Ethical conflicts and moral distress experienced by paediatric residents during their training

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BACKGROUND: Paediatric residents experience numerous ethical conflicts; some of these are experienced by all paediatricians, while others are specifically related to residency training. It has been reported that medical students often feel that they are placed in positions that compromise their own ethical principles. A study in the United States showed that interns frequently face examples of unethical and/or unprofessional conduct among staff.
OBJECTIVES: To identify the ethical conflicts and moral distress experienced by paediatric residents during their training.
METHODOLOGY: Data were collected from four focus groups, which were organized according to the four separate years of residency training. Focus groups consisting of four to 10 participants were led by a research assistant. The focus groups were recorded by an audio device and transcribed verbatim; all data that would identify any of the participants or staff were eliminated. Data analysis involved a modified thematic analysis. The study was approved by the Research Ethics Board at the Hospital for Sick Children in Toronto, Ontario.
RESULTS: While residents occasionally face traditional paediatric ethical issues, such as 'do not resuscitate' orders, more often they experience conflicts because of their inexperience and their place in the hierarchy of the medical care team, particularly when there is disagreement between trainees and senior staff. Their ability to deal and cope with these issues changes as they go through their training. Many residents in the first part of their training were more frustrated and confused with ethical conflicts. In these cases, residents found their best support from their peers and other senior residents. Residents in the later years of training seemed more accustomed to ethical issues. Furthermore, almost all of the residents believed that other members of their health care team have acted in an unethical or unprofessional way.
CONCLUSION: Paediatric residents experience significant ethical conflicts and moral distress. Understanding these ethical issues will help those responsible for postgraduate medical education to review or revise the ethics curriculum in keeping with the current moral distress experienced by residents, and help to mentor and guide trainees.

Key Words: *Ethical conflicts; Ethics; Moral distress; Postgraduate medical education; Residency training*

Les conflits éthiques et la détresse morale que vivent les résidents en pédiatrie pendant leur formation

HISTORIQUE : Les résidents en pédiatrie vivent de nombreux conflits éthiques. Certains sont partagés par tous les pédiatres, mais d'autres sont propres à la formation en résidence. On a déjà rendu compte que les étudiants en médecine ont souvent l'impression d'être placés dans des situations où ils compromettent leurs propres principes éthiques. Une étude menée aux États-Unis a démontré que les internes sont souvent témoins de conduites contraires aux règles de l'éthique et du professionnalisme au sein du personnel.
OBJECTIFS : Repérer les conflits éthiques et la détresse morale que vivent les résidents en pédiatrie pendant leur formation.
MÉTHODOLOGIE : On a recueilli les données auprès de quatre groupes de travail, organisés selon chacune des quatre années de résidence. Les groupes de travail, composés de quatre à dix participants, étaient dirigés par un adjoint à la recherche. Un dispositif audio a permis d'enregistrer les groupes de travail et de transcrire le compte rendu sténographique. On a éliminé toutes les données permettant d'identifier les participants ou le personnel. On a procédé à l'examen des données au moyen d'une analyse thématique modifiée. Le conseil d'éthique de la recherche du *Hospital for Sick Children* de Toronto, en Ontario, a approuvé l'étude.
RÉSULTATS : Les résidents affrontent parfois des problèmes éthiques classiques en pédiatrie, tels que « ne pas réanimer », mais ils vivent surtout des conflits en raison de leur inexpérience et de leur place dans la hiérarchie de l'équipe médicale, notamment lorsqu'ils ne sont pas d'accord avec le personnel supérieur. Leur capacité d'affronter et de maîtriser ces problèmes évolue tout au long de leur formation. De nombreux résidents qui commencent leur formation se sentent plus frustrés et plus tourmentés face aux conflits éthiques. Ils trouvent alors le meilleur soutien auprès de leurs pairs et d'autres résidents seniors. Les résidents en fin de formation semblaient s'être adaptés aux questions d'ordre éthique. De plus, presque tous les résidents sont d'avis que d'autres membres de leur équipe médicale ont agi de manière non éthique ou non professionnelle.
CONCLUSION : Les résidents en pédiatrie vivent des conflits éthiques et une détresse morale marqués. Si elles comprennent ces problèmes éthiques, les personnes responsables de la formation médicale postdoctorale seront mieux en mesure de revoir ou de réviser le programme éthique compte tenu de la détresse morale que vivent les résidents, de jouer le rôle de mentors et de les orienter.

