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**MEDICAL ETHICS : A STUDY OF  
MORAL DEVELOPMENT IN MEDICAL STUDENTS  
AT KUWAIT UNIVERSITY**

**by**

**Manal Mansour Bouhaimed**

**B.Med.(Sci.), M.B.Ch.B.**

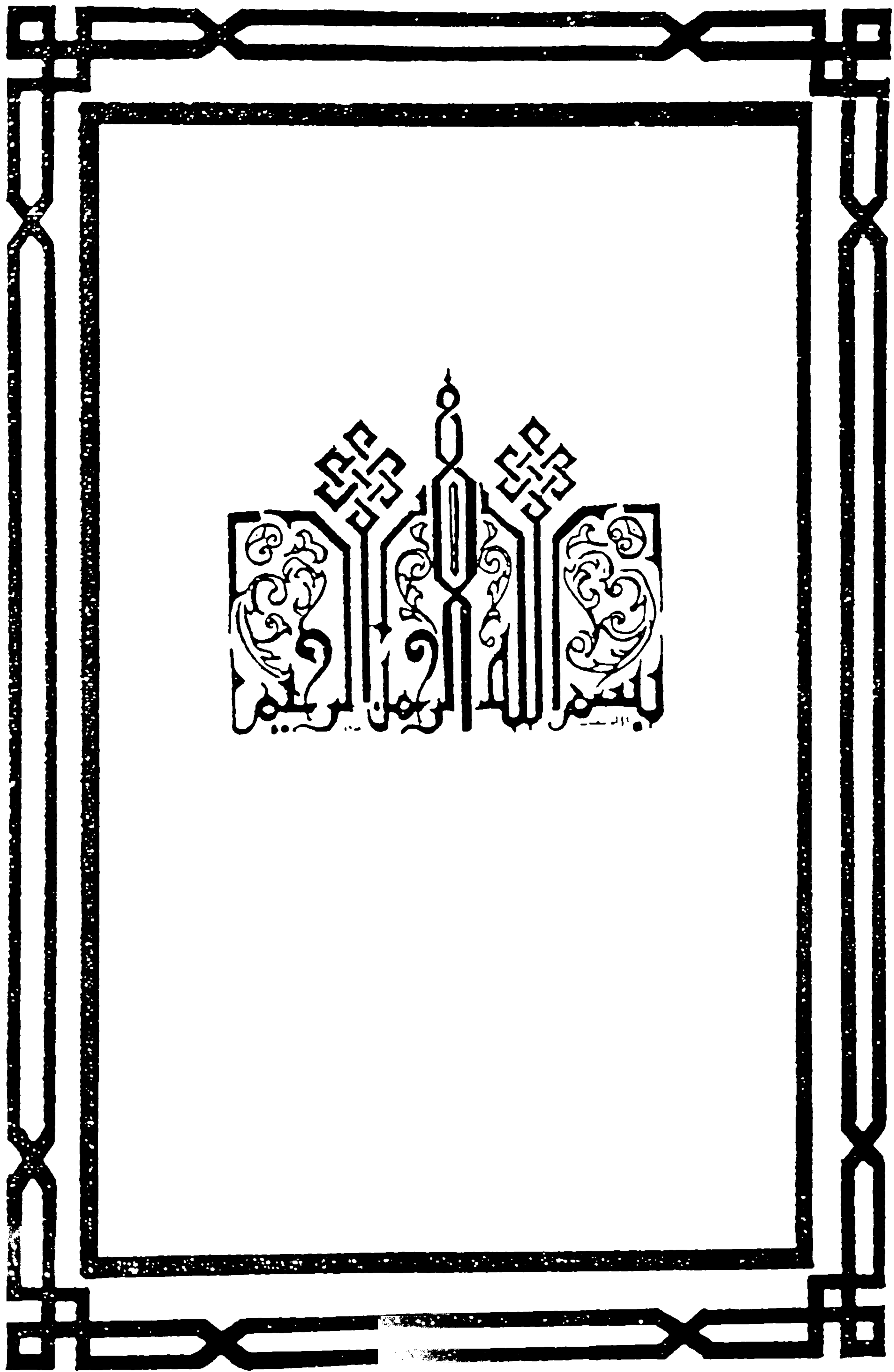
**A thesis for the degree of**

**Doctor of Philosophy**

**Submitted to the Faculty of Arts**

**UNIVERSITY OF GLASGOW**

**1997**



*I dedicate this thesis*

*In memory of my Father*

*Mansour Bouhaimed*

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## **TABLE OF CONTENTS**

	<u>Page No</u>
Acknowledgements	ii
Abstract	iii
List of Appendices	ix
List of Tables and Figures	x
Introduction	1
<u>Chapter 1. Medical Ethics Education</u>	7
1.1 The Emergence of Medical Ethics Education	8
1.2 Medical Ethics Teaching - The UK Experience	9
1.3 Types of Ethics Programmes	14
1.4 Goals of Teaching Medical Ethics	20
Summary of Chapter One	30
<u>Chapter 2. Moral Development</u>	31
2.1 Moral Development: Theoretical Foundations	32
2.2 Piaget and The Cognitive Moral Development	34
2.3 Kohlberg: Cognitive Moral Development Theory	35
2.4 Critiques of Kohlberg	39
2.5 The Four Component Model	44
2.6 The Defining Issues Test (DIT)	46
Summary of Chapter 2	49

## Table of Contents Continued

	<u>Page No.</u>
<b><u>Chapter 3. The Core Research</u></b>	<b>51</b>
3.1 Moral Development in Medical Students at Kuwait University: Research Questions and Goals	52
3.2 Administering the DIT: Design and Sample	53
3.3 Results:	
A. Listing of Raw Data	57
B. DIT Scores	61
C. How to Read the Test	64
D. Consistency Check	68
E. The Final Sample	71
F. The Statistics	72
3.4 Conclusion	77
3.5 Reliability and Validity	81
Summary of Chapter 3	88
<b><u>Chapter 4. Literature Review</u></b>	<b>89</b>
4.1 Moral Development in Medical Education: Literature Review	90
A. The Moral Judgement Interview (MJI)	91



B.	The Sociomoral Reflection Measure	92
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## Table of Contents

	<u>Page No</u>	
<u>Chapter 4 continued.</u>		
C.	The Use of (DIT) to Measure Moral Development in Medical Education: The USA Experience	93
4.2	Conclusion from the Literature	101
	Summary of Chapter 4	102
<u>Chapter 5. Setting the Scene</u>		103
5.1	Kuwait	104
5.2	Kuwait University	107
A.	The Health Service Centre	108
B.	The Faculty of Medicine	109
C.	The Structure of the Medical Programme	113
5.3	Health Care System in Kuwait	115
5.4	Islam	119
5.5	Case Study I	134
	Truth Telling in the Doctor-Patient Relationship An Islamic View	
5.6	Case Study II	136

Euthanasia: An Islamic View

Summary of Chapter 5

143

Table of Contents Continued

	<u>Page No</u>
Implications of the Study	144
Glossary	149
References	151
Bibliography	159
Appendices	

## **LIST OF TABLES AND FIGURES**

	<u>Page No</u>	
Table 1.	The Final Numbers of Students Enroled in the Study	55
Table 2.	Descriptive Statistics for Total Sample and Sub Samples	72
Table 3.	(DIT) Indices from the Standardisation Samples	74
Table 4.	Statistical Analysis - t-Test on the P-Score Differences Between Total Sample, Sub Samples and Norm Groups	76
Table 5.	The P-Score : Gender Effect	79
Table 6.	Numbers of Kuwaiti Doctor's in Training Abroad	116
Table 7.	Vital Health Indicators in Kuwait 1986-1994	118
Figure 1.	The P-Score for Study Subgroups	78
Figure 2.	Cross-Cultural Studies of Age/Education Trends in Moral Judgement	87
Figure 3.	Schematic Representation of Kohlberg's View of the Moral Journey	146

## **LIST OF APPENDICES**

- Appendix A            The Doctor-Patient Relationship  
in Clinical Practice: Description of  
the Medical Ethics Course at the Pritzker  
School of Medicine - University of Chicago
- Appendix B            The Six Story Form of the (DIT)
- Appendix C            The (DIT) Computer Scoring Form
- Appendix D            The Arabic Translation of the Six Story  
Form of the (DIT)
- Appendix E            Muktarahek - A Moral Reasoning Test  
Designed by Dr Essa - Kuwait University
- Appendix F            Listing of Raw (DIT) Data
- Appendix G            Outline of the Curriculum of the Pre-Medical  
and Pre-clinical Programme at Kuwait University
- Appendix H            Outline of the Curriculum of the Clinical  
Programme at Kuwait University
- Appendix I            The Islamic Oath of the Doctor

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## **ABSTRACT**

There are few in depth attempts to address the question: why teach ethics to medical students? This thesis argues that, identifying moral growth and development as the primary goal in teaching medical ethics is essential.

Lawrence Kohlberg's moral development theory is the starting point for this research. This is important to understand the work of the researcher at the Medical School in Kuwait.

The instrument used in assessing the moral reasoning of medical students at Kuwait University is the Defining Issues Test (DIT), which was devised at the University of Minnesota.

The study hypothesis is that the rigid, authoritarian medical education at Kuwait University that lacks any emphasis on medical ethics will inhibit the expected growth in moral development of medical students.

With a disappointing response rate of only 27.8%, it was found that normally expected growth did not occur in the first four years of medical education, suggesting that the educational experience somehow inhibited student's moral reasoning ability rather than facilitating it.

The results of this study cannot be understood in isolation from the general understanding of the fabric of the researcher society, which was detailed in Chapter Five.

The implication of this study is basically that medical education that ignores the moral nature of medicine will fail its own purpose, the needs of its students and the welfare of society.

## INTRODUCTION

**“Men and women are human beings before they are lawyers or physicians, and if you help them to be capable and sensible human beings, they will make themselves capable and sensitive lawyers and physicians”.**

**(John Stuart Mill)**



The moral problems of medicine, already strong and apparent, have generated a great deal of lay and professional interest in bioethics worldwide. To meet this growing interest, many institutes now offer courses or programmes in biomedical ethics to medical students, nursing students, young doctors, and to the general public. Presumably this increased interest in the moral aspects of medicine has revolved around the desire to produce good physicians for society - ones with excellent technical skills and sound moral integrity.

Moral development, I argue, throughout this thesis ought to be the primary goal of teaching medical ethics. This presupposes that there is such a thing as moral development or moral growth, that one can become more moral through education and that there are standards to judge if a person is growing in morality.

Moral development is a general concept that includes growth in compassion and kindness; it reflects the ability to show in action and judgements respect for autonomy and beneficence, it is all about being just and responsible.

Doctor's decisions and actions, I think, are not a simple, narrow reflection of their professional medical training or education; rather they reflect what sort of person they are.

What is central to making moral development the primary goal of teaching medical ethics, is, I believe, the unity it emphasizes of medical/professional ethics and personal/general morality. This entails the recognition that being a physician does

not dispense the doctor from the ethical challenges of being a good person. But what should the good doctor be good at?

In considering the concept of a doctor and how the job of doctor is best described, Downie et al suggests <sup>(1)</sup> that:

"Occupations can be described or classified from three different points of view, or in terms of three different sets of concepts: as role jobs, skills jobs and aim jobs".

Evidently many jobs, while they fall more clearly into one definitional category than another, will nonetheless involve the other categories also. For example, being a lord mayor while being a role job (i.e. a job defined in terms of rights and duties) is still likely to require certain skills to do the job successfully. However, as Downie suggests, an adequate definition of the job requires no reference to particular skills.

It is difficult to define some jobs within one category rather than another, medicine is a good example. Medicine is indeed clearly a role job. The roles of doctors are defined and legislated for, in terms of rights and duties. To practice competently there are certain clearly identifiable skills which the doctor must have. These skills which are based on a broad factual knowledge, range from simply knowing how to take blood to the more complex knowing how to attach a detached retina.

In addition to the practical skills, all doctors regardless of speciality require skills in communicating effectively with their patients. The doctor also has reasonable clear aims: that of alleviating suffering and the cure and/or care of the sick and promotion

of health. Therefore, the occupation of a doctor and being a doctor is accurately definable in terms of roles, skills and aims. However, looking at healthcare practice purely in terms of role, with its duties and rights, at skills necessary for competent practice, or at the end result or aim of practice may not be sufficiently rich or comprehensive analysis of what actually is of importance for doctors to know, to do, or most importantly to be.

Downie suggests that: <sup>(2)</sup>

"Moral agents are always people acting; sometimes they act simply as persons, and sometimes as persons in certain roles or capacities. However, many rights and duties of the role affect a given action, the morality of the action is never wholly reducible to the rights and duties of the role; there is always an irreducibly personal element in any moral action and a person cannot completely transfer the moral responsibility for what he/she does to his role".

What Downie says here is important to understand the following very true case:

A group of fifth year medical students at Kuwait University are having their first clinical experience in the wards of the main teaching hospital in the country. They have been introduced to Mr X, a 79-year-old male patient who, a few days earlier had been diagnosed with primary prostate cancer and secondary metastasise to his bones and liver. After 10 minutes explanation of how to (PR) the patient - examining the patient (per rectum), the senior registrar asked the five students to start the examination.

Throughout the examination the patient was very co-operative. At the end of the examination and before leaving the room the patient started shaking the students hands. The other female student in the group refused to shake his hand saying it is "Haram (Islamically Forbidden)" to touch a male's hand, the patient's reply was "so it is Haram to shake my hand, but not Haram to shove your fingers up my bottom".

To this the senior registrar had no comment to make, no gesture of disapproval and no hints of concern. By using this example, I wanted to show how medical education sometimes leaves the quality of the medical students - later the doctor - moral character to chance. The student, during preparation for the role of doctor, should be helped to become aware that fulfilling this role involves elements of respect, sympathy and the ability to relate. To have this type of respect and ability demands education that is aimed at increasing the moral sensitivity and focuses on the moral

growth of the young developing student over and above that with which they arrive to the medical school.

One approach to attain this goal is to introduce medical students to the world of medical ethics.

## CHAPTER 1

**"Medicine now as never before must be rehumanized. If this is to come about, study of the social and ethical aspects of medicine must become an integrated part of the medical school curricula".**

**(Veatch and Gaylin, 1972).**

## **1.1 THE EMERGENCE OF MEDICAL ETHICS EDUCATION**

Medical ethics, traditionally, has referred to the standards of professional competence and conduct, which the medical profession expects of its members. Medical ethics in this sense embraces formal and informal codes of practice, medical communication and accepted professional standards. Medical ethics is also used in a second sense that refers to the study of ethical or moral problems raised by the practice of medicine. These problems arise when there is a conflict between different principles embodied in accepted codes, or when principles previously accepted begin to be questioned.

The last 20 years have witnessed the emergence and establishment of medical ethics education in both senses as a standard, if not universal, component of undergraduate and graduate medical training. Many reasons and expectations underlay this growing professional interest in ethics education. First, there are changes in the societal and ideological context of medical practice. What I personally expect from my general practitioner (GP) now is different from what my parents expected from their doctor 30 years ago. Secondly, the new technical capabilities pose unprecedented ethical questions on the doctor's daily practice. Think of how ventilators, dialysis machines and the human genome project, just to mention a few, have changed forever the medical practice. Thirdly, there is increased media coverage of the ethical issues in modern healthcare that is fuelling our patients' interest in knowing more information about their health or the lack of it. To quote Downie <sup>(3)</sup>:

"The public is now better educated than ever before on healthcare, is better informed on legal rights, and in general is consumer-conscious".

## **1.2 MEDICAL ETHICS TEACHING - THE UK EXPERIENCE**

Some information on the arrangements for medical ethics teaching was included in the Survey of Basic Medical Education conducted by the General Medical Council in 1975-1976<sup>(4)</sup>. In that survey, the topic of medical ethics was discussed together with the speciality of Forensic Medicine, the GMC reported "Courses in traditional Forensic medicine appeared to be diminishing in the UK, but there was disagreement as to how to replace them". In 1984 the GMC Education Committee held a conference on the subject of medical ethics education, and in the same year, with encouragement from the GMC and a grant from the Nuffield Foundation, the Institute of Medical Ethics convened a working party to study the teaching of medical ethics in British medical school chaired by Sir Desmond Pond<sup>(5)</sup>.

The Working Party was asked to express and illustrate understanding of medical ethics teaching and to identify existing teaching arrangements.

At the end of 1984, a questionnaire on the teaching of medical ethics was sent to the Deans of 30 British medical schools, of which 26 replied. During 1985, a similar questionnaire was sent to medical students representatives (the Presidents of Medical Students Unions in each of the British Medical Schools and student Officers of Medical groups) and 30 replies were received.



The Deans and medical students were each asked seven questions. These concerned:

1. The school's policy on ethics teaching.
2. Timetabled periods.
3. Encouragement of informal discussion.
4. Involvement of non-medical teachers.
5. Assessment and encouragement of student's familiarity with ethical issues.
6. Extra-curricular activities.
7. The respondent's views on medical ethics teaching.

In 1987, evidence to the Working Party suggested the following:

1. Most British medical schools included some problem-orientated as well as traditional ethics teaching in their undergraduate curricula.
2. The total number of timetabled periods of ethics teaching is not large.
3. The amount of informal discussion of ethical topics encouraged by clinical teachers was difficult to estimate, but appeared to range from the regular to the non-existent.
4. Ethics teaching was encouraged particularly by such departments as obstetrics, Paediatrics, General Practice and community medicine, and in a few schools short ethics courses had been introduced.
5. Non-medical teachers were normally involved.
6. Very few medical teachers appeared to have had any specific training in medical ethics teaching.
7. Most Deans considered ethics teaching "important" but were doubtful about

introducing it as a separate subject.

8. Students views on these matters were not markedly different.

At the end of its three-year inquiry into medical ethics teaching, the Working Party made the following recommendations:

1. Medical ethics teaching should recur at regular intervals throughout medical training, and time should be set aside within existing teaching for ethical reflection relevant to each stage of the student's experience.
2. Clinical teaching of ethics should normally begin from clinical examples. Such teaching should be exploratory and analytical rather than hortatory, and adequate provision should be made for small-group discussions supported by critical reading of relevant papers on medical ethics.
3. Interested medical teachers should be encouraged and assisted to undertake further study of medical ethics in the context of courses already available.
4. Multidisciplinary ethics teaching sessions should be timetabled at regular intervals within existing clinical teaching. These sessions should normally involve a teacher or teachers with training in the analytic disciplines (moral philosophy, moral theology or law) and, when appropriate, representatives of the professions associated with medicine, together with representatives of articulate and considered lay opinion.
5. Course introducing students to ethics should not be undertaken without careful planning, drawing on the experience of other school and bodies (including the Institute of Medical Ethics) already involved in medical ethics teaching.

6. Care should be taken to avoid leaving ethics teaching in the hands of a teacher whose tendency is to promote a single, political, religious or philosophical viewpoint.
7. Those planning ethics teaching should bear in mind that the importance attached to a subject is clearly reflected in the hour or day set-aside for it.
8. Examination questions or essays and where appropriate project work on ethical issues should be included in the assessment leading to a medical qualification. The purpose of such assessment should be to verify that students are able to think critically and logically about ethical issues in medicine in the light of counter arguments to their own position.
9. Interested medical students should be encouraged and assisted to undertake elective courses arranged by or in co-operation with departments of philosophy, theology and law.
10. Medical ethics teaching within the curriculum should not be regarded as superseding the unique contribution of student medical groups to medical ethics teaching and learning.
11. The Institute of Medical Ethics approach post-graduate medical bodies with a view to undertaking a study of ethics teaching in continuing education.

The Working Party had consciously refrained from proposing a model curriculum.

The recommendations above, were intended to be within the scope of every medical school in the United Kingdom.

Since the publication of the Pond Report in 1987, an increasing number of medical schools around the country started developing different approaches to teach medical

ethics.

In December 1993, the document *Tomorrow's Doctors*, produced by the General Medical Council, has prompted a long-awaited change in medical education <sup>(6)</sup>. The fundamental points were, first that the curriculum suffers from an overload of subjects, and second, that there is a dearth of what could properly be called education in what the students do. To remedy these two points the GMC has proposed a new curriculum framework comprising a core and special study modules (SSMs) or options. The core will cover the knowledge required to function as a house officer, the SSMs offer the chance to study a chosen subject in greater depth. The GMC stress that SSMs should not deal entirely with medical subject matter. It made a radical suggestion in proposing that some SSMs might have a language, literature or history core. In general terms the GMC sees SSMs as fulfilling an educational aim making a contribution to the development of future doctors' training, development of personal qualities and broadening of social contacts.

In the United States the experience of teaching medical ethics is not significantly different.

Prior to the 1970s, medical ethics education occurred mainly through 'Osmosis', the informal transmission of values and practices between physicians and students, in the traditional apprenticeship model of medical education. It is both interesting and significant to note that in the 1970s, philosophers, working on their own and in collaboration with physicians were the first to show an active interest in the area of

medical ethics, their desire to counteract what appears to be the potential dehumanisation of the medical student via the medical curriculum is seen throughout medical literature. In 1972, only 4% of American medical school taught medical ethics in formal and required courses, although some other school offered medical ethics as an elective or incorporated ethical perspectives into other courses such as "Introduction to medicine" or "The doctor-patient relationship" <sup>(7)</sup>.

In 1994 every medical school in the United States taught medical ethics as part of its required curriculum <sup>(8)</sup>.

### **1.3 TYPES OF ETHICS PROGRAMMES**

Medical ethics teaching programme in North America and the UK fall broadly into two main types:

1. The Traditional Model
2. The Alternative Model.

The content of traditional courses may include ethical theories, moral principles (autonomy, justice, beneficence, non maleficence), codes of medical ethics and various clinical topics. This is delivered in general through lectures, small group discussions and general readings.

The ethics teaching programmes contained in this model tend frequently to be case based or clinical in orientation.

Mark Siegler and Edmund Pellegrino<sup>(9)</sup> suggested that ethics is central to clinical medicine for at least two reasons. First because ethical considerations cannot be avoided when physicians and patients must choose what ought to be done from among the many things that can be done for an individual patient in a particular clinical circumstance and secondly, because the concept of good clinical medicine implies that both technical and ethical considerations are taken into account.

The central focus of clinical ethics is then the individual doctor-patient decision making. The principal goal of clinical ethics is to improve the quality of patient care by identifying, analysing and contributing to the resolution of ethical problems that arise in the practice of clinical medicine. It requires a firm grasp of clinical language and clinical knowledge that must conclude in an action for an identifiable patient.

Clinical medical ethics emphasises the mutual responsibilities of physicians and patients and the view that patients' attitudes, preferences, values, and aspirations are a central consideration in the decision-making process.

An example of this model is the doctor-patient relationship in clinical practice course at the Pritzker School of Medicine at the University of Chicago, where I have spent a year as a fellow to the Maclean Center for clinical medical ethics learning how to be able to design a programme in teaching medical ethics.

**See Appendix A** for full course description.

As medical ethics education has continued to evolve, other models have been suggested to supplement or even replace traditional courses. Many of these alternative approaches deviate from the traditional model in their clear aim to shape students' attitudes, values and behaviour not only through affecting knowledge and cognitive skills, but also more directly. In these endeavours, medical ethics educators have found numerous allies among social scientists, education specialists, and medical humanists. Together and separately, these educators have proposed a wealth of different methods to promote ethical development.

"Humanising Medicine: a Special Study Module" by Robin Downie, Rob Hendry, Jane Macnaughton and Blair Smith from Glasgow University is a good example of the new alternative approaches<sup>(10)</sup>.

Their Module proposes a four week course running concurrently at three of the Scottish Medical Schools: Aberdeen, Dundee and Glasgow involving participation of students in small groups, university-based tutors - from different departments and expert lecturers participating in the plenary week. The course aims at:

1. Encouraging critical and questioning attitudes.
2. Through studying examples of good writing, the module aims at helping students learn the principles of good written communications.
3. Through using good literature, the course aims at engaging students' emotions and challenging their hidden values and prejudices allowing them to develop self-awareness.

4. By studying literature that portrays physicians and illness, students will understand different ways in which these are perceived by different sections of society.
5. The students will have the chance to break the walls that isolate them from other students, at different faculties. This will help to expand the student's outlook and reduce the damaging insularity, which is a feature of current medical education worldwide.

The impetus towards designing this course has come from the General Medical Council who are expecting medical schools to include a wide range of subjects - not just medical - within the new framework.

The reading for this module will contain a mixture of prose, poetry and drama, with a mixture of classics and modern writers.



## **Anthologies**

- Downie, R.S. (ed) (1994)      The Healing Arts: An Oxford illustrated Anthology.  
Oxford: Oxford University Press.
- Enright, D.J. (ed) (1989)      The Faber Book of Fevers and Frets. London. Faber  
and Faber.
- Porter, Roy (ed) (1991)          The Faber Book of Madness. London: Faber  
and Faber.
- Lowbery, Edward (ed) (1990) Apollo: An Anthology of Poems by Doctor Poets.  
London: The Keynes Press.

## **Illness, Disease, Disability and Madness**

- Sontag, Susan (1979)          Illness as Metaphor. Harmondsworth: Penguin Books.
- Holub, Miraslav (1990)          Vanishing Lung Syndrome. London: Faber and  
Faber.
- Ibsen, Henrik (1882)          Ghosts in Plays: One (1980) London: Methuen.
- Hogg, James (1824)          The Private Confessions of a Justified Sinner.  
Harmondsworth: Penguin Classics.

## **The Doctor**

- Berger, John and Mohr,  
Jean (1967) A Fortunate Man.  
Harmondsworth: Penguin Classics.
- Eliot, T.S. (1950) The Cocktail Party. London. Faber and Faber.
- Chekhov, Anton (1892) Ward 6 from Lady with Lapdog and Other  
Stories Harmondsworth: Penguin Classics.

## **Patients**

- Larkin, Philip (1992) Ambulances: The Building From Collected Poems.  
London: Faber and Faber.
- Lamb, Charles (1820) The Convalescent from The Essays of Elia. London:  
Dent.
- Woolf, Virginia (1925) Mrs Dalloway
- Galloway, Janice (1989) The Trick is to Keep Breathing. London:  
Minerva.

## **Death, Dying and Bereavement**

Dunn, Douglas (1985) *Elegies*. London: Faber and Faber.

Tolstoy, Leo (1879) *The Death of Ivan Ilyich*. Harmondsworth: Penguin.

Lewis, C.S. (1961) *A Grief Observed*. London: Faber and Faber.

de Beauvoir, Simone (1964) *A Very Easy Death*: Harmondsworth: Penguin.

## **Ethics**

Ibsen, Henrik (1879) *A Doll's House* from *Plays Two* London: Methuen.

Buber, Martin (1992) *Land Thous* (trans by W. Kaufmann) New York.

Twain, Mark (1884) *Huckleberry Finn*.

## **14 GOALS OF TEACHING MEDICAL ETHICS**

After taking the decision to fight for including medical ethics as a recognised course in the medical school curriculum at Kuwait University in 1992, I was faced with two

important questions:

1. Why should one want to undertake such a venture in the first place?
2. What could or should be accomplished?

There is a clear and simple answer to the first question. As a community we have a vested interest in making good individual and communal ethical choices: I argue that no doctor, regardless of how technically competent, will survive very long (academically, professionally, legally, psychologically or physically) if they practice their duties with no moral content.

As for the second question, there is one fairly based answer to quote Daniel Callahan<sup>(11)</sup>:

"At the very least, courses in ethics should make it clear that there are ethical problems in personal and civic life, that how they are understood and responded to can make a difference to that life, and that there are better and worse ways of trying to deal with them".

In attempting to answer the second question it is of interest and relevance to review the wide spectrum of objectives and goals of existing programmes both in the USA and the UK. I think that through these exercises many useful pointers and much food for thought can be generated.

The specific goals for the teaching of ethics developed by the 1980s, Hastings Center

Project on the teaching of ethics in higher education in general are:

1. Stimulating the moral imagination.
2. Recognising ethical issues.
3. Developing analytical skills.
4. Eliciting a sense of moral obligation and personal responsibility, and
5. Tolerating disagreement and ambiguity.

From the broad spectrum of the Hastings Center objectives to the very specific, narrow focused ones of Culver et al programme.<sup>(12)</sup>

Culver, et al (1985) identify their objectives as follows:

1. The ability to identify the moral aspects of medical practice.
2. The ability to obtain a valid consent or a valid refusal of consent.
3. Knowledge of how to proceed if a patient refuses treatment.
4. The ability to decide when it is morally justified to breach confidentiality.
5. Knowledge of the moral aspects of the care of patients with a poor prognosis.
6. Knowledge of issues relating to abortion.
7. Inclusion of knowledge of issues related to the equitable distribution of healthcare.

Calman and Downie (1987)<sup>(13)</sup> state their objectives as follows:

1. To make the student aware that decision making in medicine is not value free.
2. To assist the student in learning to deal with moral decision making in a more rational way, by logic and argument, and to enable them to justify their own views and explore their own attitudes to moral problems, especially the relationship between personal and professional morality.
3. To help students to come to terms with conflict in ethical problems. This includes a consideration of the role of the doctor and the relationship with other members of the healthcare team.

Osborne and Martin (1989)<sup>(14)</sup> state that the original aims of their programme were:

1. To alert the students to the subtleties and complexities of ethical reasoning.
2. To describe how the complex nature of decision-making processes in the hospital setting often involved data other than technical, medical or scientific information.
3. To make clear that there were a number of ways of analysing particular issues.
4. To point out the importance of individual value systems, both of the patient and the healthcare professional in arriving at decisions.

In 1990, Sulmasy et al suggested that<sup>(15)</sup>:

"Residency training is a critical and formative time in which to implement training in ethical aspects of patient care. Such training ought not be construed as an effort to turn morally bad physicians into morally good physicians". The goals of such training in their opinion were to enhance patient care by:

- 1 Imparting knowledge of ethics vocabulary and established principles of ethical analysis and relevant legal and historical facts.
- 2 Fostering skills that enhance the ability of physicians to communicate with patients, with families, with colleagues, and with professionals outside the healthcare field regarding ethical issues.

In 1992, Self, Baldwin and Wolinsky<sup>(16)</sup> proposed the following objectives for their medical ethics programme at the College of Medicine in Texas.

1. Students should be able to identify and apply the major ethical principles to biomedical cases using reflecting inquiry to support or refute the various positions on a given ethical issue.
2. Students should be able to display a basic knowledge of the social and ethical issues in medicine including an understanding of the terminology and distinctions that arise within them.
3. Students should enhance their self-knowledge through opportunities to clarify their attitudes, values and beliefs with respect to ethical issues.



4. Students should become more tolerant of alternative perspectives involved in the complexities of healthcare.
5. Students should enhance their moral reasoning skills in terms of applying the principle of justice in solutions of moral conflicts.

There are several important points regarding the course objectives in the literature on medical ethics teaching programmes that, I think, deserve attention.

- I. It has been noted that some ethics programmes occasionally proceed from the point of view of how best to protect patients. This approach, I think, is potentially problematic because it pictures the doctor as a threat and in teaching medical ethics the last thing we want to do is to attack the picture of "the doctor" in medical students minds. The students might hear or feel that the "person they want to be and are working very hard to become is bad". In these programmes even if the ethical presentation is accurate in its criticism, its value is questionable if it does not attend to the dynamics of the audience  
(17)

- II. Ordinary people - medical students included, pay little attention to theories and principles when they make their moral decisions, having this in mind realistically helps to design teaching programmes that are not loaded with theories. Moral decisions are tied to a society's religion, customs, traditions, and institutions.
  
- III. There is almost a universal admission throughout medical literature on the teaching of medical ethics, and its objections of the difficulty of translating knowledge or theory into action.

Although there is a growing awareness among doctors of ethical problems and the formal elements required for reasonable solutions, it is questionable whether this knowledge is reflected in more caring and compassionate behaviour.

Leon Kass, a physician and professor at the University of Chicago in an address celebrating the 20th anniversary of the Hastings Centre, commented:<sup>(18)</sup>

"Are hospital staff more civil and engaged, are nurses and doctors listening and speaking better with patients? They may now be prepared to write Do Not Resuscitate Orders, but are they better at attending the dying before the occasion of cardiac arrest? And what of their general manners and

sensibilities"?

What I understood from Leon Kass's words was that clinical ethics teaching programmes might have been successful in communicating a content and fulfilling a list of goals or objectives in the course manual - but they have not done as well in influencing physicians to be the sort of people we would want to care for us - for you, and me, our parents, children and our fellow human beings.

- IV. The literature on medical ethics on both sides of the Atlantic recognised three main functions for outlining the course objectives:
1. To make clear to the teacher, what is to be taught or facilitated.
  2. To make clear to the students what they are required to achieve.
  3. To indicate how assessment might proceed and on this point there has been a lot of debate.
- V. Options for evaluating and assessing programmes of ethics instruction tend to fall into one of two groups. The first of these is the more subjective. It relies on methods such as tests, essays, as well as research or clinical papers. These methods were the most employed in medical ethics teaching programmes evaluation.

The second group of evaluating means is the more objectives. It relies on

psychometric ethics evaluation with empirical data. It is influenced by the work of Kohlberg and his associates. One example of this approach is James Rest's Defining Issues Test (DIT) where the respondents recognise and rank solutions to moral dilemmas with the solutions being correlated to the stages of moral development in Kohlberg's theory. What is being tested is the subject's capacity for moral reasoning and not the subject's particular set of moral beliefs or values<sup>(19)</sup>.

