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MEDICAL EDUCATION

Antecedents and Consequences of Medical Students' Moral Decision Making during Professionalism Dilemmas

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Abstract

Medical students often experience professionalism dilemmas (which differ from ethical dilemmas) wherein students sometimes witness and/or participate in patient safety, dignity, and consent lapses. When faced with such dilemmas, students make moral decisions. If students' action (or inaction) runs counter to their perceived moral values—often due to organizational constraints or power hierarchies—they can suffer moral distress, burnout, or a desire to leave the profession. If moral transgressions are rationalized as being for the greater good, moral distress can decrease as dilemmas are experienced more frequently (habituation); if no learner benefit is seen, distress can increase with greater exposure to dilemmas (disturbance). We suggest how medical educators can support students' understandings of ethical dilemmas and facilitate their habits of enacting professionalism: by modeling appropriate resistance behaviors.

Introduction

For many, medical school is a time of great stress. Indeed, a systematic review of research examining psychological distress in medical students suggests they suffer a high degree of depression and anxiety and greater psychological distress than the general population [1]. In this article, we consider medical students' distress, focusing on moral distress, i.e., emotional distress arising from the dissonance between one's ethical/moral beliefs and one's behavior, which occurs when one's actions are perceived as being limited by institutional constraints or unequal power relations [2-4]. By highlighting the concepts of professionalism dilemmas and moral decision making, we examine various types of dilemmas encountered by students, how they respond to those dilemmas, and any resultant moral distress they experience. Finally, we offer suggestions for how medical educators, working at the student, faculty, and organizational levels, can reduce or prevent students' professionalism lapses in the face of ethical dilemmas, thereby reducing their moral distress.

Professionalism Dilemmas

Although regulatory body professionalism codes apply to practitioners and medical students alike and students are taught professionalism during medical school, students often experience professionalism dilemmas. Such dilemmas arise in situations in which students witness and/or are asked to participate in professional lapses such as patient safety, dignity, and consent breaches [5] rather than in ethical dilemma situations—typically encountered by health care professionals—in which decisions need to be made about life-sustaining treatment or the patient's best interest is in question. For example, a professionalism dilemma can be experienced by medical students when they witness senior clinicians jeopardizing patient safety through poor hygiene practices or disrespecting patient dignity through physically exposing patients' bodies for longer than necessary [2, 6-9]. Furthermore, medical students' seniors frequently request that they undertake activities during workplace learning that violate ethical principles, including examinations (sometimes intimate examinations) without valid patient consent and covering up mistakes, both of which potentially result in patient harm [2, 6-8, 10, 11]. Thus the dilemma students experience when witnessing professionalism lapses by seniors is whether to report such behaviors or turn a blind eye, and their dilemma when asked to participate in professionalism lapses is whether to comply with the request or resist [7]. Given the high degree of abuse that medical students report at the hands of their seniors within the health care workplace [2], resistance strategies need careful deliberation [8, 11, 12]. Thus, professionalism dilemmas require medical students to undertake some form of moral decision making.

Moral Decision Making: Ethics of Conduct, Character, and Duty

Rather than being a straightforward matter of doing the right thing, medical students' understandings of morally correct behavior differ from one individual to another [7, 13]. This is partly because moral judgments frequently concern decisions about behaviors that might entail some form of harm to another [14], and different individuals hold different perspectives about moral *trade-offs* (i.e., how to decide between two courses of action when the consequences of both have morally undesirable effects) [15]. It is partly because the majority of human behavior arises within a person-situation interaction [16]. Indeed, moral "flexibility" suggests that though we are motivated to do the right thing, any moral principle can bring forth a variety of context-dependent moral judgments and decisions [14]. Moral rules and principles are abstract ideas—rather than facts—and these ideas need to be operationalized and applied to specific situations [17]. Each situation will have different affordances highlighting one facet or another of any given moral value. Thus, when faced with morally dubious situations—such as being asked to participate in lapses of patient consent by senior clinicians during workplace learning events—medical students' subsequent actions (compliance or resistance) differ [10, 11].

We now further unpack how people react to the professionalism dilemmas they encounter by exploring different models of ethical judgments. There are two broad conceptualizations of ethical judgment: either we act according to the rules, laws, and duties that society lays down as being moral (ethics of conduct); or we act according to the type of person we think we are (ethics of character) [17].

According to the "ethics of conduct" perspective, it has been argued that, broadly speaking, people judge their actions by their conformity to a norm (deontology) or their consequences (consequentialism) [14]. In the ethics of deontology, the morality of an action is dependent upon the intrinsic nature of that action: there are *right* and *wrong* actions and the morally right thing to do is determined by duty or laws. Thus, undertaking intimate examinations on patients without valid consent is wrong as it goes against ethical and professional codes of conduct, regardless of the consequences. One form of deontology is principlism (based on the principles of autonomy, beneficence, justice, and nonmaleficence), which is often taught to medical students as a way of approaching moral decision making (see table 1) [18]. Principlism is a model of understanding one's duties in that it prescribes the way we should act on the basis of intersubjective agreements about morality.

