

ETHICS CASE

How Should Resident Physicians Respond to Patients' Discomfort and Students' Moral Distress When Learning Procedures in Academic Medical Settings?

Commentary by Bonnie M. Miller, MD, MMHC

Abstract

In this scenario, a medical student, Lauren, experiences moral distress because she feels that learning to perform a procedure on a patient who requested not to be used for "practice" puts her own interests above the patient's. Lauren might also worry that the resident physician is misrepresenting her abilities. The resident physician could help alleviate Lauren's distress and align her interests with the patient's by more clearly explaining the training situation to the patient and seeking the patient's approval. Lauren might also manage the situation by assuring the patient of the resident's supervisory role. This article argues that trainees should have the opportunities to practice procedures and difficult conversations in simulated settings and that institutions should support a culture of "speaking up" to ensure patients' and learners' safety.

Case

Lauren is a medical student who is doing her clinical year rotation in neurology. She has never performed a lumbar puncture (LP), also known as a spinal tap, but a patient on the neurology inpatient service requires one for diagnosis. Her resident physician, Adam, suggests that she attempt to perform one.

Lauren is initially excited about this prospect, and Adam demonstrates to her the steps involved in this procedure. When Adam tells her, "It might cause some pain, but you have to make sure the patient is perfectly still," she begins to feel apprehensive.

Lauren and Adam go to see the patient, Mrs. Jones, together. Adam tells the patient that they will need to do an LP. The patient looks warily at Lauren and says, "Well, I don't want you practicing on me." Adam responds, "Don't worry. You're in good hands."

Lauren feels extremely conflicted. On the one hand, she feels as though she is practicing on the patient and could cause pain or a more serious consequence, since it is her first time ever performing the procedure. On the other, she knows that she needs to learn this important skill and that "practicing" in this manner is the only way to do so. She

wonders whether to tell the resident physician that she doesn't want to do the LP on this patient, given this particular patient's statement, but she is also concerned that opting out might prompt a negative response from the resident physician, who evaluates her.

Commentary

In his 1984 book, *Nursing Practice: The Ethical Issues*, Andrew Jameton used the term "moral distress" to describe what nurses experience when they feel powerless to carry out what they believe to be a morally correct course of action because of institutional constraints [1]. Moral distress subsequently has been identified in multiple professions including medicine, pharmacy, and respiratory therapy [2-4]. Repeated episodes of moral distress may result in burnout, withdrawal from direct patient care activities, job dissatisfaction, and attrition from the health care professions [2, 5]. It has also been implicated as a factor in empathy erosion in nurses, medical residents, and fellows [5, 6].

With their subordinate position in the health care hierarchy, medical students experience moral distress in response to many different situations, including witnessing or participating in provision of futile or nonindicated care or disrespectful behavior [7, 8]. Students might remain silent because they fear that voicing concerns could offend superiors and negatively impact their evaluations, as in Lauren's case. In addition, they may feel that it is improper or disrespectful to question their teachers' authority, or they might worry that they simply don't know enough to correctly interpret complex situations. In such cases, [speaking up](#) could expose their knowledge deficits, again leaving them vulnerable to negative judgments of potential evaluators. Their own uncertainty and reluctance to act may compound their distress and cause them to feel equally culpable for any harmful consequences to patients.

In this vignette, Lauren feels legitimate and laudable concern for her patient's well-being. The primacy of patient welfare and the ethical principle of beneficence demand that the care team always act in ways that put patient interests first [9]. Yet even before she enters the patient's room, Lauren begins to worry that if she performs the lumbar puncture, she would be putting her own interests as a student before those of her patient, who should always receive the best care possible. In this case, Lauren feels that the best care possible would be provided by the resident, who has greater experience and therefore would be less likely to cause harm. Her patient's stated concerns about being practiced on amplify her preexisting apprehension.

In addition, Lauren may feel that the resident's stating, "You're in good hands," unintentionally misrepresents her abilities. The fact that Lauren is inexperienced could increase the risk of pain or an unsuccessful first attempt at obtaining spinal fluid. The ethical principle of respect for patient autonomy demands that patients be fully informed of all benefits and risks if they are to make good decisions about their own care,

consistent with both their values and their risk tolerance. Even more fundamentally, honesty and integrity are foundational concepts of medical professionalism [9-11].

On the other hand, Lauren's most important obligation as a student is to develop the competencies needed for the safe, effective, and equitable practice of medicine. Medicine's social contract with society demands that Lauren return society's investment in her by acquiring the profession's specialized knowledge and skills and by using them in a way that benefits all patients [12]. In this framework, Lauren would not be completely self-interested in seeking appropriate learning opportunities. Thus, a tension develops between what may be best for the patient immediately in front of her and what is best for all of the patients that Lauren will care for in the future.