This instrument has been used in many studies for assessing moral reasoning and moral development. There is extensive literature on the instrument and its validity that will be detailed in the next chapter.

## **SUMMARY OF CHAPTER 1**

Throughout this thesis the researcher argues that moral development should be the primary goal and the focus of teaching medical ethics. The current curriculum of the Faculty of Medicine at Kuwait University does not include any teaching in medical ethics. The first step to correct this unacceptable situation was logically to review the curricula of other medical schools and to see for ourselves why those programmes emerged, how they are organised and what types or models exist in this field.

In this chapter the following points and clarifications have been made:

1. Medicine has always and will always be a moral endeavour.
2. The increasing technical advances will change forever the way health care professionals and the public see the doctor-patient relationship.
3. How organised medical ethics programmes came to exist in the United Kingdom.
4. The different goals, objectives and emphases of courses in medical ethics both in the UK and across the atlantic.

## **CHAPTER 2**

**"The verification and elaboration of this basic idea - that  
morality develops - will no doubt stand as one of  
the central**

**Contribution of the twentieth century study of morality".**

**(Thomas Lickona - 1980).**

## **2.1 MORAL DEVELOPMENT: THEORETICAL FOUNDATIONS.**

Morality, first of all, should be distinguished from manner and mores. Manners are concerned with matters of taste and etiquette based on prudential judgements. Although one's prudential judgements and moral judgements will occasionally coincide, they frequently may differ.

By mores is meant the fixed morally binding customs of a particular group. Mores vary considerably cross-culturally and throughout human history, ranging from the noblest behaviour to the approval of slavery, genocide and other practices.

In contrast, the term 'ethics' can mean the same as 'morals'. In this sense ethics or morals or morality are concerned with how we ought to behave (as distinct from how we in fact behave), whether it is right or wrong, just or unjust, tactful etc., to behave or speak in certain ways.

Two other terms should be considered, amoral and non-moral. Amoral has more than one meaning insofar as it may refer to someone who is indifferent to or does not care to abide by moral codes, or it may refer to someone who lacks moral sensibility, such as infants, because of immaturity. A non-moral act is one, which is neither moral nor immoral, such as deciding what to wear for a meeting.

The term, development, refers to progressive and continuous changes in the organism from birth to death. These can include changes in the shape and integration of bodily

parts into functional parts: social, emotional, intellectual, and moral development that may occur at different periods of an individual's life. Moral development refers to growth of the individual's ability to distinguish right from wrong, to develop a system of ethical values, and to learn to act morally.

Thomas Lickona <sup>(11)</sup> indicated that cognitive developmental stage psychology has important implications for ethical education at the undergraduate and graduate levels. But what does this school of moral psychology teach us about moral development and behaviour? And what does this psychological knowledge suggest about the goals and methods of the teaching of ethics.

In this chapter it is proposed to take a closer look at the theory of moral development and its assessment in the belief that this should be the focus of medical ethics education.



## **2.2 PIAGET AND THE COGNITIVE MORAL DEVELOPMENT**

The idea that moral understanding progresses through a series of stages, each more mature than the preceding, gained its first empirical validation through the work of Jean Piaget and his associates.

Piaget is credited with the initial phase of moral judgement research. He is responsible for the psychological construct of "moral judgement". From early research in the developmental concept of intelligence, his developmental sequence formulations were based upon cognitive process that sequentially develop from one chronological period to the next.<sup>(20)</sup>

The contribution to moral judgement evolved as a part of his clinical method which included presenting stories to young children to elicit an explanation of their points of view on issues of justice. Piaget identified definite features in children's moral reasoning for making inferences about their underlying thought structure; these include the concepts of imminent justice, intentionality, and the relativism of perspective.

He directed researchers to a key empirical test of cognitive developmental theory - namely to look for age-related differences in types of responses - and this has been the most extensively used paradigm in cognitive developmental research.

Piaget concluded that the fundamental differences in the way children reason are age

related, and that these differences are developmental.

His three stages of moral reasoning are:

1. The pre-moral stage with no sense of obligation to rules.
2. The heteronomous stage (moral realism) where right is literal obedience to rules; the regard for obligation and submission is equated with power and punishment.
3. The autonomous stage at which consideration is given to the purposes and consequences of following the rules; obligation is based upon mutual exchange.

### **2.3 KOHLBERG: COGNITIVE MORAL DEVELOPMENT THEORY.**

Lawrence Kohlberg and his associates picked up where Piaget left off. Kohlberg has sought to overcome the deficiencies of Piaget's research by using a much larger sample that is more broadly based socially. He was also concerned with the principle of justice rather than, as with Piaget, simple virtues and vices, and such concepts as co-operation and equity.

Kohlberg undertook to extend the Piagetian line of theory and research into the study of morality in the following ways:

1. Following the Piagetian example, Kohlberg focused on cognition - the thinking process and the representations by which people construct reality and meaning.
2. Kohlberg assumed that there would be stages in the organisation of moral judgement.
3. Like Piaget, Kohlberg collected data by posing problems to subjects, asking them to solve the problem, then probing into how the subjects went about solving it. Kohlberg devised a series of moral dilemmas to give to subjects, asking for their justifications.
4. Like Piaget, Kohlberg favoured studies that presented the moral dilemmas to children of different ages, looking for age differences in their basic problem-solving strategies.

In the context of his work, moral is integral to the concept of justice or fairness. Moral rules and principles determine basic relationships in terms of rights and responsibilities and mutual expectations.

His theory, he claims, is both psychological and philosophical and his findings generate a philosophy of moral education designed to stimulate moral development rather than teach fixed moral rules.<sup>(21)</sup>

Kohlberg postulated that as persons develop intellectually in cognitive reasoning through stages, so do they develop in an invariant sequence of stages in their moral judgement. He believed that moral development is stimulated by promoting thinking and problem-solving.

Kohlberg formulated a typology of six stages in the development of moral judgement in a three-level hierarchical sequence.

## **I. Preconventional level**

**Stage 1:** Orientation to punishment, obedience, and physical and material power. Rules are obeyed to avoid punishment.

**Stage 2:** Naive instrumental hedonistic orientation. The child conforms to obtain rewards.

## **II. Conventional level**

**Stage 3:** "Good boy" orientation designed to win approval and maintain expectations of one's immediate group. The child conforms to avoid disapproval. One earns approval by being "nice".

**Stage 4:** Orientation to authority, law and duty, to maintain a fixed order, whether social or religious. Right behaviour consists of

doing one's duty and abiding by the social order.

### III. Post conventional, autonomous or principled level.

**Stage 5:** Social contract orientation, in which duties are defined in terms of contract and the respect of other's rights. Emphasis is upon equality and mutual obligation within a democratic order. There is an awareness of relativism of personal values and the use of procedural rules in reaching consensus.

**Stage 6:** The morality of individual principles of conscience that have logical comprehensiveness and universality rightness of acts is determined by conscience in accord with ethical principles that appeal to comprehensiveness, universality, and consistency. These principles are not concrete but general and abstract.

Kohlberg in his scoring guide does not score stage 6. He thought that stage 6 occurred so rarely that judge reliability is actually improved by no-one being given a score at stage 6, and therefore the scoring manuals do not contain directions for scoring it. In research with the Defining Issues Test (DIT) which will be described later, stage 5 and stage 6 items have behaved so similarly that they have been combined into a 'principled score'.

The typology is referred to as "stages" because they represent invariant developmental sequences: all movements are forward and do not omit steps, the stages arise one at a time and in the same order. The stages are hierarchical insofar as thinking at a higher stage comprehends within it thinking at lower stages.

Individuals prefer the highest stage available to them in their thinking because higher stages can more adequately organise the multiplicity of data, interests, and possibilities open to each person. Thus the higher stages are not only more "socially adaptive" but are "philosophically" superior because they move the individual closer to basing moral decisions upon a concept of justice (stage 6). This is the level of principles which can be universalised (i.e. applied to all people everywhere) where the individual views moral judgement not from his or her individual perspective or society's values, but from the perspective of any human being.

## **2.4 CRITIQUES OF KOHLBERG**

*"Kohlberg's theory is supported by a variety of longitudinal, cross-cultural, and experimental evidence that is, by social-science standards, impressive"*

(Thomas Lickona, 1980).

His theory, however, is not without its limitations and difficulties. One problem in particular is the tendency of the theory to equate moral reasoning and justice reasoning Simpson<sup>(22)</sup>, in his paper, Moral Development Research: A Case of Scientific Cultural Bias, criticised the theory for being culturally biased in the

definition of morality. Kohlberg's initial work was sex-biased in terms of studying an exclusively male sample and for defining the stages in ways that emphasize "masculine" themes of rights and justice and neglect "feminine" themes of responsibility and love.

Gilligan's work has emerged out of her criticism of the moral development theory of Kohlberg. She criticised the theory in terms of its foundations and in terms of the empirical research upon which it was based. Kohlberg's theory of moral development grew out of Piaget's theory of cognitive development. Both Piaget and Kohlberg are Kantian in their learning and see decisions based on principles which are universal as the peak of moral reasoning. Gilligan<sup>(23)</sup> argues that his approach, which sees universalizable principles as the measure of moral reasoning, does so to the exclusion of recognition of the importance of emotion, particularity and responsibility to care in moral reasoning and moral decision making. Gilligan also criticised the empirical research on which Kohlberg's theory is based. All the initial studies from which his theoretical work grew, used only male subjects. Gilligan's work identifies two dimensions in moral thought and decision making which she claims have been overlooked by Kohlberg.

These two dimensions are:

- a) The importance of relationships in moral decision making and
- b) The vital role of context in moral decision making.

The importance of Gilligan's contribution to moral thought is that she indicates that abstract principles of rights and duties are too abstract to give a true sense of the complexities of human life, and that because of this complexity a number of foci of moral thinking need to be considered to unearth all the important angles in making a moral decision.

Gilligan captured the essence of the difference between the "rights" and "responsibility" conceptions of morality as follows:



"The moral imperative that emerges repeatedly in interviews with women is an adjunction to care, a responsibility to discern and alleviate the real and recognisable trouble of this world. For men, the moral imperative appears rather as an adjunction to respect the rights of others, and thus to protect from interference the rights to life and self-fulfilment. Woman's insistence on care is at first self-critical rather than self-protective, while men initially conceive obligations to others negatively in terms of non-interference. Development of both sexes would therefore seem to entail an integration of rights and responsibilities through the discovery of the complementarity of these views. In the development of post-conventional ethical understanding, women come to see the violence inherent in inequality, while men come to see the limits of a conception of justice blinded to the differences in human life".

Gilligan described women's moral conception as being "in a different voice" than that spoken by males. The voice of female morality is that of intimacy and care while the male (Kohlbergian) ranking of virtue gave priority to autonomy and objectivity, to a morality free from both psychological and historical constraints.

Drawing on the work of Gilligan and Noddings (1984), nursing scholars who espoused an ethic of caring as primary to nursing viewed it as subjective, feminine, and connected - a way of counteracting the justice ethic which they viewed as medical, masculine, objectifying, and distancing. The field of nursing ethics is now commonly referred to as the "ethics of caring".

Kohlberg's work has also drawn fire from many camps for going from a description of what moral development is to a prescription of what it ought to be. For overestimating the role of reasoning and moral functioning, and under-estimating the role of other factors, such as affect, personality and habits.

Another kind of limitation of Kohlberg stage analysis is that other psychological component processes are involved in the psychology of morality. A stage analysis does not contain information about moral sensitivity, moral motivation, or moral character - other components involved in the psychology of morality. Another way of putting this is to say that there is more to moral development than moral judgement development, and there is more to moral judgement than six stages.

All of these criticisms have some merit and they added to and stimulated the ongoing research of moral development.

## **2.5 THE FOUR COMPONENT MODEL**

The James Rest four component model came to be formulated while he was conducting a general review of the morality literature. This literature encompasses not only the cognitive-developmental research, but also research on morality from social learning, behaviouristic, psychoanalytic, and social psychological approaches. "It became clear that all these researchers were not talking about the same thing. I had to argue either that a lot of this work really had nothing to do with morality, or that the various approaches were talking about different aspects of morality hence, morality was a multi-faceted phenomenon".<sup>(19)</sup> The four-component model starts with the question, "what must we suppose happens in order for moral behaviour to take place?"

Rest argues that there are at least four distinct process needed.

### **Component I: Moral Sensitivity**

Moral sensitivity is the awareness of how our actions affect other people. It involves **imaginatively** constructing possible scenarios, and knowing cause - consequence chains of events in the real world. It is terrible to imagine that a person fails to act morally because it just didn't occur to him/her that something he or she might be doing or could do would affect other people.

### **Component II: Moral Judgement**

This is the component that Kohlberg's work advanced and that the DIT purports to assess. Once the person is aware of possible lines of actions (one of which is not to take any action) and how people would be affected by each line of action (component I), then component II judges which line of action is more morally justifiable.

### **Component III: Moral Motivation.**

Component III has to do with the importance given to moral values in competition with other values. Deficiencies in component III occur when a person is not sufficiently motivated to put moral values higher than other values - when other values such as self-actualisation or protecting one's organisation replace concern for doing what is right.

### **Component IV: Moral Character.**

This component involves ego strength, strength of conviction and courage. "A person may be morally sensitive, may make good moral judgements, and may place high priority of moral values, but if the person wilts under pressure, is easily distracted or discouraged and weak-willed, then moral failure occurs because of deficiency in component IV".

In summary, moral failure can occur because of deficiency in any component. All four components, I would agree with James Rest are determinants of moral action.

They comprise a logical analysis of what it takes to behave morally.

## **2.6 THE DEFINING ISSUES TEST (DIT)**

In 1979, James Rest, developed and refined the Defining Issues Test (DIT) at the University of Minnesota. The DIT can be used to measure and assess cognitive development of moral reasoning (or component II of the four component model) through the levels and stages described by Kohlberg. The DIT presents six brief narrative accounts of situations that involve moral dilemmas (some of the same dilemmas used by Kohlberg in his research, such as the Heinz dilemma), see **Appendix B**. It asks respondents to decide between three courses of action to resolve a dilemma, and then to assess the relative importance of twelve considerations involved in the reasoning and judgement that led to their decision. These considerations are based on prior research of subjects verbalisation in response to the same hypothetical moral dilemmas. Finally, it asks respondents to rank in descending order the four most important considerations that provide the basis for their decision.

The subject's task is to rate and rank these statements in terms of which questions are the most important in making the decision, see **Appendix C**. The assumption is that persons at different points in development will define the issues in these moral problems differently. The issue statements were written to represent different stages of moral judgement development. Therefore the way a person rates and ranks the statements can be used to locate that person's point of development in the postulated developmental sequence.

While the DIT is derived from Kohlberg's general approach, it differs from his measure in several important ways. Theoretically the DIT differs from Kohlberg's test in the core concept of justice, Kohlberg defines the stages primarily in formalistic terms (ie. reversibility, universalizability, prescriptivity), whereas the DIT characterize the justice concept at each stage as following from different concepts of how social co-operation can be organised. For instance, according to the DIT scheme, a person thinking of social co-operation in terms of face-to-face primary relationships is at a different stage than a person thinking of social co-operation in terms of a society-wide network of role responsibilities within secondary institutions. For Kohlberg, such distinctions are "Content" differences not structural, and do not define his stages. Kohlberg's stage differentiators are more abstract than DIT stage differentiators.

The second difference between the DIT and Kohlberg's measure is a methodological one. The DIT is a multiple-choice test rather than a procedure in which subjects generate verbalizations in response to questions. The subject's task on the DIT is a recognition task.

A third difference is in the way that developmental level is indexed. Kohlberg regarded longitudinal gain as the most important evidence for his theory of moral judgement. His claim was that a 20 year longitudinal study shows gain on the Moral Judgement Interview (MJI), one stage at a time, without skipping or reverting. The DIT research on the other hand, has employed a "softer" stage theory, making the weaker claim that longitudinal research on the DIT should show general upward movement - quantitative shifts towards higher stage thinking, not one-step qualitative changes. A "soft" stage model does not completely abandon the notion of qualitative types nor of development. However, qualitative distinctions are seen as applying to types of thinking or reasoning, not to subjects. Subjects are viewed as using or having more than one type of thinking. A subject's thinking is a matter of having more or less of different types of thinking. There is still a notion of development: it is that some types of thinking become more prevalent later on (the high stages) while some types of thinking become less prevalent (the low stages). Subjects are located along the continuum of development in terms of the prevalence of different types of thinking. **The question of assessment is therefore not, what stage is a subject in? but rather is to what extent and under what conditions does the subject use different types of thinking?**

## **SUMMARY OF CHAPTER 2**

In this chapter the theoretical foundations of moral development research have been discussed.

Down through the centuries morality has been defined in many ways with both a secular and religious basis. The field of the psychology of moral development has been dominated in the past several decades by Lawrence Kohlberg's work on cognitive moral development theory. The origins of the theory can be traced back to the work of Jean Piaget and John Dewey. Based on 30 years of quantitatively reproducible research, Kohlberg's theory provides three levels of moral development known as preconventional morality, conventional morality, and post conventional or principal morality. Each level contains two stages. The validity of Kohlberg's stage theory has been well established cross-culturally and under a wide variety of socio-economic situations.

According to the theory, people proceed through these stages as they mature. The sequence is invariant, although the rate and stage reached vary with the individual. It is important to understand that only the type of justification provided or the logic of reasoning used is considered in assigning a stage score, not a particular set of values or moral beliefs. What is being tested is only the subject's capacity of moral reasoning. Kohlberg's theory is a justice based theory with the principle of justice being considered the highest form of morality.



Gilligan, Noddings and others criticised Kohlberg's justice based theory and argued for morality being interpreted in terms of care, compassion and responsiveness. If Medicine as a profession is truly concerned, as it seems to be, about issues of social justice such as access to health care as well as allocation of limited resources, then these issues can be successfully addressed and positively influenced in terms of justice reasoning by the teaching of medical ethics in the medical education curriculum and that these positive changes can be quantified by using tests like Kohlberg's MJI or Rest's Defining Issues Test (DIT).

Like the (MJI), the (DIT) present hypothetical moral dilemmas for the research subjects to resolve. However, instead of asking open-ended probe questions, the DIT offers multiple considerations for which the research subject is to choose the one believed to be the most important in resolving the dilemma.

The DIT has been used in hundreds of studies of moral reasoning, with the necessary validity studies and an extensive literature on the instrument. It is the most widely used instrument for assessing moral reasoning. Because of its extensive literature and its efficiency in data collection and scoring compared with other tests, the DIT was used in this study to measure the moral development in medical students at Kuwait University.

### **CHAPTER 3**

**"After all, anything which serves to reinforce and refresh  
the human spirit must be a good thing, especially  
in medicine".**

**(R. Downie and Bruce Charlton, 1992).**

### **3.1 MORAL DEVELOPMENT IN MEDICAL STUDENTS AT KUWAIT UNIVERSITY: RESEARCH QUESTIONS AND GOALS.**

The current study presents a cross-sectional analysis of the moral development of medical students in all seven years of medical education at the Faculty of Medicine, Kuwait University.

The hypothesis of this study is that the medical education experience at Kuwait University inhibits the normally expected increase in moral reasoning of medical students. The study specifically hypothesizes that there will be no significant increase in the moral reasoning scores of medical students from their first to seventh years at medical school. I hold the view that the rigid, hierarchical, authoritarian structure of medical education does not promote tolerance for different values, does not support the conceptual exploration of the fundamental values in medicine, and does not encourage the cognitive conflict that have been found to be important in moral reasoning growth and development. Rather, I think that medical education seems to promote an environment focused on convergent thinking, and the maintenance of the rules and regulations of the system, which according to cognitive moral development theory encourages a 'conventional level' moral ethos.

During the past two decades, one response to the concern about the moral and ethical development of medical students has been to include medical ethics courses into the formal medical education curriculum. However, despite the potential need for such courses, the lack of information about the natural course of moral development in

medical students limits the ability of educators to make informed decisions regarding the placement, structure or content of such courses in the curriculum. As a result, the writer in this research aimed at establishing a base line information about the moral development of medical students at Kuwait University and then to use this information in a formative way to help faculty and administration understand better where our students are on the developmental dimension of moral reasoning and to provide them with an opportunity to modify their teaching programmes in ways that would be more powerfully educative and focused on helping our students reach their potential maturity both technically and morally.

### **3.2 ADMINISTERING THE DIT: DESIGN AND SAMPLE**

Previous work with the DIT showed that the test is problematic for subjects whose language is not English<sup>(24)</sup>. With this in mind the writer decided to test a pilot sample before distributing the test to all medical students. Approaching different groups of students at the library and the faculty reading room, a group of 20 non-paid volunteers were recruited. This opportunity sample included students from classes one to seven. The volunteers agreed to take the English version of the DIT And see whether they can finish answering the test in less than 30 minutes and whether they can do this without the need to use a dictionary. Five students reported the need to use the dictionary after they read the first dilemma, three students felt the need to use the dictionary when they reached the third story, and the rest of the group "gave up" the whole test after scanning it quickly.

At this stage, a decision to translate the test was made. **See Appendix D.** With the help and advice of Dr Mohammed Refqi Essa, a lecturer at the Faculty of Education the DIT was fully translated to the Arabic language. Dr Essa is very familiar with the DIT, and has been using it in his research over the past ten years. In addition to using the DIT in his research, Dr Essa formulated a new test in Arabic that is "more suitable and adherent to our cultural background". No published data was found in which the alternative test was used. Dr Essa's test is known as (Muktarahek) or "your suggestion" as it translated from Arabic. **See Appendix E.** All translated materials were pilot-tested to ensure that they were easily understood, back translation was also performed to guarantee that the meaning of the original English version of the test was preserved. The test was then distributed to students in the first four years of medical school, and mailed to the students in the final three clinical years. The students were asked to take the test home, spend no more than 30 minutes attempting to go through all the stories. They were instructed to reach a decision concerning each story in the test, and then to rate and rank the order of the basic reasons for their decision from the list of provided possibilities. Students were also asked to complete a demographic data form detailing their age, gender, religion and medical class.

From the initial 493 questionnaires distributed to all Seven Year Students in Kuwait University Medical Faculty, only 180 were returned over a period of 5 months. Of these 180 questionnaires, 43 were excluded from the sample because they didn't contain any demographic data, and hence, there was no way to identify the student class, gender and other important data needed for the final analysis.

The original sample represented 36.5% of the students for that cohort and there were no significant differences between them and the rest of their class-mates with regard to age, gender, religion, or medical class. Thus, they appear to be comparable to the other medical students.

All student responses were anonymous, and confidentiality was guaranteed.

Table 1: The Final Number of Students Enrolled in the Research

Medical School	Total	Female Students	Male Students
1st Year	63	35	28
2nd Year	27	17	10
3rd Year	6	3	3
4th Year	20	4	16
5th Year	7	6	1
6th Year	13	9	4
7th Year	1	1	-
Total	137	75	62

An important point to note here is the variable response rate of different years. In years 1 and 2, I collected the forms personally one day after distributing them. the response rate was 78.75%, for the first year students and 28.7% for the second year students. In years 3 and 4, the response rate decreased to 16.5% in these two groups: and finally because the clinical year students (years 5, 6, 7) were attending different clinical rotations at different hospitals. I have asked the secretaries of the different clinical programmes (i.e. medicine, surgery, paediatrics, psychiatry, obstetrics and gynaecology) to collect the forms from the students when they were attending their lectures. The response rate was at a disappointing level of 12.9%

### **3.3 RESULTS**

#### **A. LISTING OF RAW DATA**

This list presents information on how each subject in my research responded to each item. It represents the individual answers which were recorded on the answer sheets, and obtained from the optical scanner. Where there are a lot of missing numbers, it means that the subject left out a lot of data or that the marks were too light for the scanner to read.

#### **Layout Scheme - See Appendix E.**

##### Card 1

Columns	1-5	Subjects Identification number (5 digit number).
	6-12	Lithocode (Center for the Study of Ethical Development/USA).
	13	Decision for Heinz story -
	14-25	Ratings on 12 items of Heinz - (1=great, 2=much, 3=some, 4=little, 5=no).
	26-27	Most important item from 12 Heinz items (item number).
	28-29	Second most important item.



**Card 1 continued.**

- 30-31 Third most important item.
- 32-33 Fourth most important item.
- 34** Blank
- 35 Decision for prisoner story -
- 36-47 Ratings on 12 items of prisoner.  
(1=great, 2=much, 3=some, 4=little, 5=no).
- 48-49 Most important item.
- 50-51 Second most important item.
- 52-53 Third most important item.
- 54-55 Fourth most important item.
- 56** Blank
- 57 Decision for newspaper story.
- 58-69 Ratings on 12 items of newspaper story.  
(1=great, 2=much, 3=some, 4=little, 5=no).
- 70-71 Most important item.
- 72-73 Second most important item.
- 74-75 Third most important item.
- 76-77 Fourth most important item.
- 78** Blank
- 79-80 01 (card number).

**Card 2**

- Columns 1-5 Subject identification number (same 5 digit number).

6-12 Lithocode (for Center use).

13 Decision for doctor story.

14-25 Ratings on 12 items of doctor story.

(1=great, 2=much, 3=some, 4=little, 5=no).

26-27 Most important item from 12 doctor items.

28-29 Second most important item.

30-31 Third most important item.

32-33 Fourth most important item.

**34** Blank

35 Decision for Webster story.

36-47 Ratings on 12 items of Webster.

(1=great, 2=much, 3=some, 4=little, 5=no).

48-49 Most important item.

50-51 Second most important item.

52-53 Third most important item.

54-55 Fourth most important item.

**56** Blank

57 Decision for students story.

**Card 2 continued.**

58-69 Ratings on 12 items of student story

(1=great, 2=much, 3=some, 4=little, 5=no).

70-71 Most important item.

72-73 Second most important item.

74-75 Third most important item.

76-77 Fourth most important item.

78 Blank

79-8002 (card number).

B. DIT SCORES

NUMBER OF STORIES TO BE SCORED = 6  
 ORDER OF STORIES = HEINZ PRIS. PAPER DOCTOR WEB. STUD.

NOTE: A VALUE OF 99.9 INDICATES THAT THE SCORE CAN NOT  
 BE COMPUTED BECAUSE OF MISSING DATA.

\*\*\*\*\*

SUBJECT ID	STAGE SCORES						P SCORE	D SCORE	U SCORE		
	2	3	4	5A	5B	6				A	M
10011	12.0	9.6	32.4	0.0	0.0	0.0	4.8	1.2	0.0	16.281	0.274
10021	2.0	8.0	32.0	8.0	3.0	4.0	0.0	3.0	25.0	16.144	0.083
10030	5.0	10.0	22.0	11.0	7.0	2.0	3.0	0.0	33.3	3.294	0.246
10040	6.0	9.0	20.0	8.0	3.0	5.0	5.0	4.0	26.7	15.609	0.041
10051	4.0	7.0	37.0	7.0	0.0	0.0	3.0	2.0	11.7	13.528	0.298
10061	5.0	9.0	22.0	3.0	4.0	7.0	6.0	4.0	23.3	12.002	0.001
10071	4.0	10.0	21.0	11.0	3.0	3.0	4.0	4.0	28.3	13.963	0.232
10080	4.0	12.0	20.0	8.0	0.0	4.0	7.0	5.0	20.0	16.193	-0.259
10090	3.6	9.6	28.8	7.2	6.0	4.8	0.0	0.0	30.0	16.436	0.075
10101	0.0	10.0	16.0	14.0	0.0	16.0	0.0	4.0	50.0	18.998	0.412
10111	3.0	4.0	37.0	4.0	3.0	4.0	3.0	2.0	18.3	13.033	0.212
10121	6.0	7.0	16.0	18.0	7.0	2.0	0.0	4.0	45.0	11.823	0.235
10131	3.0	11.0	30.0	4.0	3.0	3.0	0.0	6.0	16.7	13.163	0.332
10140	3.0	14.0	17.0	8.0	5.0	2.0	6.0	5.0	25.0	12.341	0.244
10150	12.0	10.0	18.0	10.0	0.0	3.0	2.0	5.0	21.7	18.093	-0.006
10160	1.0	8.0	17.0	12.0	4.0	11.0	1.0	6.0	45.0	22.995	0.136
10171	0.0	7.0	34.0	10.0	3.0	4.0	2.0	0.0	28.3	14.424	0.052
10181	1.2	12.0	13.2	12.0	8.4	8.4	4.8	0.0	48.0	19.817	-0.000
10191	0.0	6.0	34.0	8.0	1.0	6.0	3.0	2.0	25.0	23.672	0.333
10200	7.0	7.0	27.0	13.0	4.0	2.0	0.0	0.0	31.7	10.885	0.098
10210	2.0	14.0	22.0	10.0	6.0	0.0	3.0	3.0	26.7	17.686	0.091
10220	1.0	8.0	16.0	19.0	5.0	5.0	3.0	3.0	48.3	11.433	9.990
10230	6.0	10.0	18.0	9.0	3.0	6.0	6.0	2.0	30.0	10.416	-0.052
10240	0.0	4.8	24.0	9.6	7.2	6.0	0.0	8.4	38.0	27.093	0.133
10250	10.8	9.6	21.6	0.0	0.0	2.4	7.2	8.4	4.0	14.356	-0.035
10260	0.0	12.0	27.0	10.0	3.0	5.0	0.0	3.0	30.0	24.870	0.279
10271	5.0	16.0	17.0	15.0	1.0	3.0	3.0	0.0	31.7	5.586	-0.038
10280	5.0	19.0	16.0	6.0	6.0	4.0	2.0	2.0	26.7	14.089	0.098
10290	1.0	9.0	22.0	15.0	6.0	5.0	2.0	0.0	43.3	27.946	0.246
10300	3.0	9.0	29.0	3.0	7.0	4.0	1.0	4.0	23.3	13.126	0.274
10310	2.0	15.0	23.0	3.0	3.0	6.0	3.0	5.0	20.0	12.180	0.313
10320	8.0	8.0	24.0	7.0	3.0	4.0	3.0	3.0	23.3	18.235	-0.043
10330	0.0	8.0	33.0	9.0	3.0	5.0	0.0	2.0	28.3	27.415	9.990
10340	1.0	4.0	26.0	10.0	3.0	2.0	8.0	6.0	25.0	21.872	0.139
10351	3.8	13.8	25.0	2.5	5.0	7.5	0.0	2.5	25.0	17.852	0.375
10360	0.0	16.0	26.0	4.0	1.0	4.0	9.0	0.0	15.0	15.798	0.056
10371	3.0	15.0	18.0	2.0	4.0	11.0	4.0	3.0	28.3	19.025	0.150
10380	5.0	13.0	26.0	14.0	2.0	0.0	0.0	0.0	26.7	14.662	0.038
10391	2.0	12.0	25.0	3.0	6.0	7.0	5.0	0.0	26.7	18.221	0.219
10401	3.0	3.0	37.0	7.0	3.0	3.0	0.0	4.0	21.7	18.094	0.292
10411	0.0	21.0	17.0	7.0	0.0	9.0	4.0	2.0	26.7	13.577	0.331
10420	1.0	15.0	23.0	3.0	9.0	6.0	0.0	3.0	30.0	21.633	0.072