Postgraduate medical education in Canada is now being framed in the context of residents developing competence in the seven roles of a physician specialist: medical expert, communicator, collaborator, manager, health advocate, scholar and professional. Residents are expected to demonstrate a commitment to ethical and professional practice. If medical educators are to help residents prepare for the role as the professional, then it is important to understand the ethical conflicts they experience.

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In 2001, Hicks et al (1) described the clinical dilemmas that shaped medical students' ethical development. They noted that there were frequent conflicts between the objectives of medical education and those of patient care, that students were given responsibility exceeding their capabilities and that they were involved in care that they perceived to be substandard. This article was picked up by *The Globe and Mail*, a Canadian national newspaper, which ran the headline "Medical schools 'everywhere' rife with unethical practices" (2). Christakis and Feudtner (3) noted similar ethical conflicts for medical students. Many of these were intimately tied to the student's unique role on the medical health care team, and a number of these issues were not covered in existing ethical curricula. Medical students reported doing things that they believed were unethical, misleading patients and witnessing what they believed to be unethical behaviour by other medical team members (4). Other papers have described the ethical conflicts and moral distress of undergraduate medical students. Medical students often believe that they are placed in positions that compromise their own ethical principles. For example, they say that they are asked to do procedures or to provide care that they are not competent to provide or for which they do not have fully informed consent (5). Students are often uncomfortable dealing with disagreements with superiors on the medical team (6), and some students have observed unethical or unprofessional behaviour to which they do not know how to respond (7). Some students believe that they have been harassed or abused during their training (8).

Only a few articles have dealt with similar ethical issues in residency education. In a national survey, Tallett et al (9) identified ethical issues for Canadian paediatric residents: withdrawal of treatment, 'do not resuscitate' orders, futility issues such as resuscitation of extremely premature infants and treatment of severely damaged children, consent and disclosure issues, and conflicts between doctor and parents over treatment. In this survey, however, paediatric residents did not describe any ethical issues related to their training.

Using in-depth interviews, Rosenbaum et al (10) found five categories of ethical conflict for residents in internal medicine: concern over telling the truth, respecting patients' wishes, preventing harm, managing the limit of one's competence, and dealing with the perceived inappropriate performance of others. Shreves and Moss (11) found that 32 of 36 residents (89%) in internal medicine reported at least one ethical disagreement with attending physicians, the most troubling being when they considered the treatment ordered by the attending physician to be futile. The attending physicians in this survey were largely unaware of these disagreements. Similar ethical conflicts between residents and attending physicians have been described by Levi (12), Daugherty et al (13) and Baldwin et al (14).

There are no studies that are uniquely related to paediatric residency training and no similar Canadian studies. The purpose of the present study was exploratory, that is, to see whether the ethical conflicts and moral distress as perceived by medical students exist in a paediatric residency training program, and to describe the nature of the moral distress as perceived by paediatric residents.

METHODS

Similar to other studies of medical students' ethical conflicts (2,9,10), focus groups of residents in the core general paediatric program at the University of Toronto (Toronto, Ontario) were used. A research assistant (a graduate student from the University of Toronto Joint Centre for Bioethics) was hired to assist with this project and lead the focus groups.

Sampling and participants

A letter was sent to all 55 paediatric residents participating in the four-year paediatrics program at the University of Toronto between November and December 2003, inviting them to attend the focus groups. The letter explained that the focus groups were voluntary, that they would be audiotaped and transcribed, and that no names or data that could easily identify either participants or staff mentioned in the focus groups would be included in the transcripts. In order for residents to feel comfortable and not feel constrained when discussing issues, one focus group was held for each of the four years of residency.

