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Initiatives for Responding to Medical Trainees' Moral Distress about End-of-Life Cases

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Abstract

Moral distress frequently arises for medical trainees exposed to end-of-life cases. We review the small literature on best practices for reducing moral distress in such cases and propose two areas to target for moral distress reduction: medical education and organizational ethics programs. Students require training in end-of-life dialogues and truthful prognostication, which are not generally available without skilled mentors. But physician-mentors and teachers can suffer from lingering moral residue themselves, which can affect the teaching culture and student expectations. Finally, reducing unit moral distress that affects learners requires formal educational opportunities to debrief about difficult end-of-life cases and formal institutional mechanisms for effective clinical ethics consultation.

Introduction

Moral distress, initially defined by Andrew Jameton [1, 2], occurs in situations in which a person recognizes a moral problem but is constrained from acting on it or resolving it. In the case of medical students facing such a problem, internal constraints (e.g., feelings of powerlessness or insecurity from perceived low level on a team or in a hierarchy) as well as external constraints (e.g., legal or patient rights-based) prevent their taking action, resulting in moral distress and moral residue. Moral distress is not the same as feeling "sad" about a case or being vicariously traumatized by another's tragedy; rather, it occurs when the right action is identified but cannot be carried out. This is different than the limits of beneficence in patient care, in which all treatments for a patient at the end of life have been exhausted, leaving students feeling sad about a patient's death. *Moral residue* is a term initially defined by George C. Webster and Françoise E. Baylis as "that which each of us carries with us from those times in our lives when in the face of moral distress we have seriously compromised ourselves or allowed ourselves to be compromised" [3]. Moral residue thus refers to the "lingering feelings" after the morally distressing event has passed [2].

Our analysis focuses on an emerging, yet critical problem facing medical education: moral distress in medical students unprepared for end-of-life cases and patient care

dilemmas in the adult setting [4]. Reducing moral distress for students in the end-of-life patient care context involves attending to two groups whose deficits contribute to a perfect storm: medical students who may feel powerless, insecure, and ill-prepared to navigate a difficult environment and role models and mentors who could have unresolved moral residue or who are unknowledgeable about how to help medical students address moral distress. So the first questions we must address are these: Who are the students? Who are their mentors? And, finally, who are the dying patients, and why might how they're treated trigger moral distress? We argue that failure to reduce rates of moral distress can lead to a variety of consequences and may even trigger or exacerbate depression, a recognized problem in medical school [5, 6].

Demographics: Students and Mentors
The incoming medical students for fall 2017 will be graduating in 2020. The vast majority of them will be admitted because of their academic performance and grades in the sciences [7]. Although in recent years there has been much more variety in medical school admissions criteria and openness to humanities majors, the typical applicant is still a science major [7-13].

In 2003, women comprised 50.8 percent of medical school applicants, but that figure had fallen to 47.3 percent by 2011 [14]; during the same period, the percentage of female medical school graduates rose from 45 percent to 48-49 percent [15]. It has even been suggested that there are "too many" women in medicine [16] because they tend to choose more family-friendly subspecialties (e.g., family medicine, internal medicine), leaving vacuums in more demanding specialties such as surgery. This pattern appears to reflect lifestyle choices that are not affected by health care systems, as the same trends are found in the United Kingdom [16], Canada [17], and Japan [18] as in the US. We know of no studies demonstrating whether women students are better equipped than male students to handle the end-of-life patient care context, although one study found they experienced less moral distress [4]. However, given that female medical students may not be seeing enough women in medical leadership roles due to a lag in organizational ethics policies surrounding promotion of females to leadership positions [19, 20], their moral distress may be exacerbated if they feel uncomfortable discussing it with male mentors.

Ultimately, mentors in medical education need to acknowledge that the strengths that got students into medical school (aptitude in math, science, and memorization) are frequently not the same skills that students need to get through medical school and become physicians in their own right. Invariably, the skills required to succeed in the profession, including empathy and communication, will need to be both modeled and taught, which is the ongoing process of exercising *clinical phronesis*, or practical reasoning [21, 22].

Who Is Teaching Medical Students?

Mentors in charge of training the next generation of physicians were trained in an era in which palliative care and clinical ethics education were rare offerings in hospitals [23], and thus they may be ill-prepared to help students with moral distress—particularly if they are themselves unfamiliar with or habituated to the phenomenon. Female mentors who trained in the 1980s and 1990s had very different, often negative, experiences due to their gender and might have learned to repress moral distress, becoming more numb to the triggers for it over time [24, 25].

Some mentors grew up in an era in which the 1978 satirical book, *House of God* [26], was seen as reality rather than fiction [27, 28]. The book centers on the dehumanizing process of medical residency, based on the author's own experiences as a resident at Beth Israel Hospital at Harvard Medical School in the 1970s, and became a "must read" because of its accurate descriptions of the grueling training environment. Many mid-career clinicians report increased burnout and increased emotional exhaustion [29], characteristics that have been associated with unresolved moral distress issues [30]. Moreover, mid-career mentors' differences from their students can pose challenges in addressing students' moral distress. The 1970s was an era in which diversity was virtually absent in medical schools; one report noted that minority students comprised 2.8 percent of total enrollment but 11-12 percent of the US population [31]. Baby boomer physicians also value complete dedication to work and "rigid approaches to patient care" [32], which might pose barriers to shared understanding and make it more difficult for students to discuss their moral distress with mentors. For all these reasons, there may be an insufficient number of appropriate mentors to help students with moral distress.