10430	8.0	9.0	15.0	11.0	4.0	3.0	3.0	7.0	30.0	14.329	0.243
10440	1.0	15.0	23.0	4.0	2.0	9.0	1.0	5.0	25.0	11.261	0.092
10450	3.0	9.0	25.0	9.0	4.0	5.0	3.0	2.0	30.0	17.810	0.332
10461	6.0	8.4	19.2	10.8	2.4	9.6	0.0	3.6	38.0	22.222	0.432
10470	4.0	10.0	34.0	3.0	3.0	5.0	0.0	1.0	18.3	8.874	-0.045
10481	5.0	11.0	19.0	2.0	4.0	11.0	4.0	4.0	28.3	15.558	0.143
10491	4.0	12.0	21.0	9.0	4.0	6.0	4.0	0.0	31.7	13.009	0.0
10501	4.0	10.0	25.0	10.0	2.0	3.0	0.0	6.0	25.0	11.699	0.006
10511	3.0	20.0	23.0	0.0	3.0	5.0	3.0	3.0	13.3	12.823	0.002
10520	2.4	16.8	24.0	2.4	3.6	1.2	3.6	6.0	12.0	7.740	0.208
10531	8.4	16.8	9.6	8.4	0.0	8.4	1.2	7.2	28.0	19.043	0.128
10541	0.0	14.0	32.0	3.0	3.0	8.0	0.0	0.0	23.3	18.397	0.186
10550	4.0	10.0	19.0	15.0	10.0	0.0	0.0	2.0	41.7	15.356	0.124
10560	3.0	5.0	26.0	5.0	5.0	5.0	4.0	7.0	25.0	16.681	0.086
10570	4.0	8.0	24.0	4.0	3.0	9.0	2.0	6.0	26.7	16.985	0.247
10581	4.1	8.1	27.5	6.1	3.1	5.1	2.0	4.1	23.7	16.863	0.009
10590	3.0	18.0	21.0	5.0	6.0	6.0	1.0	0.0	28.3	16.919	0.264
10600	0.0	12.0	14.0	11.0	6.0	10.0	7.0	0.0	45.0	18.215	-0.096
10610	0.0	17.0	24.0	1.0	0.0	8.0	0.0	10.0	15.0	10.161	0.069
10621	1.0	8.0	24.0	14.0	4.0	3.0	0.0	6.0	35.0	16.984	0.127
10631	0.0	10.0	30.0	6.0	6.0	6.0	2.0	0.0	30.0	30.316	0.498
ZU010	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	12.168	0.052
20020	4.0	14.0	13.0	15.0	7.0	4.0	0.0	3.0	43.3	22.085	0.140
20030	1.0	7.0	10.0	17.0	7.0	8.0	8.0	2.0	53.3	17.955	0.091
20041	0.0	2.0	28.5	12.2	4.1	8.1	2.0	3.1	40.7	22.619	0.214
20051	2.0	21.0	19.0	5.0	2.0	6.0	1.0	4.0	21.7	12.581	0.558
20060	9.0	3.0	20.0	8.0	2.0	9.0	5.0	4.0	31.7	13.324	0.081
20070	2.0	2.0	35.0	12.0	2.0	6.0	0.0	1.0	33.3	15.922	-0.030
20081	4.0	14.0	15.0	9.0	3.0	5.0	7.0	3.0	28.3	19.907	0.117
20091	9.0	18.0	17.0	8.0	7.0	1.0	0.0	0.0	26.7	7.731	0.049
20100	7.0	15.0	17.0	8.0	8.0	3.0	2.0	0.0	31.7	11.560	0.185
20110	5.4	20.4	19.3	9.6	0.0	3.2	2.1	0.0	21.4	12.443	0.315
20121	3.0	15.0	18.0	10.0	9.0	5.0	0.0	0.0	40.0	24.887	0.203
20130	5.0	1.0	28.0	7.0	8.0	2.0	4.0	5.0	28.3	14.568	0.165
20140	6.0	8.0	21.0	4.0	3.0	7.0	9.0	2.0	23.3	16.654	0.309
20150	0.0	6.0	21.6	13.2	8.4	3.6	1.2	6.0	42.0	19.279	0.219
20161	3.0	17.0	12.0	7.0	4.0	11.0	2.0	4.0	36.7	12.289	0.153
20170	6.0	6.0	19.0	13.0	3.0	8.0	2.0	3.0	40.0	17.899	0.154
20180	0.0	5.0	25.0	8.0	8.0	3.0	5.0	6.0	31.7	20.707	0.221
20190	4.0	15.0	10.0	16.0	5.0	7.0	3.0	0.0	46.7	12.390	0.233
20200	1.0	7.0	20.0	13.0	8.0	2.0	7.0	2.0	38.3	17.264	0.187
20211	1.0	13.0	23.0	7.0	5.0	4.0	3.0	4.0	26.7	15.224	-0.048
20221	1.0	13.0	20.0	9.0	3.0	9.0	3.0	2.0	35.0	13.659	0.252
20231	4.0	8.0	31.0	15.0	1.0	0.0	1.0	0.0	26.7	18.407	0.263
20240	4.8	22.8	10.8	7.2	1.2	7.2	6.0	0.0	26.0	6.089	0.080
20250	4.0	14.0	13.0	13.0	3.0	6.0	7.0	0.0	36.7	5.801	0.141
20261	3.0	18.0	11.0	7.0	4.0	11.0	2.0	4.0	36.7	12.289	0.091
20270	0.0	14.0	23.0	13.0	2.0	3.0	1.0	4.0	30.0	5.983	0.099
30011	5.0	10.0	27.0	6.0	6.0	6.0	0.0	0.0	30.0	13.686	0.106
30021	5.0	12.0	25.0	4.0	1.0	5.0	3.0	5.0	16.7	11.840	0.141
30030	0.0	21.0	18.0	9.0	6.0	2.0	0.0	4.0	28.3	11.302	0.306
30040	0.0	7.0	22.0	10.0	6.0	9.0	2.0	4.0	41.7	25.170	0.162
30050	0.0	6.0	33.0	7.0	6.0	3.0	2.0	3.0	26.7	17.693	0.160
30061	0.0	16.0	17.0	10.0	2.0	9.0	6.0	0.0	35.0	16.720	0.124
40011	3.0	0.0	27.0	4.0	7.0	8.0	8.0	3.0	31.7	18.539	0.292
40021	0.0	6.0	31.0	9.0	6.0	5.0	0.0	3.0	33.3	24.022	0.226
40031	2.0	0.0	34.0	4.0	6.0	8.0	0.0	6.0	30.0	23.752	0.990
40040	1.0	23.0	17.0	4.0	5.0	3.0	3.0	4.0	20.0	16.518	0.284
40050	3.0	15.0	21.0	8.0	3.0	8.0	1.0	1.0	31.7	10.565	0.044
40060	0.0	8.0	27.0	8.0	5.0	8.0	0.0	4.0	35.0	22.631	0.135

40070	4.0	6.0	19.0	14.0	4.0	8.0	2.0	3.0	43.3	16.790	0.183
40081	3.0	6.0	17.0	11.0	6.0	12.0	0.0	5.0	48.3	15.425	0.176
40091	0.0	13.0	35.0	5.0	3.0	2.0	0.0	2.0	16.7	18.169	0.376
40101	0.0	8.0	30.0	8.0	3.0	6.0	1.0	4.0	28.3	18.704	0.149
40111	0.0	7.0	26.0	11.0	1.0	5.0	5.0	5.0	28.3	17.887	0.360
40121	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	99.9	20.779	9.990
40131	2.4	7.2	13.2	12.0	7.2	6.0	12.0	0.0	42.0	21.910	0.125
40141	7.0	24.0	11.0	2.0	6.0	6.0	3.0	1.0	23.3	4.513	-0.025
40151	0.0	5.0	21.0	8.0	6.0	7.0	7.0	6.0	35.0	13.909	-0.027
40161	0.0	10.0	31.0	5.0	2.0	7.0	3.0	2.0	23.3	14.231	0.463
40171	0.0	0.0	60.0	0.0	0.0	0.0	0.0	0.0	0.0	22.475	9.990
40181	5.0	2.0	27.0	5.0	2.0	7.0	8.0	4.0	23.3	12.810	0.167
40191	1.0	13.0	27.0	5.0	5.0	7.0	2.0	0.0	28.3	25.127	0.458
40201	1.0	7.0	18.0	11.0	5.0	6.0	2.0	10.0	36.7	10.135	0.087
50011	5.0	9.0	22.0	7.0	3.0	3.0	3.0	8.0	21.7	18.108	0.171
50020	0.0	9.0	22.0	13.0	4.0	6.0	6.0	0.0	38.3	17.973	0.047
50030	4.0	19.0	24.0	5.0	4.0	0.0	0.0	4.0	15.0	7.802	0.116
50040	3.0	4.0	32.0	4.0	3.0	10.0	2.0	2.0	28.3	25.172	0.373
50050	4.0	12.0	23.0	10.0	8.0	3.0	0.0	0.0	35.0	15.600	-0.030
50060	0.0	13.0	28.0	10.0	1.0	4.0	4.0	0.0	25.0	23.271	0.291
50070	6.0	19.0	29.0	2.0	1.0	0.0	3.0	0.0	5.0	12.022	0.198
60010	1.6	8.1	37.3	4.9	4.9	3.2	3.0	0.0	21.6	22.389	0.392
60020	2.0	3.0	25.0	12.0	8.0	1.0	5.0	4.0	35.0	20.391	0.012
60030	7.0	10.0	20.0	6.0	7.0	5.0	5.0	0.0	30.0	15.380	0.355
60040	0.0	4.0	33.0	11.0	1.0	5.0	3.0	3.0	28.3	23.863	0.287
60051	2.0	22.0	22.0	9.0	2.0	0.0	0.0	3.0	18.3	15.587	0.185
60061	3.0	4.0	33.0	4.0	5.0	6.0	0.0	5.0	25.0	23.193	0.325
60071	7.0	12.0	22.0	11.0	1.0	4.0	0.0	3.0	26.7	16.685	0.231
60080	6.0	0.0	34.0	6.0	1.0	7.0	6.0	0.0	23.3	18.450	0.134
60091	6.0	9.0	26.0	9.0	1.0	6.0	0.0	3.0	26.7	8.484	0.067
60100	0.0	10.0	17.0	16.0	5.0	7.0	4.0	1.0	46.7	9.837	0.228
60110	1.0	9.0	10.0	18.0	8.0	7.0	4.0	3.0	55.0	25.359	0.385
60120	2.0	10.0	21.0	13.0	4.0	8.0	1.0	1.0	41.7	8.314	0.209
60130	0.0	10.8	22.8	21.6	0.0	0.0	4.8	0.0	36.0	16.951	0.002
70010	3.0	6.0	25.0	14.0	1.0	5.0	4.0	2.0	33.3	14.632	0.096

C. **HOW TO READ THE TABLE:**

Subject ID (5 digit number)

1st digit: the student year

1	=	First Year.
2	=	Second Year.
3	=	Third Year.
4	=	Fourth Year.
5	=	Fifth Year.
6	=	Sixth Year.
7	=	Seventh Year.

- 2nd digit: which faculty.

0 = Faculty of Medicine.

- 3rd and 4th digits: number allocated to student enrolled in the study. In each year there is a maximum of 80 students, therefore the numbers start from 01 through to 80.

- 5th digit: gender.

0 = Female Student.

1 = Male Student.

For example, I.D. number 10011 refers to the first student enrolled in the

study from the first year in the medical school. This was a male student.

At this point it may be useful to give some brief characterisations of each of the scores listed.

Stage 2: Represents considerations that focus on the direct advantages to the actor and on the fairness of simple exchanges of favour for favour.

Stage 3: Represents considerations that focus on the good or evil intentions of the parties, on the party's concern for maintaining friendships and good relationships, and maintaining approval.

Stage 4: Represents considerations that focus on maintaining the existing legal system, maintaining existing roles and formal organisation structure.

Stage 5A: Represents considerations that focus on organising a society by appealing to consensus producing procedures (such as abiding by the will of the people), insisting on due process and safe guarding minimal basic rights.

Stage 5B: Represents considerations that focus on organising social arrangements and relationships in terms of intuitively appealing ideals (but which may lack a rationale for gaining general support).



**Stage 6:** Represents considerations that focus on organising society in terms of ideals that appeal to a rationale for eliminating arbitrary factors and that are designed to optimise mutual human welfare.

**A:** Represents considerations that reflect an **Anti-establishment** attitude. These considerations pre-suppose an understanding of Stage 4, but fault existing authorities and "the establishment" are seen to be hypocritical and inconsistent with its own rationale. The 'A' point of view is critical but offers nothing positive in its place.

**M:** Does not represent any point of view or type of moral reasoning. 'M' stands for **Meaningless items**. These are items written to serve as an internal reliability check on whether subjects are following directions or not. 'M' items are written in a pretentious and lofty sounding manner, but are really meaningless on the 6-story form, if a subject's 'M' score is 8 or above. his/her questionnaire results are discarded because their high 'M' score signifies that he/she was attending more to perceived complexity and loftiness of the items than to the meaning of the items.

**P score:** This is the most important DIT score. It is interpreted as the relative importance that subjects give to principled moral considerations, that is, to stage 5 and stage 6 items. It is the simple sum of scores from

stages 5a, 5b and 6, divided by 0.6 and converted to a percent (the number for stages 2, 3, 4, 5a, 5b, 6, A and M should always add up to 60 in the 6-story form of the DIT). If too much data is missing for a questionnaire, the computer program used inserts 99.9 to indicate that the questionnaire should be invalidated and removed from further analysis.

**D score:** Represents a composite score based on Professor Mark Davison's scaling analysis of DIT items.<sup>(25)</sup> It bypasses all a priori stage designations and derives scale values for the items through a latent-trial unfolding process.

The subject's ratings of the items are multiplied by the item's scale values and summed up. The D score behaves very much like the p score, and its the p score that is of importance in this study.

**U score:** Represents a new index, the 'utilizer' score, investigated by Dr Stephen Thoma.<sup>(19)</sup> Theoretically this score represents the degree to which a subject uses concepts of justice in making moral judgements. By implication this asserts that some people use considerations and criteria for deciding what is morally right other than concepts of justice. For instance, some people use religious doctrine to decide what is morally right even if this contradicts what they think is fair

and just. The U score is derived from two pieces of DIT data: the action choices that people make (i.e. Heinz should steal, or Heinz should not steal), and secondly from the items that they rank as most important. Thoma has shown that each of the 12 items for each story has a logical implication that favours one action choice or the other. If the items that a person picks tend to go along with the person's action choice, then the person has a high U score because it is inferred that the person's concepts of Justice (exemplified in DIT items) is driving the advocacy of a particular course of action. If there is little fit, then the person has a low U score and it is inferred that the person makes moral decisions on some different basis than concepts of justice. The practical importance of the U score is that it can be used to increase the predictability to behaviour. The U score can range from +1.0 to -1.0, but usually most scores are between 0.1 and 0.2.

#### **D. CONSISTENCY CHECK**

Another check on the reliability of the subject in taking the DIT (in addition to the M score check), is the Consistency Check. This procedure is especially designed to pick-up those subjects who are randomly marking the items without reading them or without understanding the questionnaire's instructions. It works by comparing the rating data (the circles to the left of the 12 items) with the ranking data (the block of four lines of circles at the bottom of each story). Ordinarily we expect there to be some consistency between the ratings and the rankings (as a common sense

assumption). For instance, if a subject ranked item number 7 as the most important item out of 12, then we would expect that no other item would be rated by the same subject higher than item number 7. The Consistency Check works this way: counting up the number of times that those expectations are violated, if there are too many inconsistencies, then the questionnaire fails the Consistency Check. Furthermore, subjects who do not discriminate items and repeatedly go down the list and mark items with the same rating are also caught by the Consistency Check. If a subject completely omits a story that was assigned, then the 'non-discrimination' condition is also invoked since then all of the ratings are rated the same (e.g., all left blank), and that subject's questionnaire will fail the Consistency Check.

It is usual in studies using the DIT to lose between 5% and 15% of a sample to invalidating from the Consistency Check or M score. Anything much higher than this generally means that the subjects for the study were insufficiently motivated to take the test or were tired when taking the test or have insufficient reading skills to understand it.

I think that the insufficient motivation would apply to the results obtained from this study, since first, the students were asked to take the test home and answer it at their convenience, provided they don't take more than 30 minutes to go through the 6-story form and secondly, the DIT was translated fully to Arabic and hence any difficulty with reading skills will not apply. Another explanation of the poor response might be the "Western/different" theme of the stories used in the DIT. It would therefore be interesting to see whether the use of more "Islamic/Arabic" theme to the stories will

yield more response:

## **E. THE FINAL SAMPLE**

Here are the various ways that subjects may be eliminated from the final sample.

- 1 -if the questionnaire could not be run through the optical scan machine because:
  - The paper was folded, torn, mutilated.
  - The DIT was not filled in.
  - The subject put multiple checkmarks, where only one response was required (e.g. marking several items as first importance).
- 2 - The subject's M score is too high.
- 3 -The subject is too inconsistent on the consistency check.
- 4 - The subject uses the same response too much and is non-discriminating or leaves out a whole story.
- 5 -The subject has too much missing data scattered throughout the questionnaire (indicated by having 99.9 scores).
- 6 -The subject's ID is not a real integer (that is, has a blank space in the 5 digit ID number like 123-5 instead of 12345).

In this study 53 questionnaires were eliminated from the final sample because of a combination of the above mentioned ways. There is no reason to believe that these students were any different from the rest of the students who were included in the final statistics.

## E. THE STATISTICS

**Table 2. Descriptive Statistics For Total Sample and Sub Samples.**

GROUP	DIT SCORES											
		Stage2	Stage3	Stage4	Stage5A	Stage5B	Stage6	A	M	P	D	U
Sub 1 (n= 34 )	MEAN	3.262	10.350	24.162	7.282	4.297	5.165	2.353	3.135	27.900	15.864	0.169
	SD	1.927	3.853	5.660	4.570	1.849	2.787	2.173	2.180	7.706	5.423	0.135
Sub 2 (n= 24 )	MEAN	3.100	10.850	20.808	10.083	4.438	5.204	2.929	2.587	32.888	17.127	0.158
	SD	2.550	6.830	7.347	3.890	2.850	3.276	2.312	1.910	11.422	4.366	0.101
Sub 3 (n= 4 )	MEAN	2.500	11.000	25.500	6.750	3.750	5.750	2.750	2.000	27.100	14.985	0.133
	SD	2.887	4.163	6.608	2.500	2.630	2.500	2.500	2.449	7.727	2.703	0.023
Sub 4 (n= 10 )	MEAN	2.340	8.820	23.520	7.500	4.620	6.700	3.700	2.800	31.360	16.647	0.188
	SD	2.404	6.936	7.763	3.375	2.196	2.627	4.347	1.751	9.259	6.016	0.129
Sub 5 (n= 5 )	MEAN	3.400	12.600	26.000	6.800	4.000	3.800	2.200	1.200	24.320	15.714	0.141
	SD	2.191	6.504	4.301	4.550	2.550	4.266	2.490	1.789	14.013	6.535	0.155
Sub 6 (n= 6 )	MEAN	3.000	10.300	24.133	11.767	3.167	2.500	2.967	2.167	29.050	18.143	0.179
	SD	3.225	6.828	4.633	5.269	3.430	2.429	2.418	1.722	6.423	3.331	0.145
TOTAL (N= 84 )	MEAN	3.056	10.420	23.308	8.455	4.212	5.113	2.751	2.687	29.632	16.415	0.164
	SD	2.273	5.515	6.392	4.420	2.379	3.032	2.551	2.013	9.488	4.955	0.120

This table provides means, standard deviations and sample numbers for all the DIT indices (stages 2, 3, 4, 5A, 5B, 6 and A, M, P, D and U). It provides these descriptive statistics for the total sample, and for each of the subgroups formed by grouping on the first digit of the ID number i.e. first year students, second year students, etc.

It is of significance here to notice that mean P score for the different subgroups is as follows:

- First year medical students:  
mean P score = 27.900
- Second year medical students:  
mean P score = 32.888
- Third year medical students:  
mean P score = 27.100
- Fourth year medical students:  
mean P score = 31.360
- Fifth year medical students  
mean P score = 27.320
- Sixth year medical students  
mean P score = 29.050
  
- Total mean P score = 29.632



## NORMS

Data from thousands of subjects have recently been summarised by the Center for the study of ethical development of the university of Minnesota, in two secondary analyses. The data came from hundreds of studies and do not constitute a truly representative sample of the USA drawn at random. Rather, the samples came from hundreds of investigators from all over the USA who have conducted studies with the DIT and sent reports of their findings to the Center. This data provides a basis for comparing the responses to the DIT made by subjects in any study (including mine) with those samples drawn from the various populations on which the DIT has been normed.

Table 3. (DIT) Indices from the Standardisation Samples.

GROUP		Stage2	Stage3	Stage4	Stage5A	Stage5B	Stage6	A	M	P	D	U
Jr Hi (n= 270 )	MEAN	6.300	15.000	20.240	8.010	2.580	1.410	3.760	2.680	20.000	10.340	0.103
	SD	3.100	5.310	5.740	4.610	2.490	1.890	2.890	2.210	9.040	5.830	0.039
Sr Hi (n= 270 )	MEAN	5.150	11.340	19.170	13.100	3.090	2.420	2.720	2.510	31.030	19.480	0.195
	SD	3.440	5.630	7.280	6.460	2.780	2.450	2.640	2.050	13.900	7.230	0.031
College (n= 270 )	MEAN	3.050	8.600	17.010	15.810	5.200	4.890	2.540	2.390	43.190	25.410	0.108
	SD	2.810	5.140	8.070	6.310	3.400	3.340	2.610	2.240	14.320	7.800	0.029
Grad Stu (n= 270 )	MEAN	2.240	7.960	17.970	15.090	5.260	6.560	1.860	3.040	44.350	28.260	0.094
	SD	2.510	5.660	8.670	6.110	3.520	3.350	2.430	2.350	15.060	8.030	0.026
Phil/Sem (n= 40 )	MEAN	2.000	7.800	11.400	0.000	0.000	0.000	0.000	0.000	65.100		
	SD	2.700	6.400	4.700	0.000	0.000	0.000	0.000	0.000	11.700		

As can be seen from this table, the generalisation seems to hold pretty well that the P scores of junior high school subjects averages in the 20s, senior high school subjects are in the 30s, college subjects are in the 40s, graduate students are in the 50s, and adults in general, are in the 40s. Among demographic variables, education is by far the most powerfully associated with DIT scores. In school age samples, age and education are confounded, but in post high school samples, education is far more predictive of DIT scores than chronological age<sup>(19)</sup>. This is true in both cross-sectional studies and in longitudinal studies. Sex differences are trivial on the DIT accounting for less than  $\frac{1}{10}$  of a percent of DIT variance. IQ and religion are somewhat correlated with DIT scores, and sometimes geographic region, especially when the geographical locale signifies a conservative social-political milieu. However, education is really the only demographic variable on which norms were based.

**Table 4. Statistical Analysis: t-Test on the P-Score Differences Between Total Sample, Sub Samples, and Norm Groups.**

Group	Statistic	Norm Groups*				
		Junior	Senior	College	Grads	Phil/Sem
Sub 1	t-test	5.519	-1.995	-9.659	-10.539	-16.362
	df	302.	302.	302.	302.	72.
	prob	0.000	0.044	0.000	0.000	0.000
Sub 2	t-test	6.541	0.636	-3.427	-3.733	-10.757
	df	292.	292.	292.	292.	62.
	prob	0.000	0.532	0.001	0.001	0.000
Sub 3	t-test	1.562	-0.563	-2.240	-2.350	-6.322
	df	272.	272.	272.	272.	42.
	prob	0.116	0.577	0.024	0.019	0.000
Sub 4	t-test	3.399	0.074	-2.590	-2.610	-8.453
	df	273.	273.	273.	273.	43.
	prob	0.000	0.527	0.010	0.006	0.000
Sub 5	t-test	1.048	-1.069	-2.921	-3.023	-7.204
	df	273.	273.	273.	273.	43.
	prob	0.296	0.286	0.004	0.003	0.000
Sub 6	t-test	2.436	-0.348	-2.410	-2.561	-7.335
	df	274.	274.	274.	274.	44.
	prob	0.015	0.681	0.016	0.011	0.000
TOTAL	t-test	8.217	-1.046	-10.019	-11.007	-16.731
	df	352.	352.	352.	352.	122.
	prob	0.000	0.297	0.000	0.000	0.000

This is basically to show whether my sample and each sub sample in it is statistically different from a USA norm sample of junior high students, senior high students, college students, college graduates or Ph.D students in moral philosophy/political science or liberal seminary students.

Whenever the probability is less than 0.05, then there is a statistical evidence

that there is a significant difference between the two groups being compared.

It is significant to notice that the total P score of my subjects is less than the P score of the college students, graduate students, and students in philosophy and similar education.

The total P score of my subjects from year one to year seven is comparable to the P score of the senior high school students in the USA norm standardised groups.

### **3.4 CONCLUSIONS**

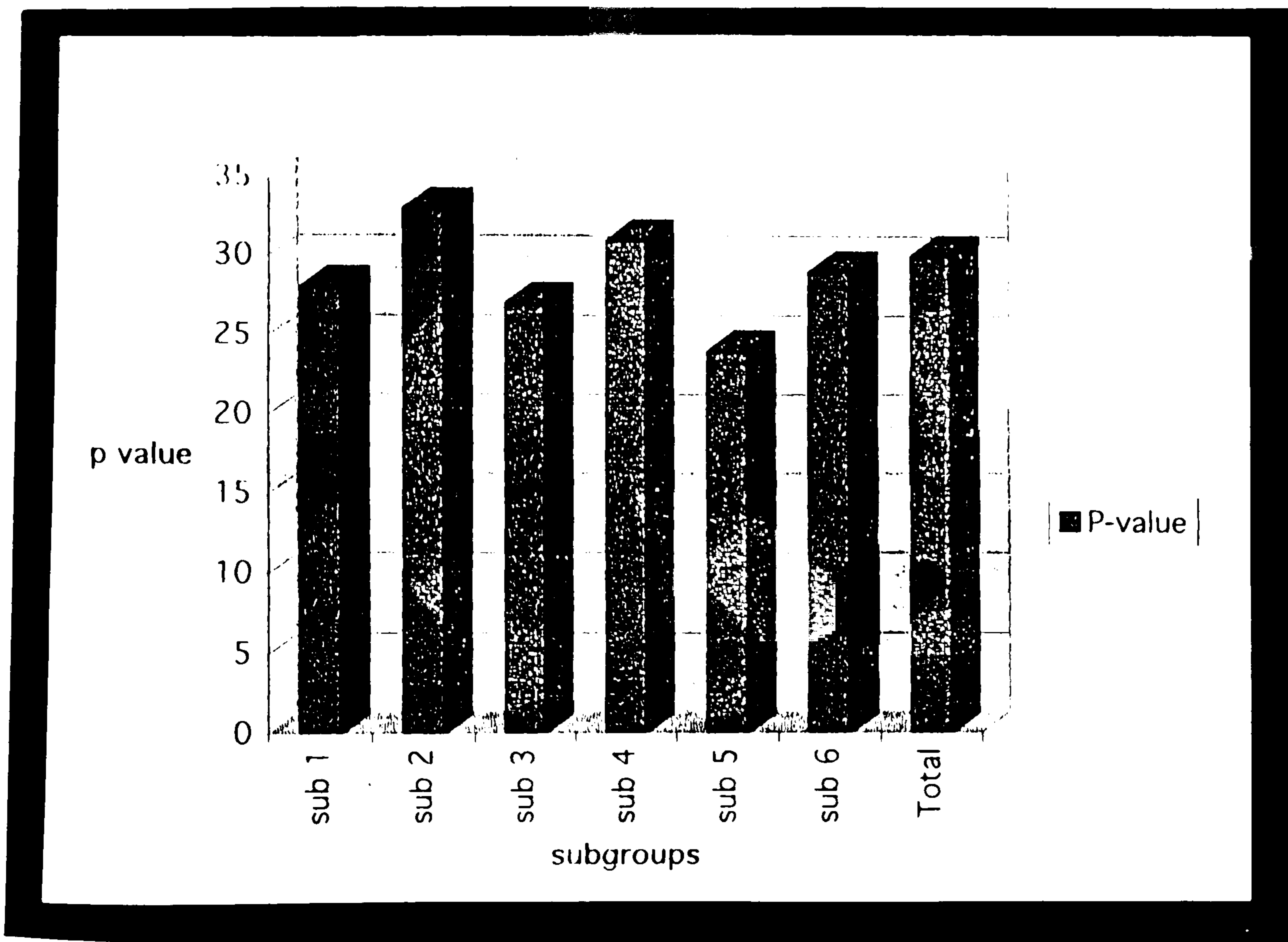
A total of 180 medical students participated in this study on a purely voluntary basis. 493 DIT forms were initially distributed to all seven year medical students. Pre-medical and pre-clinical students (years 1, 2, 3, 4) received their forms in person, while clinical year students (years 5, 6, 7) who were attached to different teaching hospitals around the country received their forms via the university internal mail. From this subject pool, the scoring of the DIT checks for internal consistency and meaningfulness of the responses yielded a 29% sample loss, which is not unusual for DIT studies.

The statistical analysis was performed on the subjects who passed the scoring criteria (27.8%). The first four years had substantial representation in the final sample, this however, was not the case for students in the three clinical years.

### The Medical Class effect

There was no significant difference found in the DIT scores of students between classes, although age increased with class year, as expected, this was not reflected in the P-score of the students. There was also no significant difference between the moral reasoning scores of pre-clinical students compared to the scores of clinical students, if at all there was a decrease in the scores for students in years five and six.

**Figure 1. The P-Score for Study Subgroups (Years 1-6).**



### The Gender Effect

There were significant differences with the DII scores by gender in all the tested years with exception to year four. The p-score of female students was statistically higher than the p-score of their male colleagues.

To date, the literature reviewed examining gender differences in moral reasoning as defined by Kohlberg's theory does not support Gilligan's claim that Kohlberg's moral reasoning theory is gender biased. The meta analysis of 56 samples of over 6,000 male and female subjects by Thoma in 1986 reported that at every age and educational level, females scores significantly higher than males. However, he found that education was 500 times more powerful in predicting moral judgement level than gender.

Table 5. The P-Score: The Gender Effect

Faculty of medicine	Mean P score	
	Female students	Male students
Year 1	27.68	27.00
Year 2	38.68	31.9
Year 3	32.23	27.23
Year 4	32.5	33.00
Year 5	24.4	21.7
Year 6	35.28	24.17
Year 7	—	36.00

It is interesting to notice that a Professor of Psychiatry and Humanities in medicine thinks that<sup>(26)</sup>

"During the past 30 years, the two influences that have had the greatest impact on the moral growth and moral reasoning capacity of medical students have been the incorporation into the medical school curriculum of courses in medical humanities and the admission to medical school of an increasing number of female students".

Professor Knight also added that:

"Anyone who has been involved in academic medicine during the past three decades will testify, from an observational viewpoint, that women have brought to medicine an increased commitment to the morality of care or responsibility, to blend with the male emphasis of morality as justice and rights".

The trends in the data indicates a strong socialising factor of the medical education experience. There appears to be a homogeneity in moral thinking among medical students regardless of the gender, class or clinical experience.

Of course with only one point of measurement - as it is the case in this study, there is no way of knowing what will happen to the moral reasoning of the individual student after the measurement. This question can only be answered with a longitudinal study measuring moral reasoning of each student and following it through the seven years at the medical school.

### **3.5 RELIABILITY AND VALIDITY**

Moral judgement is a psychological construct that cannot be validated or invalidated by a single kind of finding. It is a construct with many empirical implications. What follows is a brief outline of the Center for the Study of Ethical Development at the University of Minnesota <sup>(19)</sup> treatment of reliability and validity discussed in terms of:

1. Face validity.
2. Criterion group differences.
3. Longitudinal change.
4. Experimental enhancement.
5. Resistant to faking.
6. Cross-cultural studies and universality.
7. Cross-cultural studies using the DIT.



## 1. FACE VALIDITY

Like most other tests of moral judgement, the DIT task itself obviously involves making judgements about moral problems (unlike, say, the interpretation of ink-blot or story completions which are indirect ways of assessing psychological variables), the DIT does not only ask what line of action the subject favours (i.e. to steal or not steal a drug), but is concerned with a subject's reasons behind the choice.

## 2. CRITERION GROUP VALIDITY

The basic strategy of criterion group validation is to demonstrate that groups of subjects who ought to have different scores on a measure do in fact have different scores. On a measure purporting to measure the development of moral judgement, we would expect (on a common sense basis) that world renown moral philosophers would have high scores. At the other extreme one would expect the scores of a ten year old subject to be lower than those of the moral philosopher group because of their young age and lack of education.

### 3. **LONGITUDINAL VALIDITY**

A crucial test of any developmental measure is to show change in the direction of higher stages for subjects who are retested. Several longitudinal studies by Rest reported significant upward trends over four years at three testings for the P score and for the D score.

Similarly, analysis of individual patterns of change show an upward trend. Cohort-sequential and time-sequential analysis indicate that this upward movement cannot be attributed to generational or cultural change, testing effects or sampling bias. In "Moral development: advances in research and theory" by Rest and colleagues<sup>(27)</sup>, ten longitudinal studies are cited which show significant upwards trends. Among the most interesting study is a report of a ten year longitudinal studies showing significant changes over time, in relation to education and to life experiences.

### 4. **VALIDATION THROUGH EXPERIMENTAL ENHANCEMENT STUDIES**

If the DIT is measuring moral judgement, and if moral judgement is a distinctive domain of development, then experiences which focus on the enhancement of moral reasoning ought to increase DIT scores. At the same time, if the DIT is assessing something fundamental (like a person's basic problem-solving strategies in dealing with moral dilemmas) and is not measuring a surface phenomenon (like learning a special vocabulary or learning particular slogans) then we would expect progress in

stimulating moral development to be slow and gradual. Indeed, intervention studies do give us that picture of the change in DIT scores by educational interventions. The movement of the experimental groups in these moral education interventions is slow (even if significantly greater than in control groups), the amount of change was less than in the longer term longitudinal studies, and change by educational intervention requires a heavy focus on moral problem solving. A particularly interesting study showed that an ethics class increased DIT scores but not logic scores, and a logic class increased logic scores, but not the DIT scores<sup>(19)</sup>. This indicates that each test (the DIT, the logic test) is sensitive to specific domains of cognitive development and that specific interventions are more effective when focused on a specific domain.

## 5. **EAKING STUDIES**

McGeorge<sup>(28)</sup> asked one group of subjects to "fake good" on the DIT by pretending that they were taking the test to show "the highest Principles of Justice". McGeorge asked another group to "fake bad", and a third group to take the DIT under regular conditions. He found that under the "fake bad" conditions, scores were lower than under the usual conditions, but under the "fake good" conditions, scores were no higher than under the normal test conditions. These findings suggest that under the usual conditions, subjects are giving their best notions of the highest Principles of Justice, and that the test-taking set off "faking-good" does not appreciably increase scores. Basically this study showed that under normal test conditions, the DIT is eliciting a person's best notion of justice and fairness.