Data collection

The focus groups were held at the end of the working day following handover. The names of participants were not known to the senior investigators. An initial interview guide was developed based on relevant literature and previous research. The interview guide contained five main questions that explored the participants' views of ethical issues experienced during residency: what are some of the ethical dilemmas or ethical issues that you have faced in your career as a resident; how did you resolve these dilemmas; have you ever felt that you were in a situation during training where your own ethical principles were compromised; have you ever witnessed unprofessional or unethical behaviour in your colleagues, other students, residents or other medical staff; and, how did you resolve these concerns? A dilemma was defined as 'a problem involving a difficult choice' where the 'right' or 'ethical' decision may not be clear to the residents.

Data analysis

Data analysis involved a modified thematic analysis that proceeded in two steps: open and axial coding. The validity of the findings was addressed in three ways. First, three researchers (from different disciplines) coded and analyzed the raw data to ensure accuracy and reduce biased interpretation. Second, throughout the entire research process, all research activities were rigorously documented to permit critical appraisal of the methods. Third, results were presented in a formal teaching session with paediatric residents, who verified the descriptive results of the study. Although fewer than 50% of the residents attended the focus groups, 71% signed in for the formal teaching session

and completely concurred with the discussions expressed in the focus groups.

Research ethics

Approval for the study was obtained from the Research Ethics Board of The Hospital for Sick Children, Toronto, Ontario. Written informed consent was obtained from each resident. All data were protected as confidential using codes instead of names and were available only to the research team.

RESULTS

In total, 21 of the 55 residents participated: five first-year, eight second-year, three third-year and five fourth-year residents. Although the focus groups were held at the end of a work day, many residents found it difficult to attend or were away from the hospital at the time of the focus groups. Each of the four focus groups was about 90 min in length and produced 57 pages of transcripts. Overwhelmingly, the residents demonstrated deep humanitarian values, wanting the best for their patients, and expressing the desire to help, support and be with their patients and families. However, there were conflicts because of their own lack of experience, as well as conflicts with those with more power and responsibility in the hierarchy of a medical residency training program. This section has been organized according to categories of ethical conflicts brought up through the focus group discussions: ethical conflicts in the practice of paediatrics, ethical conflicts in training and the residency program, ethical conflicts in staff relations, and personal moral distress. In each of the quotations, 'A' represents first-year, 'B' second-year, 'C' third-year and 'D' fourth-year residents.

ETHICAL CONFLICTS IN THE PRACTICE OF PAEDIATRICS

Residents commented on many typical paediatric ethical issues, such as futility of treatment, no cardiopulmonary resuscitation, withdrawal of treatment, withdrawal of life supports, the best interests of the child, informed consent, justice, and compassion and caring. Because these ethical issues have been well described in the literature, the focus group leader directed the discussion toward the ethical conflicts and moral distress experienced during residency training.

ETHICAL CONFLICTS RELATED TO TRAINING AND THE RESIDENCY PROGRAM

It was clear that the residents, in their clinical work, wanted to do what was 'right' and what was 'best' for their patients. Residents experienced distress when they did not know what was 'best' for their patients or when there was conflict between decisions made by those higher in the hierarchy and their own perception of what was 'best'. Most of the residents' ethical conflicts and moral distress arose from their position as trainees in a residency program, their inexperience, and their position in the hierarchy of physicians and trainees.

Lack of experience

The moral distress experienced by junior residents stemmed from their limited clinical experience dealing with patients and families. Residents frequently said they felt uncomfortable explaining decisions or giving advice to the family. They felt unable to effectively answer questions or talk about future outcomes. The residents seemed to indicate that they may not have been providing the best care possible because of their lack of experience.

