PERSPECTIVE

# Moral Distress in Medical Education and Training

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Moral distress is the experience of cognitive-emotional dissonance that arises when one feels compelled to act contrary to one's moral requirements. Moral distress is common, but under-recognized in medical education and training, and this relative inattention may undermine educators' efforts to promote empathy, ethical practice, and professionalism. Moral distress should be recognized as a feature of the clinical landscape, and addressed in conjunction with the related concerns of negative role modeling and the goals and efficacy of medical ethics curricula.

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## INTRODUCTION

Moral distress is the cognitive-emotional dissonance that arises when one feels compelled to act against one's moral requirements. Moral distress is common in clinical practice, because caring for the ill is an inherently moral activity. Medical students and junior practitioners may be particularly challenged by morally distressing situations. Their development into attending physicians involves a process that is complex intellectually, sociologically, and culturally, and is no less complex in its moral dimensions.[1] Yet the phenomenon of moral distress is not widely recognized by medical educators,[2,3] which may undermine their efforts to promote medical professionalism. Additionally, the insidious yet powerful effects of moral distress on learners may overwhelm medical schools' efforts to advance students' moral reasoning skills, levels of empathy, and related outcomes, and may contribute to the persistent lack of demonstrable efficacy of ethics and humanities curricula. Moral distress should be acknowledged as a feature of the clinical landscape and forthrightly addressed in both undergraduate medical education (UME) and graduate medical education (GME). It is best addressed in conjunction with two related concerns: negative mentoring and the goals of medical ethics education.

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## MORAL DISTRESS

Clinical care involves an interfacing of multiple moral actors, including patients, family members, and clinicians; each of whom holds a perspective on good and bad, right and wrong, desirable and undesirable, and whom exercises judgments about the degrees and relative weight of each. Although any of these actors can experience moral distress, it has been best described among nurses, who often are responsible for implementing plans of care over which they have little authority. For similar reasons, moral distress is also prevalent among house staff.[4–7] Situations that often produce moral distress include aggressive treatment of dying patients, witnessing or participating in substandard care, and involvement in the withholding of information from patients.[6] Clinicians' levels of moral distress often crescendo around a crisis and then fall after the precipitating incident has resolved. However, a "moral residue" contributes to a new and higher baseline level of distress to which subsequent crises add.[8] Therefore, the effects of morally distressing situations may be cumulative.[9]

Responses of medical students and house staff to moral distress and the prevalence of adaptive and maladaptive behaviors have not been well described. However, a number of coping strategies are apparent. Avoidance is one such strategy, an example of which is when a resident directs a more junior one to deal with a distressing patient-related issue while he or she recedes to a peripheral role. Avoidance also may factor into some residents' pursuit of less morally distressing subspecialty careers (e.g. rheumatology versus critical care). Other coping strategies include moral disengagement, blunting, denial, and the use of gallows humor. Moral distress may contribute to cynical attitudes and diminished empathy among some physicians,[10] and a decline in empathy may begin during medical school.[11] Few residency training programs actively address moral distress and few are well prepared to address the moral objections of house staff to participate in particularly disagreeable cases, with reproductive medicine a notable exception.

## NEGATIVE ROLE MODELING

Medicine has been taught to its students using a variety of modalities, including pedagogical instruction, problem-

based learning, and simulated patients. Learning to *practice* medicine continues to require an apprenticeship in which a more senior physician demonstrates all the facets of 'doctoring' to a more junior one. Apprenticeship provides trainees with experiential learning in diagnosis and treatment and in building skills for developing therapeutic relationships with patients and families. Apprenticeship also acculturates the learner to the norms of practice and behavior—the ways in which physicians comport themselves with patients, family members, colleagues, and other health professionals, define and act on thresholds of diagnostic and therapeutic uncertainty, and manage ethical dilemmas and conflicts of interest. Strong mentoring has powerful effect on the level of empathy observed among medical students and may be an important protection against the development of cynicism.[12–14]

The apprenticeship model also allows for negative acculturation through what is often referred to as the hidden curriculum. This pernicious dimension to medical training has been blamed for the persistence of undesirable behaviors among physicians, as well as for a collective de-professionalization perceived by some within and without medicine. Negative role models sometimes misuse and abuse their positions of authority. They may belittle or demean students and physicians under their tutelage. They also may act arrogantly towards nonphysician staff and may act with little empathy towards patients and their family members. Negative role models also may discount or deride normative ethical positions of their profession, may represent their personal value judgments as professional judgments, and may even impose these on their patients.