## 6. CROSS-CULTURAL STUDIES AND UNIVERSALITY

Kohlberg argued that certain concepts are so fundamental to human interaction in groups that they are relevant regardless of one's particular culture. Kohlberg also argued that because the dilemmas focus on universal issues such as life, property, authority and trust they will represent real moral conflicts to anyone anywhere. At this stage, two questions need to be asked. The first is whether Kohlberg's moral dilemmas present in the DIT adequately sample the universe of moral dilemmas or are they so culture-bound that they do not elicit a subject's best performance when the subject is from another culture? Secondly, whether the moral issues contained in the dilemmas reflect the general issues that people, universally, tend to see as ethically relevant?

George Lind<sup>(29)</sup> asked similar questions: "how can we know that an (X) value is a universally valid one and can thus be made the basis for constructing a measure of moral development?"

The simple answer to this question, I think is that rational judgement and empirical evidence are needed. Rational Judgement cannot totally be replaced by empirical evidence, nor can it be made the sole basis of cross-cultural measurement.

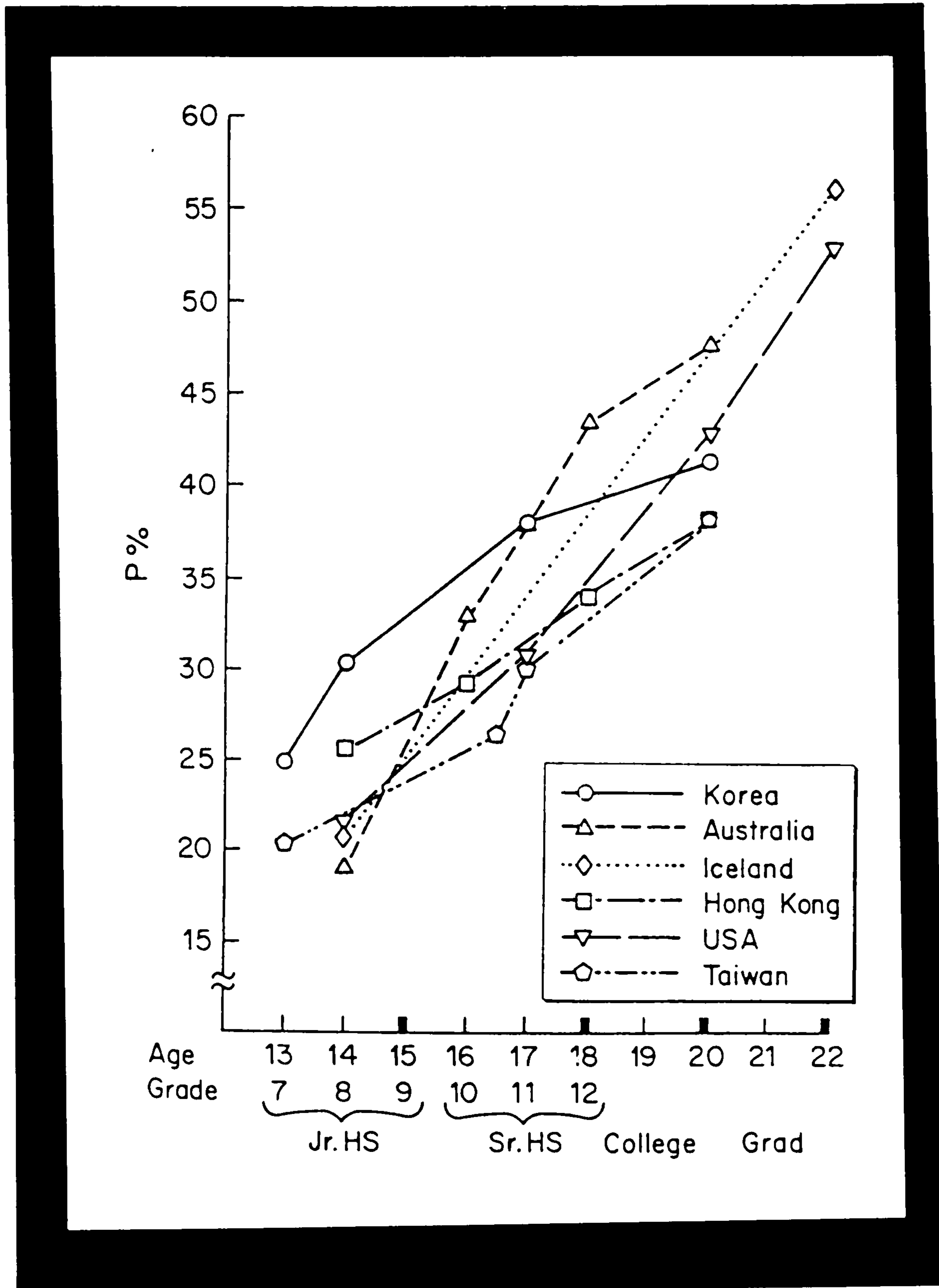
With more emphasis on methodology, Carolyn Edwards<sup>(24)</sup> in her cross-cultural research on Kohlberg's stages: The Basis for consensus, argued that for the moral dilemma methodology to be considered valid for either a particular research study or

comparative research in general, it requires three things: first, the specific dilemmas used in research must be real to the particular people involved, that is, they must raise issues and pit values important to the respondents. Secondly, dilemmas and probing questions must be well translated into respondents' native language, and respondents' answers must be translated without distortion back into the language of scoring. Thirdly, the methodology itself must be adequate to the sensitive task of eliciting respondents' best, highest, and most reflective reasoning about morality.

## 7. CROSS-CULTURAL STUDIES USING THE DIT

The DIT has been used extensively since the 1970s. James Rest in 1994 reported that the number of studies using the DIT totals well over 1,000; and that the total of subjects taking the DIT, numbers in the hundreds of thousands; the DIT has been used in over 40 countries; and the published literature on the test is extensive, with about 150 new studies each year.

Figure 2 presents data from 6 countries (Western and non-western). Age and education are represented on the X-axis, and DIT P score are represented on the Y-axis. As can clearly be seen from this figure in every country, DIT scores increase with age and education.



**Figure 2.** Cross-Cultural Studies of Age/Education Trends in Moral Judgement. From Rest, 1986, p.408. Published by Praeger Publishers.

### **SUMMARY OF CHAPTER 3**

The hypothesis of this study is that the medical education experience at Kuwait University inhibits the normally expected increase in moral reasoning of medical students. The study specifically hypothesizes that there will be no significant increase in the moral reasoning scores of medical students from their first to seventh year at medical school.

The student's moral reasoning was assessed using the Defining Issues Test (DIT) of Rest. It was selected because of the extensive literature supporting its use including reliability and validity studies, as well as its efficiency. A total of 180 medical students from across the seven years of the curriculum completed the DIT. As expected, no significant differences were found in the DIT P-score between years with males and female students combined. However, significant differences were found in the data concerning the effect of gender on the DIT moral reasoning scores with females scoring higher than did their male classmates in five of the six years tested. Also, there were no significant differences between the moral reasoning scores of pre-medical, pre-clinical students and the scores of clinical students. These results came as no surprise to the researcher. The rigid, hierarchical, authoritarian structure of medical education worldwide and that of the medical school in Kuwait combined with the absence of a teaching course or programme in medical ethics will no doubt have its negative effect accumulated over seven years on the moral development of students.

## **CHAPTER 4**

**"An educational activity should satisfy certain criteria: it should be worthwhile and valuable for its own sake; it should have a wide cognitive perspective, it should stimulate interest and dedication in the student; and it should transform his/her outlook".**

**(Calman and Downie, 1988).**



#### **4.1 MORAL DEVELOPMENT IN MEDICAL EDUCATION: LITERATURE REVIEW.**

In order to place my results in a larger context, I conducted an extensive literature search to identify methodology, instrumentation and results of moral development research in the context of medical education, mainly in the United States.

Three kinds of studies using different moral judgement instruments to describe levels of moral judgement predominate in the literature:

1. Studies that compare one subgroup of professionals with another (e.g. doctors with nurses).
2. Studies that compare students beginning a professional programme with students finishing the programme.
3. Studies that use existing moral judgement instruments to pre-test and post-test subjects trying to evaluate the effect of courses in moral education.

The instruments used, differed from study to study. The most frequently used was the DIT.

Several studies have utilised Kohlberg's original Moral Judgement Interview MJI, as well as Gibbs' Sociomoral Reflection Measure SRM. At this stage, I think it is appropriate before reviewing the rest of the literature to briefly describe the MJI and SRM measures.

#### **A. THE MORAL JUDGEMENT INTERVIEW (MJI).**

The MJI is considered to be the most accurate instrument for measurement of moral development. It consists of a 45 minute, semistructural interview in which subjects are asked to resolve a series of three hypothetical moral dilemmas. Each dilemma is followed by a systematic set of open-ended probe questions designed to enable the subject to reveal the logic of his or her moral reasoning. Successful administration of the interview instrument involves getting the research subjects, to respond as to what the person in the story should do and not just on what he/she would do if he/she were the person in the story. This is followed by probe questions aimed at elucidating the reasoning used to arrive at the answer.

A transcript of the interview is scored, yielding two numerical values. One score, the Global Stage Score, represents a category describing the stage structure of the research subject's reasoning in Kohlberg's cognitive moral development theory. The other score, the weighted average score, is a continuous score that ranges from a possible low of 100 to a maximum high of 500 and is correlated to the stages in cognitive moral development theory.

The actual scoring of the transcript of the interview is highly sophisticated and requires specialised training. The scoring is time consuming and labour intensive just as the data collection from one-on-one interviews is very labour intensive also. As a result, the MJI is the most expensive of the assessment instruments available.<sup>(30)</sup>

## **B. THE SOCIOMORAL REFLECTION MEASURE**

The SRM developed by Gibbs is a written version of the original oral MJI that attempts to simplify the collection and scoring of moral reasoning data. It is much less complicated to score than the MJI and thus much less time consuming and less expensive to use. The SRM enables researchers to incorporate considerably larger group sample sizes than would be the case with the MJI. The SRM like the MJI aims to get justification rather than the recognition or preference of given moral reasons, such as is accomplished with the use of the DIT. Scores on the SRM range from a low of 100 to a high of 400 and are highly correlated to the stages of moral reasoning found in Kohlberg's Cognitive moral development theory. The SRM only allows for assessment of stages one through four and not for the post conventional or principled reasoning of stages five and six.

### **C. THE USE OF (DIT) TO MEASURE MORAL DEVELOPMENT IN MEDICAL EDUCATION: THE USA EXPERIENCE.**

Empirical studies of moral reasoning and development in medical students and residents is associated primarily with the work of two research groups. The first is the group led by Shehan and a group of collaborators at the University of Connecticut Health Center. The second group led by Donnie J. Self and his associates at the Texas A & M University College of Medicine. The first group work occurring from about 1977-1985 and the second from 1985 to the present.

The work of these two groups have primarily featured the use of the DIT. The earliest study reporting use of a measure of principled moral reasoning in medical students appeared in the Journal of Medical Education in 1977 under the section called "Briefs", and simply reports without detail that there was no significant difference in DIT scores between students who took an experimental class in human values in medicine and a comparison group<sup>(31)</sup>.

In 1978, Husted from Sheehan's group at the University of Connecticut Health Center, presented reports on her studies assessing moral reasoning at the Annual Research in Medical Education (RIME) Conference<sup>(32)</sup>. She studied moral reasoning in 488 medical students utilising the DIT. The p scores of 50.2 for the first year medical students and 50.8 for the third year students showed a lack of progression in their moral development. In addition, she compared DIT results for 46 USA-educated paediatric residents with 58 graduates of foreign schools and found dramatic differences with the USA residents scoring higher (p scores of 57.2 vs 32.3 for the

foreign school residents).

Cook working with Sheehan's group in 1978<sup>(33)</sup> and testing the same residents, found a significant correlation between their p scores and attitudes towards aggressive treatment of the critically ill. Those with higher p scores tended to be more sensitive to negative family attitudes and treat less actively than those with lower p scores.

In the 1979 RIME proceedings<sup>(34)</sup>, Daniels and Baker reported on changes in moral development in 60 students (41 males and 19 females) as measured by the DIT over an 18-month period, starting at entry into medical school. The Fundamental Interpersonal Relationship orientation - behaviour scale (FIRO -B) developed by Schutz (1966) was also utilised to relate changes in moral development to concomitant changes in Interpersonal relationship style. Daniels found that there was a significant decrease in the use of less mature, stage 3 responses and a significant increase in more complex stage 5 responses, as well as in the p index. He also concluded that the manner in which students adapt to their social environment influences their moral development, suggesting that "people who are comfortable with sensitive interpersonal involvements demonstrate greater development on a variable that is rooted in social relationship, i.e. morality."

In 1980 Sheehan and co-workers<sup>(35)</sup> were the first to report findings with regard to moral reasoning and clinical performance. Having hypothesized a threshold level of moral reasoning as a necessary condition for adequate physician performance, 244 paediatric house officers were followed for four years. The DIT was used as a

measure of their moral reasoning and faculty ratings as measures of their clinical performance.

Their work which was published in "Evaluation and the health profession" indicated that a canonical correlation between the six levels of moral reasoning on the DIT and the 18 dimensions of clinical performance was statistically significant. "The results firmly support the hypothesis that moral reasoning is a predictor of clinical performance. The Association between moral reasoning and clinical performance shows up consistently across many approaches to the data. The nature of the relationship suggests that high moral reasoning virtually excludes the possibility of poor performance. In addition, it appears that the very highest level of clinical performance is rarely achieved by those at the lowest level of moral thought".

Givner and Hynes in 1983<sup>(36)</sup> conducted a study of first year medical students who took a course in medical humanities. The DIT was used to assess their moral reasoning: fifty-one of 108 students fulfilled a commitment to complete the pre-tests and were compared with the 57 other students who failed to do so, the hypothesis being that students with higher levels of moral reasoning would be more likely to live up to their commitments. Results revealed that the mean principal reasoning score of the fulfillers was significantly higher (50.25) than that of the non-fulfillers, (45.75) on the pre-test. The authors also observed that the principal reasoning scores of the fulfillers increased significantly from 50.75 to 54.75 from pre-test to post-test. Stage 5 scores increased significantly, whereas stage 3 scores decreased significantly. Thus, the study confirmed their hypothesis that principled persons would be more likely to

live up to their commitments, while also demonstrating that a course on medical humanities that discussed moral dilemmas and ethical issues in medicine would enhance moral reasoning.

The DIT was used again in 1984<sup>(37)</sup>, but this time to assess moral reasoning as a criterion for admission to medical schools in Israel. This project involved two schools, one of which selected its students in a traditional manner based on competitive cognitive performance criteria, whereas the other, an innovative, community-based school, selected its students based on a complex process where personal interviews considering a number of non cognitive criteria determined the final choice after a basic screening for academic performance. 240 out of 319 finalists at the community-based school agreed to take the DIT, while 216 of the 316 finalists at the traditional school participated. Both of these groups were further subdivided into accepted and rejected students. Results indicated that the overall p score for the entire studied population of applicants was  $41 \pm 13.8$ . The subgroup admitted by interview to the community-based school scored significantly higher ( $50.08 \pm 17.0$ ) than the other 3 subgroups: namely, applicants rejected at the community-based school, applicants admitted to the traditional school and applicants rejected at the traditional school. There was another significant correlation between p score and interview score, suggesting that the interview process was successful in the selection of students with higher principled thinking.

Sheehan and his co-researchers continued to study moral development throughout 1980s. They used other accepted measures of moral reasoning beside the DIT. They

used Kohlberg's Moral Judgement Interview MJI, as well as Gibb's Sociomoral Reflection Measure SRM.

Self, Baldwin and Wolinsky in 1992<sup>(16)</sup> used the DIT again to assess the hypothesis that the formal teaching of medical ethics promotes a significant increase in the growth and development of moral reasoning in medical students. Their study involved comparison of a 39 first year medical school class who received a two-quarter long, two-credit course in medical ethics and a 54 first year veterinary medical school class who received no such course in medical ethics. Both groups were pre-tested at the beginning of the first quarter and post-tested at the end of the second quarter.

They found a statistically significant increase in the level of moral reasoning of students exposed to a course in medical ethics. Adjustment of the post-test scores by subtracting the pre-test scores revealed that the differences between the control group and the experimental group were even more significant.

Concerns regarding the retention of moral reasoning skills have also been addressed by Self's group. Self and Olivarez, (1994)<sup>(38)</sup> documented an increase in moral reasoning skills following exposure to a medical ethics course taught in the first part of the first year of medical education and then tracked the same group of students who were retested annually until their graduation four years later. The hypothesis of this study was that retention of the increased moral reasoning skills would be maintained over the course of medical education. This hypothesis is in keeping with the theory of cognitive moral development, which claims that there is no significant



regression from once-attained higher levels of moral reasoning. Confirmation of this hypothesis would affirm the importance of teaching medical ethics early in the medical education curriculum and offering a large enough exposure to make a significant difference when it is taught. At the end of their longitudinal study, their hypothesis was confirmed.

Baldwin et al (1994) have been involved in an intriguing follow-up of the Sheehan hypothesis, that there is a relationship between moral reasoning and clinical performance by examining this relationship in cases of malpractice claims against the orthopaedic surgeons.<sup>(39)</sup> Demographic and malpractice claims data on the surgeons were available through a regional interindemnity liability trust. DIT's were secured from 149 physicians, of whom 57 were orthopaedic surgeons. Results indicated that orthopaedic surgeons with few (less than 0.09) or no claims per year demonstrated higher levels of moral reasoning with P scores of 44, as compared with P scores of 38 for orthopaedists with multiple claims. This relationship approached statistical significance ( $p \leq .07$ ). Pursuing another of Sheehan's findings, this study also showed that for orthopaedists with P scores over 50, the result is even more dramatic ( $p \leq .02$ ), suggesting once more that "there may be a floor effect", or protective element, provided by higher levels of moral reasoning. 64 additional orthopaedists in the study who did not take the DIT brought out two additional factors of importance in malpractice claims experience: holding a clinical teaching appointment, and membership in a professional society. This suggests that physicians with higher levels of moral reasoning (and lower claims experience) may be more likely to open themselves to peer review and professional relationship. These studies are continuing

with larger samples and broader categories of physicians.

Finally, a recent significant cross sectional study by Donnie Self, Margie Olivarez and Dewitt Baldwin is summarized here.<sup>(40)</sup>

For their cross-sectional study, students from all four years in the Texas A & M University College of Medicine were asked at the end of the year to complete a moral reasoning questionnaire. Demographic data collected on the students including gender and age along with the moral reasoning score. A total of 851 medical students from across the four years of the curriculum were asked to complete the DIT. From that subject pool, 598 students completed the questionnaire for a 70.3% response rate. The 488 subjects who passed the consistency scoring criteria yielded an 18.4% sample loss. The statistical analysis performed on these 488 subjects showed the following:

1. No significant differences were found in the DIT scores between years with males and females combined.
2. There were significant differences in the DIT scores by gender in each of the four years with females consistently scoring higher. However, no significant differences were found in the DIT scores of females between years.
3. No significant differences were found in the DIT scores of males between years.
4. There were no significant differences between the moral reasoning scores of

the pre-clinical students and clinical students.

5. There were no significant correlations between age and DIT scores.
6. With the mean DIT scores for the four years showing less than 2 points difference in any combination of year, the moral reasoning development of these students appears to be virtually the same across the curriculum.

The findings of the researcher work at Kuwait University are consistent with the findings of Self, Oliveray and Baldwin study. The similarities are striking, for even with a different religion, cultural background, different medical curriculum in terms of the number of years spent in the medical school in Kuwait and Texas, the disturbing fact remains the same.

To quote Self et al:

"there may be something in the structure of medical education that appears to inhibit the expected growth in moral reasoning of the medical students".

## **4.2 CONCLUSION FROM THE LITERATURE**

In spite of the encouragement from all the previous work discussed here, there is still much work to be done. We need to see for ourselves whether we (in Kuwait) will have similar findings. All these studies demonstrated that moral reasoning skills can be taught and retained during medical education.

Further longitudinal studies need to be done to assess the status of moral reasoning skills during residency training and throughout the years of medical practice. Similarly, further studies are needed regarding both the quantity and quality (content and structure) of activities required for increasing one's moral reasoning skills.

What kinds of educational interventions best foster the increase in moral reasoning? Are lectures the answer? but what about role playing or case study discussion? How would students receive the use of films or the arts in education? and what is the potential of successfully using literature in teaching medical ethics? Much work is waiting ahead.

## **SUMMARY OF CHAPTER 4**

This chapter has outlined the use of moral reasoning evaluating instruments in medical education. The information given in this chapter is essential for a proper understanding of the results obtained from measuring moral development in medical students at Kuwait University.

Many studies have shown that moral reasoning can be measured and stimulated.

Moral dilemma discussions in a structured medical ethics course which create cognitive conflict by pitting arguments at one stage of reasoning against arguments at a different stage of reasoning have been shown to be very effective.

The work of Rest and others reviewed in this chapter has clearly shown that contrary to popular belief, it is not developmentally too late for moral reasoning growth to occur in young adults. Thus, it appears possible that the moral reasoning and moral development of medical students at Kuwait University, could be enhanced by improvements in the structure of medical education, more specifically by integrating medical ethics teaching in the medical curriculum.

## **CHAPTER FIVE**

**"Ethics is one thread in the fabric of society, and it is intertwined with others. Ethical concepts are tied to a society's customs, manners, traditions, institutions - all of the concepts that structure and inform the ways in which a member of the society deals with the world. When we forget this, we are in danger of leaving the world of genuine moral experience for the world of moral fiction - a simplified, hypothetical creation suited less for practical difficulties than for intellectual convenience".**

**(Carl Elliot, 1992).**

## **5.1 SETTING THE SCENE: KUWAIT**

Bioethical problems in any culture or society involve patients, healthcare professionals, families, representatives of religious denominations, ethics committees (if present), politicians (always!) and the courts.

Solving these problems requires a respectful awareness of the religious, cultural, social and legal views of those involved. Both the law and bioethics will be influenced by the patterns of practice and behaviour that make the healthcare system. These patterns will in their turn be shaped by the underlying culture. So when these problems arise in the clinical setting, administrative setting or the public policy setting, it is of great importance to understand the underlying "fabric of society".

What will follow is a general introduction to the setting the writer is returning to. The country, the healthcare system and the university. This is introduced here in an attempt to familiarise the reader with the fabric of the writer's society.

Kuwait, or officially the State of Kuwait lies at the northwest corner of the Arabian Gulf, between latitudes 28° and 30° N and between longitudes 46° and 48° E. To the north and west it shares a border of 240km with the Republic of Iraq, and to the south and south west it shares a border of 250km with the Kingdom of Saudi Arabia. To the east it has a coastline of 290km on the Arabian Gulf. The total area of the State of Kuwait is 17,818 square kilometres. The Kuwait mainland, having no mountains or rivers or other natural features was for a long time, a transit area of nomadic tribes

and caravans. Such freedom of movement made delineation of borders rather difficult and resulted in some border problems.

The first population census in Kuwait was conducted in 1957. Little was known about the population of Kuwait before that date, although some travellers gave estimates which lacked accuracy. The central statistics office in Kuwait tentatively estimates the 1910 population at about 35,000. Since 1957, a census of the population in Kuwait has been conducted every five years.

The mid-year population of the country in 1994 stood at 1,620,086, of these 670,344 or 41% were Kuwaitis, and 948,742 or 59% were non-Kuwaitis.

Kuwait is a fully independent Arab State with a democratic style of government, where sovereignty rests with the nation, which is the source of power.

As prescribed by the Constitution, the system of government is based on the separation of powers; although co-operation is required. The legislative authorities vested in the Amir and the National Assembly, while executive power is vested exclusively in the Amir and his Cabinet and ministers. The judicial power is entrusted to courts in the name of the Amir within the limits specified by the Constitution.

The Constitution of the State of Kuwait is composed of 183 articles divided into five chapters:



1. The State and the system of government.
2. The basic components of Kuwait society.
3. The general rights and duties.
4. Authorities.
5. General and provisional statutes.

The pillars of the Constitution are the Sovereignty of the State, public freedom and equality before the law. It was drawn up by a constituent assembly composed of 20 elected members. The late Amir of Kuwait, Sheikh Abdallah Al-Sabah ratified it on November 1962 and it became valid on 29 January 1963.

The Constitution specified that the National Assembly shall be composed of fifty members elected directly by universal suffrage and secret ballot in accordance with the provisions of the electoral law (that exclude woman in Kuwait from this whole process!), obviously against the letter of the Constitution.

Article 2 of the Constitution states that:

"The religion of the State of Islam, and the Islamic Shariah shall be a main source of legislation".

Article 35 states that:

"Freedom of belief is absolute. The State protects the freedom of practising religion

that it does not conflict with public policy or morals".

School attendance in Kuwait is compulsory for all children between the ages of six and fourteen, i.e. in the primary and intermediate stages. All stages of State education are free.

The three governmental bodies responsible for education services in Kuwait are:

1. The Ministry of Education which is responsible for the supervision of the private and public sectors of education until the end of the secondary stage.
2. The Public Authority for Applied Education and Training which is responsible for vocational education in the applied education institutes and training centres.
3. Kuwait University which is responsible for university and higher education in the country.

## **5.2 KUWAIT UNIVERSITY**

Kuwait University commenced teaching in October 1966 and provides undergraduate and postgraduate education. It is located on four campuses including Khaldiya, Adeliya, Shuwaikh and Jabriya.

The University follows the course unit system with two semesters a year. The first semester starts in September and continues for 16 weeks. The second semester also lasting 16 weeks starts in February.

The present faculties in the University are:

The Faculty of Arts

The Faculty of Commerce, Economics & Political Science

The Faculty of Education

The Faculty of Engineering and Petroleum

The Faculty of Law

The Faculty of Shariah

The Faculty of Science

The Faculty of Medicine

The Faculty of Allied Health Sciences and Nursing

The College of Graduate Studies

The language of instruction in the University is Arabic, except in the Faculties of Science, Engineering and Petroleum, Medicine and Allied Health Sciences and Nursing which teach in English.

#### **A. THE HEALTHSERVICE CENTRE**

Kuwait University Health Sciences Centre was established in 1982. Presently it consists of the Faculties of Medicine and Allied Health Sciences and Nursing.

Planning is now underway for the development of a semi-autonomous Centre comprising of several Faculties. The Centre will include the present Faculties and the Faculties of Pharmacy which will open in 1998 and the Faculties of Dentistry and Family Medicine which are currently in the planning stages.

The Health Sciences Centre was established with a view to expand the Medical education in Kuwait and to create a community of healthcare professionals, with high international standards.

The objective of the Health Sciences Centre is to improve the healthcare delivery and maintain a high standard of medical education and professional training in Kuwait.

## **B. THE FACULTY OF MEDICINE**

After several years of intense study and careful planning, the Faculty of Medicine was formed with objectives of producing high quality healthcare professionals and medical scientists and playing a major role in the development and upgrading of the country's healthcare system.

Since its establishment in 1973, the Faculty of Medicine has developed into an internationally recognised medical school, serving Kuwait and the Gulf region. The number of students enrolled in the programme has increased from 48 in 1976 to the present 80 students per year.

538 students have completed the seven year programme and received the B.M., B.Ch. degree since the first batch of students graduated in 1983.

Located in Jabriya adjacent to Mubarak Al Kabeer Teaching Hospital the Faculty employs academic, technical and administrative staff catering for the medical students and the Allied Health students.

The departments that make up the body of the Faculty of Medicine include Anatomy, Biochemistry, Community Medicine and Behavioural Science, Medicine, Microbiology, Nuclear Medicine, Obstetrics and Gynaecology, Paediatrics, Pathology, Pharmacology and Toxicology, Physiology, Primary Care, Psychiatry, Radiology and Surgery.

Four departments are currently running graduate programmes, Microbiology, Pathology, Physiology and Pharmacology. Since the programmes began in 1983, more than 49 students have graduated.

In addition to Mubarak Al-Kabeer hospital, other facilities utilised for teaching purposes are Amiri, Adan, Maternity, Farwania, Jahra, Ahmadi, Subah, Chest, Al-razi, Psychiatric and Ibn Sina hospitals, as well as several polyclinics throughout Kuwait.

In addition to the professional services provided by the clinical academic staff serving the teaching hospital and the specialised units in other hospitals, each



- \* **Have developed an attitude to medicine which is a blend of scientific and humanitarian and be imbued with the high ethical standards required of a doctor.**
- \* Possess a knowledge of the structure, function and development of the human body, and of the development of human abilities and personality, and factors which may disturb these and of the disorders which may result.
- \* Be able to relate clinical symptoms and signs to structural and functional changes so that the management of patients can be rational.
- \* Have learned how to elicit facts from a patient. He/she should have a good knowledge of those diseases which are an acute danger to life and of the more common diseases. He/she should recognise the limitations of his/her own clinical knowledge and should be prepared, when necessary, to seek further help.
- \* **Have learned how to deal with patients and their relatives with sympathy and understanding.**
- \* Understand the effect of environment on health and appreciate the responsibility of his/her profession for the prevention of disease.
- \* **Know that conclusions should be reached by logical deduction and be able to assess evidence both as to its reliability and to its relevance.**
- \* Appreciate that medicine is a continuing education and that he/she has an obligation to remain a student and to contribute to the progress of medicine throughout his/her professional career.

## **C THE STRUCTURE OF THE MEDICAL PROGRAMME**

The medical programme consists of three elements: the premedical curriculum (three semesters' study); the preclinical curriculum (five semester's study); the clinical curriculum (six semesters' study).

The three semesters (one and a half year) premedical curriculum includes Chemistry, English Language, Mathematics, Physics, Zoology and two University General elective courses. **See Appendix G.**

The system of study is conducted under the credit hour system and students have to obtain a total of 46 credit hours with a minimum of 'C' average in these subjects. Premedical students are taught largely by the Faculty of Science with some contributions by the Faculties of Arts and Medicine. The examinations in the premedical programme are conducted after every course according to the system approved by the college offering it.

The successful completion of the premedical programme is a prerequisite for admission to the preclinical programme. The five semesters (two and a half years) preclinical programme is designed to give students a thorough grounding in the basic medical sciences, **see Appendix G.** Taught by the Faculty's own staff, a departmentally based, coordinated approach has been adopted for the curriculum requiring a high degree of co-operation between the various medical sciences departments and the clinical sciences departments. The students are required to



obtain a total of 76 credit hours in the subjects studied in the preclinical programme with a minimum of 'C' average in these subjects. Students who successfully complete the premedical and preclinical programmes are awarded the degree of Bachelor of Medical Sciences (B.Med.Sc).

The subjects studied in the first preclinical programme (three semesters) are Anatomy, Biochemistry Sciences and Physiology and there is a final examination in these subjects with an External Examiner invited for each discipline. The subjects studied in the second preclinical programme (two semesters) are Pathology, Pharmacology, Microbiology and Neuroscience and External Examiners are invited for the final examination in these disciplines.

The successful completion of the B.Med.Sc. degree is a prerequisite for admission to the clinical period of study.

During the clinical programme (three years) students are trained on the wards and in the out-patient clinics of the teaching hospital, as well as in the community. Lectures, tutorials and seminars constitute an important part of the programme, see **Appendix H.**

The final grade point average for the degree of Bachelor of Medicine and Bachelor of Surgery (B.M.,B.Ch.) is determined by the performance in both, the preclinical and the clinical period of study.

### **5.3 HEALTHCARE SYSTEM IN KUWAIT**

#### **Healthcare Statistics at the National Level**

The history of healthcare in Kuwait dates back to the year 1912, when the first medical clinic was opened. Since then government officials have paid increasing attention to the improvement and development of the healthcare services in the country. Since independence in 1961 Kuwait provided health services free of charge to all citizens and residents of the country. Should a citizen require specialised medical care unavailable in Kuwait, the ministry of health undertakes his/her treatment abroad and the full costs are borne by the State.

There has been a tremendous development in Kuwait's healthcare delivery system since 1980. Until 1989, the progress was linear. This linear progression, seen till 1989, suffered a setback between 1990-1992 in all the infrastructural aspects of healthcare. The number of clinics, hospital beds, doctors, dentists, nurses...etc, all showed a significant decrease as compared to 1989 levels. This phenomenon is not surprising, as the year 1990 was the year when Kuwait was occupied by the invading Iraqi forces. The country was under occupation from August 2nd 1990 until February 1991. Even after the liberation, and for quite some time afterwards, the population balance and the healthcare system did not reach the 1989 (or pre-invasion) level. The healthcare statistics for 1993, and 1994 once again showed the same momentum set in motion in the early 1980s.

In Kuwait there are six government general hospitals, one in each region; 11 specialised hospitals; 70 primary healthcare clinics, and 17 diabetes clinics. In 1994, the number of doctors working in the Ministry of Health was 2,690. More than two-thirds of these were non-Kuwaitis (68.5%). Female physicians constituted 27.1% of the total. The number of male to female Kuwaiti physicians was almost the same.