A2: *You're the one who then has to relay the information or you have to explain things to families about things that you don't have very much experience with, and they ask you all these questions and it's like, what about this, what's the future outcome for my child about, this and that, and you don't know and your staff's not there to help you answer those questions.*

A1: *I find it very, I guess if you want to call it ethically difficult, when parents ask you about their child, when first of all I don't have kids of my own, I haven't seen enough kids to be able to do that and you read some of the articles … you can't recall things as much as you'd like to.*

A2: *But then it's okay to say I don't know.*

A3: *Exactly.*

A1: *It is but, you know what, I feel like an idiot when I say I don't know a thousand times [laughter]…. No, I know and you have to be honest, you can't just give them information that you don't know.*

Learning procedures

The residents recognized that because they are inexperienced and learning new skills, they may not always provide the best treatment. This was highlighted by the conflicts experienced by some residents when leaning new procedures. Some residents were uneasy about using their newly learned procedural skills on young patients. Residents wanted to learn these new skills and felt some pressure from supervisors to do so, but worried about the patients who might suffer because of their inexperience. One participant acknowledged a feeling of hypocrisy: she would not want someone junior doing a new procedure on her child or on herself.

B3: *Learning how to do procedural skill, it's something that we all want to do, we all want to get better at, and we really can only practice, in any way that makes sense, on patients. And the ethical dilemma part of it is that while it's benefiting us in terms of our training and our learning, and hopefully will benefit other kids, one may maybe can cause pain, it means that it could get three attempts at an LP if you couldn't get it the first time and stuff, it may be dangerous for the kid.*

Residents were also conflicted about being completely honest with parents. Two residents agreed that they did not tell parents when they were doing a procedure for the first time.

B3: *Even sometimes you'll pretend to families that you've done it many times before, even though you've seen it once and you're about to attempt it for the first time on their kid, even though you have supervision and it's controlled, anyways…I'm selfish though, personally I want to learn.*

Unreasonable expectations and inappropriate supervision

The residents participating in the study also expressed concerns about being placed in situations in which inappropriate expectations were being placed on the care that they were going to provide or in which the supervision was inappropriate, although not to the same extent as the reports about medical students. Some residents thought that they were expected to do things that staff should have done themselves.

B2: *My first night on call, there was a child who was palliative and everyone thought he was going to die that night overnight … it was my first night on call, I didn't know the patient, the kid had been sick for five years, I didn't know the family and it was just me in house … it felt way over my head. You know I hadn't signed a death certificate before, I hadn't counselled a family through something like that and I didn't feel like I was the right one to do it, and I actually thought it was pretty crappy that the attending physician wasn't going to come in for something that difficult for a family to go through.*

In this scenario, the resident did not state that the child died and the staff did not come in, but that the resident started his first night call with the perception that the staff might not come in and would leave it up to an inexperienced resident to deal with the death of a child. Junior residents also thought that having to explain the team's decision to families and patients, when the decision was made by the responsible physician, was an ethical conflict.

C2: *And while it's not our decision because we aren't the most responsible physician by definition, you're the one who has to go back in to the family and spend all the time talking to them, speak to the kids and explain to the nurses and do all the things that need to be done.*

ETHICAL CONFLICTS IN STAFF RELATIONS

The hierarchical status of physicians and trainees in the hospital – that is, who makes the decision and whose opinion counts – was at the root of many of the ethical issues that all levels of trainees experienced. For example, when a senior attending physician alone made a decision for a treatment and the resident thought that the treatment was unethical, the resident was often left to cope with the decision and the outcomes on his or her own, and not to voice an opinion. This was particularly difficult when residents were not part of the decision-making process, or when they were asked to participate in clinical procedures or explain things to parents that they did not agree with. This internal ethical conflict made some residents uncomfortable.

