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# GENDER DIFFERENCES IN THE PERCEPTION OF ETHICS AND CIVIC MORAL DISENGAGEMENT IN MEDICAL DOCTORS

**Sauliha Ali [1,*], Asma Majeed [1], Zara Haroon [1] and Komal Faisal [2]**

[1] *Department of Applied Psychology, Kinnaird College for Women, Lahore, Pakistan*
[2] *Center of Leadership and Decision Making, University of the Punjab, Lahore, Pakistan*

**ABSTRACT**

The present study aims to find the gender differences in the perception of doctors while making ethical decisions and their level of civic morality. A simple distinction between ethics and morality would be that ethics are in reference to an external source, they come from the work environment. A comparative research design has been used in this study for which a Purposive sampling strategy was selected. The participants of the study selected were 75 male and 75 female doctors aged 25-40 years, practicing in Jinnah Hospital and Services Hospital, Lahore. Ethics Position Questionnaire (EPQ) and Moral Disengagement Scale (MDS) were utilized to collect the data. To identify the differences among the variables Independent Sample T-test was administered on the collected data. The results of the study revealed that there is no significant difference in the perception of ethics and civic moral disengagement, this brought to the view that gender alone does not influence one's ethics, pro-social reasoning, and behavior. The findings of this current research state that there are no differences among doctors working in two different locations, among genders, or between ethics and civic moral disengagement. This would be helpful to know because doctors constantly face questions regarding ethics and have to make fast, effective decisions that will affect their patient's life.

*Keywords: Ethical decisions; Civic morality; Moral disengagement; Pro-social reasoning; Perception.*
** Email: f17bpsy021@gmail.com*

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## INTRODUCTION

There has been a recent surge of interest in finding how various professions deal with issues of ethics and morality, furthermore, exploring gender differences among professionals has also been of great interest. Doctors are renowned for having a strict code of ethics to follow which sometimes proves to be difficult (MacKenzie, 2009). Over the past few years, morality and ethics have been the subject of interest by many psychologists and there have been several researches to study them. The initial research and theory was started by Jean Piaget in 1932, while his development focused on moral issues and reasoning among children. It was Lawrence Kohlberg who further developed the theory and organized it into various categories (McLeod, 2013). The theory of moral development defines that the development of morality starts at a very young age during adolescence and then continues through several stages. It can be affected and developed by various factors. The development of morality can either be done negatively or positively. This is all dependent on how the individual manages to accomplish the task that is faced by him/her before going through each stage (Kohlberg, 1958).

Kohlberg held the belief that a person will progress through each stage one after the other. They only comprehend and come to a moral rationale at the morality understanding of their own stage. When they see the reasoning of higher moral stages, they are attracted to it and it encourages them to reach out and

achieve a higher stage of moral understanding. Kohlberg also held the belief that higher moral understanding can be achieved through formal education. The theory is based on the fact that people develop and increase their understanding of their conflicts at each stage (Kohlberg, 1958). Moral disengagement was initially introduced by Albert Bandura (1997) in order to speak to the psychosocial mechanisms by which method they lessen the moral consequences of harmful behaviors. Bandura proposed that moral disengagement occurs through a set of eight interrelated cognitive mechanisms that facilitate unethical behavior. Moral justification, euphemistic labeling, and advantageous comparison are three mechanisms of moral disengagement that serve to cognitively restructure unethical acts so that they appear less harmful (Achenbach & Edelbrock, 1979).

Medical professionalism is essential for maintaining the integrity of the profession, and it includes demonstrating compassion, caring, and a willingness to put the concerns of patients and society above one's own. Medical education should promote the development of these professional qualities. However, studies have shown that medical school can often have a detrimental effect on certain aspects of students' professional growth. Negative characteristics such as cynicism may increase, and ethical and moral development can be stunted. Empathy is one of the most highly desirable professional traits that medical education should promote because empathic communication skills promote patient satisfaction and adherence to treatment plans while decreasing the likelihood of malpractice suits. Patients view physicians who possess the quality of emotional empathy as being better caregivers. A physician may possess competent diagnostic skills, yet be considered by patients as "ineffective" because the physician misses the link between patient satisfaction, adherence to medical instructions, and physician empathy. Previous studies suggest that certain measures of a medical student's personality may predict whether the student will enter one of five core specialties that are characterized by the continuity of patient care (i.e., family medicine, pediatrics, internal medicine, obstetrics-gynecology, and psychiatry) versus noncore specialties, where there is less interpersonal contact and continuity of care (all other specialties, for instance, emergency medicine, surgery, radiology, pathology). With these possible personality–specialty connections in mind, we designed the present study to determine whether vicarious empathy decreases as students progress through medical school, this also brings into view the students who choose different specialties regarding patient contact, and those students might have vicarious empathy whose patient contact is higher compared to students having less patient contact specialties (Bandura, 2001).