The number of Kuwaiti doctors undertaking higher specialisation outside Kuwait as for June 1996 was 154. They are sponsored by the Kuwait government to specialise in the following countries:

Table 6. Number of Kuwaiti Doctors in Training

Residency Programs	No. of Kuwaiti Doctors in Training
Canada	85
UK	41
USA	11
Germany	5
Ireland	4
Egypt	3
Bahrain	1
Saudi Arabia	1
Sweden	1
Poland	1
Holland	1

The total number of dentists in 1994 was 395, of these, less than a quarter were Kuwaitis (23.8%). There were twice as many male than female dentists in total but among Kuwaiti dentists there were more females 53.2% than males.

A total of 7,419 nurses worked for the Ministry of Health in 1994. Only 15.4% of them, Kuwaitis. The proportion of male to female nurses was 1:5.

The number of pharmacists was 432. Only 14.4% of them Kuwaitis.

Healthcare is also provided in Kuwait by five private sector hospitals. In 1994, this sector had a combined total of 531 beds, 277 doctors and 694 nurses. There are also private clinics that provide healthcare in Kuwait, a total of 108, 77 of these are medical clinics and 31 dental clinics. These were run by a total of 117 doctors (26% non-Kuwaitis) and 156 nurses (100% non-Kuwaitis).

The government expenditure on healthcare has more than doubled between 1986 and 1994. The percentage of money allotted to the Ministry of Health from the National Budget has also shown a steady increase except in 1992 when it was greatly cut down. The healthcare cost per capita in Kuwait is K.D. 109 in 1994.

Table 7. Vital Health Indicators in Kuwait, 1986-1994.

	1986	1994
Crude Birth Rate	29.9	24.0
Crude Death Rate	2.4	2.1
Rate of Natural Increase	27.5	21.9
Infant Mortality Rate	15.7	12.7
Neonatal Mortality Rate	10.1	9.4
Post-neonatal Mortality Rate	5.6	3.3
Perinatal Mortality Rate	18.5	15.2
Maternal Morality Rate	5.6	2.6
Kuwaiti Gross Reproduction Rate	3.2	2.6
Non-Kuwaiti Gross Reproduction Rate	1.4	1.0

## 5.4 ISLAM

Devoting a chapter to talk about the researcher society might be criticised unless the following facts are taken into consideration. Firstly, all the medical students who participated in this research are Muslims. Secondly, I am of the opinion that medical ethics is rooted in religious commitments and theological assumptions.

Campbell<sup>(41)</sup> suggests that, to be comprehensive, bioethics would find in religious discourse:

"An important source of moral correction and balance, one that plans our decisions about health care within the context of a fuller account of purpose and meaning in life".

In the last decade bioethics has become increasingly an international enterprise. Although there may be consensus regarding the inherent value of ethical discourse as it relates to health and medical care, there are disagreements about the nature and parameters of medical morality. Pellegrino<sup>(42)</sup> observed that the challenge of transcultural biomedical ethics is "vastly complicated because medical sciences and technology, as well as the ethics designed to deal with its impact, currently are western in origin". He stated that the western values of empirical science, principle-based ethics, and democratic political philosophy "are often alien, and even antipathetic, to many non-western world views".

Some are not familiar with Muslim tradition and may have difficulty comprehending thoroughly how religion can pervade one's daily life. For Muslims every custom, institution, relationship and attitude has some conscious or unconscious connection to the faith; even the most minor and private matters are subject to sacred regulations.

Islam has a long and distinguished history of extensive involvement in the provisions of healthcare including the establishment and support of hospitals and clinics, the recruitment and training of medical personnel, and the education of its constituency in the relation of health care to the proximate and ultimate ends of religious and secular life. And since Islam advocates a complete code of human conduct, it contains a number of directives which apply to the conduct of healthcare professionals. The writer is of the opinion that in the "Kuwaiti Context" medical ethics education cannot be conceived, understood, or applied outside the context of the Islamic Religion which is consciously or subconsciously invariably involved.

Of all the major religions of the world, Islam does not derive its name from a tribe or a person, like Christianity, Buddhism or Judaism.

The term "Islam" derives from two sources *Tasleem*, meaning surrender which refers to the complete submission to the will of Allah (God) and *Salaam*, meaning peace which should govern the relationships of human beings amongst themselves. When asked to define Islam the Prophet said:<sup>(43)</sup>

*"it is to submit your heart to God and to harm no one by word or deed".*

The main requirement of Islam is a single affirmation. The believer must affirm, at least once during his/her life that, *"there is no God but Allah and Muhammad is his prophet"*. This requirement called the *shahada* (witness) is the first of the five pillars of Islam, the basic obligations of the believer. The second is prayer. In his prayer, a Muslim faces the direction of the city of Mecca. Facing one direction is a symbol of unity of purpose for the millions of Muslims offering their prayers at the same time. The Muslim says the *fatihah* (opening of the Qur'an).

*"In the name of Allah, most gracious, most merciful.*

*Praise be to Allah the cherisher and sustainer of the worlds;*

*most gracious, most merciful master of the day of judgement*

*Thee do we worship, and thine aid we seek,*

*show us the straight way,*

*the way of those on whom thou hast bestowed thy grace.*

*Those whose portion is not wrath and who go not astray"*.

The daily prayers are made by practising Muslims individually. A family can join in prayer, or any group which happen to be together. On Friday, however, the noon prayers should be made collectively.

The third pillar of Islam's giving *zakat* (alms) interpreted both as making an annual donation of a certain percentage of one's property to the poor, as well as responding generously to evident situations of need.



The fourth is the discipline of fasting the month of Ramadan during which the devout Muslim may not drink, eat, have sexual intercourse or even smoke from dawn to sunset.

The fifth is the pilgrimage to Mecca - to be performed once in a lifetime by every Muslim who is physically and financially able.

Most Muslims are adherent of Sunni Islam, which takes its name from the word *Sunnah* which means the path of tradition and refers to the practices of the Prophet. These, they believe, ensure the unity of the Muslim Community. Sunni Muslims do not believe that any particular individual is a religious successor or continuer of Muhammad's work.

This belief played a major role in the Islamic history. The difference that initiated the split between the sunni and the shi'ite tradition in Islam was a dispute about the successor to the Prophet as the leader of the community after his death. A small group then, believed that such a function must remain in the family of the Prophet and backed Ali-Muhammad's cousin and son-in-law, whom they believed to have been designated for this role by *ta'yin* (appointment). They became known as his *shi'ah* (partisans) while the majority at the time of the Prophet death agreed on Abu Baker as a successor to the Prophet on the assumption that no instruction on this matter; was left by the Prophet before his death, they gained the name of the people of tradition and the consensus of opinion (*ahl al-Sunnah wa'l - Jamaah*) or Sunni.

When Ali finally became Caliph (central religious authority) many refused to accept his authority. Ali was murdered, and one of his enemies declared himself Caliph of Damascus and a central authority. Led by Ali's son Hussain, the supporters of Ali's cause challenged the second Caliph of Damascus and were slaughtered in 680 in the massacre of Karbala. The sunni Muslim tradition accepts as legitimate the Caliphate of Damascus, which ruled for nearly a century. The Shi'ites, however, defend the claim of Ali's descendants. They commemorate the bloody massacre of karbala in an annual re-enactment, ensuring that the horror of this event, in which Muhammad's only grandsons were among the victims, will never be forgotten, either intellectually or emotionally.

The total address of Islam to its followers is called the *Shari'ah*. The word Shari'ah itself is derived etymologically from a root meaning *shar'* (road). The supreme goal of the Shari'ah is the welfare of the people, this is clearly obvious when we look at the way Islam protects and preserves life, mind, religion, honourship and the protection and preservation of the species.

The sources of the Shari'ah are:<sup>(47)</sup>

1. The Qur'an.
2. The Sunnah.
3. Ijma.
4. Qiyas.

The primary source of the Shari'ah is the Qur'an, the literal word of God. The text of the Qur'an itself states in several places that the Qur'an is verbally revealed and not merely in its meaning and ideas. The Qur'anic term for revelation is *Wahy* which is close in its meaning to inspiration. The language of the Qur'an is Arabic, in which it is considered an inimitable literary miracle. The Qur'an is divided into 114 chapters or Suras. The early Meccan Suras - those revealed in Mecca - are charged with deep and powerful psychological moments, they carried a purely moral and religious tone. This tone gradually changed to lay the basis of the construction of an actual social fabric in the Medina period.

Fazlur Ruhman stated that:<sup>(44)</sup>

"The Qur'an gradually worked out its world-view more fully, the moral order for men comes to assume a central point of divine interest in a full picture of a cosmic order which is not only charged with a high religious sensitivity but exhibits an amazing degree of coherence and consistency".

The Qur'an contains basically three types of message. Firstly, it contains a doctrinal message, a set of doctrines which expound knowledge of the structure of reality and man's position in it. As such it contains a set of moral and juridical injunctions which is the basis of the Muslim sacred law or Shari'ah.

*"It is no new tale of fiction, but a confirmation of previous scriptures, and an explanation of all things. and a guidance and mercy to those who believe."*

(Qur'an 12:111).

It also contains information about the structure of the universe, the multiple states of being, the man's final end and the hereafter. It bears all the teachings necessary for man to know who he is, where he is and where he should be going. It is the foundation of both Divine Law and metaphysical knowledge.

*"It is not righteousness that you turn your face towards East or West, but it is righteousness to believe in God and the last day and the angels and the book and the messenger; to spend of your substance, out of love for him, for your kin, for orphans,*

*for the needy, for the wayfarer, for those who ask, and for the freeing of slaves; to be steadfast in prayer and give Zakah; to fulfil the contracts which you have made; and to be firm and patient in suffering adversity and times of panic. Such are the people of truth, the God-fearing".*

(Qur'an 2:177).

Secondly, the Qur'an contains a message which Seyyed Hossein Nasr in his book, "Ideals and Realities of Islam" described as that of a vast book of history.<sup>(45)</sup>

"It recounts the story of peoples, tribes, kings, prophets and saints over the ages, of their trials and tribulations. It is, therefore, a vast commentary on man's terrestrial existence".

*"The same religion he has established for you as that which he enjoined as Noah, that which we revealed unto you (Muhammad), and that which we enjoined on Abraham, Moses and Jesus: that you should steadfastly uphold the faith and break not your unity therein".*

(Qur'an: 42:13).

*"O children of Israel, call to mind the favor which I bestowed on you, and that I preferred you to all others. Then guard yourselves against a day when one soul shall not avail another, nor shall intercession be accepted for it, nor shall compensation be taken from it, nor shall anyone be helped (from outside). And remember, We delivered you from the people of the Pharaoh: they set you hard tasks and chastisement, slaughtered your sons and let your womenfolk live; therein was tremendous trial from your Lord. And remember We parted the sea for you and saved you and drowned Pharaoh's people within your very sight. And remember We appointed forty nights for Moses, and in his absence you took the calf (for worship) and you did grievous wrong. Even then We did forgive you; there was a chance for you to be grateful".*

(Qur'an 2: 47-52).

Thirdly, the Qur'an contains a quality which Seyyed Nasr called a "divine magic" that should be understood in the metaphysical and not the literal sense of the phrase.

"The Suras of the Qur'an, because they come from God, have a power which is not identical with what we learn from them rationally by simply reading and reciting. They are rather like a talisman which protects and guides man. That is why even the physical presence of the Qur'an carries a great grace of *Barakah* with it". This is difficult to explain or analyse logically.

"The Muslim lives by the Qur'an" such is the importance of the Qur'an to Muslims states Professor Yusuf Iqbal, Professor of Islamic Political Theory and Institutions. In

describing the Qur'an he also added that it is not a book in the ordinary sense, nor is it comparable to the Bible, either the Old or New Testaments. "It is an expression of Divine Will, if one wants to compare it with anything in Christianity, it must be compared with Christ himself. Christ was the expression of the Divine among men. If one wants a comparison for the role of Muhammad, the better one in that particular respect would be Mary. Muhammad was the vehicle of the divine, as she was the vehicle. His illiteracy was comparable with her virginity, symbolic of purity. The Qur'an was divinely inspired, then it was compiled, and what we have now is the expression of God's will among men".

The second source of the Shari'ah is the *Sunnah* (tradition) of Prophet Muhammad in what he ordered, forbade, did or acknowledged in his capacity as prophet. *Hadith* (the saying of the Prophet) were collected as the spread of Islam and the gradual moving away from the early Muslim community endangered their integral existence. The devoutest of men set about to collect the prophetic sayings, examining the chain of transmitters for each saying. As a result, six major collections of Hadith became assembled such as those of Bukari and Muslim.

The Sunnah at times explains the Qur'an, illustrates it, details some of its generalization and complement it in some areas.

From the Muslim point of view, the Prophet is the prototype of human and spiritual perfection and a guide towards its realization. for as the Qur'an states:

*"Ye have indeed in the Messenger of Allah a beautiful pattern of conduct for any one whose hope is in Allah and the final day and who engages much in the praise of Allah".*

(Qur'an 33:21)

In essence all of the Shari'ah is contained in the Qur'an. The principles of the law contained in the Qur'an were as I have mentioned above - explained and amplified in the prophetic Hadith and Sunnah, which constitute the second basic source of the Shari'ah. These in turn were understood with the aid of the consensus of the Islamic Community *Ijma* - the third source of the Shari'ah. *Ijma* is considered important on the authority of the Hadith saying:

*"my community shall never agree in error".*

*Ijma* can only operate where the Qur'an and Hadith have not clarified a certain aspect of the Islamic law; it is a gradual process through which the community comes to give its consensus over a period of time. Muslims over the centuries were of the opinion that the community meant here is the community of the *Ulama* (those qualified in matters of Islamic law and Islamic Jurisprudence *Fiqh*).



The fourth source of the Shari'ah is *Qiyas* (Analogy). It is resorted to through a process of deductive reasoning that equate a new issue with one already decided by the Qur'an and/or the Sunnah.

If the Qur'an has banned wine it means that by analogy it has also banned any form of alcoholic drink whose effect is like wine. To quote Seyyed Nasr:

"The use of qiyas is not a licence for rationalism but an exercise of reason within the context of the revealed truths which are the basis of the Shari'ah and the prophetic utterances and practices which have made these truths known and have clarified them for the Muslim community".

Both Ijma and qiyas are closely connected to the function of the Ulama as authorities on law. There is no priesthood in Islam. However, a passing judgement upon the law is not the right of every Muslim. The ulama are the custodians of the law only because they have undertaken the necessary studies and mastered the required disciplines to make them acquainted with its teachings.

The authority of expertise in any field or area is recognised in the Qur'an.

*"Ask those who have knowledge, if you do not know"*.

(Qur'an 21:7).

The giving of advice which is very likely to be taken is not something which should

be undertaken lightly. While Muslims must make up their own minds as to whether they agree with propriety of the advice, any wrong doing caused by those who decide to accept it is the personal responsibility of the original proposal of the interpretation.

The moral responsibility of religious leaders in Islam is very substantial.

*Ijtihad* (Juristic reasoning) and not *Jihad* is the term indicating the utilisation of available evidence (religious, scientific, social...) to determine the best course of action to be taken when facing new problems that arise with the changing times and the changing needs of the Islamic community.

There are two major schools of thought on the matter of *Ijtihad*, one favouring a close adherence to the text of Qur'an and its literal interpretations without much thought to its objectives, the other looking more for purpose and wisdom underlying the legal enactments.

This discourse between the prophet and Muadh ibn Jabal - a *qadi* (judge) on his way to al-yaman illustrates the importance Islam gives to *qiyas* and *Ijtihad*:

- Prophet: How will you decide a problem?
- Muadh: According to the Qur'an.
- Prophet: If it is not in it?
- Muadh: According to the Sunnah.
- Prophet: If it is not in that either?
- Muadh: Then I will use my own reasoning.
- Prophet: Praise God who guided me to choose my messenger.

During the evolution of the science of jurisprudence, juridical rules were established through the application of Islamic principles derived from the guidance of the Qur'an and the Prophet for new rulings in new situations.

I think it is useful to shed light on some of these principles since most of the new rules governing the medical practice in Islamic society rely on them.

The most cited principles by Fiqh Scholars as the basis for argumentation when deciding whether a new medical intervention is Halal (legally permitted in Islam) or Haram (legally prohibited) are:<sup>(48)</sup>

1. "Necessities overrule prohibitions".

For example, drinking alcohol is prohibited in Islam, but if alcohol is the only drink

available to let say a traveller lost in the desert, it becomes permissible in amounts necessary for survival until lawful drink becomes available.

2. *"Harm is to be removed"*.
3. *"Harm should not be removed by an equal harm"*.
4. *"The lesser of two harms should be chosen when both together cannot be avoided"*.
5. *"Removing the harm comes first before realising the benefit"*.

The overall rule, when there is no conflict with the Qur'an and the Sunnah is:

*"Wherever welfare goes, there goes the Statue of God"*.

The Shari'ah as explained above, is not a rigid set of rules and regulations copied and applied generation after generation. It allows for human ingenuity to address changeable situations through progressive legislation.

## **5.5 CASE STUDY I**

### **TRUTH TELLING IN THE DOCTOR-PATIENT RELATIONSHIP: AN ISLAMIC VIEW**

The question of directly telling the patient the diagnosis of his/her illness has no direct mention in the Qur'an or the Sunnah. On the ethics of 'visiting patients' in general the Prophet Muhammad instructed to uplift the moral and boost the patient's hopes. Further detail lies in the domain of Fiqh and its rulings. Needless to say, these rulings are liable to change with the passage of time and change of places in order to address variation in social milieu, but never conflicting with Qur'an and Sunnah.

As we consider the issue of disclosing a serious diagnosis to the patient, we find that most Western societies have adopted this policy under the concept of patients' autonomy.

The concept of autonomy was the outcome of a process of social evolution. Decades ago this did not pertain, and decades from now new patterns might erupt that seem unimaginable today. In the Muslim world some considerations must be taken into account. Due to the cultural diversity and disparity in social evolution a universal rule cannot be enforced, nor are the criteria adopted by the West suitable to be imposed as a blanket policy for all muslim societies, or even all the people in the same society. Clinical individualisation is called for. In a personal correspondence with Professor Hassan Hathaut - a retired Professor of Obstetrics and Gynaecology at Kuwait University and an active Muslim advocate living in the United States, he

wrote:<sup>(46)</sup>

"A nickname for "doctor" to a majority of Muslims is *Hakeem* (wise-man). In this time of hurried medicine our teachers still emphasize to us the significance of gauging a patient's personality, and say "listen to what the patient says, and listen to what the patient does not say". We will encounter the patient whom we assess is likely to go into a heart attack if you throw the diagnosis of cancer in his face. On the other extreme we may encounter the patient who is very ready to take it, who believes that people's patience is tested by these afflictions, is confident that medical science will offer what it can, and if the outcome is death then death is merely the crossing of a bridge going to a better place.

Between these poles we get a wide spectrum of personalities. What and how we tell them is individually tailored to each of them.

But under all circumstances we should not tell a lie. To the direct question: do I have cancer, doctor?, there is only one answer: yes. To the question: what do I have, doctor?, you evaluate your patient, to some you will say: you have cancer, to others you may say: it seems that some of the cells of your (organ) have started to multiply erratically on their own forming a mass, and if left without treatment might invade neighbouring tissue or even spread to distant organs. Some patients do not want to hear the word cancer, and we should respect their wish.

One also encounters the kind of patient with deep faith in their heart, and who has

been looking forward for years and years to that day when their soul will be freed from the cage of their body to enter into the realm of God's mercy and compassion.

## **5.6 CASE STUDY II**

### **EUTHANASIA: AN ISLAMIC VIEW**

Euthanasia has gained a legal foothold in Holland. It went to the ballot box in two states in America but was defeated, although its lobby is becoming more active. Islam has its own definite views of euthanasia.

The sanctity of human life is a basic value as decreed by God even before the times of Moses, Jesus and Muhammad. Commenting on the slaying of Abel by his brother Cain, God says in the Qur'an:

*"On that account We ordained for the children of Israel that if anyone slay a person - unless it be for murder or spreading mischief in the land - it would be as if he slew the whole people. And if anyone saved a life, it would be as if he saved the life of the whole people"*

(Qur'an 5:32).

*"Take not life, which Allah made sacred, otherwise than in the course of justice"*

(Qur'an 6:151 and 17:33).

The Shari`ah goes into great detail in defining the conditions under which taking life is permissible, whether in war or in peace, with rigorous prerequisites and precautions to restrict its use.

Islam does not recognise suicide as a right, but rather considers it a violation. Since we did not create ourselves, we do not own our bodies. We are entrusted with them for care, nurture and safe-keeping. God is the owner and giver of life and His rights in giving and in taking are not to be violated. Attempting to kill oneself is a crime in Islam as well as a grave sin. The Qur'an says:

*"Do not kill (or destroy) yourself, for verily Allah has been to you most Merciful"* (Qur'an 4:29).

Justification of taking life to prevent or escape suffering is not acceptable. Prophet Muhammad taught, 'There was a man in older times who had an infliction that taxed



his patience, so he took a knife, cut his wrist and bled to death. Upon this God said: 'My subject hastened his end, I deny him paradise'. During one of the military campaigns, one of the Muslims was killed and the companions of the Prophet kept praising his gallantry and efficiency in fighting, but, to their surprise, the Prophet commented, "His lot is hell". Upon inquiry, the companions found out that the man had been seriously injured and so he supported the handle of his sword on the ground and plunged his chest onto its tip, committing suicide.

The Islamic Code of Medical Ethics endorsed by the First International Conference on Islamic Medicine<sup>(49)</sup> stated that mercy killing, like suicide, finds no support except in the atheistic way of thinking that believes that our life on this earth is followed by void. The claim of killing for painful hopeless illness is also refuted, for there is no human pain that cannot be largely conquered by medication or by suitable neurosurgery.

The Islamic Oath<sup>(49)</sup> **Appendix I**, that medical students take at Kuwait University upon graduation states specifically that:

"I swear by God the greatest to protect human life in all stages and under all circumstances".

Furthermore, there is a transcendent dimension to the question of pain and suffering.

Patience and endurance are highly regarded and highly rewarded values in Islam:

*"...Those who patiently preserve will truly receive a reward without measure" (Qur'an 39:10).*

*"...And bear in patience whatever (ill) may befall you; this, behold, is something to set one's heart upon"*

(Qur'an 31:17).

Prophet Muhammad taught, "When the believer is afflicted with pain, even that of a prick of a thorn or more, God forgives his sins, and his wrongdoings are discarded as a tree sheds off its leaves".

When means of preventing or alleviating pain fall short, the spiritual dimension can be very effectively called upon to support the patient who believes that accepting and standing unavoidable pain will be to his or her credit. To a person who does not believe in a hereafter this might seem insupportable, but to one who does, euthanasia is certainly insupportable.

There is no question that the financial cost of maintaining the incurably ill and the senile is a growing concern, so much that some pro-euthanasia groups have gone beyond the concept of the "right to die" to that of "duty to die". They claim that when

the human machine has outlived its productive span, its maintenance is an unacceptable burden on the productive segment of society and it should be disposed of, abruptly, rather than allowing it to deteriorate gradually.

This logic is completely alien to Islam. The care of the weak, old and helpless is a value in itself for which people should be willing to sacrifice time, effort and money, and this starts, naturally, with one's own parents:

*"Your Lord decreed that you worship none but Him, and that you be kind to your parents. Whether one or both of them attain old age in your life, say not to them a word of contempt but address them in terms of honour. And lower to them the wing of humility out of compassion, and say: 'My Lord, bestow on them Your mercy even as they cherished me in childhood'"*

(Qur'an 17:23-25).

Because such care is a virtue ordained and rewarded by God in this world and in the hereafter, believers regard it not as a debit, but as an investment. When individual means cannot cover the cost of necessary care, it becomes, according to Islam, the collective responsibility of the society.

In an Islamic setting the question of euthanasia does not usually arise, and if it does, it is dismissed as religiously unlawful. The patient should receive every possible psychological support and compassion from family and friends, including the spiritual or religious advisors. The doctor participates in this also and provides

therapeutic measures for the relief of pain. A dilemma arises when the dose of the pain killer necessary to alleviate the pain approximates or overlaps with the lethal dose that might bring about the patient's death. Ingenuity on the part of the doctor is called upon to avoid this situation, but from a religious point of view, the critical issue is the doctor's intention: is it to kill or to alleviate pain?

The seeking of medical treatment for illness is mandatory in Islam, according to two sayings of the Prophet: "Seek treatment, subjects of God, for to every illness God has a cure", and "Your body has a right on you". But when the treatment holds no promise, it ceases to be mandatory. This applies both to surgical and/or pharmaceutical measures, and, according to the majority of scholars, to artificial equipment. Ordinary needs that are the right of every living person and which are not categorised as "treatment" are regarded differently. These include food and drink and ordinary nursing care, and they are not to be withheld as long as the patient lives.

The Islamic Code of Medical Ethics, states: "In his or her defense of life, however, the doctor is well-advised to realize his limit, and not transgress it. If it is scientifically certain that life cannot be restored, then it is futile to diligently keep the patient in a vegetative state by heroic means or to preserve the patient by deep freezing or other artificial methods. It is the process of life that the doctor aims to maintain and not the process of dying. In any case, the doctor shall not take a positive measure to terminate the patient's life".

The writer is fully aware that some of these concepts might be so alien to the Western mind as to be relegated to the realm of mythology or fiction. But it is these concepts that form the basis of the moral reasoning skills used by the medical students tested by the DIT in this research. Their understanding of what is Halal and Haram was, I believe, a major underlying reason for choosing how to deal with every situation or story introduced in the test.

An important thesis of this research is that morality can be taught and learned, and that values, opinions, and attitudes can change. They will not change, however, if individuals do not actively engage in discussing the basis of their judgements and reasoning.

Even if these values and judgements do not change, through the introduction of a course in medical ethics, the researcher hopes that medical students will be clearer in their own mind as to why the particular values they hold are important to them.

## **SUMMARY OF CHAPTER 5**

The study has thus far moved through outlining the theoretical foundation of moral development research, discussing the Defining Issues Test and its uses, validity and the results obtained at Kuwait University. In this chapter the fabric of the Kuwaiti setting the researcher is going back to was described in terms of the health system, education system, namely, the higher education level at the medical school and the Islamic religion with its implications on the health care profession. An understanding of Islamic's moral reflections based on the Qur'an, on the tradition of the Prophet Mohammed, the Qias, and Ijtehad is vitally needed in medical education. One goal of introducing the fabric of my society was to show that one can be religious, rational and oriented to a lasting meaning and still be free, committed, and self guided.

### **IMPLICATIONS OF THE STUDY**

**"It is impossible to give a satisfactory answer to the perennial question: 'what makes a good doctor?' There are surely a number of answers, and much depends on the circumstances of the health services and the society in which the doctor practices. We can, however, be confident of the need to put education back into medical training. We feel that if the parts are properly educational the whole will take care of itself. There will always, of course, be a place in medical practice for the expert technician - but only in the context of a broadly educated medical profession".**

**(Downie, R. and Chorlton, B, 1992).**

Everyone is in favour of moral growth and development, but disagreements about what it consists of, how it is recognised, and the means by which it is achieved are legion.

Kohlberg offered a meaning for moral growth and a standard measure of that meaning, based on empirical studies in psychology. Kohlberg argued that the process of moral development, like the process of intellectual or cognitive development, can be described as the movement through distinct stages of awareness, with the later stage being more adequate or better than the earlier. Kohlberg's six-stages of moral development are empirical abstractions. As such they must not be viewed as the result of previous theoretical speculation about the history and development of moral theories or as a dissection of a preferred theory of ethics.

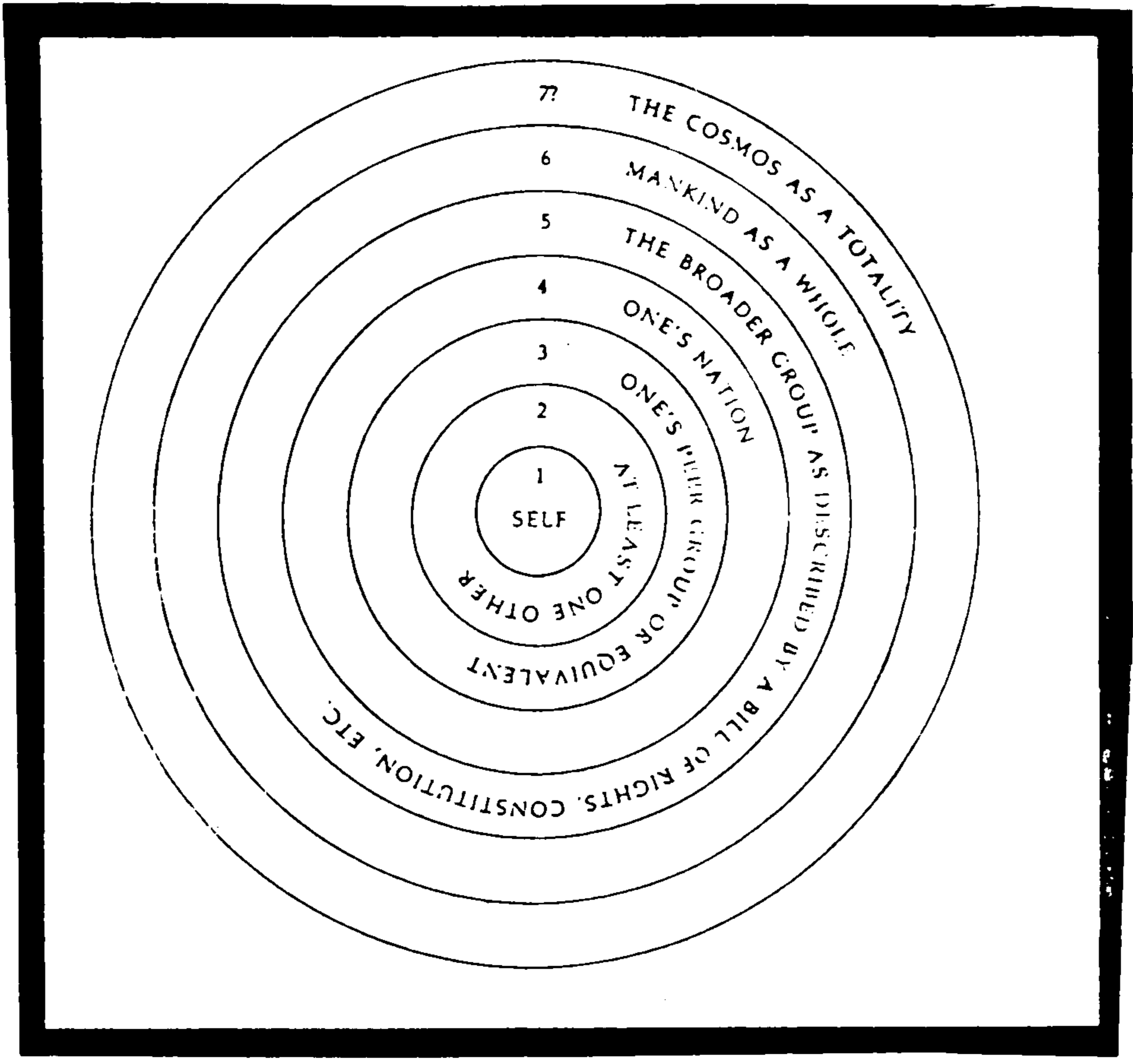
A cognitive or moral stage in Kohlberg's theory is a distinct mental structure, an internally organised whole or system of internal relations, by means of which information is processed, connected and experienced. Kohlberg often referred to his theory as "methodological non-relativism, and the congruence of multi-societal data allowed him to leave cultural relativism behind.

The six-stages of moral development, in addition to being empirical generalisations and sequential and invariant, are also held to be universal. They are universal in that the last thirty years of research have seemed to confirm that all people, from a wide sample of cultures, move through the same stages.



As an additional reflection on the cross-cultural studies, Kohlberg stated that he found no important differences in development of moral thinking between Catholics, Protestants, Jews, Buddhists, Moslems and Atheists.

Schematically, Kohlberg's view of moral journey might be depicted as the stage by stage enlargement of what is to be included in our ethical deliberations.



**Figure 3. Schematic Representation of Kohlberg's View of the Moral Journey from Dimensions of Moral Education by Carter, R. (1984).**

The stage is set now, the theory has been explained the results from Kuwait points to a growing problem: medical education in its current form and design has an inhibitory effect on the expected moral growth and development of medical students.

The writer strongly believes that higher education that does not foster, support and implement an examination of the moral life will fail its own purposes, the needs of its students and the welfare of society. In addition, since the medical profession appears to accept the importance of moral character and the pursuit of a high moral code of ethics for its members, then closer attention needs to be given to the structure of medical education and its influence.

Having a code of ethics or a set of rules and regulations suffice in the medical profession; some would argue.

To this the argument can be that rules are very useful guidelines which can, if adapted, provide a basis for daily practice and behaviour in the medical profession. But, it is essential to remember that there are many situations which might occur in which rules are unable to advise an appropriate course of action. Codes of Practice usually lay down general principles but they cannot advise the doctor on the best interpretation of the principles, or inform his/her about how to decide between principles which may conflict in practice.

I believe that having a code of ethics and a set of rules and regulations is good, but people's powers of judgement and autonomous decision-making tend to atrophy if

they are not used and explored. These powers will not be used if all that a person has to do is follow a number of pre-decided principles in all possible circumstances. It is too frequently too easy in medical education for educators to keep their eyes fixed on the rules and ensure that they are enforced and thereby achieved as ends in themselves. But if the goal however, is to assist the students in coming to see the worth and soundness of these rules, to explain to them both their necessity and their value, in a supportive and yet firm manner, then growth should become the focus.