A2: *I could not go in the room when they were examining her – why should I go in and see something that I completely disagree with, just so that I can say that I fulfilled my duty as a resident to write my little note that day … It's not my decision, right?*

A2: *I find it hard when you try to explain things to parents that you don't agree with but somebody else made that decision, and you don't agree with them, and [the parents ask] "but why do we need to do this?" and you have to try and find a reason and try to look convinced … I hate that. What are you supposed to say? Well I don't agree with it but, you know, your doctor thinks that you should be doing that.*

Some residents talked about this internal conflict being exacerbated when they needed to justify the decision of the staff attending physician to other members of the health care team. One third-year resident noted the awkwardness of being caught between the attending physician and nurses:

C2: *It was very difficult because I got put in the middle of the nurses coming to me and saying why are we doing this and… I was quite opposed to doing anything to begin with and balancing the ethics of what's the right thing for the child, yet the staff is saying to do another thing; it really put me in the middle.*

C1: *When I look back, I was writing these orders and signing my name to these orders for something that I totally didn't agree with, and not like anybody was forcing my hand to do it, but when you're on a team and you're lower on a team and it's the plan and your staff is mandating it, you feel like, okay, this is what the team is doing so I guess this is what I order.*

Unprofessional or unethical behaviour

Residents commented on observing behaviours that they thought were unprofessional or unethical, and did not know how to respond or whether to report these incidents. They mentioned a variety of unprofessional activities – for example, residents leaving the hospital or going home early while on call, or writing inappropriate notes in the chart. These unprofessional behaviours involved their peer residents or fellows, or their supervising staff physicians. Several residents commented on fellows and staff physicians signing consult notes without seeing patients.

B1: *Like the patient that I saw today who … the fellow didn't want me to review with her, the staff that I reviewed with wouldn't let me finish the history, never saw the patient and signed his name on the consult.*

B2: *That's what we just said. It's terrible, it's terrible!*

B7: *I take my consult note into their clinic and they sign the consult note.*

B1: *Without seeing the kid?*

Residents also talked about witnessing disrespectful treatment, inappropriate care or substandard practice, and discussed their dilemma about how to respond or to whom to report these actions. This situation was even more difficult if the physician in question was a senior staff physician.

B3: *I saw some things done that were just wrong, like in a few cases like you just said … you don't want to discredit the fellow.*

B2: *But it's our responsibility as the front line people who see malpractice, I think, to report it. But the staff people never know about those things unless someone mentions it because it's a hierarchy, right?*

PERSONAL MORAL DISTRESS

Residents expressed moral distress when they felt torn between their caring for and responsibility to the patient, and their accountability to their supervisor, especially when they disagreed with the staff. Many of these conflicts came from observing supervisors' actions that residents thought were unprofessional. Another issue they discussed was senior staff physicians not adequately explaining treatments and prognoses to parents or not spending enough time with the patients and family. They also expressed moral distress about seeing their patients suffer or seeing patients managed in ways that they did not think was appropriate.

D2: *We had a case where one of the staff physicians didn't want to call the CAS [Children's Aid Society] about a case that I think was quite clearly by anybody else's indication needed to be followed up by CAS, and that was difficult because you're as responsible for that… I mean, when it comes down to the legalities, you can be just as liable for not having informed CAS as anybody else, but at the same time when you have a staff person who's saying I don't want to call the CAS, we're not calling the CAS.*

Residents' ability to cope with moral distress

Residents at all levels of training in the study thought that their own moral principles had been compromised and were unsure of how to deal with this. Most residents dealt with these situations inwardly or did not deal with them at all. They thought that there were few opportunities to discuss ethical issues and that these issues were often not recognized as unethical by senior staff, making it very difficult for residents to cope or even discuss an issue that they thought unethical.

A3: *If you're opposed to something, then you distance yourself, you don't involve yourself.*

A3: *Like, I felt there were a lot of ethical dilemmas that came up that nobody talked about … just sweep them under the rug.*

Peer and staff supports

Residents in the study most often found support in dealing with ethical conflicts and moral distress from their peer residents or more senior residents.

