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Moral distress in medical residents from Chilean universities

Pamela Jofré [1], *Rodrigo Vergara* [1,2], *Thelma Suau* [3], *Jaime Bastidas* [4], *Diego de la Barra* [5], *Sofía Salas* [6]

1. Universidad de Valparaíso, Viña del Mar, Chile. **2.** Hospital Carlos van Buren, Valparaíso, Chile. **3.** Universidad de Chile, Santiago, Chile. **4.** Universidad Católica del Norte, Coquimbo, Chile. **5.** Universidad Austral, Valdivia, Chile. **6.** Universidad del Desarrollo, Santiago, Chile.

Abstract

Moral distress, defined as the suffering a person experiences when forced to actions or omissions that contradict their values, has been described in all medical professions and related training, associated with consequences such as depersonalization in care, low motivation at work, vocational questioning, and in connection with burnout. In Chile, moral distress has been scarcely researched, and even less in medical students. This is an observational, descriptive and mixed research with medical residents from four universities in Chile using an electronically distributed questionnaire to study its frequency and main triggering factors. Participants included 56 students. The results show transversal occurrence of moral distress in students from the researched universities. The difficulty in obtaining informed consent from patients is noted as the main moral distress source. The results provide useful knowledge for designing educational programs that address moral distress and its main associated sources.

Keywords: Moral distress. Bioethics. Informed consent. Medical education.

Resumo

Sofrimento moral em residentes de medicina de universidades chilenas

O sofrimento moral, definido como o sofrimento que uma pessoa experimenta quando é obrigada a executar ações ou omissões que contradizem seus valores, tem sido descrito em todas as profissões da área da saúde e na formação delas, associando-se a consequências como despersonalização nos cuidados, baixa motivação no trabalho, questionamento vocacional e vínculo com o burnout. No Chile, tem sido pouco estudado e menos ainda em estudantes de medicina. Foi realizado um estudo observacional, descritivo e misto com internos de medicina de quatro universidades chilenas, por meio de um questionário distribuído eletronicamente, para conhecer sua frequência e principais fatores desencadeantes. Participaram 56 estudantes. Os resultados expressam a presença transversal de sofrimento moral nos estudantes das universidades exploradas. Destaca-se como principal fonte a dificuldade em obter o consentimento informado dos pacientes. Os resultados fornecem conhecimento útil para projetar programas educativos que abordem o sofrimento moral e suas principais fontes associadas.

Palavras-chave: Bioética. Consentimento livre e esclarecido. Formação médica.

Resumen

Angustia moral en internos de medicina de universidades chilenas

La angustia moral, definida como el sufrimiento que experimenta una persona cuando se ve obligada a ejecutar acciones u omisiones que contradicen sus valores, ha sido descrita en todas las profesiones sanitarias y también en la formación de ellas, asociándose a consecuencias como despersonalización en los cuidados, baja motivación laboral, cuestionamiento vocacional y vinculación al burnout. En Chile, ha sido poco estudiada y menos aún en estudiantes de medicina. Se realizó un estudio observacional, descriptivo y mixto en internos de medicina de 4 universidades chilenas, mediante un cuestionario distribuido electrónicamente, para conocer su frecuencia y principales factores desencadenantes. Participaron 56 estudiantes. Los resultados expresan la presencia transversal de angustia moral en los estudiantes de las universidades exploradas. Destaca como fuente principal la dificultad en obtener el consentimiento informado de los pacientes. Los resultados aportan conocimiento útil para diseñar programas educativos que aborden la angustia moral y sus principales fuentes asociadas.

Palabras clave: Bioética. Consentimiento informado. Educación médica.

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Research

Admission to a medical school involves acquiring much knowledge. As studies progress, some medical culture and practice elements are acquired. In the latter appear the professional virtues that seek refined attitudes of value that can impact the decisions of students. These virtues will transform students, making them progressively internalize the experience of "being a physician" [1]. However, a good professional is usually someone who has mastered certain skills in a field of knowledge, beyond responsible moral commitment and practice [2].

In the last years of study, clinical residency enables students to acquire experiences that are very influential in the development of "professional character." Several of the situations to which they are exposed make them experience moral conflicts that, if not resolved properly, can decrease empathy and contribute to exhaustion [3-6].