Other negative role models exhibit professionally inept behavior, which may be far less malignant but ultimately just as detrimental. Examples include physicians who demonstrate clumsy communication skills, who avoid morally uncomfortable clinical problems, who poorly manage conflicts of interest as well as conflicting interests, who negotiate ethically feeble resolutions to clinical dilemmas, and who remain silent when circumstances demand advocacy of patients, peers, and trainees. Negative role modeling may correlate with higher levels of moral distress among medical students.[15]

## MEDICAL ETHICS EDUCATION

Ethics and humanities curricula are widespread in undergraduate medical education, appropriately reflecting the prevalence of ethical issues in clinical practice.[16] However, its content is highly variable across schools of medicine, often reflecting local interests and available expertise in bioethics, jurisprudence, humanities, and social sciences.[2,3] These educational efforts are sometimes linked to broadly stated objectives, such as the promotion of professionalism or the nurturing of empathy and humanism. Outcomes measures remain poorly refined and the efficacy of these efforts to produce better physicians has been difficult to demonstrate.[17,18] The impact of ethics and humanities curricula may be further undermined by its typical placement alongside basic sciences in the first one or two years of undergraduate education, and its more limited or absent profile in the clinical years. This inverse relationship between ethical exposure and clinical exposure can foster a perception that ethics and humanities have academic value but are clinically extraneous, and can leave students with deficits in knowledge and skills that may render them more vulnerable to the impact of moral distress.

## ADDRESSING MORAL DISTRESS

Educators must first acknowledge the ubiquity of moral distress in order to begin to mitigate its effects on physicians. Unfortunately, most physician mentors had poor support for their own moral distress during their training experiences and, because of long standing coping through blunting and denial, may not fully appreciate its impact or even validate its existence. Moreover, morally blunted residents who become morally blunted attending physicians may disproportionally engage in negative mentoring, thereby exacerbating and perpetuating this problem.

Therefore, a foundational intervention for addressing moral distress is faculty development, including didactic programs on normative medical and professional ethics, skill-building workshops on mediation and communication. Training in peer-to-peer support and conflict management should be incorporated.[19] Quality improvement activities can be redesigned to include institutional and peer support for clinicians in managing the use of clinically and ethically challenging treatments, such as the use of life support, cardiopulmonary resuscitation (CPR), and medical nutrition.[20]

Faculty development notwithstanding, some poor role modeling will always persist, and the mere presence of good role modeling is evidently insufficient to counteract the negative influences. However, bad role modeling offers a compelling opportunity, and a rich substrate, for teaching and for learning.[21] Morally stressful incidents associated with bad role modeling can be identified through debriefing sessions regularly held with students and house staff. Qualified faculty can deconstruct these incidents using a number of frameworks, including normative bioethics, profession-based virtue ethics, and organizational ethics. Relevant content from moral psychology, medical sociology, and other related fields can be valuable.[22] Faculty can use the precipitating incident to engage learners in mentored problem solving and other exercises in order to help them develop skills in managing both inter-professional dynamics (between mentor and mentee) and patient-professional

dynamics. A variety of other learning strategies linked to negative occurrence should be considered, such as self-narrative reflection and role play.[23]

In addition to providing faculty development and leveraging negative mentoring as a teaching vehicle, revising the goals and structure of ethics education is warranted. Employing ethics and humanities education to increase trainees' humanistic virtues may be a difficult goal to achieve. However, mitigating the observed decrease in ethical reasoning skills is a more specific and measured objective. In fact, securing improvement in these skills has been demonstrated and should be a primary aim of these curricula.[24–26] Nascent clinicians, whose reasoning skills and understanding of professional and clinical ethics are commensurate with their clinical responsibilities, will be empowered to identify, analyze, and manage situations that commonly cause moral distress.

Ethics curricula should be more deeply integrated into students' third and fourth year experiences. A pragmatic approach focusing on ethical problem solving, ethical mediation, consensus building and communication skills, will offer students important tools for managing stressful clinical situations.[27,28] In addition, a core curricula in the relevant biomedical ethics should be developed for each clinical rotation and its content reinforced using actual cases, and contemporaneous ones when possible. Mentors should consistently identify the ethical, sociological, and related aspects of clinical care, embrace moral uncertainty, and encourage students to seek out problem solving opportunities. Such activities should continue on seamlessly throughout GME and should be integrated whenever cases are deconstructed, such as during attending rounds and morning report. Experiences in the medical humanities should be encouraged through a range of enrichment activities, such as writing awards, book clubs, movie screenings, and poetry readings.

Academic health institutions whose leadership presupposes that moral distress affects all of its clinicians will be best positioned to mitigate this stress and to promote moral wellness and professionalism. Programs should expect that their trainees will experience moral distress and trainees should be aware of this expectation. Mentored forums to address shared causes of moral distress may be unit based (e.g. intensive care units, oncology unit) and interdisciplinary (e.g. nurses, respiratory therapists). These may prove valuable in providing all parties with a richer understanding of ethical concerns, power differentials, and operational constraints that fuel moral distress. Forums that are organized around level of experience are opportunities to acculturate young physicians in providing and receiving peer support, and similar forums for attending physicians may be particularly important because few formally organized supports exist. Institutions should provide all of its clinicians with structural empowerment; that is, the capability to impact institutional culture to reduce the frequency and intensity of moral distress[29,30]—for example, house staff representation on the hospital ethics committee, faculty-house staff committees, access to department chairs and chief medical officers.

## CONCLUSION

Moral distress is a silent epidemic that undercuts efforts to promote professionalism and to sustain empathetic physicians. Medical educators have an enormous opportunity to impact the training and life-long practice experiences by recognizing the ubiquity and impact of moral distress of medical students and residents; by confronting negative role modeling; and by remediating deficiencies in trainees' ethical analytic skills and knowledge.

***Conflict of Interest:*** *The author declares no conflicts of interest.*

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