A1: *We had each other and I think that the most support that I got was from the other junior residents, and occasionally the seniors, they were pretty good but that was it … aside from that, there was no person in a real senior position or, like, in the fellowship or attending level that would say … it was almost like they weren't up to it.*

A senior resident confirmed this:

D2: *Support [around ethical] issues is talking to other people that are at the same training level as you in terms of how they would have dealt with the situation, and sometimes it's not so much to resolve the situation but, like you said, kind of venting or telling somebody else about it and seeing whether they think you were being unreasonable or not.*

Many residents believed that there was a disconnection between themselves and the fellows in subspecialty training or senior staff physicians. Some felt that senior staff were a little insensitive to patient and family concerns. However, residents spoke highly of the program director and some staff, and also gave a number of positive examples in which their supervisors had been helpful and accepting of a resident's position:

D2: *There was one situation just recently where I felt that I wasn't willing to support a decision that was going to be made and I voiced that to my supervisor, and he was fine with that because I had said that I wasn't willing to back a decision that might be made because I didn't feel that it was appropriate for the patient … he was okay with that.*

Most participants in all years of residency agreed that the best way to deal with ethical issues was to have an open communication process with the people who were involved in the case, although this was sometimes difficult and didn't often happen in a large hospital with multiple services. Many of the junior residents expressed a desire for a more formal type of conflict resolution that would involve anonymous reporting of ethical or unprofessional conflicts.

Education support

Very few of the residents participating in the focus groups talked about learning how to deal with these ethical issues in the training program. When probed, they often said that the training they received did not help them deal with the kinds of issues they were facing.

D2: *I don't think any of the training sessions have really changed anything because it doesn't give you a solution. It may give you a way with dealing with an individual problem but I find that it doesn't give you solutions to specific problems.*

When residents were asked what could be done differently to improve the state of the training, some responses included improving the formal seminars on ethics, having more formal discussions, and having ethics rotations.

D2: *I think the ones that have been more useful have been the ones that have been more based around scenarios where you do have a chance to kind of do the talking to people in small groups after we had them. The lecture kind of style doesn't … I don't think you really get that much out of them.*

D1: *I think ethics rounds on rotations would be good but it has to be clinically relevant to what you're doing at the time.*

PROGRESS DURING THE TRAINING PROGRAM

In comparing the four focus groups, it seemed that residents' ability to cope with ethical issues changed as they went through their training. Many of the residents in the study who were in the first part of their training were more frustrated and confused than their more senior residents about ethical issues, how to address them with others and how to deal with them on their own. By the fourth year of residency, the confidence level of the residents seemed considerably higher, and they tended to talk in terms of finding solutions to problems. The residents recommended approaches to dealing with ethical dilemmas, including talking to others, bypassing the person who was causing the problem, developing policies and guidelines, and dealing with problems before they escalated.

AN OVERALL PERSPECTIVE

When comparing paediatrics and other specialties, residents in the present study thought that paediatrics was a specialty in which caregivers were more humane. Participants felt that senior residents in paediatrics were more supportive, and that less of a hierarchy existed in paediatrics than in other specialties. Despite comments concerning the lack of discussion of ethical issues, many residents found that ethical issues were discussed more readily in paediatric health care centres than in adult centres.

C2: *I've found … on a number of rotations that the discussions actually happen a lot more than they did when I was a medical student doing the adult training.*

A2: *And that's partly why I chose paediatrics, because I think people are more humane and have a more humane outlook than in adult medicine.*

One resident attributed this increased discussion in paediatric medicine to the consent and assent process. Residents thought that having to explain things to the child and the parents often fostered more discussion. As a consequence, they thought that communication was better. Overall, the residents felt well supported in the program by the program director and the majority of staff.

