomy even in the absence of rationality, and that this was why they encouraged their severely senile patients to do so. But other explanations are possible. One is that the nurses were uncertain as to how much the patients really had lost their ability to reason, as distinct from losing their ability to *manifest* their ability to reason. For example, the "sexagenarian patient with rapidly progressing dementia" who was able to express tenderness and humour "despite his dysphasia" might well have been assessed, by the nurse describing him, as autonomous in the ordinary sense of being able to make rational choices for himself despite not being able to discuss such choices because of his dysphasia.

Such points do not undermine the importance of Mr Robertson's study in showing that ethnography can be a useful method for studying the ethical concepts and theoretical approaches actually employed by clinicians in their clinical practice. Such studies may be predicted to become an ever more important part of the dynamic moral reflective equilibrium that is needed between theoretical medical ethics and the norms of clinical practice.

References

1 Robertson DW. *Journal of Medical Ethics* 1996; 22: 290–7.
2 Rawls J. *A theory of justice*. Oxford: Oxford University Press, 1971: 20–1, 46–53, 579–83.
3 Beauchamp T, Childress J. *Principles of biomedical ethics* [4th ed]. Oxford: Oxford University Press, 1994: 3–43.