In Chile, in almost all universities that offer the medical program, the last two years are dedicated to a professional internship called residency, which includes internships in different clinical areas. In residency, students are constantly challenged as to their knowledge and exposed to complex situations that involve health care teams, patients, and families, and they may face challenges or have to make decisions that contrast with their values and facilitate the emergence of episodes of moral distress (MD) [7].

Moral distress was defined by Andrew Jameton [8] in 1984 and arose from the primary observation of the experience of nurses in end-of-life care. It refers to the suffering a person experiences when forced to perform actions or omissions that contradict their values. It was later described in other medical professions [9-12]. Several MD-associated factors have been observed and have been related to important consequences, including: depersonalized treatment, vocational crisis, abandonment or change of functions, and its contribution to professional exhaustion or burnout, which was more evident during the COVID-19 pandemic [13-15].

Moral distress studies in medical students are scarce and maybe more complex, since the approach to this issue must include factors related to academic hierarchies and interpersonal relationships [16]. Particularly in the Latin American context, information is very scarce, and, in turn, it is not known how MD impacts the education on professionalism and bioethics. Considering the above, the objective of this study was to determine whether MD occurs in medical students from Chilean universities and the main predisposing factors.

Method

This is a cross-sectional, descriptive, non-experimental and mixed (quantitative and qualitative) study carried out from December 2020 to January 2021. All 7th-year students who completed medical residency in 2019, from the Universities of Valparaíso, Chile, Austral and Católica do Norte, were invited to participate. The selection was based on convenience and sought to represent different regions of the country (northern, central and southern regions). This study was authorized and supported in writing by the directors of the participating medical schools or their representatives. An electronic research was carried out, inspired by some of the MD-associated factors described in the literature [17-22].

In medical students, MD has been explored mainly by qualitative methods and, less frequently, by means of questionnaires and quantitative measurements. In our case, a 2007 study by Vanderbilt University partially inspired some of the questions included in the instrument we adopted [17]. In addition to the above information, we added data collected from the Narrative Medicine Laboratory at the University of Valparaíso.

This is an analysis of reflective writing material that medical students have been producing since 2017. In this analysis, we observed the presence of MD, in different descriptions, as well as the way students experience the distress. Based on this information, we developed a questionnaire on MD, consisting of 34 items or questions, which were answered according to a Likert scale from 1 to 5.

Between the scores from 2 to 5, we considered the option of recording whether the moral distress experienced was mild, moderate or severe.

The instrument was tested with 6th year students, the questions were corrected as to language and style and, later, it was emailed to participants using the QuestionPro® platform. The participants were volunteers and signed an informed consent for the study, present at the beginning of the form, after a brief explanation of the concept of moral distress. Quantitative data were analyzed using Jamovi software, version 2021.

After data collection, we performed a descriptive analysis that provided percentages and frequencies for each question, which are shown in Tables 1, 2 and 3. The qualitative section included an open-ended question allowing students to describe MD sources not included in the instrument.

Results

We sent 361 research forms and recorded 56 completed submissions (15.5% response rate). Of this total, 59% were women (n=33) and 41% were men (n=23). The participants' mean age was 25 years. Tables 1, 2 and 3 group the results organized according to the MD sources; for a didactic presentation, the options "never" and "almost never" were grouped into one, and the same criteria were applied to "frequent" and "very frequent." Table 1 groups the sources of MD experienced by students in teamwork, Table 2 shows the results for MD that emerges from the students' own behaviors, and Table 3 shows MD experienced due to lack of resources or associated with issues inherent in health institutions. Regarding MD that emerges in work in health care teams (Table 1), the highest frequency perceived by students was associated with patients signing the informed consent form without fully understanding the procedure or surgery to which they would be submitted (58.9%).

Table 2 shows the MD associated with the students' own behaviors. It should be noted that the most frequently observed item was "during my internship round I learned that a colleague was mistreated by a tutor and I remained silent" (26.7%).

Table 3 shows the MD related to the institution's own factors, including the availability of resources. The highest frequency of MD was: "I dealt with a patient whose disease was advanced because they had not had timely access to health care" (58.9%).