Table 1. The four main concepts of principlism [18]

Respect for autonomy: respecting patients' rights to decide a course of action, so long as they have the capacity to consider and act on that plan.
Beneficence: both positive benefit and weighing benefits and risks for best outcomes.
Justice: the fair distribution of scarce health care resources and costs.
Nonmaleficence: typified by the phrase *primum non nocere*, first do no harm.

By contrast, in consequentialism the morality of an action is wholly determined by its *consequences*. Utilitarianism, whereby any act is judged on the basis of the total utility of that act, is an example of consequentialism [19]. Thus, undertaking intimate examinations on patients without valid consent may be acceptable according to a utilitarian position if the knowledge and skills obtained by the learner are used for the greater good [2]. The dual-process theory of moral judgment, which asserts that both affective and cognitive processes contribute jointly to moral decision making, relates to this concept of utilitarianism [19, 20]. When a moral decision has to be made, the dual-process theory suggests that our negative emotional reactions (i.e., prepotent emotions) inhibit a utilitarian decision [20]. For example, if the patient is *conscious*, the intimate examination is overtly coerced and could cause discomfort. However, if the prepotent

emotions are inhibited by the patient being *unconscious*, utilitarian reasoning tends to prevail, as the patient would be unaware of the exam and discomfort would be avoided.

Finally, virtue (character) ethics is a perspective including core concepts such as *arête*, *eudaimonia*, and *phronesis* (see table 2) [21]. Here, moral decision makers are not merely disembodied rational agents; rather they are individuals, shaped through their own experiences, and the master narratives they embody set the boundaries for what kind of persons they are and how they should act [22].

Table 2. The three main concepts of virtue ethics [21]

Arête: an embodied disposition to be virtuous (e.g., honest, compassionate, courageous), cultivated through experience and deliberate decision making. When taken to extremes these virtues can become "faults."
Eudaimonia: happiness or flourishing. Happiness is thought to depend on living a virtuous life. When one fails to be virtuous in one's actions, one might feel dissatisfaction, unhappiness, and even (moral) distress.
Phronesis: also known as practical (or moral) wisdom. Given that virtues taken to excess sometimes lead to failings, possessing the capacity to understand that some aspects of a situation are more essential than others is important. Phronesis is a type of wisdom that is drawn upon in practical decision making.

Having identified some of the ways in which individuals approach their moral decision making, we now consider the emotional impact of professionalism dilemmas for medical students whose actions run counter to their personal morals and consider how certain models of moral decision making are reflected in individuals' experiences of moral distress.

Moral Distress and Its Correlates

People who act against either their embodied moral code (virtue ethics) or normative rules (deontology) or who disregard consequences (consequentialist) may experience moral distress [3, 23]. Moral distress can occur solely in the moment in which a person feels upset or uncomfortable (classified as mild distress) [3]. However, sometimes distress continues for weeks or even months after an event (moderate distress) [3]. In extreme circumstances, distress is experienced many months or even years later (severe distress) [3]. Moral distress is different from other feelings (e.g., moral uncertainty or emotional distress) [23]. The distinction between emotional and moral distress is illustrated by the following example: "Psychiatric nurses may, for example, be

emotionally distressed while restraining a patient, but they are likely to become morally distressed only if they believe that restraining the patient is morally wrong" [24].

Historically, research investigating moral distress has focused primarily on the nursing context [25-30]. However, a recent review of health care professionals' moral distress identified the following correlates of higher levels of moral distress: perception that workplaces have poor ethical climates (among nonphysician health care professionals); poor nurse-physician relationships; low job satisfaction; low quality of care (among nurses but not physicians); intention to leave the job; lack of engagement at work; burnout; and, in acute care settings, working under 30 hours per week, lack of time for patients, and instrumental leadership [31].

Unlike the voluminous research on moral distress in nurses and nursing students, little research has been conducted with medical students. Wiggleton et al. [32] found that female medical students reported witnessing distressing dilemmas significantly more frequently than male medical students, although males tended to report experiencing greater distress than females with each dilemma they encountered [32]. In our questionnaire study of 2,397 medical students in the United Kingdom (UK), we found that males typically classified themselves as experiencing no distress, whereas females typically categorized themselves as experiencing distress [2]. Furthermore, moral distress demonstrated two distinct patterns: *habituation*, whereby students have a *lower* probability of experiencing moral distress the higher the frequency of occurrence of situations wherein they witness or participate in patient care being compromised for the justifiable purpose of their learning; and *disturbance*, whereby students have a *higher* probability of experiencing moral distress the higher the frequency of occurrence of lapses not directly beneficial to their learning (e.g., breaches of patient safety) [2]. The first finding suggests that when students justify their actions for their own learning (and thus for the greater good, per utilitarianism), their experience of moral distress is reduced. This finding is consistent with the dual-process theory of moral reasoning discussed earlier wherein negative emotions are suppressed, leading to more instances of such lapses. The second finding suggests that students' empathy for patients related to unjustified unethical events does not decline across their education, but remains steady [2]. Indeed, across many of our studies investigating students' dilemmas, students frequently reported experiencing distress during and sometimes up to a year after these events and narrated events with a great deal of negative emotion [2, 6-8, 11]. Having examined students' emotional reactions to their experiences of professionalism dilemmas, we now consider in greater depth students' actions in the face of their dilemmas and the reasons they give for such actions.