Who Are the Morally Distressing Patients in the End-of-Life Context?

When medical students have moral distress about end-of-life cases, it usually concerns the quality of life of the dying patient or the psychosocial circumstances surrounding the patient's death. Delayed decision making and delayed truth telling are the most common triggers [2, 33]. The patient population is heterogeneous, as are the many causes of death. However, the literature supports that the most frequent triggers involve the following types of cases:

1. *Delayed end-of-life discussions.* A common example in critical care involves patients on extracorporeal membrane oxygenation (ECMO) who are being "bridged to nowhere." In these cases, health care clinicians' reluctance to discuss death and dying leads to offering ECMO to poor patient candidates as a last resort. Families may consent to ECMO without really appreciating what it means. As a result, discussions about withdrawing from ECMO become delayed [34], creating moral distress in the unit.

2. *Delayed or poor decision making.* A common example involves incapacitated, unrepresented (i.e., unbefriended) patients waiting for guardianship. In such patients, end-of-life options are often delayed due to an overburdened guardianship system, which in many states, does not routinely consent to comfort care [35]. Patients might also have inauthentic surrogate decision makers who may not respect known patient preferences concerning end-of-life care.

3. *Medically inaccessible or inappropriate care.* Common examples involve families and patients requesting aggressive care that is either not financially feasible due to coverage problems or medically inappropriate because it does not offer benefit [36, 37].

4. *Poor communication during notification of death determined by neurologic criteria.* In many such cases, there is very poor understanding of how to talk to families about brain death, and there may be chaos at the bedside [38].

5. *Codes gone bad.* This involves misunderstanding about code status and what full code actually means [33, 39].

6. *Health disparity cases.* Such cases include patients presenting with end-stage diseases that are clearly preventable with proper primary care access [4, 40].

7. *Patients with psychiatric problems, including end-stage addiction patients.* Such patients can be violent towards nurses and health care professionals [41].

8. *Grieving family members.* Grieving can occur in either the adult or pediatric setting; however, in the latter, moral distress is pronounced because of the age of the patient and the suffering of the parents.

Reducing Moral Distress: Best Practices Solutions
Although the moral distress literature is still short on proven intervention strategies [42, 43], several strategies have been identified: discussion of issues and debriefing [44, 45]; an ethics consultation service and ethics rounds conducted by trained personnel to promote in-depth and personal conversations [44, 46, 47]; reflection, including mindfulness as a source of personal empowerment [30]; and peers and mentors to aid in the process of coping with moral distress [30]. The following organizational programs have been recommended to reduce moral distress within academic medical centers in which medical students are dealing with death and dying.

24/7 Clinical ethics consultation service. This model involves a 24/7 pager-responsive service in which trained clinical ethicists respond promptly to a request for consultation. Such services need to ensure that "anyone" can call a clinical ethics consult, and medical students should learn how to contact the service—in either their preclinical or their clinical years. In a typical ethics consultation, the ethicist reviews the case with relevant stakeholders; organizes multidisciplinary team meetings (e.g., huddles) or meetings, sometimes with families; and provides chart documentation and formal opinion notes in the chart with recommendations [48].

Preventative ethics rounding in targeted areas. Regular weekly rounding by either a clinical ethics team or a multidisciplinary team that includes pastoral care, social workers, and mental health care professionals should be done in ICUs or other units where end-of-life cases are common as a preventative ethics mechanism [49, 50]. Rounding permits early identification of potential dilemmas before they reach a crisis, planning goals of care discussions, identifying surrogates before a patient loses capacity, and so on. Chief beneficiaries of such rounding typically include nursing staff, residents, and medical students in their clinical years.

Moral distress debriefings. Some end-of-life cases leave the health care team with such profound moral distress and moral residue that there is a risk that the next similar case will have a "crescendo effect" [2], in which the moral distress intensifies with each repetitive situation. A debriefing involves a skilled facilitator (often a social worker or mental health care practitioner) who sits down with the team members and allows them to air frustrations and feelings [51]; medical students who were affected by such cases should be encouraged to participate.

Schwartz Rounds^{TM}. This is a specific type of panel-based grand rounds that presents one difficult end-of-life case from the perspectives of the multidisciplinary team members looking after the patient and then invites audience feedback. The goal of such rounds is to discuss health care professionals' emotions rather than focus on the case from a medical science perspective. These are specific types of rounds that involve training and accreditation through the Schwartz Center for Compassionate Healthcare [52], and medical students at all stages should be encouraged to attend as a way to sensitize them and prepare for difficult cases.

Medical Education Initiatives
Stewards of medical school curricula should ensure that all physician-educators have opportunities to debrief about moral residue [4, 53], thus preparing them to serve as mentors to medical students and residents. These are, effectively, "train the trainers" programs. Physician-mentors should attend faculty development programs specifically aimed at equipping them with strategies to reduce learner moral distress, including open-communication strategies, facilitation skills for learners to debrief about "difficult" patients [54], the use of narrative ethics for self-reflection [55], an enhanced ethics curriculum [56], and peer-support programs [57]. Such initiatives also allow mentors to identify their own current or past experiences of moral distress, which can enable greater empathy and better communication with students.

Conclusion
Reducing students' moral distress in end-of-life cases is not of the "one solution fits all" variety. Strategies involve effective mentorship concerning end-of-life dialogues and

management of difficult cases as well as responsive clinical ethics services and training to support students, hospital staff, other trainees, and faculty, including medical education faculty who mentor students.

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