**GLOSSARY****1. CRUDE BIRTH RATE (C.B.R.)**

The number of live births in a year per 1000 mid-year population.

$$\text{C.B.R.} = \text{B/P} \times 1000$$

Where B = total number of live births in a year.

P = mid-year population for the same year.

**2. GROSS REPRODUCTION RATE (G.R.R.)**

The average number of daughters that a group of females starting their life together would bear if all the initial groups of females survived the child bearing age.

**3. CRUDE DEATH RATE (C.D.R.)**

The number of deaths in a year per 100 population.

$$\text{C.D.R.} = \text{D/P} \times 1000$$

Where D = total number of deaths per year.

P = mid-year population for the same year.

**4. INFANT MORTALITY RATE (I.M.R.)**

The number of infant deaths in a population per year per 1000 live births during the year.

$$\text{I.M.R.} = \text{D} \times 1000 / \text{B}$$

Where D = deaths of infants during a year.

B = live births during the same year.

**5. NEONATAL MORTALITY RATE.**

The number of deaths of infants under 4 weeks of age (28 days) during a year per 1000 live births during the same year.

$$\text{N.M.R.} = \text{C} \times 1000 / \text{B}$$

Where C = deaths of infants before reach 4 weeks of age.

B = live births during the same year.

6. **POST-NEONATAL MORTALITY RATE.**

The number of infant deaths at 4 through 51 weeks of age during a year per 1000 live births during that year.

$$Y \times 1000 / B.$$

Where Y = infant deaths from 4 weeks up to one year of age.

B = live births during the same year.

7. **MATERNAL MORTALITY RATE.**

The number of maternal deaths due to complications of pregnancy, childbirth and puerperium per 100,000 live births.

$$\text{Maternity Mortality Rate} = DP \times 100,000 / B.$$

Where DP = number of maternal deaths due to puerperal causes.

B = live births.

8. **PERINATAL MORTALITY RATE.**

The number of infant deaths under 1 week of age and late foetal deaths per 1000 births in a year.

$$Dx + Df / B + Df \times 1000$$

Where D = late foetal deaths.

B = live births.

**REFERENCES**

1. Downie, R.S., Charlton, B.. (1992). *The Making of a Doctor*. Oxford University Press, Oxford.
2. Downie, R.S. (1971). *Roles and Values: An Introduction to Social Ethics*. Methuen and Co. Ltd., London.
3. Downie, R.S., Calman, K.C. (1987). *Healthy Respect*. Faber and Faber. London.
4. General Medical Council (1977). *Basic Medical Education in the British Isles*, London, Nuffield, Provincial Hospitals Trust, p.448.
5. *Report of a Working Party on the Teaching of Medical Ethics (1987)*. Chairman: Sir Desmond Pond. Edited by Kenneth M. Boyd. IME Publication Ltd. London.
6. General Medical Council (1993). *Tomorrow's Doctors*. Recommendations on Undergraduate Medical Education. General Medical Council, London.

7. Veatch, R.M., and Sollitto, S. (1976). "Medical Ethics Teaching: Report of a National Medical School Survey". JAMA 235: 1030-1033.
8. Fox, E., and Arnold, R., and Brady, B. (1995). "Medical Ethics Education: Past, Present and Future". Academic Medicine. 70, 761-769.
9. Siegler, M. (1978). "A Legacy of Osler: Teaching Clinical Ethics at the Bedside". JAMA. 239, 951-956.
10. Downie, R.S., Hendry, R. Macnaughton, J., Smith, B. (1997). Humanising Medicine: A Special Study Module. Unpublished Data.
11. Callahan, D., Bok, S. (1980). *The Teaching of Ethics in Higher Education*. Hastings on Hudson. New York. Hastings Center.
12. Culver, C.M. et al (1985). "Basic Curricular Goals in Medical Ethics". New England Journal of Medicine. 312: 253-256.
13. Calman, K.C., Downie, R.S. (1987). "Practical Problems in Teaching of Medical Ethics to Medical Students". Journal of Medical Ethics, 13: 153-156.

14. Osborne, L. and Martin, C. (1985). "The Importance of Listening to Medical Students when Teaching Them Medical Ethics". *J. Med. Ethics* 15, 35-38.
15. Sulmasy, et al (1990). "Long-term Effects of Ethics Education on the Quality of Care for Patients who do not have Resuscitate Orders". *J. General internal Medicine*, 9: 622-626.
16. Self, D.J., Baldwin, D. and Wolinsky, D. (1992). "Evaluation of Teaching Medical Ethics by an Assessment of Moral Reasoning". *Medical Education*, 26, 178-184.
17. Sheehan, M.N. "Why Doctors Hate Medical Ethics" (1994). *Cambridge Quarterly of Health Care Ethics*. 3: 289-295.
18. Kass, L.R. "Practising Ethics: Where's the Action?" (1990). *Hastings Center Report*. 20(1): 5-12.
19. Rest, J. (1988). *Manual for the Defining Issues Test Minneapolis: Center for the Study of Ethical Development*, University of Minnesota.
20. Piaget, J. (1965). *The Moral Judgement of the Child*, New York, Free Press.



21. Kohlberg, L. (1981). *The Psychology of Moral Development (Vol.2)* San Francisco: Harper and Row.
22. Simpson, E.L. (1974). "Moral Development Research: A Case Study of Scientific Cultural Bias". *Human Development*, 17: 81-106.
23. Gilligan, C. (1982). *In a Different Voice: Psychological Theory and Women's Development*. Cambridge, Harvard University Press.
24. Edwards, C. *Cross-cultural Research on Kohlberg's Stages: The Basis for Consensus*. Part XIV: Cross-Cultural Morality. p.419-429.
25. Davidson, M., Robbins, S. & Swanson, D. (1978). "Stage Structure in Objective Moral Judgements". *Developmental Psychology*, 14(2), 137-146.
26. Knight, J. (1995). "Moral Growth in Medical Students". *Theoretical Medicine* 16, 265-180.
27. Rest, J. Deemer, D. (1986). *Life Experience and Developmental Pathways*. *Moral Development: Advances in Research and Theory*. New York. Praeger.

28. McGeorge, C. (1975). *The Susceptibility to Faking of the Defining Issues Test of Moral Development*. *Developmental Psychology*, 11 (108).
29. Lind, G.(1995). "Cultural Fairness and the Measurement of Morality". *Culture* 95/November 13.
30. Self, J. and Davenport, E. (1996). "Measurement of Moral Development in Medicine". *Cambridge Quarterly of Health Care Ethics* 5 (2), 269-77.
31. Blizek, W.L. and Finkler, D. (1977). "Teaching Human Values in Medicine". *Journal of Medical Education*, 52, 858-859.
32. Husted, S.D. (1978). Assessment of Moral Reasoning in Paediatric Faculty, House Officers and Medical Students. *Proceedings of the 17th Annual Conference on Research in Medical Education*, 17, 439-441.
33. Cook, C.D. (1978). Influence of Moral Reasoning on Attitudes Toward Treatment of the Critically Ill. *Proceedings of the 17th Annual Conference on Research in Medical Education*, 17, 442-443.

34. Daniels, M.H., & Baker, G.L. (1979). Assessing the Moral Development of Medical Students: An Empirical Study. Proceedings of the 18th Annual Conference on Research in Medical Education, 18, 87-92.
35. Sheehan, et al (1980). "Moral Judgement as a Predictor of Clinical Performance". Evaluation and the Health Professionals, 3, 393-404.
36. Givner, N. & Hynes, K. (1983). "An Investigation of Change in Medical Students' Thinking". Medical Education, 17, 3-7.
37. Benor, D.E., Notzer, N., Sheehan, T.J. (1984). "Moral Reasoning as a Criterion for Admission to Medical School". Medical Education, 18, 423-428.
38. Self, D.J. & Olivarez, M (1996). "Retention of Moral Reasoning Skills over the Four Years of Medical Education". Teaching and Learning in Medicine. 8 (4), 195-199.
39. Baldwin, D.C. et al (1994). "Moral Reasoning and Malpractice: A Study of Orthopaedic Surgeons". The American Journal of Orthopaedics 25 (7), 481-484.

40. Self, D.J., Olivarez. M. & Baldwin, D. (1997). Moral Development During Medical School: A Cross-sectional Study. Unpublished Data.
41. Campbell, C.S. (1990). "Religion and Moral Meaning in Bioethics". Hastings Center Report 20. (4): 9-10.
42. Pellegrino, E.D. (1992). "Intersection of Western Biomedical Ethics - and World Culture: Problematic and Possibility". Cambridge Quarterly of Health Care Ethics. 3: 191-196.
43. The Prophetic Statements in this Thesis are Taken from the Recognised Books of Hadith.
44. Fazlur Rahman. (1979). *Islam*. University of Chicago Press.
45. Naser, S.H. (1994). *Ideals and Reality of Islam*. Aquarian, London.
46. Hathout, Personal Correspondence.
47. A. Khallaf, *Islamic Jurisprudence*, Cairo, 1977.
48. A. Hasaballah, *Principles of Islamic Jurisprudence*, Cairo, 1967.
49. *The Publications of the Islamic Organization of Medical Sciences*,

Kuwait, 1985.

## **BIBLIOGRAPHY**

A World Conference (1993). The changing medical profession:implication for medical education. World federation for medical education. Medical Education;27:pp.291-296.

Ali, A (1991) The meaning of the Holy Qur'an. Amana Corporation.

Ales, K et al (1992). Using faculty consensus to develop and implement a medical ethics course. Academic Medicine, vol.67, No.6:pp.406-408.

Amado, R.G. (1995). Values education:a new direction for medical education. Journal of medical ethics;21:pp.174-178.

Andre, J. (1992). Learning to see:moral growth during medical training. Journal of medical ethics. 18:pp.148-152.

Babapulle, C. (1992). Teaching of Medicine in Sri Lanka. Medical Education;26:pp.185-89.

Baldwin, D.C., Daugherty, S.R., and Self, D.J. (1991). Changes in moral reasoning during medical school. Academic research; vol.66, No.9:pp.51-53.

Barry, F.R. (1966). Christian Ethics and Secular Society. Hodder and Stoughton.

Belgum, D. (1983). Medical ethics education: A professor of religion investigates; 9: pp. 8-11.

Berseth, C.L. and Durand, R. (1990). Evaluating the effect of a human values seminar series on ethical attitude towards resuscitation among paediatric residents. Mayo Clin. Proc. vol; 65: pp. 337-343.

Bickel, J. (1987). Human Values teaching programs in the Clinical Education of Medical Students. Journal of Medical Education; vol. 62: pp. 369-78.

Bicknell, D. (1985). Current arrangements for teaching medical ethics to undergraduate students. Journal of Medical Ethics; 11: pp. 25-26.

Blum, L.A. (1988). Gilligan and Kohlberg: Implication for Moral Theory. Ethics 98: pp. 472-491.

Bordens, K.S., Abbott, B.B. Research design and Methods: A Process Approach. Indiana University-Purdue University at Fort Wayne. Chapter 7: pp. 169-196.

Brennan, T.A. and Kirschner, R. (1992). Medical Ethics and Human Rights Violations: The Iraqi Occupation of Kuwait and its Aftermath. Annals of Internal Medicine 117, 1: 78-87

Brody, H et al (1995). Commentary: Moral Growth in Medical Students. *Journal of Theoretical Medicine*;16:p.281-89.

Bulger, R.E. (1988) COMMUNICATION. The need for an Ethical Code for Teachers of the Basic Biomedical Sciences. *Journal of Medical Education*;vol.63:pp.131-133.

Burling, S.J. et al (1990). Review of the teaching of medical ethics in London Medical School. *Journal of Medical Ethics*;16:pp.206-209.

Byk, C. (1993). The European Convention of Bioethics. *Journal of Medical Ethics*;19:pp.13-16.

Cain, J.M., Elkins, T. and Bernard, P.F. (1994). The status of ethics education in Obstetrics and Gynaecology. *Obstetrics and Gynaecology*;vol.83, No.2:pp.315-320.

Callahan D. & Bok, S. (1980). *Ethics Teaching in Higher Education*. Plenum Press.

Calman K.C. and Downie, R.S. (1988) *Education and Training in Medicine*. *Medical Education*, 22, 488-91

Caplan, A and Callahan, D (1981) *Ethics in Hard Times*. Plenum Press.

Candee, D., Sheehan, J., Cook, C.D. and Husted, S.R. (1979). Moral reasoning and



physicians' decision in cases of critical illness. Eighteen Annual Conference on Research in Medical Education:pp.93-99.

Carney, F.S. (1981). Justice and Health Care:A Theological Review:pp.37-50.

Chaim, V.R. (1993). The ethics of postmortem examination in contemporary Islam  
J. Med. ethics;19:pp.164-168.

Christakis, N.A. (1992). Ethics Are Local:Engaging Cross - Cultural Variation in  
The Ethics For Clinical Research. J. Soc Sci Med. vol.35, p.1079-91.

Clouster, K.D. (1975). Medical Ethics:Some Uses, Abuses and Limitations. The  
new England Journal of Medicine.vol.239, No.8:pp.384-88.

Cohen D et al (1988). A national survey concerning the ethical aspects of informed  
consent and role of medical students. Journal of Medical Education; vol.63 :p.821-  
829.

Colby, A and Kohlberg, L (1982) the Measurement of Moral Judgement. Vol(1)  
Theoretical Foundations and Research Validations. Cambridge University press.

Corley, M.C. and Selig, P.M. (1992). Nursing Moral Reasoning Using the Nursing  
Dilemma Test. Western Journal of Nursing Research:14(3):pp.380-88.

Crandall, S.J.S. (1993). Medical students' attitude towards providing care for the undeserved. *JAMA*;vol.269,No.19:pp.2519-23.

Crisham, P. (1981). Measuring Moral Judgement in Nursing Dilemmas. *Nursing Research*;vol.30.No.2:pp.104-110.

Douglas, M. Morality and Culture. *Ethics* 1983; 93: 786-91.

Downie, R.S. (1980). Words. *J Med Ethics*;6:pp.33-34.

Downie, R.S. (1984). Ethics and Surveys. *J Med Ethics*;2:pp.77-78.

Downie, R.S. (1991) Literature and Medicine. *Journal of Medical Ethics*,  
17, 93 - 6

Downie, R.S. (1994). Definition. *J Med Ethics*;20:pp.181-84.

Ebrahim, A.M. (1995). Organ Transplantation:Contemporary Sunni Muslim Legal and Ethical Perspectives. *Bioethics* vol.9, No.3/4:pp.292-302.

Elkins, T.E. (1988). Introductory course in Biomedical Ethics in the Obstetrics-Gynaecology Residency. *Journal of Medical Education*, vol.63:pp.294- 300.

Fentem, P.H. (1985). Methods of teaching medical ethics at the University of Nottingham. *Journal of Medical Ethics*;11:pp.27-28.

Fields, S.A. & Toffler, W.L. (1993). Hopes and concerns of a first year medical school class. *Medical Education*. 27:pp.124-29.

Fox, E et al (1995). *Medical Ethics Education, Past, Present and Future*. *Academic Medicine*, vol.70, No.9:pp.761-69.

Gilligan, C. (1982). *In a different voice. Psychological Theory and Women's Development*. :Harvard University Press.

Gillon, R. (1992). Caring, men, women, nurses and doctors, and health care ethics. *Journal of Medical Ethics*. 18:pp.171-172.

Glick, S.M. (1994). The teaching of medical ethics to medical students. *J Med Ethics*. 20:pp.239-43.

Grunstein-Amado, R. (1993). Ethical decision-making processes used by health care providers. *Journal of Advanced Nursing*;18:pp.1701-09.

Hafferty, F.W. & Franks, R. (1994). The Hidden Curriculum: Ethics teaching and the Structure of Medical Education. *Academic Medicine*;vol.69, No.11:pp.861-71.

Hatch, E. Culture and Morality. The Relativity of Values in Anthropology. New York: Columbia University Press, 1983.

Hasan, K.Z. (1994). Islam and the Four Principles:A Pakistani View. Principles of Health Care Ethics. Chapters 9:pp.93-103.

Hatch, E. (1983). Culture and Morality. Columbia University Press, New York.

Herbert, P.C., Meslin, E.M. and Dunn, E.V. (1992). Measuring the Ethical Sensitivity of Medical Students:A study at the University of Toronto. Journal of Medical Ethics;18:pp.142-147.

Hitti, P.K. (1970). Islam A Way of Life. University of Minnesota Press, Minneapolis & Oxford University Press. London, Bombay, Karachi.

Holm, S et al (1996). Ethical reasoning in Mixed Nurse Physician groups. J Med Ethic;22:pp.168-73.

Hope and Fulford, K. (1994). The Oxford Practice Skills Project: Teaching Ethics, Law and Communication Skills to Clinical Medical Students. Journal of Medical Ethics;20:pp.229-34.

Howe, K.R. (1982). Evaluating Philosophy Teaching. Assessing Student Mastery of Philosophical Objectives in Nursing Ethics. Teaching Philosophy:pp.11-22.

Hugh, A.F. (1988). A Required and Elective Curriculum in Ethics for Medical Students. *J Med Educ*;vol.63:pp 329-31.

Jacobson, J.A et al (1989). Internal Medicine Residents' Preferences Regarding Medical Ethics Education. *Academic Medicine*;pp.760-74.

Johnson, A.G., (1983). Teaching Medical Ethics as a Practical Subject:Observations from Experience. *Journal of Medical Ethics*;9:pp.5-9.

Jonsen, A.R. (1987). Leadership in Meeting Ethical Challenges. *Journal of Medical Education*;vol.62.pp.95-99.

Jonsen, A.R. (1991). American Moralism and the Origin of Bioethics in the United States. *J Med Phil*;16:pp.113-130.

Knight, J.A. (1995). Moral Growth in Medical Students. *Theoretical Medicine*;16:pp.265-80.

Kohlberg, L. (1981). *The Philosophy of Moral Development (Vol 1)* San Francisco, Harper & Row.

Kohlberg, L. (1984) *The Psychology of Moral Development (Vol 2)*. San Francisco, Harper & Row.

Kraemer, J.L. (1986). *Philosophy in The Renaissance of Islam*. Leiden, E.J. Brill.

Law, S. (1985). The Teaching of Medical Ethics from a Junior Doctor's Viewpoint. *J Med Ethics*;11:pp.37-38.

Ledingham, I., Harron, D. and Walton, H. (1995). *Towards Partnership:Healthcare Delivery and Medical Education:A Blueprint for Change*. A Report by World Federation for Medical Education;29:pp.1-2.

Loewy, E.H. (1992). Suffering as a Consideration in Ethical Decision Making. *Cambridge Quarterly of Healthcare Ethics*;2:pp.135-42.

Loewy, E.H. (1994). Institutional Morality, Authority and Ethics Committees:How Far Should Respect For Institutional Morality Go? *Cambridge Quarterly of Health Care Ethics*;3:pp.578-584.

Loewy, E.H. (1994). Physicians, Friendship and Moral Strangers:An Examination of a Relationship. *Cambridge Quarterly of Health Care Ethics*;3:pp.52-59.

Loewy, E.H. (1994). Teaching Medical Ethics:Is it a Waste of Time? *Cambridge Quarterly of Healthcare Ethics*;3:pp.296-99.

Loewy, E.H. (1995). Care Ethics:A Concept in Search of a Framework. *Cambridge Quarterly of Healthcare Ethics*;4:pp.56-63.

Loewy, E.H. (1995). Compassion, Reason and Moral Judgement. Cambridge Quarterly of Healthcare Ethics;4:pp.466-75.

Loewy, E.H. (1993). An Inquiry into Ethics Committees' Understanding:How does one educate the educators? Cambridge Quarterly of Health Care Ethics;2:pp.551-55.

Louden, R.B. (1992). Morality and Moral Theory. Oxford University Press, Oxford.

Marshall, P et al (1994). Intercultural Reasoning:The Challenge for International Bioethics. Cambridge Quarterly of Healthcare Ethics;3: pp.321-28.

Midgley, M. (1991). Can't we make moral judgements? The Bristol Press.

Milcinski, J. & Straziscar, S. (1980). Teaching Medical Ethics:Ljubljana School of Medicine, Yugoslavia. J Med Ethics;6:pp.145-48.

Milder, J.E. and Novelli, V.M. (1992). Clinical, Social and Ethical Aspects of HIV-1 Infection in an Arab Gulf State. Journal of Tropical Medicine and Hygiene;95:pp.128-131.

Miles, S.H. (1989). Medical Ethics Education:Coming of Age Academic Medicine;pp.705-14.



Miller, J.G. (1992). Culture and Moral Judgement: How are Conflicts Between Justice and International Responsibilities Resolved? *Journal of Personality and Social Psychology*; vol.62, No.4:pp.541-54.

Mitchell, B. (1967). *Law, Mortality and Religion in a Secular Society*. Oxford University Press. New York, Toronto.

Mitchell, B. (1980). *Morality: Religious and Secular*. Clarendon Press. Oxford.

Mitchell, K.R et al ((1993). Assessing the Clinical Ethical Competence of Undergraduate Medical Students. *J Med ethics*;19:pp.230-236.

Mitchell, K.R. (1992). Teaching Bioethics to Medical Students: The Newcastle Experience. *Medical Education*;26:pp.290-300.

Molloy, A. (1980). Attitude to Medical Ethics among British Muslim Medical Practitioners. *Journal of Medical Ethics*;6:pp.139-44.

Myser, C et al (1995). Teaching Clinical Ethics as a Professional Skill; Bridging the Gap between Knowledge about Ethics and its use in Clinical Practice. *J Med Ethics*;21:pp.97-103.

Nasr, S.H. (1994). *Ideals and Realities of Islam*. Aquarian, London.

Norberg, A et al (1994). Ethical Reasoning Concerning the Feeding of Severely Demented Patients:An International Perspective. *Nursing Ethics*;1(1):pp.3-13.

Palmer. F. (1992). *Literature and Moral Understanding*. Clarendon Press. Oxford.

Pellegrino, E.D. (1990). Teaching Clinical Ethics. *The Journal of Clinical Ethics*;vol.1,No.3:pp.175-80.

Pellegrino, E. D. Intersections of western biomedical ethics and world culture: problematic and possibility. *Cambridge Quarterly of Healthcare Ethics* 1992; 1:191-196.

Pellegrino, E.D. (1991). Future Directions in Clinical Ethics. *The Journal of Clinical Ethics*;vol.2, No.1:pp.5-9.

Pellegrino, E.D. (1992). Intersection of Western Biomedical Ethics and World Culture:Problematic and Possibility. *Cambridge Quarterly of Healthcare Ethics*;3:pp.191-96.

Pellegrino, E.D. and Thomasma, D.C. (1981). *Medicine and Philosophy. A Philosophical Basis of Medical Practice*. Chapter 1:pp.9-38.

Pellegrino, E.D., Hart, R.J. and Henderson, S.R. (1985). relevance and Utility of

Courses in Medical Ethics. JAMA;vol.253, No.1:pp.49-53.

Price, D.A. & Mitchell, C.A. (1993). A Moral for Clinical Teaching and Learning. Medical Education;27:pp.62-68.

Priel, B. and Rabinwitz, B. (1988). Teaching Social Science in the Clinical Years through Psychosocial Conferences. Journal of Medical Education;vol.63:pp.555-558.

Qadir, C.A. (1988). Philosophy and Science in The Islamic World. Croom Helm, London, New York, Sydney.

Quintana, O. (1993). International Bioethics? The Role of the Council of Europe. Journal of Medical Ethics;19:pp.5-6.

Rest, J. R. (1974). The Hierarchical Nature of Moral Judgement of Personality, 41, 86  
□109.

Rest, J. R. (1986) Manual for the DIT. Minneapolis, University of Minnesota

Rest, J. R. and Narváez, D. (1994) Moral Development in the Professional Psychology and Applied Ethics. Lawrence Erlbaum Associates.

Rest, J et al (1995). In Search of a Better DIT:A New Index. University of

Minnesota.

Rest, J., Thomas, S. and Edward, L. (1995). designing and Validating a Measure of Moral Judgement:Stage Preference and Stage Consistency. Report by the Centre For the Study of Ethical Development, University of Minnesota.

Rezler, A.G et al (1992). Assessment of Ethical decisions and Values. Medical Education;26:pp.7-16.

Riis, P. (1993). Medical Ethics in the European Community. Journal of Medical Ethics;19:pp.7-12.

Rogers, A. & De Bousingen., D.D. (1995). Bioethics in Europe. Council of Europe Press.

Rosalki, J. (1993). The Hippocratic Contract. Journal of Medical Ethics;19:pp.154-156.

Sachs, G. & Siegler, M. (1993). Teaching Scientific Integrity and the Responsible Conduct of Research. Academic Medicine;vol.68, No.12:pp.871-75.

Schlaefli, A., Rest, J.R., Thomas, S.J. (1985). Does Moral Education Improve Moral Judgement? A Meta-Analysis of Intervention Studies Using the Defining Issues Test. Review of Educational Research;vol.55, No.3:pp.319-52.

Seedhouse, D. *Ethics: The Heart of Health Care*. Wiley Medical Publication. 1988.

Self D.J., Baldwin, D.C. and Olivarez, M. (1993). Teaching Medical Ethics to First-year Students by Using Film Discussion to Develop their Moral Reasoning. *Academic Medicine*, vol.68, No.5:pp.383-85.

Self, D.J. (1995). Moral Integrity and Values in Medicine:Inaugurating a New Section. *Theoretical Medicine*;16:pp.253-264.

Self, D.J. et al (1993). The Moral Development of Medical Students:A Pilot Study of the Possible Influence of Medical Education. *Medical Education*:27:pp.26-34.

Self, D.J. and Baldwin, D.C. (1995). Moral Reasoning in Medicine. Chapter 8:pp.147-61.

Self, D.J. and Skeel, J.D. (1992). Facilitating Healthcare Ethics Research:Assessment of Moral Reasoning and Moral Orientation from a Single Interview. *Cambridge Quarterly of Healthcare Ethics*,4:pp.371-76.

Self, D.J., Baldwin, D.C. and Wolinsky, F.D. (1989). The Effect of Teaching Medical Ethics on Medical Students' Moral Reasoning. *Academic Medicine*:pp.755-59.

Self, D.J., Baldwin, D.C. and Wolinsky, F.D. (1992). Evaluation of Teaching Medical Ethics by an Assessment of Moral Reasoning. *Medical Education*;26:pp.178-84.

Self, D.J., Gopalakrishnan, G., Kiser, W.R. and Olivarez, M. (1995). The Relationship of Empathy to Moral Reasoning in First Year Medical Students. *Cambridge Quarterly of Healthcare Ethics*;4:pp.448-53.

Self, D.J., Skeel, J.D. and Jecker, N.S. (1993). A Comparison of the Moral Reasoning of Physicians and Clinical Medical Ethicists. *Academic Medicine*, vol.68, No.11:pp.848-55.

Self, D.J., Skeel, J.D. and Jecker, N.S. (1993). The Influence of Philosophical Versus Theological Education on the Moral Development of Clinical Ethicists. *Academic Medicine*, vol.68, No.11:pp.848-51.

Serour, G. (1994). Islam and the Four Principles. *Principles of Health Care Ethics*. Chapter 8:pp.75-91.

Sheehan, M.N. (1994). Why Doctors Hate Medical Ethics? *Cambridge Quarterly of Healthcare Ethics*;3:pp.298-95.

Sheehan, T. J et al (1980). Moral Judgement as a Predictor of Clinical Performance. *Evaluation & The Health Professions*, vol.3, No.4:pp.393-404.

Sheehan, T.J et al (1989). Teaching Humanistic Behaviour. *Teaching and Learning in Medicine*, vol.1, No.2:pp.82-84.

Shelp, E.E., Russel, M.L and Grose, N.P. (1981). Students' Attitude to Ethics in the Medical School Curriculum. *Journal of Medical Ethics*;7:pp.70-73.

Shorr, A.F., Hayes, R.P. and Finnerty, J.F. (1994). The Effect of a Class in Medical Ethics on First Year Medical Students. *Academic Medicine*;vol.69, No.12:pp.998-100.

Siegler, M. (1978). A Legacy of Osler: Teaching Clinical Ethics at the Bedside. *JAMA* 239, 951-956

Siegler, M. (1979). Clinical Ethics and Clinical Medicine. *Arch Intern Med.*, vol.139:pp.914-16.

Siegler, M. (1982) Decision □making Strategy for Clinical-Ethical Problems in Medicine. *Arch Intern Medicine* 142, 2178-2179.

Siegler, M., Pellegrino, E.D. and Singer, P.A. (1990). Clinical Medical Ethics. *The Journal of Clinical Ethics*;vol.1, No.1:pp.5-9.



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Singer, P.A., Siegler, M. and Pellegrino, E.D. (1990). Research in Clinical Ethics. *The Journal of Clinical Ethics*, vol.1, No.2:pp.95-99.

Skeel, J.D., Self, D.J. and Skeel, R.T. (1993). A Description of Humanist Scholar Functioning as Ethicists in the Clinical Setting. *Cambridge Quarterly of Healthcare Ethics*;2:pp.485-94.

Sledge, W., Lieberman, P. and Reiser, L. (1987). Teaching about the Doctor-Patients Relationship in the first Postgraduate Year. *Journal of Medical Education*. vol.62:pp.187-190.

Smith, A. (1982). The Ethics of Society rather than Medical Ethics. *Journal of Medical Ethics*;8:pp.120-121.

Smith, A. (1985). The Teaching of Medical Ethics. *Journal of Medical Ethics*;11:pp.35-36.

Smith, S.R., Balint, J.A et al (1994). Performance-based Assessment of Moral Reasoning and Ethical Judgement among Medical Students. *Academic Medicine*, vol.69, No.5:pp.381-86.

Stemmler, E.J. (1988). Medical Education:Is it?. *Journal of Medical Education*. voi.63:pp.81-87.

Strong, C., Connelly, J.E., and Forrow, L. (1992). Teachers' Perceptions of Difficulties in Teaching Ethics in Residencies. *Academic Medicine*;vol.67, No.6:pp.398-402.

Sulmasy D. P et al (1993). A Randomized Trial of Ethics Education for Medical House Officer. *Journal of Medical Ethics*;19:pp.157-63.

Sulmasy, D. P et al (1990). Medical House Officers' Knowledge, Attitude and Confidence regarding Medical Ethics. *Arch Intern Med*;vol,150:pp.2509-13.

Sulmasy, D. P et al (1994). Long-term Effects of Ethics Education on the Quality of Care for Patients who have do-not-resuscitate order. *Journal of Internal Medicine*;vol.9:pp.622-626.

Swales, J.D. (1982). Medical Ethics:Some Reservations. *Journal of Medical Ethics*;8:pp.117-119.

Thomasma, D.C. and Loewy, E.H. (1996). Exploring the Role of Religion in Medical Ethics. *Cambridge Quarterly of Healthcare Ethics*, 5:pp.257-268.

Waddy, C. (1990). *The Muslim Mind*. Grosvenor, London.

Walker, R.M., Sigler, M. and Lane, L. W. (1989). development of a Teaching Program in Clinical Medical Ethics at the University of Chicago. *Academic Medicine*;pp.723-729.

Walton, H.. (1993). Medical Education Worldwide:A Global Strategy for Medical Education:Partners in Reforms. *Annals of Community-orientated Education*;vol.6:pp.327-32.

War. R.C. (1996). Ethics as a Surrogate Religion. *Human Healthcare International*;vol.12, No.1:pp.20-23.

Watty, W.M. (1988). *Islamic Fundamentalism and Modernity*. Routledge, London.

Weatherall, D.J. (1995). Teaching Ethics to Medical Students. *Journal of Medical Ethics*;21:pp.133-134.

Welbourn, R.B. (1985). A Model for teaching Medical Ethics. *Journal of Medical Ethics*,11:pp.29-31.

Wolstenholme, G. (1985). Teaching Medical Ethics in Other Countries. *Journal of Medical Ethics*;11:pp.22-24.

Yeo, M. (1993). Prolegomena to any future code for Bioethicists. *Cambridge Quarterly of Healthcare Ethics*,2:p.402-415.

Zeldow, P.B., Daugherty, S. and Leksas, L. (1987) A Four-year longitudinal Study of Personality Changes in Medical Students. *Journal of Medical Education*, vol.62:pp.992-995.

## APPENDIX A

# UNIVERSITY OF CHICAGO

## Pritzker School of Medicine

### THE DOCTOR-PATIENT RELATIONSHIP IN CLINICAL PRACTICE

#### Why Teach a Course about the Doctor-Patient Relationship (DPR)?

During this course we hope to show that good doctor-patient relationships can improve the patient's quality of care and health outcomes, and also the quality of your practice experience as a physician.

Increasingly, good patient care addresses not only the technical question of "What *can* physicians do for a patient", but also the ethical (and increasingly, economic and political) question, "What *should* physicians do for this patient?" Today, to be a good practitioner, physicians require knowledge of the ethical and social dimensions of medicine as well as knowledge of medical science.

