Commentary

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Instances of Moral Distress in Medical Education: Recognition and Approaches

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Abstract

The care of sick people is a moral issue. In a highly technological era, it risks becoming a matter of repairing unhealthy bodies by means of evidence-based strategies, neglecting the human component. To teach these issues has become a challenge and ignoring it has important consequences. Andrew Jameton described moral distress in medicine in 1984 as the negative feelings that arise when one feels compelled to act against what one considers morally correct. It is usually due to external or organizational circumstances, but in the case of health careers students, residents or young professionals, it is hierarchies that often impose themselves as a relevant factor, affecting the moral decisions the students would make if the case that such hierarchies did not exist. The issue is complex, because long-term consequences have been described, which have to do with exhaustion, disenchantment with the chosen profession, low job satisfaction and therefore demotivation, depersonalization and moral scars. The latter is a topic currently on the rise in the literature, probably motivated by post COVID-19 era. This text will emphasize the need to address moral distress in medical education, and will try to show some strategies to address it.

Keywords: Moral distress, Medical education, Narrative medicine

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Introduction

Students of health professions face different situations in their practices that bring them closer to human suffering: physical pain, grief, complex clinical situations, or end-of-life patient care. These circumstances expose them to conflicts where their beliefs, principles, and values contrast with those of the staff who care for these patients, the people themselves, and their families. All this must be balanced with expectations, roles, and responsibilities that are often not fully defined, generating an environment very conducive to the development of moral distress (MD). This is defined as the negative feelings that appear when, in health care, we cannot do what we consider correct, whether by action or omission. It can be related to factors such as the student's personality, external coercion from hierarchies or tutors, organizational circumstances, or even the socioeconomic conditions of the patients (1, 2).

Medical education has not widely recognized this phenomenon. To be precise, MD was initially described in nurses who cared for patients at the end of their lives. It was later recognized in emergency care, intensive care, oncology physicians, and even other professions (3). Over time, different MD scales were developed, validated, and refined, with the aim of describing the phenomenon, measuring it, and trying to understand the associated factors.

The importance of recognizing MD among students and residents

When MD is not sufficiently recognized,

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efforts made to promote medical professionalism may be affected (4). Therefore, medical schools and health careers seek to improve the moral reasoning skills of students, reinforce the development of empathy, and promote virtuous relational behaviors. Generally, these ideas are realized through the planning of ethics, bioethics, and humanities programs, which, if not linked to clinical practices, could have little influence on expected behaviors, and their results are unknown. As already mentioned, MD occurs in the context of clinical activities, and it is there that pre- and post-graduate medical education needs to be able to visualize it.

Students facing clinical situations may experience moral dilemmas that, if unresolved, persist and have consequences. The scope of these includes moral injury, compromise of mental health, and, therefore, well-being, among other issues (5). The MD experienced by students may include everyday challenges such as ordering tests, performing procedures without consent on sedated patients, performing tasks with no sufficient training which violate the safety and dignity of patients. Sometimes it could be related to administering risky medications without proper information to patients, discussing confidential issues in inappropriate environments, and eventually covering up errors (6). Another aspect that usually involves students is related to informed consent. This can be entrusted to students and may become a procedure of signature to obtain. Students should be aware that it is a procedure proper to the clinical relationship, where the communication process and distribution of information must be high-level, slow, corroborating that the patient has fully understood what is going to be done and can, therefore, fully exercise autonomy (7).

Furthermore, there are studies that show that, regardless of the frequency of MD in a specific situation, the level of discomfort experienced by students is higher when they witness situations that degrade the integrity of one of the members of the work team or their own colleagues. These episodes of MD are remembered by students and persist as unresolved phenomena that affect their well-being (2).

In Chile and the world in general, in recent years, the mental health of medical students and students of other health careers has become fragile (8). Given that MD often contributes to this, it should be recognized by training entities and introduced into the curricula of health careers. In this way, visibility and questioning could be provided to facilitate feedback to clinical teachers, staff, and residents. All this, to avoid situations that compromise the moral judgment of students, prevents weakening the promotion of professionalism and affects their well-being.