A study conducted in the clinical setting held 20 interviews and four focus group discussions used to identify the nurse's clinical experience of ethical violations. Several categories of ethical violations were found which included the patient reluctance to receive treatment from nurses, the practice of patient discrimination on the basis of a patient's socio-demographic status, the near-absence of consent taken from patients for most non-surgical medical procedures, the absence of patient consent taking for receiving treatment from student nurses, nurses withdrawing treatment out of fear for their safety, a non-learning culture and, finally, blame-shifting and non-reportage of errors (Jafree et al., 2015). A recent cross-sectional study was conducted in Jinnah Postgraduate Medical Centre, Karachi among the Medicine, Surgery, and Gynecology and Obstetrics Ward from December 2020 to June 2021, analyzing the awareness of medical ethics among practicing medical officers. An account of 227 house officers participated among which 59 percent had not even read the PDMC code of medical ethics. It was concluded that there is a lack of emphasis on teaching medical ethics in the medical curriculum (Aleem et al., 2021).

**The Rationale of the Study**

The aim of this research study is to evaluate the difference in ethics and civic moral disengagement and whether gender differences exist in the doctors' perception. Its purpose is to determine differences in the perception of ethics and civic moral disengagement among doctors from different locations. The benefit of this study would be to know if the environment that the doctors work under makes a difference in their perception of ethics and civic moral disengagement. The primary reason for identifying whether there is

the presence of ethics and moral codes is due to the absence of the rule of law in the healthcare domain. Every year there are multiple incidents reported in the country where patients report the negligence and lack of expertise of the doctors and other medical professionals. Similarly, with regards to gender differences among the ethical and moral standards in the doctors, it has been seen that female doctors are considered to be empathic and more concerned with the well-being of both the patients and their families, in contrast to male doctors who are reported to be harsh and less empathetic. Keeping in mind this aim of the study, it will be beneficial in understanding if the doctors are affected by the environment that they work in which could lead to investigation on the factors that affect a doctor's perception.

### Hypotheses

The study will either prove or falsify the following:

1. There is a significant gender difference in Ethics Position and its categories.
2. There is a significant gender difference in Pro-social Behavior and its types
3. There is a statistically significant difference in the perception of doctors regarding civil moral disengagement

There is a significant difference in perception of ethics and civic moral disengagement among doctors of two hospitals and their categories.

## METHODOLOGY

Under quantitative research, a comparative research design has been used in this study. For the collection of data, a purposive sampling strategy was utilized. The participants of the study selected were doctors of ages 25-40, practicing within Lahore. A research sample of 150 doctors (N = 150, Male = 75, Female = 75) has been selected from Jinnah Hospital and Services Hospital. These two government hospitals were selected because of their high presence from every sector patients (i.e. different socio-economic backgrounds, provinces). These hospitals are well-known among the patients and are highly visited. For the data collection, two main measures were selected, including the Ethics Position Questionnaire (EPQ) and the Moral Disengagement Scale (MDS). The Ethics Position Questionnaire (EPQ) consists of 20 items and was developed by Forsyth (1980) to measure individual differences in moral thought, prompted in part by curiosity about the diverse reactions. The EPQ contains two subscales: one assesses idealism and the other relativism. In most cases, respondents indicate the degree of agreement with each item using a scale that ranges from disagreement (1) to agreement (9). Idealism scores are calculated by summing responses from items 1 to 10. The Moral disengagement scale was used, and exonerations were presented in 32 items (with a 5-point response) tapping the three different mechanisms by which moral self-sanctions can be disengaged from aggressive conduct (a = .92).

### Procedure

The research was conducted once approval had been given by Jinnah Hospital and Services Hospital. Prior to getting the questionnaire, informed consent was taken from the participants. Participants were thereby explained orally and through a written form about how their personal information would be confidential and privacy would be ensured as well as the time limit alongside any additional information about the questionnaires. The scales took around 15-20 minutes to complete.

## RESULTS AND DISCUSSION

Table 1 shows the independent sample t-test carried out on the scales and subscales of the Ethical Positions questionnaire. The results indicate that there is no gender difference between the scale and subscales. Therefore the alternative hypothesis is rejected. This indicates that males and females do not show any differences in the categories of pro-social moral reasoning.