In the US in the 1990s, good medical decisions require that we balance the patient's objective medical needs with the patient's values, religious beliefs and personal preferences. Successful doctor-patient relationships, therefore, are measured not only with "hard" outcomes like mortality or morbidity and the cost of care, but also with "soft data" such as the quality of life as perceived by the patient, the patient's functional capacity, the impact of illness on the patient's family, and the patient's satisfaction with care.



The need to balance the technical and moral dimensions of medical decisions puts a premium on shared decision-making. This means making decisions *with*, we well as *for* the patient. This, in turn, means that in educating medical students, emphasis must be not only on the actual decision but also on the decision-making process. A good decision will be based upon sound analysis of the technical issues as well as on a morally sound decision-making process that respects the dignity, autonomy, and values of the patient, as well as respecting the values of physicians, nurses, other health professionals and the family.

For these reasons, we realise that a program to teach the doctor-patient relationship must provide students with two kinds of knowledge: cognitive and behavioural. Cognitive knowledge can be acquired through reading, lectures and discussion. Instruction in the behavioural skills needed to develop effective doctor-patient relationships requires teaching and role modelling by experienced clinicians who demonstrate these skills in practice. It further requires that students have the opportunity to practice these skills while being supervised by experienced clinicians. This behavioural training must be accomplished during the students' clinical education during the second, third and fourth year of medical school.

Our course will primarily address the *cognitive* dimensions of the DPR, exploring issues such as:

- Should medical students and physicians take a medical oath? If so, when, which and why?
- A structured approach to how doctors and patients reach decisions.
- Informed consent and "informed refusal".
- Assessment of patient competency and decision-making capacity.
- Truth-telling and confidentiality in the DPR.
- End-of-life decisions including CPR and DNR; patient use of advance directives such as living wills and health care proxies; withholding or withdrawing life support such as respirators, dialysis, and fluid and nutrition; physician-assisted suicide and euthanasia.
- The influence of payers, on decision-making by doctors and patients.
- Clinical research trials, and the potential tension in the DPR between the physician-as-clinician and the physician-as-scientist.
- "Triage", or the allocation of scarce clinical resources (e.g. physician's time, ICU beds, organs for transplantation, etc).
- The American Health System and its dual crises: access to care and cost.

In designing this course, we have tried to emphasise the "Five Cs" of teaching:

- 1) Clinically based teaching.

- 2) Cases as the teaching focus.
- 3) Continuous teaching throughout the medical curriculum.
- 4) Co-ordinating teaching with the trainees' other learning objectives.
- 5) Clinician's active participation both as co-instructors and as role models for students.

Preparation for small group sessions. The assigned readings *and* the lecture/multi-media presentations will serve as background for the small-group discussions. Students are strongly encouraged to attend both the lecture and small groups, and to read the (relatively short) assignments (including the cases) before each session.

Evaluation of students in the ethics course. At the mid-term, students will be asked to write a short paper discussing the ethical and social dimensions of a particular case. In writing the mid-term paper, students are encouraged to refer to the course readings and to the decision-making approaches emphasized in the course. There will be an objective final exam to prepare students for later Board exams. Student grades (pass-fail) will be based on attendance at lectures, small group participation, and written work.

**Feedback.** This is an experimental course, with maximum participation and audio-visual content, and a minimum of lecture material. We very much want your constant feedback about what you like about the course and how it can

be improved. Please speak or write to any of the instructors with your suggestions or comments.

### COURSE CONTENT

Class presentations: 10.30-11.30.

Small group discussions: 11.45-12.50

Date: January 4 - March 14, 1996.

1. Truth telling, are ethical standards relative?
2. "Whose life is it anyway?"  
Informed consent and patient autonomy.
3. End of life decisions, physician - assisted suicide and euthanasia.
4. AIDS: An ethical crucible for modern medicine.
5. Domestic violence.
6. Rehabilitation ethics.
7. Neonatal ethics.
8. Ethics and reproduction.
9. Ethics, aging and geriatrics.
10. Transplant ethics.
11. Your future under managed care.

## APPENDIX B

## THE SIX - STORY FORM OF THE (DIT)

### 1) HEINZ AND THE DRUG

In Europe a woman was near death from a special kind of cancer. There was one drug that doctors thought might save her. It was a form of radium that a druggist in the same town had recently discovered. The drug was expensive to make, but the druggist was charging ten times what the drug cost to make. He paid \$200 for the radium and charged \$2,000 for a small dose of the drug. The sick woman's husband, Heinz, went to everyone he knew to borrow the money but he could only get together about \$1,000, which is half of what it cost. He told the druggist that his wife was dying, and asked him to sell it cheaper or let him pay later. But the druggist said, "No, I discovered the drug and I'm going to make money from it". So Heinz got desperate and began to think about breaking into the man's store to steal the drug for his wife.

### SHOULD HEINZ STEAL THE DRUG?

The three courses of action available to resolve the dilemma are:

- Should steal.
- Can't decide.
- Should not steal.

The considerations to be ranked in terms of importance are:

1. Whether a community's laws are going to be upheld.
2. Isn't it only natural for a loving husband to care so much for his wife that he'd steal?
3. Is Heinz willing to risk getting shot as a burglar or going to jail for the chance that stealing the drug might help?
4. Whether Heinz is a professional wrestler, or has considerable influence with professional wrestlers.
5. Whether Heinz is stealing for himself or doing this solely to help someone else.
6. Whether the druggist's rights to his invention have to be respected.
7. Whether the essence of living is more encompassing than the termination of the dying, socially and individually.
8. What values are going to be the basis for governing how people act towards each other.
9. Whether the druggist is going to be allowed to hide behind a worthless law which only protects the rich anyhow.
10. Whether the law in this case is getting in the way of the most basic claim of any member of society.
11. Whether the druggist deserves to be robbed for being so greedy and cruel.
12. Would stealing in such a case bring about more total good for the whole society or not.

## 2) ESCAPED PRISONER

A man had been sentenced to prison for ten years. After one year, however, he escaped from prison, moved to a new area of the country, and took on the name of Thompson. For eight years he worked hard, and gradually he saved enough money to buy his own business. He was fair to his customers, gave his employees top wages, and gave most of his own profits to charity. Then one day, Mrs Jones, an old neighbour, recognised him as the man who had escaped from prison eight years before, and whom the police had been looking for.

### SHOULD MRS JONES REPORT MR THOMPSON TO THE POLICE AND HAVE HIM SENT BACK TO PRISON.

The three courses of action available to resolve the dilemma are:

- Should report him.
- Can't decide.
- Should not report him.

The considerations to be ranked in terms of importance are:

1. Hasn't Mr Thompson been good enough for such a long time to prove he isn't a bad person?
2. Every time someone escapes punishment for a crime, doesn't that just encourage more crime?



3. Wouldn't we be better off without prisons and the oppression of our legal system?
4. Has Mr Thompson really paid his debt to society?
5. Would society be failing what Mr Thompson should fairly expect?
6. What benefits would prisons be apart from society, especially for a charitable man?
7. How could anyone be so cruel and heartless to send Mr Thompson to prison?
8. Would it be fair to all the prisoners who had to serve out their full sentences if Mr Thompson was let off?
9. Was Mrs Jones a good friend of Mr Thompson?
10. Wouldn't it be a citizen's duty to report an escaped criminal, regardless of the circumstances?
11. How would the will of the people and the public good best be served?
12. Would going to prison do any good for Mr Thompson or protect anybody?

### 3) NEWSPAPER

Fred, a senior in high school, wanted to publish a mimeographed newspaper for students so that he could express many of his opinions. He wanted to speak out against the use of the military in international disputes and to speak out against some of the school's rules, like the rule forbidding boys to wear long hair. When Fred started his newspaper, he asked his principal for

permission. The principal said it would be alright if before every publication Fred would turn in all his articles for the principal's approval. Fred agreed and turned in several articles for approval. The principal approved all of them and Fred published two issues of the paper in the next two weeks. But the principal had not expected that Fred's newspaper would receive so much attention. Students were so excited by the paper that they began to organize protests against the hair regulation and other school rules. Angry parents objected to Fred's opinions. They phoned the principal telling him that the newspaper was unpatriotic and should not be published. As a result of the rising excitement, the principal ordered Fred to stop publishing. He gave as a reason that Fred's activities were disruptive to the operation of the school.

### SHOULD THE PRINCIPAL STOP THE NEWSPAPER?

The three courses of action available to resolve the dilemma are:

- Should stop it.
- Can't decide.
- Should not stop it.

The consideration to be ranked in terms of importance are:

- i. is the principal more responsible to students or to parents?

2. Did the principal give his word that the newspaper could be published for a long time, or did he just promise to approve the newspaper one issue at a time?
3. Would the students start protesting even more if the principal stopped the newspaper?
4. When the welfare of the school is threatened, does the principal have the right to give orders to students?
5. Does the principal have the freedom of speech to say "no" in this case?
6. If the principal stopped the newspaper would he be preventing full discussion of important problems?
7. Whether the principal's order would make Fred lose faith in the principal.
8. Whether Fred was really loyal to his school and patriotic to his country.
9. What effect would stopping the paper have on the student's education in critical thinking and judgement?
10. Whether Fred was in any way violating the rights of others in publishing his own opinions.
11. Whether the principal should be influenced by some angry parents when it is the principal that knows best what is going on in the school.
12. Whether Fred was using the newspaper to stir up hatred and discontent.

#### 4) DOCTOR'S DILEMMA

A lady was dying of cancer which could not be cured and she had only about six months to live. She was in terrible pain, but she was so weak that a good dose of pain-killer like morphine would make her die sooner. She was delirious and almost crazy with pain, and in her calm periods, she would ask the doctor to give her enough morphine to kill her. She said she couldn't stand the pain and that she was going to die in a few months anyway.

#### SHOULD THE DOCTOR GIVE HER AN OVERDOSE OF MORPHINE THAT WOULD MAKE HER DIE?

The three courses of action available to resolve the dilemma are:

- He should give the lady an overdose that will make her die.
- Can't decide.
- Should not give her the overdose.

The considerations to be ranked in terms of importance are:

1. Whether the woman's family is in favour of giving her the overdose or not?
2. Is the doctor obligated by the same laws as everybody else if giving an overdose would be the same as killing her?
3. Whether people would be much better off without society regimenting their lives and even their deaths?

4. Whether the doctor could make it appear like an accident?
5. Does the state have the right to force continued existence on those who don't want to live?
6. What is the value of death prior to society's perspective on personal values?
7. Whether the doctor has sympathy for the woman's suffering or cares more about what society might think?
8. Is helping to end another's life ever a responsible act of co-operation?
9. Whether only God should decide when a person's life should end.
10. What values the doctor has set for himself in his own personal code of behaviour?
11. Can society afford to let everybody end their lives when they want to?
12. Can society allow suicides or mercy killing and still protect the lives of individuals who want to live?

5) WEBSTER

Mr. Webster was the owner and manager of a gas station. He wanted to hire another mechanic to help him, but good mechanics were hard to find. The only person he found to be a good mechanic was Mr. Lee, but he was Chinese. While Mr. Webster himself didn't have anything against Orientals, he was afraid to hire Mr. Lee because many of his customers didn't like Orientals. His customers might take their business elsewhere if Mr. Lee was working in the gas station. When Mr. Lee asked Mr. Webster if he could

have the job, Mr. Webster said that he had already hired somebody else. But Mr. Webster really had not hired anybody, because he could not find anybody who was a good mechanic besides Mr Lee.

### SHOULD MR WEBSTER HAVE HIRED MR LEE?

The three courses of action available to resolve the dilemma are:

- Should have hired Mr Lee.
- Can't decide.
- Should not have hired him.

The considerations to be ranked in terms of importance are:

1. Does the owner of a business have the right to make his own business decisions or not?
2. Whether there is a law that forbids racial discrimination in hiring for jobs?
3. Whether Mr Webster is prejudiced against orientals himself or whether he means nothing personal in refusing the job?
4. Whether hiring a good mechanic or paying attention to his customers' wishes would be best for his business?
5. What individual differences ought to be relevant in deciding how society's rules are filled?

6. Whether the greedy and competitive capitalistic system ought to be completely abandoned?
7. Do a majority of people in Mr Webster's society feel like his customers or are a majority against prejudice?
8. Whether hiring capable men like Mr Lee would use talents that would otherwise be lost to society?
9. Would refusing the job to Mr Lee be consistent with Mr Webster's own moral beliefs?
10. Could Mr Webster be so hard-hearted as to refuse the job, knowing how much it means to Mr Lee?
11. Whether the Christian commandment to love your fellow man applies to this case.
12. If someone's in need, shouldn't he be helped regardless of what you get back from him?

#### 6) STUDENT TAKE-OVER

Back in the 1960s at Harvard University there was a student group called Students for a Democratic Society (SDS). SDS students were against the war in Vietnam, and were against the army training program (ROTC) that helped to send men fight in Vietnam. While the war was still going on, the SDS students demanded that Harvard end the army ROTC program as a university course. This would mean that Harvard students could not get army training as part of their regular course work and not get credit for it towards

their degree. Harvard professors agreed with the students. The professors voted to end the ROTC program as a university course. But the President of the University took a different view. He stated that the army program should stay on campus as a course. The SDS students felt that the President of the University was not going to pay attention to the vote of the professors, and was going to keep the ROTC program as a course on campus. The SDS students then marched to the university's administration building and told everyone else to get out. They said they were taking over the building to force Harvard's President to get rid of the army ROTC program on campus for credit as a course.

WERE THE STUDENTS RIGHT TO TAKE OVER THE  
ADMINISTRATION BUILDING?

The three courses of action available to resolve the dilemma are:

- take it over
- Can't decide.
- Not take it over.

The considerations to be ranked in terms of importance are:

1. Are the students doing this to really help other people or are they doing it just for kicks?



2. Do the students have any right to take over property that doesn't belong to them?
3. Do the students realise that they might be arrested and fined, and even expelled from school?
4. Would taking over the building in the long run benefit more people to a greater extent?
5. Whether the president stayed within the limits of his authority in ignoring the faculty vote?
6. Will the takeover anger the public and give all students a bad name?
7. Is taking over a building consistent with principles of justice?
8. Would allowing one student take-over encourage many other student take-overs?
9. Did the president bring this misunderstanding on himself by being so unreasonable and unco-operative?
10. Whether running the university ought to be in the hands of a few administrators or in the hands of all the people?
11. Are the students following principles which they believe are above the law?
12. Whether or not university decisions ought to be respected by students?

## APPENDIX C

DEFINING ISSUES TEST

University of Minnesota  
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IDENTIFICATION NUMBER

Grid for identification number with numbers 0-9 in circles.

GREAT  
MUCH  
SOME  
LITTLE  
NO

HEINZ AND THE DRUG:  Should Steal  Can't Decide  Should not steal

- 1. Whether a community's laws are going to be upheld.
2. Isn't it only natural for a loving husband to care so much for his wife that he'd steal?
3. Is Heinz willing to risk getting shot as a burglar or going to jail for the chance that stealing the drug might help?
4. Whether Heinz is a professional wrestler, or has considerable influence with professional wrestlers.
5. Whether Heinz is stealing for himself or doing this solely to help someone else.
6. Whether the druggist's rights to his invention have to be respected.
7. Whether the essence of living is more encompassing than the termination of dying, socially and individually.
8. What values are going to be the basis for governing how people act towards each other.
9. Whether the druggist is going to be allowed to hide behind a worthless law which only protects the rich anyhow.
10. Whether the law in this case is getting in the way of the most basic claim of any member of society.
11. Whether the druggist deserves to be robbed for being so greedy and cruel.
12. Would stealing in such a case bring about more total good for the whole society or not.

Most important item (1-12)
Second most important (1-12)
Third most important (1-12)
Fourth most important (1-12)

GREAT  
MUCH  
SOME  
LITTLE  
NO

ESCAPED PRISONER:  Should report him  Can't decide  Should not report him

- 1. Hasn't Mr. Thompson been good enough for such a long time to prove he isn't a bad person?
2. Everytime someone escapes punishment for a crime, doesn't that just encourage more crime?
3. Wouldn't we be better off without prisons and the oppression of our legal system?
4. Has Mr. Thompson really paid his debt to society?
5. Would society be failing what Mr. Thompson should fairly expect?
6. What benefits would prisons be apart from society, especially for a charitable man?
7. How could anyone be so cruel and heartless as to send Mr. Thompson to prison?
8. Would it be fair to all the prisoners who had to serve out their full sentences if Mr. Thompson was let off?
9. Was Mrs. Jones a good friend of Mr. Thompson?
10. Wouldn't it be a citizen's duty to report an escaped criminal, regardless of the circumstances?
11. How would the will of the people and the public good best be served?
12. Would going to prison do any good for Mr. Thompson or protect anybody?

Most important item (1-12)
Second most important (1-12)
Third most important (1-12)
Fourth most important (1-12)

PLEASE DO NOT WRITE IN THIS BOX

Barcode area with numbers 0-9 in circles.

351606



GREAT  
MUCH  
SOME  
LITTLE  
NO

NEWSPAPER:  Should stop it  Can't decide  Should not stop it

- 1. Is the principal more responsible to students or to parents?
- 2. Did the principal give his word that the newspaper could be published for a long time, or did he just promise to approve the newspaper one issue at a time?
- 3. Would the students start protesting even more if the principal stopped the newspaper?
- 4. When the welfare of the school is threatened, does the principal have the right to give orders to students?
- 5. Does the principal have the freedom of speech to say "no" in this case?
- 6. If the principal stopped the newspaper would he be preventing full discussion of important problems?
- 7. Whether the principal's order would make Fred lose faith in the principal.
- 8. Whether Fred was really loyal to his school and patriotic to his country.
- 9. What effect would stopping the paper have on the student's education in critical thinking and judgment?
- 10. Whether Fred was in any way violating the rights of others in publishing his own opinions.
- 11. Whether the principal should be influenced by some angry parents when it is the principal that knows best what is going on in the school.
- 12. Whether Fred was using the newspaper to stir up hatred and discontent.

- Most important item  1  2  3  4  5  6  7  8  9  10  11  12
- Second most important  1  2  3  4  5  6  7  8  9  10  11  12
- Third most important  1  2  3  4  5  6  7  8  9  10  11  12
- Fourth most important  1  2  3  4  5  6  7  8  9  10  11  12

GREAT  
MUCH  
SOME  
LITTLE  
NO

DOCTOR'S DILEMMA:  He should give the lady an overdose that will make her die  Can't decide  Should not give the overdose

- 1. Whether the woman's family is in favor of giving her the overdose or not.
- 2. Is the doctor obligated by the same laws as everybody else if giving an overdose would be the same as killing her.
- 3. Whether people would be much better off without society regimenting their lives and even their deaths.
- 4. Whether the doctor could make it appear like an accident.
- 5. Does the state have the right to force continued existence on those who don't want to live.
- 6. What is the value of death prior to society's perspective on personal values.
- 7. Whether the doctor has sympathy for the woman's suffering or cares more about what society might think.
- 8. Is helping to end another's life ever a responsible act of cooperation.
- 9. Whether only God should decide when a person's life should end.
- 10. What values the doctor has set for himself in his own personal code of behavior.
- 11. Can society afford to let everybody end their lives when they want to.
- 12. Can society allow suicides or mercy killing and still protect the lives of individuals who want to live.

- Most important item  1  2  3  4  5  6  7  8  9  10  11  12
- Second most important  1  2  3  4  5  6  7  8  9  10  11  12
- Third most important  1  2  3  4  5  6  7  8  9  10  11  12
- Fourth most important  1  2  3  4  5  6  7  8  9  10  11  12

PLEASE DO NOT WRITE IN THIS AREA

GREAT  
MUCH  
SOME  
LITTLE  
NO

WEBSTER:  Should have hired Mr. Lee     Can't decide     Should not have hired him

- 1. Does the owner of a business have the right to make his own business decisions or not?
- 2. Whether there is a law that forbids racial discrimination in hiring for jobs.
- 3. Whether Mr. Webster is prejudiced against orientals himself or whether he means nothing personal in refusing the job.
- 4. Whether hiring a good mechanic or paying attention to his customers' wishes would be best for his business.
- 5. What individual differences ought to be relevant in deciding how society's rules are filled?
- 6. Whether the greedy and competitive capitalistic system ought to be completely abandoned.
- 7. Do a majority of people in Mr. Webster's society feel like his customers or are a majority against prejudice?
- 8. Whether hiring capable men like Mr. Lee would use talents that would otherwise be lost to society.
- 9. Would refusing the job to Mr. Lee be consistent with Mr. Webster's own moral beliefs?
- 10. Could Mr. Webster be so hard-hearted as to refuse the job, knowing how much it means to Mr. Lee?
- 11. Whether the Christian commandment to love your fellow man applies to this case.
- 12. If someone's in need, shouldn't he be helped regardless of what you get back from him?

Most important item    (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12)  
 Second most important    (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12)  
 Third most important    (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12)  
 Fourth most important    (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12)

GREAT  
MUCH  
SOME  
LITTLE  
NO

STUDENTS:  Take it over     Can't decide     Not take it over

- 1. Are the students doing this to really help other people or are they doing it just for kicks.
- 2. Do the students have any right to take over property that doesn't belong to them.
- 3. Do the students realize that they might be arrested and fined, and even expelled from school.
- 4. Would taking over the building in the long run benefit more people to a greater extent.
- 5. Whether the president stayed within the limits of his authority in ignoring the faculty vote.
- 6. Will the takeover anger the public and give all students a bad name.
- 7. Is taking over a building consistent with principles of justice.
- 8. Would allowing one student take-over encourage many other student take-overs.
- 9. Did the president bring this misunderstanding on himself by being so unreasonable and uncooperative.
- 10. Whether running the university ought to be in the hands of a few administrators or in the hands of all the people.
- 11. Are the students following principles which they believe are above the law.
- 12. Whether or not university decisions ought to be respected by students.

Most important item    (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12)  
 Second most important    (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12)  
 Third most important    (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12)  
 Fourth most important    (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) (11) (12)

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## APPENDIX D

## القصة الأولى :

### هاينز وزوجته

حدث ذات مرة في أوروبا أن أشرفت امرأة على الموت نتيجة لإصابتها بنوع معين من السرطان . وكان هناك نواء واحد فكر الأطباء أنه ربما ينقذ حياتها . وهذا النواء نوع من الراديوم اكتشفه حديثا أحد الصيادلة في المدينة . وكان تحضير هذا النواء بتكلف الكثير . ولكن الصيدلي كان يتقاضى عشرة أمثال تكلفته فقد كان النواء بتكلف مائتي جنيه بينما يتقاضى هو ألفين من الجنيهات مقابل جرعة صغيرة منه ، وذهب زوج هذه السيدة ويدعى « هاينز » لكل من يعرفهم لكي يجمع ثمن النواء ولكنه لم يستطع أن يجمع سوى ألف واحد من الجنيهات أي نصف ما يطلبه الصيدلي ثمنا للنواء . وذهب هاينز إلى الصيدلي وأخبره بأن زوجته تحتضر ، وطلب منه أن يبيعه النواء مقابل ما جمعه - أي الألف جنيه فقط - أو أن يسمح له بأن يدفع له فيما بعد ولكن الصيدلي رفض قائلا بأنه صاحب الاختراع وأنه سيستخدمه في الحصول على المال . وتملك اليأس هاينز وبدأ يفكر في السر على الصيدلية لسرق النواء لزوجته .

فهل ترى أن هاينز يجب عليه أن يسرق النواء ؟ ( اختر اجابة مما يلي )

أ - يجب عليه أن يسرقه      ب - لا أستطيع ان اقرر      ج - كلا يجب ألا يسرقه

أ - الجزء الأول : بناء على قرارك الذي اتخذته ، بين درجة الأهمية التي تعطها لكل من القضايا الآتية عشرة التالية على اساس دورها في اتخاذ هذا القرار :

	مهم جدا	مهم	مهم نوعا	قليل الأهمية	غير مهم
١ - وجوب تأييد قوانين المجتمع .		✓			
٢ - اعتبار إقدام الزوج على سرقة دواء لعلاج زوجته التي يحبها أمرا طبيعيا .		✓			
٣ - استعداد هاينز لتعريض حياته للخطر أو نفسه للسجن من أجل دواء قد ينفع .		✓			

	مهم جدا	مهم	مهم نوعا ما	قليل الأهمية	غير مهم
٤ - قدرة هاينز على مواجهة من يتعرض له أو لديه من يساعده على ذلك .				✓	
٥ - قيام هاينز بذلك من أجل مصلحته الذاتية أو خالصا من أجل زوجته .				✓	
٦ - وجوب احترام حقوق الآخرين في استغلال اختراعاتهم .			✓		
٧ - أهمية جوهر الحياة إذا ما قيس بالاهتمام بتأجيل الموت عند الأفراد والمجتمع .			✓		
٨ - طيبة القيم التي يجب ان تتحكم في تصرفات الناس تجاه الآخرين .					✓
٩ - مدى السماح للتبديل بالتمسك وراء قانون يحمي الأغنياء فقط .				✓	
١٠ - وقوف القانون حائلا دون توفر أبسط المتطلبات الأساسية لأي فرد في المجتمع .					✓
١١ - إباحة سرقة الصيدلي باعتباره جشعا وقاسيا .				✓	
١٢ - كون السرقة في هذه الحالة سنعود بالخير على المجتمع ككل أو لا .				✓	

ب - الجزء الثاني :

من بين القضايا الاثني عشرة السابقة اختر الأربع الأكثر أهمية وفقا للترتيب المبين ( دون الرقم فقط ) :

مهمة بالدرجة الأولى ..... ٨ ..... مهمة بالدرجة الثانية ..... ١ ..... مهمة بالدرجة الثالثة ..... ٥ ..... مهمة بالدرجة الرابعة ..... ١٠ .....



## الثمة الثانية :

### حركة طلابية

كانت إحدى الجامعات تقدم برنامجاً للترغيب السياسية يشترك فيه بعض الطلبة مقابل مكانة مالية تصرف لهم من ميزانية اتحاد الطلبة . وتكونت جمعية طلابية مناهضة لهذا البرنامج وتنادى بإيقافه لأنه إلى جانب استهلاكه ميزانية الاتحاد فإنهم يعتقدون أن السياسة لا مبادئ لها وأنها سوف تؤدي إلى إفساد الجو الجامعي . وفي اجتماع عام تعاطف الأساتذة مع هؤلاء الطلبة وندوا بإلغاء هذا البرنامج . ولكن رئيس الجامعة أراد الإبقاء عليه . وأحس الطلبة برغبة رئيس الجامعة هذه وأنه لن يُعير رأيه أو موقف الأساتذة أى اهتمام . وذات يوم توجه مائتا طالب إلى مبنى إدارة الجامعة وطلبوا من الموظفين أن يتركوا مكاتبيهم وأن يغادروا المبنى واستولوا عليه وقالوا إنهم يفعلون ذلك لكي يجبروا الجامعة على إنهاء هذا البرنامج ... والسؤال الآن :

هل كان على الطلبة أن يستولوا على مبنى الإدارة أو لا ؟

١ - نعم كان يجب عليه ذلك .....  
ب - لا أستطيع أن أقرر .....  
ج - كلا لم يكن يجب عليه ذلك .....  
.....

أ - الجزء الأول :

بناء على قرارك الذي اتخذته ، بين درجة الأهمية التي تعطيها لكل من القضايا الآتية عشرة التالية على أساس دورها في اتخاذ هذا القرار .

	مهم جداً	مهم	مهم نوعاً	قليل الأهمية	غير مهم
١ - قيام الطلبة بعملهم هذا من أجل الصالح العام فعلاً أو مجرد مظهرية .			✓		
٢ - مشروعية استيلاء الطلبة على أشياء لا تخصهم .				✓	

مهم جيدا	مهم	مهم نوعا	مهم الأمية	مهم
		✓		٣ - إدراك الطلبة بأنهم قد يقبض عليهم أو يُعزَّمون أو يُفصلون من الجامعة .
	✓			٤ - كون الاستيلاء على مبنى الجامعة سيفيد عدد أكبر من الناس على المدى البعيد .
		✓		٥ - مدى التزام رئيس الجامعة بحدود مسؤولياته حين اتخذ هذا القرار .
		✓		٦ - احتمال أن يؤدي هذا العمل الى إثارة غضب الناس وفقدان الثقة بالقاعدة الطلابية .
✓				٧ - مدى تناسب هذا العمل مع مبادئ العدل .
		✓		٨ - احتمال أن يؤدي تفاضينا عن هذه الحادثة الى تشجيع الطلاب على القيام بمحوادث مشابهة .
	✓			٩ - مدى مسؤولية رئيس الجامعة في إثارة الطلبة حين أظهر عدم التعقل وعدم التعاون في حل هذه المشكلة .
		✓		١٠ - ترك إدارة الجامعة بأيدي قلة من الإداريين أو بأيدي الجميع .
		✓		١١ - التزام الطلبة بمبادئ معينة يعتقدون أنها فوق القانون .
		✓		١٢ - مدى وجوب احترام الطلبة لقرارات الجامعة أو لا .

ب - الجزء الثاني :

من بين القضايا الاثني عشرة السابقة اختر الأربع الأكثر أهمية وفقا للترتيب المين ( دون الرقم فقط ) :

مهمة بالدرجة الأولى ..... ٧ ..... مهمة بالدرجة الثانية ..... ٩ ..... مهمة بالدرجة الثالثة ..... ٤ ..... مهمة بالدرجة الرابعة ..... ١١ .....

القصة الثالثة :

السجين الهارب

حُكِمَ على رجل بالسجن لمدة عشر سنوات ولكنه استطاع الهرب من السجن بعد سنة واحدة واستقر به المقام في مكان جديد واتخذ اسما جديدا ، واستطاع أن يلتحق بالعمل في متجر كبير ، وظل يعمل فيه بجد وإخلاص شديدين لمدة ثماني سنوات واستطاع فيها أن يدخر من أجره ما يجعله يشتري نفس المتجر الذي كان يعمل به ، واشتهر بالأمانة والنزاهة مع عملائه وكان يعطى العاملين لديه أعلى الأجور وينفق أغلب أرباحه في أعمال الخير وذات يوم قدمت إلى المدينة سيدة وسمعت بنزاهة التاجر وسمعت الطيبة فذهبت لتشتري منه بعض الأشياء وما أن رآته حتى تعرفت عليه باعتباره السجين الهارب الذي تبحث عنه الشرطة فقد كانت جارته في تلك البلدة التي كان يها قبل أن يفر من سجنه .

والسؤال هنا هل تبلغ السيدة الشرطة عن هذا الرجل ؟

أ - نعم تبلغ الشرطة ب - لا استطع ان اقرر ج - كلا لا تبلغ الشرطة  
.....  
.....

أ - الجزء الأول :

بناء على قرارك الذي اتخذته، يبين درجة الأهمية التي تعطيها لكل من القضايا الآتية عشرة التالية على أساس دورها في اتخاذ هذا القرار .

	مهم جدا	مهم	مهم نوعا	قليل الأهمية	غير مهم
١ - طيبة الرجل طيلة هذه المدة بما يشهد أنه شخص غير شريف .					✓
٢ - السماح لهذا الرجل وأمثاله بالهروب من العقاب يكون دافعا لزيادة الجريمة .			✓		
٣ - ربما يكون حال المجتمع أفضل بدون السجن وسيطرة الأنظمة القانونية .					✓
٤ - مدى قيام الرجل بأداء دينه نمو المجتمع .					✓

	غير مهم	قليل الأهمية	مهم نوعا	مهم	مهم جدا
٥ - مدى تأييد المجتمع لهذا الرجل فيما يتوقفه من محاكمة عادلة .				✓	
٦ - فائدة فصل السجون عن المجتمع .			✓		
٧ - إعادة هذا الرجل إلى السجن قد يكون عملا يتسم بالنسوة الشديدة .				✓	
٨ - اعتبارات العداة بالنسبة للمساكين الذين نفلوا العقوبة كاملة اذا ما ترك هذا الرجل طليقا .			✓		
٩ - مدى صلة القرابة بين هذه السيدة والرجل .			✓		
١٠ - واجب المواطن الصالح تجاه إبلاغ الشرطة عن أى مجرم هارب بغض النظر عن الظروف المحيطة به .		✓			
١١ - مدى اتفاق مثل هذا القرار مع ارادة الجماعة ومصالحها .			✓		
١٢ - الفائدة المتوقعة لهذا الرجل أو لغيره من وراء إعادته إلى السجن .		✓			

ب - الجزء الثانى :

من بين القضايا الاتى عشرة السابقة اختر الأربع الأكثر أهمية وفقا للترتيب المبين ( دون الرقم فقط ) :

مهمة بالدرجة الأولى ..... ١  
مهمة بالدرجة الثانية ..... ٢  
مهمة بالدرجة الثالثة ..... ٣  
مهمة بالدرجة الرابعة ..... ٤

القصة الرابعة :

مشكلة طبيب

كانت هناك سيدة تحتضر من مرض السرطان وليس هناك أمل في شفائها وأجمع الأطباء أنه لم يبق من عمرها سوى ستة شهور وكانت تعاني من آلام مبرحة فيما عدا بعض أوقات قصيرة جناً . وقد كانت ضعيفة البنية للدرجة أن تناوذا جرعة مسكنة من المورفين قد تعجل بوفاتها وفي أثناء فترات الراحة من الألم كانت تطلب من طبيبها أن يعطيها جرعة كافية من المورفين لكي تموت وتستريح فهي لا تتحمل هذا الألم كما أنها ستتموت حتماً .