As the physician immediately responsible for this patient's care, the resident carries the primary responsibility for resolving the current dilemma. Ideally, given the scenario described, the resident would acknowledge his patient's concerns, sense Lauren's discomfort, and gently and diplomatically reframe the conversation in order to align the patient's best interests and her need for autonomy with Lauren's need to learn. For example, he could say:

Mrs. Jones, the good hands are both Lauren's and mine. Lauren is an excellent medical student who needs to learn how to perform lumbar punctures if she is going to provide the very best care to her own patients in the future. I have walked Lauren through the procedure and am confident that she will do a good job. However, there is a risk that with Lauren performing the procedure, you will experience more pain or that the initial attempt will be unsuccessful and I will need to undertake a second attempt. I will do everything possible to lessen these risks by directing her carefully and taking over if I feel she will cause you any harm, including excessive pain. In addition to the benefit you will gain from having this procedure, you will provide benefit to Lauren and her future patients. If you are uncomfortable with this plan, I will perform the procedure and Lauren will observe and assist.

This kind of communication expresses respect for the patient's moral agency and could help ease Lauren's distress because it provides a truthful description of the situation and shifts control of the care plan back toward the patient. The patient is now able to weigh her added risks against the added benefit gained from helping Lauren learn and can make a good decision consistent with her values.

If the resident physician does not recognize or accept his ethical responsibility, Lauren is left with several choices. She could simply proceed despite her concerns and discomfort, taking advantage of this opportunity to learn and avoiding any semblance of insubordination. Studies of moral distress show that students do indeed select this

option and may even [habituate](#) to these situations such that the experienced distress eventually diminishes [5]. Alternatively, Lauren could attempt to explain the situation to the patient herself:

Mrs. Jones, while I won't really be practicing on you, I am a medical student who needs to learn how to do this procedure if I am to become a good doctor. My resident physician is an outstanding teacher and has already instructed me on all of the steps. He will guide me, and if at any time he thinks that you might be harmed or that you are experiencing unusual pain, he will take over. There might be an increase in your risk of pain or the need for a second attempt, but with my resident physician directing me, that risk will be reduced. If you agree, I will be very grateful for your contribution to my education.

This sample statement seeks to express respect for both the patient and the resident physician.

If Lauren feels so uncomfortable that she cannot proceed, she can ask the resident physician if they can leave the room briefly so that she can explain her concerns: "Adam, I really appreciate your confidence in me, but with Mrs. Jones seeming so reluctant, I'm much more comfortable watching you this time. Then maybe the next time an opportunity arises, I'll feel more confident and prepared." By asking to leave the room for this conversation, Lauren would avert potential embarrassment for the resident physician and lessen her own fears about a negative impact on her evaluation. Her resident could then return to the room with a statement similar to the following: "Mrs. Jones, Lauren and I discussed the situation, and, given your concerns, I will perform the procedure and Lauren will observe and assist."

In reality, the types of conversations described above require poise and readiness that might be difficult to muster in the midst of evolving care episodes. Practice can help. Medical educators should anticipate such situations and provide opportunities for trainees to practice responses in controlled settings, through either role play or [simulation](#). Ethical preparation is just as important as technical preparation in assuring that our trainees provide the best possible care to patients as they fulfill their obligation to learn.

Simulation technologies provide an important and increasingly available means of mitigating risk to patients. High-fidelity simulations exist for many procedures, including lumbar puncture [13]. Instead of "practicing" on her patient, Lauren could have practiced safely in the simulation lab while receiving feedback that would have allowed her to improve her technique. Although at some point a real patient would be her "first," Lauren would feel more confident and prepared after being coached in a simulated setting.

During their training and beyond, all doctors will perform procedures on patients for the first time. This circumstance is necessary not only for initial skill development but also for the advancement of medicine. In the late 1980s, an entire generation of practicing general surgeons had to relearn gall bladder removal with the introduction of laparoscopic cholecystectomy [14, 15]. Even the patients of experienced physicians found themselves being the “first.” However, by informing patients of trainees’ roles and by doing everything possible to mitigate risks of potential harm, physicians and students can actively learn while still protecting patient welfare, thereby aligning their own interests and those of the public with those of their individual patients.

The tension between what is best for a single patient and what is best for all patients plays out at the institutional level as well. While academic health centers have a moral responsibility to train a highly competent physician workforce, thereby returning society’s investment, they have an equally strong moral obligation to provide the highest quality care to every individual patient while respecting each patient’s autonomy [16]. The resulting conundrum cannot be easily reconciled. Training involves a trajectory over time. Patients as a group must inevitably participate in the training of future physicians by accepting care from trainees who are not yet at the top of the learning curve, even if patients as individuals exercise their right to refuse such care. While simulation helps, ultimately there is no other way for physicians to become fully competent than to care for real patients. Institutions must manage the tension between learners’ and patients’ needs by ensuring that patients are clearly informed of the system’s educational mission and its implications for their care; by respecting each patient’s autonomy in decision making; by providing adequate supervision for trainees; and by providing alternative learning resources, such as simulation, that allow safe practice and reduce the risks in being the “first” patient [17].

Finally, we should do our best to nurture a culture of safety in our academic health centers in which speaking up is viewed as a moral action taken in the best interest of patients and not an act of insubordination [18]. Realizing this cultural change would require that faculty members at the top of the hierarchy receive training to accept these messages graciously, with the understanding that a “speaking up” culture advances all academic missions. It also would require the support and role modeling of committed and enlightened leaders, along with strict enforcement of antiretaliation policies.

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