D2: *I think I've been fortunate in that most people I have worked with … there have been some situations where I felt uncomfortable but I was fortunate at the times to be working with people I felt comfortable saying that I was uncomfortable.*

DISCUSSION

Residents in the present pilot study faced significant ethical conflicts and moral distress. Many of these conflicts were common paediatric ethical issues, as previously identified in a survey conducted by Tallett et al (9); however, residents also experienced ethical dilemmas and conflicts because of their position in a residency training program. Our paediatric residents all seemed to have an inherent compassion and caring for children, but because of their lack of experience and their junior positions on their health care team, seeing patients suffer often caused them significant moral conflict and distress. They realized that they lacked experience, were still learning, and were low in the hierarchy under the supervision of senior residents, fellows and staff. These findings are consistent with those of the studies by Rosenbaum et al (10) and Shreves and Moss (11). Although we did not try to quantify the number of ethical dilemmas, conflicts or disagreements, our paediatric training program is probably similar to other residency programs.

Residents recognized the conflict inherent in their wanting to learn, for example, to do procedures while still providing good patient care and what was 'best' for their patients. Similar to the findings of other studies, residents thought that they were sometimes placed in a position complicated by inappropriate expectations or lack of supervision. Paediatric residents faced ethical dilemmas when they disagreed with senior responsible staff about the care of their patients. As in the studies by Baldwin et al (14) and Daugherty et al (13), although perhaps not to the same extent, our residents recognized unprofessional or unethical behaviours but did not always know how to respond to them.

Although our residents expressed strong support for their residency program and for the program director, it was concerning that the junior residents seemed to have some moral distress, and did not always have opportunities to discuss their concerns in an open and safe forum. Junior residents usually found support from their own peers or senior residents, or from their own families. As in the study by Shreves and Moss (11), our residents preferred a formal process for resolution of serious ethical conflicts. Further, if similar ethical conflicts persist, as our participants suggested, it may be beneficial to have a reporting body to which these issues may be brought anonymously for discussion.

The present study demonstrates the importance of being aware of and recognizing the ethical conflicts faced by paediatric residents. Bioethics is now incorporated into the residents' formal curriculum and their academic half-days, but residents seemed to indicate that these sessions did not help with some of their day-to-day ethical issues and conflicts. More open discussions of the ethical issues involved in residency training, both in formal teaching sessions and informally in clinical settings, are needed. Partly as a result of the present study, the topic 'Ethical Dilemmas for Paediatric Residents' has been included in the residents' seminar series, with the discussion confirming the comments made by residents in the focus groups.

The present study is also important for the faculty in paediatric training programs. As Shreves and Moss (11) found in their study of an adult centre, staff at our institution or other paediatric centres may not be aware of these ethical dilemmas for residents. If our faculty is more aware of the ethical dilemmas faced by residents in training, they may introduce discussions of these issues in the clinical setting.

Like many qualitative studies, the present study has some limitations. A small number of residents participated in the focus group and they may not have been representative of the entire group. The study is limited to our residents' perceptions of their ethical conflicts during training. We did not ask faculty, other health professionals or the bioethics department about their understanding of the conflicts facing paediatric residents. Residents may also have been reluctant to discuss personal conflicts among a group of peers. We plan to follow this with a questionnaire survey of all residents in our program and residents across Canada.

CONCLUSION

Understanding the ethical conflicts and moral distress experienced by paediatric residents will help those responsible for postgraduate medical education to review or revise the ethics curriculum so that it reflects the current ethical conflicts residents face, and to mentor and guide these trainees. Based on the results of the present study, we offer the following observations and recommendations to help guide those directing these programs in paediatrics:

- Although paediatric residents experience classical paediatric ethical issues during their training, the ethical conflicts they face more often relate to their training, their inexperience and the hierarchical structure of the medical education program.
- In helping to mentor residents through their training, faculty should be aware of these conflicts. Senior residents who have more experience and who seem to have learned how to deal with ethical conflicts may also provide mentoring and counselling to junior residents.
- Despite a formal ethics curriculum, sessions on ethics did not always help residents with the ethical dilemmas they faced. Those planning an ethics curriculum for paediatric residents need to be aware of the ethical dilemmas faced by residents, and incorporate these ethical conflicts and a discussion of residents' moral distress into the formal curriculum.

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