Table 1. Work-related moral distress in health care teams

Research items	Never and almost never N (%)	Occasionally N (%)	Frequent and very frequent N (%)
1. During my internship, members of my team spoke ill of other groups of physicians from other services.	6 (10,7)	23 (41,1)	27 (48,2)
2. During my internship, a member of my team made a medical mistake, and I didn't say anything.	26 (46,4)	24 (42,9)	6 (10,7)
3. During my internship, a member of the team made derogatory comments about a patient.	13 (23,2)	26 (46,4)	17 (30,3)
4. In my work team, a member was disrespectful to a lower-level colleague.	20 (35,7)	21 (37,5)	15 (26,8)
5. A member of the work team was disrespectful to non-medical health care personnel.	31 (55,3)	22 (39,3)	3 (5,5)
6. The resident and/or physician who was treating the patient with me did not answer the patient's questions properly or simply did not answer them.	21 (37,5)	19 (33,9)	17 (30,3)
7. During one of my internship rounds, I was discredited in public by my tutor.	32 (57,1)	19 (33,9)	5 (8,9)
8. A member of the work group (nurse, nurse technician, resident, etc.) made inappropriate comments about my experience to perform a procedure.	35 (62,5)	13 (23,2)	8 (14,3)

continues...

Table 1. Continuation

Research items	Never and almost never N (%)	Occasionally N (%)	Frequent and very frequent N (%)
9. While caring for one of my patients, I noticed a lack of collaboration in the work team, which influenced the patient's recovery.	21 (37,5)	28 (50)	7 (12,5)
10. One of my patients did not receive adequate treatment because they were stigmatized because of social issues or other conditions (drug abuse, alcoholism, HIV, homelessness, etc.).	40 (71,4)	11 (19,6)	5 (8,9)
11. I believe that one of my patients did not really understand the procedure/surgery to which they would be submitted, even having accepted and signed the consent.	10 (17,9)	13 (23,2)	33 (58,9)
12. Several people were involved in the care of one of my patients and, as their roles were unclear, this caused confusion for the patient and/or family.	28 (50)	15 (26,8)	13 (23,2)
13. The team that served one of my patients performed treatments that I consider inadequate, due to lack of reflection or little discussion of cases among them.	36 (64,2)	16 (28,6)	4 (7,1)
14. During my internship round, there were inadequate or suboptimal services due to team overwork and fatigue.	15 (26,8)	22 (39,3)	19 (33,9)
15. I served a patient who was feeling much pain and I believe that we did not do everything possible to alleviate their suffering properly.	22 (39,3)	23 (41,1)	11 (19,6)
16. In my work group, a member of the team continued to treat a patient, at the request of the family, although I believed this would only prolong the patient's suffering.	42 (75)	10 (17,9)	4 (7,1)
17. In a case we served, we denied information to the patient at the request of the family.	47 (83,9)	8 (14,3)	1 (1,8)
18. I served a patient who underwent examinations or procedures at the request of the family, even without indication, for fear of a lawsuit.	45 (80,3)	9 (16,1)	2 (3,6)

Table 2. Moral distress related to the students' own behavior

Research items	Never and almost never N (%)	Occasionally N (%)	Frequent and very frequent N (%)
19. I have made derogatory comments about a patient to others.	49 (87,5)	6 (10,7)	1 (1,8)
20. I participated in conversations in which people spoke ill of other services of the hospital where I worked.	34 (60,7)	20 (35,7)	2 (3,6)
21. I concealed patient information because I felt it did not make sense to share it with the team.	36 (64,3)	14 (25,0)	6 (10,7)
22. During my internship round, I learned that a colleague was mistreated by a tutor and I remained silent.	32 (57,1)	8 (14,3)	16 (26,7)
23. In my case, I felt that I was not really qualified to perform a procedure on a patient, but my team insisted that I performed it.	21 (37,5)	10 (17,9)	5 (8,9)

continues...