والسؤال هنا : ماذا يجب على الطبيب أن يفعل : هل يعطيها الجرعة القاتلة أم لا ؟

أ - يعطيها ب - لا أستطيع أن أقرر ج - لا يعطيها

.....

أ - الجزء الأول :

بناء على قرارك الذي اتخذته ، بين درجة الأهمية التي تعطيها لكل من القضايا الأتية عشرة التالية على أساس دورها في اتخاذ هذا القرار :

	مهم جداً	مهم	مهم نوعاً	قليل الأهمية	غير مهم
١ - تأييد أسرة السيدة لفكرة إعطائها الجرعة القاتلة .			✓		
٢ - مدى خضوع الطبيب لنفس القوانين - كأي شخص آخر - ومساواته لهم في قتلها - إذا ما أعطاهما الجرعة القاتلة .		✓	١		
٣ - قد تكون حياة الناس أفضل إذا كف المجتمع يده عن التدخل في تنظيم حياتهم وموتهم .				✓	
٤ - قدرة الطبيب على إظهار الأمر وكأنه حادث طبيعى .		✓			

	غير مهم	قليل الأهمية	مهم نوعا	مهم	مهم جدا
٥ - حق النولة في إرغام الأفراد على الحياة حتى ولو كان ذلك ضد رغبتهم .					✓
٦ - قيمة الموت إذا ما أعطيت له الأولوية على موقف المجتمع من القيم الشخصية .			✓		
٧ - إشفاق الطبيب على السيدة المريضة أكثر من اهتمامه بموقف المجتمع تجاه ما قد يفعله .					✓
٨ - اعتبار مساعدة شخص آخر على إنهاء حياته عملا يتسم بالمسؤولية وبدل على التعاون .		✓			
٩ - إرجاع الأمر إلى الله وحده في إنهاء حياة أى فرد .					✓
١٠ - نوع القيم الأخلاقية التي يؤمن بها الطبيب .					✓
١١ - مدى أحقية المجتمع في أن يسمح لكل فرد أن ينهى حياته وقتما يشاء .		✓			
١٢ - إباحة المجتمع للانتحار أو القتل من أجل الرحمة وقتلته مع ذلك على حماية الراغبين في الحياة .		✓			

ب - الجزء الثانى :

من بين القضايا الاثني عشرة السابقة اختر الأربع الأكثر أهمية وفقا للترتيب المبين ( دون الرقم فقط ) :

مهمة بالدرجة الأولى      مهمة بالدرجة الثانية      مهمة بالدرجة الثالثة      مهمة بالدرجة الرابعة

..... ٥ ..... ٧ ..... ٩ ..... ١٢

## القصة الخامسة :

### مشكلة السيد « وبستر »

حدث هنا في إحدى ولايات الجنوب في الولايات المتحدة الأمريكية حيث مازال بعض كبار السن يؤمنون بالثقافة العنصرية رغم القوانين التي تقضى عليها . فقد كان السيد « وبستر » يمتلك محطة لخدمة السيارات وكان يريد ان يستخدم « ميكانيكياً » يساعده في عمله ولكن الميكانيكيين المبرة من الصعب وجودهم في هذه الأيام ، وشاءت الظروف أن يتقدم للعمل عنده ميكانيكى على جانب كبير من المهارة هو السيد « لى » ولكنه صينى الأصل . ورغم أن السيد « وبستر » لا يحمل في قرارة نفسه أى شيء ضد أهل الشرق أو الجنس الأصفر إلا أنه تردد في قبوله فير يعلم أن كثيرا من عملائه لا يميلون إلى الشرقيين بصفة عامة وربما لا يأتون إلى ورشته بعد ذلك ويذهبون إلى ورشة أخرى إذا ما قبله للعمل عنده فطلب منه أن يمر عليه بعد يومين ولما عاد السيد « لى » أخبره السيد « وبستر » أنه استأجر عاملا آخر بينما الحقيقة غير ذلك فمن أين يأتي بميكانيكى في مثل مهارة السيد « لى » .

والسؤال الآن هو ماذا كان على السيد « وبستر » أن يفعل بالنسبة لاستخدام السيد « لى » ؟

أ - أن يستخدمه  
ب - لا أستطيع أن أقرر ج - ألا يستخدمه  
.....

أ - الجزء الأول :

بناء على قرارك الذى اتخذته ، بين درجة الأهمية التي تعطيها لكل من القضايا الاتية عشرة التالية على أساس دورها في اتخاذ هذا القرار .

	مهم جدا	مهم	مهم نوعا	قليل الأهمية	غير مهم
١ - حق صاحب العمل في اتخاذ قراراته بنفسه .	✓				
٢ - وجود قانون يحرم التفرقة العنصرية في استخدام الشرقيين .	✓				
٣ - اعتبار النافع وراء قرار السيد « وستر » ما إذا كان بسبب تمييزه ضد الشرقيين أو دون أي دافع شخصي .			✓		
٤ - مدى التقيده التي تعود على عمل السيد « وستر » من استخدام ميكانيكي كفاءه أو اعتبار رغبات الزبائن .		✓			
٥ - نوعية التفرقة الفردية الواجب مراعاتها حين تقرر إسناد المهمات المختلفة في المجتمع .		✓			
٦ - وجوب التخلص نهائيا من النظام الرأسمالي القائم على المنافسة والمجتمع .	✓				
٧ - نسبة المؤيدين الى المعارضين من أفراد مجتمع السيد « وستر » لرأى عمله في تمييز العنصرى .		✓			
٨ - استخدام كفاءة مثل السيد « لى » أفضل من تركها تضيق في المجتمع .	✓				
٩ - مدى انسجام استخدام السيد « لى » مع أخلاقيات السيد « وستر » شخصيا .		✓			
١٠ - مدى التسوة التي يمكن أن يكون عليها قلب السيد « وستر » في رفضه استخدام السيد « لى » رغم علمه بقيمة الوظيفة بالنسبة له .		✓			
١١ - مدى اتفاق هذه الحالة مع القاعدة الأخلاقية الدينية التي توجب حب الآخرين .	✓				
١٢ - وجوب مساعدة الشخص المحتاج بغض النظر عما ستحصل عليه منه في مقابل ذلك .	✓				

ب - الجزء الثاني :

من بين القضايا الآتية عشرة السابقة اختر الأربع الأكثر أهمية وفقا لترتيب الترتيب السابق ( دون الرقم فقط )

مهمة بالدرجة الأولى مهمة بالدرجة الثانية مهمة بالدرجة الثالثة مهمة بالدرجة الرابعة

١٠ ١١ ١٢ ١٣



## القصة السادسة :

### مجلة الحائط

حدث هذا في إحدى الولايات المتحدة الأمريكية وكان « فريد » طالبا بالسنة النهائية في مدرسة ثانوية وأراد أن يصدر جريدة حائط للطلبة لكي يمارس هواية ملحة لديه وينشر بعض أفكاره كأن يتكلم ضد حرب فيتنام وضد بعض قوانين المدرسة وتنظيماتها المصحفة مثل إرغام التلاميذ على عدم إطاعة شعورهم أو لبس زي موحد وعندما بدأ « فريد » في إخراج فكرته إلى حيز الوجود طلب تصريحا من إدارة المدرسة وأخبره المدير أنه ليس لديه أي مانع طالما التزم « فريد » بعرض المقالات عليه قبل نشرها حتى يوافق عليها . وقبل « فريد » ذلك وقام بعرض مقالاته على السيد مدير المدرسة الذي وافق عليها كلها وتمكن « فريد » من إصدار عشرين متالين للجريدة ولكن مدير المدرسة لم يكن يتوقع أن تنال مثل هذه الجريدة كل هذه الشعبية فقد أعجب بها الطلبة حتى أنهم بدأوا في تنظيم احتجاجات ضد قوانين المدرسة التي تؤكد توحيد الزي وغيره واعترض أولياء الأمور الغاضبين على آراء « فريد » واتصلوا بالمدير يعبرون عن رأيهم المعارض لهذه الجريدة وكيف أنها غير ملتزمة . ويجب إيقافها ونتيجة للاثارة المتزايدة أمر مدير المدرسة « فريد » بإيقاف إصدار هذه المجلة ولما سأله عن السبب قال إن هذه المجلة تؤثر على سير العمل في المدرسة .

والسؤال هنا : هل كان على المدير أن يوقف صدور هذه المجلة أو لا ؟

أ - نعم كان يجب عليه ذلك ب. - لا أستطيع أن أقرر ج - كلا لم يكن يجب عليه ذلك

.....

.....

.....

أ - الجزء الأول :

بناء على قرارك الذي اتخذته ، بين درجة الأهمية التي تعطيتها لكل من القضايا الالنتى عشرة التالية على أساس دورها في اتخاذ هذا القرار :

جدا	نوعا	الأهمية	مبهم
✓			١ - شعور المدير بالمسئولية تجاه الطلبة أو أولياء الأمور .
	✓		٢ - إعطاء المدير وعده الأول بإصدار المجلة كان لمدة طويلة أو لكل عدد على حدة .
	✓		٣ - احتمال زيادة اعتراض الطلبة بعد إيقاف المدير للمجلة .
✓			٤ - حق المدير في إصدار أوامره للطلبة عندما تهدد مصلحة المدرسة .
	✓		٥ - حق المدير في رفض اعتراضات أولياء الأمور .
	✓		٦ - مدى تأثير إيقاف المجلة في عدم سائتة المشكلات الميعة .
	✓		٧ - تأثير إيقاف المجلة على ثقة « فريد » في المدير .
✓			٨ - مدى ولاء « فريد » للمدرسة ووطنه .
	✓		٩ - تأثير إيقاف المجلة على تربية الطلبة على التفكير الناقد وإصدار الأحكام .
	✓		١٠ - مدى إنتهاك « فريد » لحقوق الآخرين بنشر هذه المجلة .
✓			١١ - مدى التزام مدير المدرسة بالأخذ برأى بعض أولياء الأمور الغاضبين على حين أنه هو الأتقر على إدراك مصلحة المدرسة .
	✓		١٢ - نية « فريد » في استخدام المجلة لإثارة الكراهية والاستياء .

ب - الجزء الثاني :

من بين القضايا الأتتى عشرة السابقة اختر الإجابة الأكثر أهمية وفقا لترتيب المين ( درن الرقم فقط ) :

مهمة بالدرجة الأول ..... ١ ..... مهمة بالدرجة الثانية ..... ٤ ..... مهمة بالدرجة الثالثة ..... ٧ ..... مهمة بالدرجة الرابعة ..... ١١ .....

## APPENDIX E

## مقياس ترجيح الاحكام

( مقترحك )

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الجزء الاول

التعليمات

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## اجراءات التطبيق

هذا المقياس جسمى أى يمكن تطبيقه على مجموعة أو مجموعات كبيرة من الافراد كما يمكن تطبيقه فى صورة فردية ومن خلال مقابلة كلينيكية مقننة لأولئك الذين يصعب عليهم القراءة ويتم الفاحص قراءة القصة وما يليها من قضايا للشخص المراد اختباره ومعرفة رأيه وتسجيل ذلك بدلا منه فى ورقة الاجابه ولكن يجب مراعاة ذلك المتغير عند حساب النتائج ومناقشتها والمقياس ليس مقياس سرعة ولكن يكفى للمفحوص ٥٠ دقيقة (حصة دراسية) لا تتفاه الاستجابة عنه ، ويعتمد استيائه فى هذه المدة على مدى الجدية التى تشير الى اهتمام المفحوصين . مما يشر الى أهمية تقديم الاختبار بطريقة تحقق هذا الأهتمام وتلك الجديه ويمكن للفاحص كذلك اشعار المفحوصين بالوقت حتى يتسنى لهم تقسيمه على القعتن الأربع .

يجب ألايتدخل الفاحص بتقديم شروحات اضافية أو تفسير للقضايا الخاصة بالقصص واذا ما عادف المفحوص قضية غير مفهومة فما عليه الا ان يقيّمها تحت بند " غير مهم "

تدور أهمية هذا المقياس حول التعرف على آراء الافراد فى ترجيح بعض الأسس التى يعتمدون عليها عند اتخاذهم قرارا معنيا يتصل بمآزق حياتى . مما يعطى صيغة للمقياس صيغة جدلية يجعل الاجماع على رأى واحد أمرا مستعدا .

تلى كل قصة احدى عشرة قضية وأول ما يجب عمله بعد قراءة القصة هى أن يقرأ المفحوص كسئل بند ( قضية ) على حدة ويقيم أهميتها فى اتخاذ القرار الذى ينهى هذه القصة أو يحدد هذه الأهمية طبقا للجدول الموضوع ، وبعد أن ينتهى المفحوص من تقييم كل قضية على حدة يضع مجموعته القضايا الاحدى عشرة فى اعتباره ككل ويختار من بينها القضايا الأربع الأكثر أهمية ويرتبها طبقا لأهميتها فى القسم الثانى من المقياس .

"مثال"

ذهب الطبيب الى غرفة الأفاقة ليظمن علي مريضه بعا اجراء عملية جراحية له ، وعندما دخل الغرفة وجده يهذى ببعض العبارات ، ونهم منها أن مريضه يعاني من عقده ذنب عميقة ، فقد اعتسرف تحت وطأة المخدر بأنه ارتكب جريمة ترحها تفديليا ، وذكر اسم المجنى عليه وهو يتمحه النفسو والمفخرة ، ومع انتباه الاعتراف أفاق الطبيب نفسه من دهشته ليقع في حيرة من أمره ، أبلغ الشرطة

يا سمع أم يسكت عنه ؟

أتاك يستصحك أن تخرجه من عا ايه ، لكي تعطيه النصيحة أردت التأكد أولا من :-

مهم جدا	مهم نوعا	قليل الأهمية	غير مهم
✓	✓		
		✓	
	✓		✓
		✓	
		✓	✓
		✓	
✓			✓

١- هل هذه الجرعة قد انتهى أثارها ؟

٢- هل هذا المريض يمدت بعملة قرابة للطبيب ؟

٣- هل افشاء الطبيب لهذا السر حرام أم كونه هو المنكر بعينه ؟

٤- هل يمكن أن يتم الأمر كبلاغ من مجهول ؟

٥- هل يؤدي افشاء سر هذه الجريمة الي صالح أفراد آخرين ؟

٦- هل سينقد الطبيب زبائنه اذا ما عرف عنه افشاء السر أم لا ؟

٧- هل ابلاغ الشرطة في هذه الحالة ضد القانون أم استنادا الي القانون ؟

٨- هل يجب أن نخفي بسمعتنا من أجل مجتمع أو قوانين فاطلة ؟

٩- هل رفض الشخص نفسه الابلاغ عما ارتكب ليبريح ضميره ؟

١٠- هل الاعتراف يمكن تسجيله أم لا ؟

١١- هل دفع الرجل عن جريمته من مراعه الفردي ؟

٢ سهم بالدرجة الثانية

١ سهم بالدرجة الاولى

٣ سهم بالدرجة الرابعة

١١ سهم بالدرجة الثالثة

وبالرجوع الى جدول معايير التصحيح لاستبدال المقادير الرقمية وتحويلها الى الدرجات العوزونية

تصير الدرجات كالتالي :-

١	٢	-	٦	١٩	٣	-
٤	٦	--	٦			-

قيمة المثال

الدرجة الموزونة

معايير التصحيح :

١- تبديل الاختيارات وفق الدلالات الرقمية التالية

البند	١	٢	٣	٤	٥	٦	٧	٨	٩	١٠	١١
١	١	٥	٩	٦	٢	٣	٧	٤	٨	ر	ك
٢	ك	٨	٩	٧	٣	٥	١	٦	٤	خ	٢
٣	ر	٢	١	٧	٨	٩	٥	٦	٤	٣	ك
٤	٢	٢	ك	٥	٩	٨	٧	٦	٤	/	١
المثال	١	٢	٩	٥	٧	٣	٨	٦	/	٤	ك

٢- ويثبت في (ن) درجلا عدم الاتاق لكل قيمة على حدة -

٣- تضرب كل قيمة في الرقم الممثل لدرجة الأهمية (  $4 \times$  ) إذا كانت مهمة بالدرجة الأولى  $2 \times$  ، مهمة الثانية  $2 \times$  مهمة بالدرجة الثالثة  $1 \times$  مهمة بالدرجة الرابعة ) - ثم يجمع حاصل الضرب وسيكون الحد الأقصى بالطبع (٨٠) ثمانون درجة وإذا احتوت أي من الخانات العشرية ( ر ) فتعامل وكأنها (١) وتوضع قيمتها الموزونة في خانة (ر) لتكون درجات  $ر_١$  ،  $ر_٢$  ،  $ر_٣$  ،  $ر_٤$  ويتبع نفس الأسلوب مع ك لتكون درجات  $ك_١$  ،  $ك_٢$  ،  $ك_٣$  ،  $ك_٤$  .

٤- يتم جمع الخانات الأربع (مع استبعاد دلالة ك، ر لتكون درجة  $ح_١$  ،  $ح_٢$  ،  $ح_٣$  ،  $ح_٤$  ) .

٥- للتحليل على الدرجات الكلية  $ح$  ،  $ر$  ،  $ك$  يتم جمع القيم بالنسبة للقسم الأربع .

ضوابط الثبات الداخلي

هناك ضوابط للثبات الداخلي لاستجابات كل مفحوص :

أولهما : درجة ك التي تعيظها لاختيار بند عديم الصلة وربما المعنى وتم وضعه لكي نتيقن إذا ما كان

اختيار البنود بطريقة عشوائية أو وفق ألتناظها الطنانه غير المفهومة . ويجب استبعاد استبعاد  
المفحوص اذا ما نكرر هذا الاختيار ووصلت درجة ( ك ) الى ( ٨ )

ثانيهما : درجة (ق) وتنتج من مقارنة التقييم الذي أعطاه المفحوص للقضايا الاحدى عشر فى الجزء  
الأول بالاختيار الذى قام به للقضايا الأربع التى تحدت أهميتها فى الجزء الثانى فاذا كان تقييم  
المفحوص بقضية ما فى الجزء الأول باعتبارها مهم جدا فيجب ألا تسبقها قضية أدنى منها فى التقييم  
( مهم نوعا ما ) فى تحديد درجة الأهمية فى الجزء الثانى . فاذا ما اختار المفحوص قضية كان قد سبق  
تقييمها على اسها (مهم نوعا ما ) باعتبارها مهمة بالدرجة الأولى سابقا قضية مهم جدا فيعطى درجة  
واحدة فى (ق) وتزداد الى درجتى عندما يتخطى قضيتين وهكذا ، وتستبعد استجابة المفحوص اذا  
ما وصلت درجة (ق) الى (٦) .

#### تشير بطاقة التفريغ لكل فرد :

بالإضافة الى أية بيانات ديموجرافية يمكن للباحث اضافتها ( من المحتمل عدم اللجوء  
الى طلب بيانات كثيرة على هذه البطاقة ) تحوى بطاقة التفريغ درجات ح ، ر ، ك ، ق ، لكل فرد  
( قصة ) وكذلك الدرجات الكلية لهذه البنود حيث تمثل ح درجة ترجيح الاحكام وفقا لمبادئ النظرية  
المذكورة فى الاطار النظرى للمقياس وبدل ارتفاع الدرجة الى ارتفاع مستوى الفرد عند ترجيح الاحكام  
$$ح = ح_١ + ح_٢ + ح_٣ + ح_٤$$
  
وعدم الثقة فيها  $ر = ر_١ + ر_٢ + ر_٣ + ر_٤$  ...  
ودرجة ك وتشير الى اختيار البنود الجوفاء أو السخلة وتشير الى عدم جدية المفحوص

ك  $ك = ك_١ + ك_٢ + ك_٣ + ك_٤$  أما درجة ق فنشير الى درجة عدم الاتساق بين التقييم الأول  
وتحديد الأهمية فى الجزء الثانى

ق  $ق = ق_١ + ق_٢ + ق_٣ + ق_٤$  ونشير هذه الدرجة الى امكانية استخدام استجابة هذا الفرد  
الفرد من عدمه .



مقياس ترجيح الاحكام

( مقترحك )

الجزء الثاني

الاستبانة

رقم	المادة	نوع الحكم	المرجع	ملاحظات	الترتيب	التعليق
1	المادة 1	القانون	المرجع	ملاحظات	1	التعليق
2	المادة 2	القانون	المرجع	ملاحظات	2	التعليق
3	المادة 3	القانون	المرجع	ملاحظات	3	التعليق
4	المادة 4	القانون	المرجع	ملاحظات	4	التعليق
5	المادة 5	القانون	المرجع	ملاحظات	5	التعليق
6	المادة 6	القانون	المرجع	ملاحظات	6	التعليق
7	المادة 7	القانون	المرجع	ملاحظات	7	التعليق
8	المادة 8	القانون	المرجع	ملاحظات	8	التعليق
9	المادة 9	القانون	المرجع	ملاحظات	9	التعليق
10	المادة 10	القانون	المرجع	ملاحظات	10	التعليق

الاسم : العمر : الجنس : الفرقة الدراسية :

### مقياس ترجيح الاحكام

تهدف هذه الاستبانة الى التعرف على طريقة تفكير الناصر بالنسبة لامداد الاحكام والاساليب التي يعتمد عليها عند توجيه نصيحة معينة في موقف حياتي ما . ويقدر تعدد الافراد بتعدد الآراء .  
 وجدير بالذكر أنه ليس هناك اجابة خاطئة و أخرى صحيحة وانما المهم ان تظهر رأيك بصدق . وهذه الاوراق لن يطلع عليها أحد . وانما ستستخدم لمعرفة متوسط المجموعات التي تساهم في هذه الاستبانة

أ - الجزء الأول : بعد قراءة كل قصة اقرأ كل قضية تليها لتحديد درجة أهميتها في اصدار قسوارك وذلك عن طريق وضع علامة ( ) في احدى الخانات الدالة على مدى أهميتها :

مهم جدا      مهم نوعاً      قليل الأهمية      غير مهم

ب - الجزء الثاني : من بين القضايا الاحدى عشرة التي اطلعت عليها في الجزء الاول اختر اربعة تعتبرها اكثرها أهمية ثم بترتيبها تارلياً .

مهمة بالدرجة الاولى      مهمة بالدرجة الثانية      مهمة بالدرجة الثالثة      مهمة بالدرجة الرابعة

(      )      (      )      (      )      (      )

م	البيان	مهم بالدرجة الاولى	مهم بالدرجة الثانية	مهم بالدرجة الثالثة	مهم بالدرجة الرابعة	ح	ر	ك	ق
١	اعمال أم الدرجة الموزونة								
٢	الاستحان الدرجة الموزونه								
٣	مشكلة طبيب الدرجة الموزونه								
٤	السجين الهارب الدرجة الموزونة								
	الدرجة								

ملحوظة : لا تكتب شيئاً في هذا الجدول

(١) اهمال الام

مكن انست بعد أن خرج ولداها الى العمل . فتوجهت الى الشبان المظل على الشارع تفتحه ، وتلقسى نظرة على المحلات وقد بدأت تفتح ابوابها ويمتلاء الشارع بالحركة ، وترامى الي سمعها من المنسزل المتناثر نراخ جاريتها تمتد انتها الصغيرة ، وكان يحدث هذا التعريف كثيرا حتى أنها كانت تظن أن الصغيرة ليست انتها ، توجهت نظرها بتلقائية الى الشبان المفتوح ورأت الام تدفع ابنتهمسا لتسقط ويرتطم رأس الصغيرة بالارض وتفقد وعيها ، ومع نراخ جاريتها يجتمع الناس ويعمل والد الطفلة ، وسخطهم بعمد ذلك يتولون ان الصغيرة أصيبت عقب سقوطها وهي تلعب اصابة ربما ينتج عنها عاقبة سيئة وسمعت في داخلها صوتا عاليا يأمرها بان عليها أن تبلغ الشرطة فقد رأت جريمة تستوجب الشكر . وجاءت تلك النتيجة ، ولكن قيل النسيحة يجب التأكد من بعض الامور :

أ - الجزء الاول :

مهم جدا	مهم نوعا ما	قليل الأهمية	غير مهم

- ١ - أن الام سذورة فيما فعلت ، وأنها لم تكن تتخذ حذره النهائية .
- ٢ - ابلأخ الاب بالجريمة غير كاف لضمان عدم حدوث ذلك سره أخرى مع باقي الاولاد .
- ٣ - أن ابلأخ الشرطة أو عدمه يعد أمرا محرما شرعيا .
- ٤ - ان الام لن تخضع للمنيحة بعدم الاهتمام وحسن معاملة ابنتها .
- ٥ - أن الصغيرة هي ابنتها فعلا وليست ابنة زوجها .
- ٦ - أن ابلأخ الشرطة سوف لا يشير مشاعر عدوانية ضدنا (الحيطة) .
- ٧ - ان في ابلأخ الشرطة تنفيذ للقانون الذي يستهدف المتلحة العامة .
- ٨ - ان من غير الممكن ان يتم ذلك عن طريق رسالة من مجهول .
- ٩ - الا يؤدي ابلأخ الشرطة الى اضرار اكثر .
- ١٠ - ان الشرطة والناس يستحقون ان يبذل من أجلهم مثل هذا الجهد .
- ١١ - أن التوازن بين مصالح الافراد يؤدي الى بناء شخصية موحده .

الجزء الثاني : من بين القفاري الاحدى عشر السابقة اختر الاربع الاكثر اهمية حسب ترتيب أهميتها  
 مهمه بالدرجة الاولى مهمه بالدرجة الثانية مهمه بالدرجة الثالثة مهمه بالدرجة الرابعة  
 ( ) ( ) ( ) ( )

## (٢) الامتحان

كانت تحس دائما بمكانتها المتميزة في الفصل ولكنها دائما في قلق مترابد من فقدان هذه المكانة خاصة لانها ستؤدي امتحانها الاعم بعد غد ، رغم أنها قامت بمراجعة دروسها ، وتبنت على صوت مدرسيتها تطلب منها الذهاب لاجرة ، ثم تقدير الدرجات من فوق مكتبها في غرفة المدرسات وأرغمت تلميها ودخلت غرفة المدرسات الخاوية ، وفتحت درج المدرسة دون ان تنبه السمسرة ان الدفتر المطلوب على المكتب وأحست بالخطأ الذي أدى الي ارتباكها عن غير قصد ، ولكن هذا الاحساس تحول الي صراع نفسي . لم تصدق عينها وهي ترى الظروف الذي يحتوي على أوراق الأسئلة الاصحاح القادم ونظر قلبها بقوة وهي تنحس المظروف والبرق البارز منه . وراودتها فكرة الاطلاع على الاسئلة . انها حقا في صراع .

هل تتقرأ الاسئلة وتعرف الامتحانات ؟ أم ترجع كل شيء ، وكما كان ؟ فما هو سر هذا الصراع في رأيك .  
أ - الجزء الاول :

استند ان سب الصراع هو :

مهم جدا	مهم	مهم نوعا ما	قليل الأهمية	غير مهم

- ١ - طبيعة الفرفة جغرافيا وانفعالات الامتحانات .
  - ٢ - أن ذلك قد يعطيها شيئا لا تستحق وربما يشجعها على الفشل في المستقبل .
  - ٣ - أن هذا الامر حرام .
  - ٤ - ان احساسها بحلاوة النجاح سيبعد عنها الاحساس بالذنب .
  - ٥ - ماذا لو اكتشفت المدرسة الامر .
  - ٦ - انها راجعت المادة العلمية وربما لا تكون هناك فائدة من ذلك .
  - ٧ - أن من الممكن أن تدخل عليها أخرى وتكتشف الامر .
  - ٨ - ربما تكون طالبة أخرى من اللاتي يأتين الي المكتب قد تعرفت على الاسئلة وتتفوق عليها .
  - ٩ - انها تحت الدرج دون أن يطلب منها ذلك .
  - ١٠ - ان نظام الامتحان نظام فاشل وتقويمه غير حقيقي .
  - ١١ - حب المدرسة وثقتها فيها .
- ب - الجزء الثاني :

من بين القضايا الاحدى عشر أختبر منها الاربعة الاكثر أهمية حسب ترتيب أهميتها .

سبعة بالدرجة الاولى ( ) مهمه بالدرجة الثانية ( ) مهمه بالدرجة الثالثة ( ) مهمه بالدرجة الرابعة ( )



## APPENDIX F

Listing of Raw DIT Data

100110351532221112111523301030204	141512112412101020403	11221 351352504030211
10011035153235115155555502030401	111522152111101020403	3
100210351615123323111321208070611	131423242513210020804	111513543323204020111
100210351615322252344115509100205	111221131321112110802	315141111122105090111
100300301616131120323411110010309	211331412341112080507	331131111151511030715
100300351616341114255115510040309	115511111311110111201	333142141114108120515
100400351617333254212113207100908	213511312221204050107	212111122251504031111
100400351617341232434114309100205	111211431212108041205	325443121213106100812
100510351618212244323435501060702	131432431412402081011	333233222142403060715
100510351618342242234133309020305	111424442422201020812	322442201424202083811
1006103516191311121311524407080306	311111423542405030104	113511111211304080111
100610351619351151315115510050903	331513124342402040611	314152131135112093333
100710351620132213221554303081001	13133243513502041011	31422323233501050613
100710351620354553445125509051006	231534141223206101112	235334133234401040312
100800351621221112311552207100809	23142531353103040505	114242 311111101111011
100800351621143133244143101020304	231 255 1411501020304	132313424414101020314
1009003516222	333515513533501040708	315113233351501040311
100900351622313313111113109101205	111212341311102081211	351141112151207021103
101010351623151141131511108061211	313511112352407050604	
101010351623		311411311252306050417
101110351624321354122534101060712	315511112524404050810	112512551331504010311
101110351624311255445115509100103	211513151111402020608	345131311123112030307
101210351625121132312552207031210	241433235433412011110	332133122144509060313
101210351625344452544124509100502	111534141322308021004	234353231253308120709
101310351625142131511555407080503	141543141514210020805	315114132232501040603
101310351626343352234113509100506	211414431525102010304	224553123124109120601
101400351627132231312123107090512	311412313231407040111	311123113142206030307
101400351627321342145114509100206	111211121211111060502	334324421132209060401
101500351628125253311455403010708	241513232323209121001	332313424243201020304
1015003516283323232325305060708	131211331311201030405	34234323232103041012
101600351629123223311215507081001	233212153541211040605	314213111233406060107
101600351629334254324113410090703	131321221431105080212	342242211325112070603
1017103516301232332235301060908	122543224433202051012	33333322224 406090401
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## APPENDIX G

**FACULTY OF MEDICINE  
CURRICULUM OF THE CLINICAL PROGRAMME**

<b>YEAR FIVE - First Clinical</b>		Medicine, Surgery, Pathology	
<b>YEAR SIX - Second Clinical</b>			
Psych/Comm.Med.	Obst. & Gynaee	Paediatrics	
Obst. & Gynaee.	Paediatrics	Psych/Comm.Med.	
Paediatrics	Psych/Comm.Med.	Obst. & Gynaee	
<b>YEAR SEVEN - Third Clinical</b>			
Medicine	Surgery	Medicine	Surgery
	Sub-specialities*		Sub-specialities*
Surgery	Medicine	Surgery	Medicine
	Sub-specialities*		Sub-specialities*
Sub-specialities*	Medicine	Sub-specialities*	Surgery
	Surgery		Medicine
			Exam

5th year students are divided into 3 groups distributed over 3 rotations.  
6th year students are divided into 3 groups distributed over 6 rotations.

\* Nine integrated system courses including Cardiovascular, Respiratory, Genito-Urinary, CNS, Gastro-intestinal, Endocrinology, Haematology, Musculo-Skeletal/Immunology, and Infectious diseases with an exam at the end of each system course. Students should have a grade of pass (P) in these exams along with satisfying a clinical exam in Medicine and Surgery before being promoted to the second clinical year.

\*\* Sub-specialities are  Pathology, Ophthalmology, ENT, and Primary care and they are examined with their relevant departments.

APPENDIX H

FACULTY OF MEDICINE  
CURRICULUM OF THE CLINICAL PROGRAMME

YEAR FIVE - First Clinical		Medicine, Surgery, Pathology	
YEAR SIX - Second Clinical		Medicine, Surgery, Pathology*	
Psych/Comm.Med.	Obst. & Gynaec	Paediatrics	Exam
Obst. & Gynaec.	Paediatrics	Psych/Comm.Med.	
Paediatrics	Psych/Comm.Med.	Obst. & Gynaec	
YEAR SEVEN - Third Clinical			
Medicine	Surgery	Medicine	Surgery
Surgery	Sub-specialities*	Surgery	Sub-specialities*
Sub-specialities*	Medicine	Sub-specialities*	Medicine
			Exam

6th year students are divided into 3 groups distributed over 3 rotations.  
7th year students are divided into 3 groups distributed over 6 rotations.

\* Nine integrated system courses including Cardiovascular, Respiratory, Genito-Urinary, CNS, Gastro-intestinal, Endocrinology, Haematology, Musculo-Skeletal/Immunology, and Infectious diseases with an exam at the end of each system course. Students should have a grade of pass (P) in these exams along with satisfying a clinical exam in Medicine and Surgery before being promoted to the second clinical year.

\*\* Sub-specialities are relevant departments.

Dermatology, Ophthalmology, ENT, and Primary care and they are examined with their