Professionalism Dilemmas: Acts of Resistance and Compliance

In an examination of 680 UK medical students' written narratives of their most memorable professionalism dilemmas (both witnessing and participating in

transgressions), Rees, Monrouxe, and McDonald found that 55 percent contained evidence of students' resistance to lapses, often detailing multiple acts of resistance [8]. The most common actions were verbally challenging the perpetrator directly; reporting the perpetrator; displaying concern for the wronged person (often the patient), both during (in front of the perpetrator) and following the incident (by staying behind or returning to the scene); and debriefing with a supportive person post-event. Rees and Monrouxe also examined 71 narratives of medical students who were asked by senior clinicians to undertake intimate examinations without valid patient consent to understand students' reasoning concerning why they complied or resisted and, if they resisted, how [11]. Only 18 percent reported resisting senior clinicians' requests to conduct intimate examinations without valid patient consent. Students cited multiple reasons for complying including, most commonly, their desire to fulfill their higher-order obligations to observe and perform, the strong climate of social acceptability (i.e., their peers and other seniors did not complain), their strong desire to learn, and their belief that doing so benefited the patient [11]. Reasons for resisting included the lack of consent, belief that the examination was inappropriate or unnecessary, and that features of the situation facilitated refusal (e.g., the request came from a less senior person) [11]. Furthermore, although this study did not specifically examine moral distress in relation to resistance and compliance, we have noticed how students' compliance with requests to perform consent-related professionalism lapses (across a wider range of consent dilemmas) can cause substantial upset for patients and distress for learners (as evidenced by their negative emotional talk), whereas positive emotional reactions and better protected patients can be seen within students' narratives of resistance [7].

Finally, analyzing over 2,000 health care students' written and oral professionalism dilemma narratives from multiple studies conducted in Australia, Sri Lanka, Taiwan, and the UK, Monrouxe and Rees [7] identified seven distinct modes of resistance: the most common acts comprised direct verbal resistance, directly raising concerns, and indirect verbal acts (e.g., when patient consent was coerced by their seniors, students directly addressed the patient to establish consent for their learning on them). Other acts of resistance included bodily acts such as students removing themselves from the scene of the lapse, drawing curtains to protect patient dignity, and washing hands/donning gloves when seniors did not [7].

As we can see, despite medical students learning within a hierarchical culture that justifies their involvement in professionalism lapses (which support a utilitarian model of ethical reasoning), they often have a desire to resist such participation. When resistance occurs, it can manifest in a variety of direct and indirect verbal and bodily acts. Resistance also contributes to students experiencing more positive emotional reactions.

Students' moral decision making and subsequent actions stemming from professionalism dilemmas can be influenced by external factors at the faculty and

organizational levels. It is to these we now turn as we discuss the implications of students' experience of professionalism dilemmas and subsequent decision making for the training of doctors.

Implications for Medical Education

Medical educators need to consider how best to support students' moral decision making in the face of professionalism dilemmas: whether to go along with lapses or resist them. We think that students need support at three levels: direct support for their learning, support for faculty development, and support for their institutions.

In terms of direct support for student learning, medical students need to understand their moral responsibilities by being aware of professionalism codes and the different ways in which ethical issues can be considered [7]. Although large-scale lectures can facilitate this goal, small-group interactive sessions with clinical facilitators appear to develop students' understanding of the ethical and professional complexity within which they are learning. Indeed, when considering students' understanding of what comprises professionalism, Wiggleton et al. have found that those who have experienced early patient contact and who are learning within small clinician-led interactive groups in which personal experiences are shared and professionalism issues are discussed demonstrate a more sophisticated and embodied understanding of what comprises professionalism than those learning predominately within a lecture-based curricula [33]. The latter students tend to focus on *acting* like a professional (e.g., through the clothes they wear, the way they talk), rather than embodying a strong sense of their professional self [33]. Furthermore, a number of students from lecture-based learning curricula commented on their learning at the end of the session and how they had participated in professionalism lapses without realizing they were ethically problematic. Finally, activities such as providing students with opportunities to share their professionalism dilemmas and share them with emotion [34-36], and to role-play idealized actions (i.e., how they wished they had acted), can empower students to recommit to their professionalism values and act on them in the future.

With respect to faculty development, medical educators need to ensure that clinical teachers are up-to-date with new professionalism policies and to increase these teachers' awareness of their positions as professionalism role models. Monrouxe and Rees [7] and Rees, Monrouxe, and McDonald [8] report that it is useful to share students' professionalism dilemma narratives with clinical teachers as part of formal faculty development in order to facilitate best practice.

Finally, organizations need to find ways to support staff and students' reporting of substandard behaviors. Such a joined-up approach to supporting medical students to become empowered, autonomous, and self-reflective moral decision makers would

enable them to choose the right action for the benefit of themselves, the profession, and patients.

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