Hierarchies in Medicine

Hierarchies are recognized in all work environments, and when well organized, they facilitate efficient and safe work. During their medical studies, students benefit from mentoring, role modelling, teaching, guiding, and providing security by their training institution within the framework of functional hierarchies. These activities consider individuals of lower rank as valuable members of the group who are empowered to speak up and share relevant information. In contrast, dysfunctional hierarchies tend to be rigid and can result in disastrous consequences for students and their patients. Witnessing these situations, such as mistreatment of a colleague and inability to do anything about it, or experiencing a situation with which one does not personally agree morally, facilitates the appearance of MD, questions professionalism, and undermines patient safety and the quality of their care (9). Because of this type of hierarchy, students' stress is amplified, and the risk of burnout and loss of empathy increases. From an educational point of view, this type of hierarchy hinders learning and autonomy, decreases satisfaction with training and discourages opinions, thereby legitimizing mistreatment. This will contribute to a negative impact on the mental health and well-being of students, residents, and younger doctors in general.

Over time, rigid hierarchies tend to shape professional behaviors, fostering a form of cultural conditioning that is undesirable. Within the context of moral distress, such dynamics may perpetuate situations that provoke similar responses in new learners, thereby reproducing the previously noted adverse consequences (10).

Addressing MD from a medical education perspective

In the education of professionalism, it is recognized that much of it exists in the hidden curriculum. In moral issues, medical education has used instructional pedagogical formats, problem-based learning, role-playing, and simulated patients. Unfortunately, in many medical schools, these issues are addressed in the first years, far from clinical practices, which does not contribute to reflecting deeply on what happens precisely in these same practices (11). The practice of medicine has traditionally been taught through the demonstration of an experienced professional to a younger one. The experiences acquired in this way facilitate the

learning of diagnostic and therapeutic processes and, of course, the development of skills inherent to clinical practice with patients and families.

Students acquire what some have called "medical culture", in which there are standards of practice and conduct: ways of behaving with patients, families, colleagues, and other health professionals. Likewise, they experience, together with the teams, uncertainties in their management, ethical dilemmas, and conflicts of interest, among other complex situations. If, in all this, they are accompanied by consistent mentoring, they will be able to develop a level of moral assertiveness that tends to minimize the expression of MD (12).

Unfortunately, our era is characterized by a lack of time, high technologization of medical work and standardization of practices, all of which generate risks of compromising professionalism. Furthermore, medical schools are often unable to address what is currently expected of a clinical tutor and how to mentor him/her. For this reason, in the teaching of clinical medicine, it has been suggested that learning based on reflection, is the exemplary way of being able to address issues that compromise bioethics and professionalism, such as those that produce MD in students (13).

If MD is currently little recognized in apprentices, it has received even less attention in current mentors, which could be an obstacle to introducing these issues in medical education. However, it is estimated that the experimentation of MD transversally in the COVID-19 pandemic would favor these purposes (14). A robust intervention in MD should include students and teachers using some methodology that facilitates reflection on the same practices that are being developed in parallel. It seems that the modality which would best fit these purposes is the use of narrative medicine. Through reflective writing, inherent to its practice, it allows us to reflect on clinical situations that have occurred, on conflicts and critical situations that have been faced; even if they do not occur, it is possible to use narrative devices that illustrate what is intended to be reflected. It also allows us to appreciate real or fictitious negative models as fruitful pedagogical tools for reflection (15).

Conclusion

In summary, recognizing the harmful impact of MD on the training and future performance of professionals and, therefore, on their own well-being and patients' care, it is suggested that training entities support these ideas and implement them through the innovation in medical education, moving from instructional teaching of ethics and human virtues to a deeply reflective one. In this task, narrative medicine, with its structure and extensive current development, seems to be a coherent tool for these purposes (16). Furthermore, it could achieve an impact that deserves to be explored if it is included in pre- and post-graduate clinical subjects, taking the participation of students and clinical tutors into account.

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Authors' Contribution

PJ researched the topic and contributed to the writing of the text, bibliographical research and layout. RV corrected, translated and edited the text. All authors gave final approval and agreed to be accountable for all aspects of the work.

Conflicts of interest

The authors declare no conflicts of interests.

Declaration of use of AI

The authors declare that no AI tools were used in the preparation of this manuscript

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