Table I. Gender Differences in the Ethics Position Questionnaire (EPQ), Idealism and Relativism Categories

| Variables | Females | | Males | | | 95% CI | | | |
|---|---|---|---|---|---|---|---|---|---|
| | M | SD | M | SD | t(df) | P | LL | UL | Cohen's d |
| EPQ | 7.14 | .00 | .03 | .00 | 1.61(148) | . | -.00 | .00 | 0.47 |
| Idealism | 7.26 | 7.14 | 7.14 | .00 | -1.35(148) | .70 | -.00 | .00 | -.80 |
| Relativism | .5.56 | 5.78 | 5.78 | .00 | -.83(148) | .32 | -.00 | .00 | -.74 |

Note: Females=75; Males=75; M=Mean; SD=Standard Deviation; df =degree of freedom; CI=confidence interval; LL=lower limit; UL=upper limit

Table 2. Gender Differences in the Civic Moral Disengagement Scale and its Variables.

| Variables | Females | | Males | | | 95% CI | | | |
|---|---|---|---|---|---|---|---|---|---|
| | M | SD | M | SD | t(df) | p | LL | UL | Cohen's d |
| CMD | | | | | -.79(148) | .60 | -.18 | .07 | -.12 |
| Moral Justification | 2.51 | .99 | 2.59 | .92 | .51(148) | .60 | | .01 | -.31 |
| Euphemistic Language | 2.61 | 1.05 | .95 | .19 | .77 (148) | .44 | -.02 | .07 | .13 |
| Advantageous Comparison | 2.57 | .91 | 2.56 | .90 | -.06(148) | .94 | -.06 | .01 | -.27 |
| Displacement of Responsibility | .65 | .23 | .64 | .23 | -.19(148) | .84 | -.05 | .06 | .05 |
| Diffusion of Responsibility | 2.59 | .97 | 2.81 | 1.72 | .96(148) | .33 | -.06 | .05 | -.05 |
| Distorting Consequences | 2.53 | .91 | 2.67 | .98 | .92(148) | .35 | -.03 | .02 | .05 |
| Attribution of Blame | 2.55 | .96 | 2.63 | 1.01 | .51(148) | .82 | .60 | .05 | -.05 |
| Dehumanization | 2.79 | .95 | 3.10 | .95 | 1.96(148) | .67 | .05 | .02 | .05 |

Note: Females=75; Males=75; M=Mean; SD=Standard Deviation; df=degree of freedom; CI=confidence interval; LL=lower limit; UL=upper limit

According to Table 2, there has been no significant gender difference seen among the civic moral disengagement and its prospective variables t(148)= -.79, p>.001. However, it can be assessed that gender alone can be proven to be influential for one's pro-social behavior and reasoning.

Table 3. Differences in perception of ethics and civic moral disengagement among doctors.

| Variables | Jinnah Hospital | | Services Hospital | | | | 95% CI | | |
|---|---|---|---|---|---|---|---|---|---|
| | M | SD | M | SD | t(df) | p | LL | UL | Cohen's d |
| EPQ | 7.14 | .00 | .03 | .00 | -4.35(148) | . | -.00 | .00 | 0.47 |
| Idealism | 7.13 | 2.47 | 7.27 | .1.14 | -4.35(148) | .66 | -.76 | .48 | -.80 |
| Relativism | .5.45 | 1.35 | 5.89 | 1.36 | -1.95148) | .05 | -.87 | .00 | -.74 |

Note: Jinnah Hospital=75; SIMS=75; M=Mean; SD=Standard Deviation; df=degree of freedom; CI=confidence interval; LL=lower limit; UL=upper limit

Table 3 is based on the evaluation of the third hypothesis of this study, whereby it can be analyzed that there has been no significant variance reported in the changes in the perception of doctors from both the local hospitals regarding ethics and civic moral disengagement.

Table 4. Differences among doctors of both hospitals and their perception of Civic Moral Disengagement Scale and its categories.

| Variables | Jinnah Hospital | | Services Hospital | | | | 95% CI | | |
|---|---|---|---|---|---|---|---|---|---|
| | M | SD | M | SD | t(df) | p | LL | UL | Cohen's d |
| CMD | | | | | -.79(148) | .28 | -.18 | .07 | -.12 |
| Moral Justification | 2.63 | .90 | 2.47 | .99 | 1.01(148) | .28 | -.14 | ..47 | -.31 |
| Euphemistic Language | 2.81 | 1.01 | 2.53 | .98 | 1.72 (148) | .08 | -.04 | ..60 | .13 |
| Advantageous Comparison | 2.61 | .87 | 2.52 | .93 | .65(148) | .51 | -.19 | .39 | -.27 |
| Displacement of Responsibility | .67 | .23 | .62 | .23 | 1.37(148) | .17 | -.02 | .12 | .05 |
| Diffusion of Responsibility | 2.92 | 1.72 | 2.48 | .92 | 1.94(148) | .05 | -.00 | .88 | -.05 |
| Distorting Consequences | 2.69 | .94 | 2.51 | .95 | 1.18(148) | .23 | -.12 | .48 | .05 |
| Attribution of Blame | 2.68 | .94 | 2.50 | 1.02 | 1.13(148) | .25 | -.13 | .50 | -.05 |
| Dehumanization | 3.03 | .95 | 2.86 | .99 | 1.09(148) | .27 | -.13 | .48 | .05 |

Note: Females=75; Males=75; M=Mean; SD=Standard Deviation; df=degree of freedom; CI=confidence interval; LL=lower limit; UL=upper limit.