Table 2. Continuation

Research items	Never and almost never N (%)	Occasionally N (%)	Frequent and very frequent N (%)
24. During my internship round, I performed tests or procedures on patients that, despite having consented, I doubted their ability to make that decision at that time.	41 (73,2)	9 (16,1)	6 (10,7)
25. I felt that a procedure performed on one of my patients was not safe for them, and that better precautions could have been taken to care for them.	44 (78,8)	11 (19,6)	1 (1,8)
26. I had to give bad news to a patient's family and I thought this was the attending physician's responsibility.	37 (66,0)	13 (23,3)	6 (10,7)

Table 3. Institution-related (resources) moral distress

Research items	Never and almost never N (%)	Occasionally N (%)	Frequent and very frequent N (%)
27. I dealt with a patient whose disease was advanced because they had not had timely access to health care.	7 (12,5)	17 (30,4)	33 (58,9)
28. Delays in the delivery of results of laboratory and imaging tests had negative impacts on the care of one of my patients.	18 (32,1)	20 (35,7)	18 (32,1)
29. I treated a patient, and we did not try to do anything to correct their social condition, which was extremely important for their prognosis.	21 (37,5)	18 (32,1)	17 (30,4)
30. One of my patients did not receive proper treatment due to problems with their social security and/or health insurance coverage.	27 (48,2)	16 (28,6)	13 (23,8)
31. During my internship round, a patient was not treated properly due to lack of resources in the place where we were working.	19 (33,9%)	23 (41,1)	14 (25)
32. A patient was discharged early, and I believed this was not appropriate because no one could really take good care of them at their home.	33 (58,9)	17 (30,4)	8 (14,3)
33. I felt uncomfortable in my relationship with a patient I was caring for or who was in my setting because there were no adequate privacy conditions for them.	10 (17,9)	27 (48,2)	19 (33,9)
34. A patient I was serving did not receive proper care due to language barriers.	34 (60,7)	14 (25)	8 (14,3)

As for the intensity of moral distress perceived by students, the items with the highest values were: a) "in one of my internship rounds I was discredited in public by my tutor" (84.8%); b) "in my work team, a member was disrespectful to a colleague of a lower hierarchical level" (76.92%); and c) "I served a patient who was feeling much pain and I believe that we did not do everything possible to adequately relieve their suffering" (75%).

The analysis of the open-ended question (qualitative data) showed new sources associated with the students' MD: hierarchies in medical education; and sexism and misogyny.

Hierarchies in medical education

Students referred to hierarchical subordination that makes decision-making complex and the possibility of making explicit clinical situations and decisions with which they do not agree. For example, one participant said:

"I experienced that frequently, commenting on or suggesting a conduct that I believed was the best for a patient, and my opinion was not taken into account, and I did not receive an explanation as to why. (...) it is common to be accompanying a doctor in service and feel that they could explain better to the patient or give another solution, among other things, and I feel that I cannot, for reasons of hierarchy, I feel that if I speak I will disrupt the doctor's service."

Sexism and misogyny

On this issue, a student said:

"I have often encountered sexist situations in which a female patient, my female colleagues or I were underestimated for being women; and I could not say or do anything because I am at the lowest level of the medical hierarchy."

Discussion

The results show that MD is expressed transversally in medical training, since it is observed in students from all medical schools analyzed. Most MD sources observed in this study involve the clinical relationship, and that is where the higher frequencies of MD are reported, which is consistent with the literature [17,23,24].

As for the clinical relationship, the main MD source in this study was the inadequate way informed consent was obtained. That should start with adequate communication and understanding of the clinical needs and/or diagnostic or therapeutic procedures, with the objective of ensuring consented and agreed health care. The study findings were mostly contrary to the principles currently recommended for modern clinical practice and medical education, which in recent years have emphasized the value of autonomy [25].

This observation enables addressing a need already raised in the literature, since the point is not only teaching, in bioethics, how to conduct the process of obtaining informed consent, but, for educators, the point is being very explicit on the need for supervision so these tasks, in case they are delegated, comply with patient right and confidentiality preservation [26].

Given the current working conditions in health care systems, which face high demands, a hierarchical superior delegating the task of obtaining informed consent to a student may imply difficulties for the latter; if they feel unable to perform this task—either because they feel incompetent or because of the complexity of the case—they may not recognize it as their responsibility. That will pose the dilemma of informing their superiors or refusing to comply, a situation that can result in MD. This study is consistent with other studies that found that relational issues are associated with patients, among members of the health care team or dependent on academic hierarchies in the clinic, although they are not often expressed and are perceived as sources of major moral distress [24,27].

Medical training and the related principles of professionalism seek to fulfill society's tacit mandate: that its students be able to act with moral assertiveness. The goal is that they learn to work with patients in close collaboration with a team, often an interdisciplinary team, respecting the dignity of patients and of all professionals who participate in these contexts. This contributes toward providing safe and good quality care. In short, medical professionals and students are expected to act with integrity. These results show that, while learning to "be doctors," students experience MD, and these situations can affect their integrity as individuals, leading them to face professional and ethical dilemmas.

Moral judgments about an action derive from the position established by a set of estimated values. They are often related to universal human concerns, such as freedom, justice, and dignity, among others, and have arisen from individuals and societies questioning how and why we should consider and ponder them. In fact, they have motivated deep discussions between philosophers,

theologians, historians, and psychologists for centuries [28]. Perhaps that is why an issue such as item 7—"in one of my internship rounds I was discredited in public by my tutor"—without a high frequency (8.9% frequent or very frequent), leads to the perception of severe moral distress in students (84.8%) in our hypothesis, a discreditation in public is perceived as an affront to human dignity.

Hierarchies in medicine

Health and education institutions constitute a form of power organization that stratifies individuals based on social resources considered valuable. Medicine, in both spheres, is a highly organized social context, where work and learning combine, interact and feed each other, influenced at the same time by social power and hierarchy [29].

This study provides an insight into MD sources related to these hierarchies, which are expressed in difficulties for open communication when a disadvantage is perceived, repressing these experiences and affecting their capacity for autonomy. Thus, the conceptualization of hierarchy becomes very necessary, as it shows an issue that helps in understanding the experiences of medical students.

From the student's perspective, they are subordinated to the power of different actors, such as medical residents, tutors in clinical fields and even other health care professionals, and there may be overlaps between them, which leads to situations that are minimally complex and easy to remedy, even incomprehensible, which oscillate between the oppressive and the harmful, the productive and the useful.

Power would allow shaping human behavior, and recognizing good- or ill-intentioned practices would enable educational institutions to develop proposals that do not limit the natural and expected development of students, making them competent professionals and persons who, as a result of higher education, have achieved some degree of personal growth [30]. Finally, we note the presence of gender discrimination, which affects medical students and constitutes an issue that emerged in this study, which would require a broader and more in-depth analysis.

Final considerations

The results of this study show that MD occurs among medical residents from some Chilean universities. It originates mainly around relational situations with their peers and teachers, issues related to their own behavior by action or omission, and factors related to the students' work setting.

The process of obtaining valid informed consent raises a critical reflection for medical training and clinical tutoring, in addition to exploring the role of hierarchies in the moral distress of medical students.

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Pamela Jofré – Master – pamela.jofre@uv.cl
0000-0002-0787-1867

Rodrigo Vergara – Master – rodrigo.vergara@uv.cl
0009-0008-8860-5050

Thelma Suau – Master – thelmasuau@gmail.com
0009-0004-2985-8956

Jaime Bastidas – Master – jbastidas@ucn.cl
0009-0003-5384-4274

Diego de la Barra – Master – diegodelabarra@gmail.com
0009-0007-6759-7410

Sofia P. Salas – Undergraduate – sofiasalas@udd.cl
0000-0002-7865-291X

Correspondence

Pamela Jofré – Universidad de Valparaíso/Escuela de Medicina. Angamos, 655, Edificio R3, sala 11. CEP 2540064. Viña del Mar, Chile.

Participation of the authors

Pamela Jofré proposed the idea of the research as part of her master's thesis in bioethics, compiled bibliographic information, developed the protocol, recruited collaborating researchers, drafted the main body of the article, and conducted discussions and reflections. Rodrigo Vergara participated in the research discussions and recruitment in universities, manuscript review, preparation of discussions, and review of style. Thelma Suau collaborated in sample recruitment and manuscript review. Jaime Bastidas contributed to sample recruitment and manuscript review. Diego de la Barra participated in sample recruitment and manuscript review. Sofía Salas contributed to research protocol development, manuscript revision and style review, and participated in discussions and final reflections.

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