In analyzing the results (Table 4) for the differences in Civic Moral Disengagement and its categories, there has been no significant difference documented in the perception of the doctors from both hospitals.

## Discussion

### *Differences in Gender in Perception of Ethics*

The first hypothesis stated that there is a significant gender difference in the perception of ethics. As this hypothesis was rejected interesting aspects are brought in to see why gender alone does not influence one's ethics and behavior.

In a study by Cronso and Gneezy (2009), in a survey, they studied and examined the differences between men and women on factors that are relevant in the labor market. In their study, they found that although when it came to risk-taking women, they were more aversive to it than men. Gender differences in competitive preferences were much smaller when they were placed in a similar profession. This was due to the fact that when they have chosen to be in a similar competitive environment, they will have similar or more familiar levels of competitiveness. This shows that under the same influences men and women are more likely to make similar decisions.

Dalton and Ortegren (2011) concluded in their study that even though gender is the most vastly researched and studied factor in ethics literature, in previous research it was seen that differences in gender showed that women would consistently report more ethical situations. The previous research also showed that women were more likely to answer in a way that showed more socially desirable responses. Therefore, it remains to be seen if women are more likely to make more ethical choices due to the social desirability factor or due to the fact that they are more ethical, which is one of the most frequently studied variables within the ethics literature. Their research results lead to the conclusion that the basis for ethical decisions was rather based on social desirability standards and not in fact gender.

Furthermore, Hyde (2005) researched differences in gender and found that gender differences seem to depend on the context in which they were measured. In studies designed to eliminate gender norms,

researchers demonstrated that gender roles and social context strongly determined a person's actions. For example, after participants in one experiment were told that they would not be identified as male or female, nor did they wear any identification, none conformed to stereotypes about their sex when given the chance to be aggressive. In fact, they did the opposite of what would be expected - women were more aggressive and men were more passive.

***Differences in gender in perception of Civic Moral Disengagement***

According to the second hypothesis being rejected, there is no significant difference in the perception of civic moral disengagement. The second hypothesis stated that there is a significant gender difference in civic moral disengagement. As this hypothesis was rejected interesting aspects are brought in to see why gender alone does not influence one's pro-social reasoning and behavior.

Perren and Helfenfinger (2012) concluded that even though men report greater heights of bullying and lowered morality when taken to cyber bullying, where their identities were not as important, the gender differences would become non-significant. The findings of the study were that individual differences were much more important to understanding moral disengagement rather than just gender differences. A lack of moral emotions was a better predictor for morally disengaged behavior.

Pornari and Wood (2010) found that moral disengagement was more correlated to aggression and not to any significant gender differences. This led to the conclusion that those who engaged more in aggressive behavior had more distortion in their patterns. They could rationalize and justify their behavior even more. They did not find any strong differences in gender with regard to moral disengagement. These findings are in line with earlier studies, which found high levels of MD in generally aggressive youngsters and school bullies and not in boys rather than girls.

***Differences among Doctors in the perception of ethics and civic moral disengagement***

The hypothesis said that the perception of ethics and civic moral disengagement would be different. As the hypothesis was rejected further aspects that would affect the ethics and civic moral disengagement of the doctors.

Bandura's moral disengagement theory has hypothesized that the personal values of a person affect and influence moral disengagement and influence their decisions. Therefore, the influence is not due to the factor of the environment but rather due to internalized factors. This can explain why the hypothesis was rejected as the environmental influence does not affect the ethics and moral disengagement of the doctors.

In a study by Whipple and Swords (1992), they examined the differences in ethics between students from various colleges for positions in the management of business. The results of the study indicated that there are no differences between the demographics and they do not affect their perception of the ethical decision-making process.

## CONCLUSIONS AND RECOMMENDATIONS

Medical ethics has to be considered an essential part of the belief system of a physician. There is a lack of emphasis on the teaching of ethical practices in the medical curriculum resulting in a lack of knowledge and practice regarding ethical issues among the great majority of doctors across Pakistan. Hence no particular gender difference is also noted in the study. In order to ensure a healthy environment in the hospital and medical system, medical practitioners should be taught civil and moral ethics as a mandatory part of their medical education curriculum so that a better quality of healthcare can be delivered to the patients. Among the limitations of this study, it provides only an Independent sample T-test addressing the differences among hospitals and gender among the medical doctors. For further enhancement and knowledge among the variables of this study, different statistical tests could be considered by increasing the sample and range of hospitals.

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