Perspectives

Organizational Ethics in Residency Training: Moral Conflict with Supervising Physicians

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As a resident I worked for a while with a pediatric intensivist who was an incredibly bright doctor. He was Board certified in both pediatric intensive care and anesthesia. His privileges gave him wide access to drugs, and it was known that this doctor had a cocaine habit. One day he came to work wired out of his mind. We were doing rounds and all I could think of was how to protect the patients? He was far beyond being able to carry out his responsibilities and his drug-induced state was exposing patients to terrible risk. At the same time, I thought whistleblowers take a lot of heat, particularly when you are a nobody.

—Thomasine K. Kushner and David C. Thomasma, *Ward Ethics: Dilemmas for Medical Students and Doctors in Training*

It is inevitable that physicians in training will be exposed to behavior by supervising physicians that the trainees find unethical. By nature these events are rare. It is imperative within any residency training program that resident physicians have immediate access to a meaningful review process in cases of moral conflict with supervising physicians. Here, I discuss the reasons why this issue must be recognized and what it entails. Most important, I discuss the procedural steps that are essential for the training program to make this a meaningful safety mechanism in residency training. This issue is central to promoting conscious development of professionalism in clinical training. Physicians in training, especially resident physicians, need to be taught to value and protect their own professional integrity. The responsibility for fulfilling this ethical duty falls on the individual residency programs as well as the administrative organizations that regulate residency training. Thus, ensuring this process of review is an organizational ethical imperative. Availability of this process is fundamental to promoting and ensuring ethical behavior by all participants in residency training.

The substance of the process I am advocating is that residents may initiate review of the actions or behavior of supervising physicians any time the resident has an ethically based objection to the actions or behaviors of supervising physicians. The most important application is when a resident believes that a supervising physician is providing care that is substandard or unsafe. However, it extends to cases of unprofessional behavior by supervising physicians, whether directed at patients, other staff, students, or the resident him- or herself. Because of the reality of the hierarchy of medical training residents, this right is unlikely to be abused. Residents will not want to call attention to their own disagreements with their attendings unless there is

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some genuine moral conflict. The hierarchical nature of medical training creates the need for this right to initiate external review, while inherently curbing the abuse of it.

This principle that trainees have the right and obligation to protect their own moral principles is essential for development of professional integrity in clinical training. It is crucial that residents receive from their training program the message that moral integrity is protected. The culture of medical education requires that physicians in training defer to supervising physician on a variety of issues, including clinical judgment and ethical standards. Despite the strong deference that must be given to supervising physicians on issues of clinical judgment, this deference should not be absolute. However, in practice, deference to supervising physicians often is absolute. In ethical considerations, the supervising physician exercises his or her own judgment as a sort of proxy for the physicians training on the service. Whenever a physician in training feels that this judgment is being exercised erroneously on his or her behalf, the trainee has the right to exercise his or her own independent judgment. When this occurs, the resident should not suffer any adverse consequences.

Absent abuse of the process, to be discussed later, this process must carry with it immunity from impact outside the immediate clinical situation in which it arose. This unilateral privilege to initiate review is essential for resident physicians and other physicians in training to learn to develop and rely on their own sense of professionalism. Immunity from retribution is central to creating an environment where trainees will learn to exercise and act on their professional and moral judgment. Providing adequate protection for whistle-blowers is challenging, but it is something that programs must strive to achieve. Without protection against unfair repercussions trainees will be reluctant to act on their moral and ethical instincts. This reluctance may undermine professional integrity by encouraging trainees to ignore professional conflicts to preserve equanimity.

The American Medical Association has also advocated for rights of trainees in situations of moral conflict between trainees and supervisors. The AMA policy documents the prevalence of these types of conflicts, while recognizing that quantification of this phenomenon is elusive.[1] This analysis examines the ethical and moral foundations of this security mechanism for trainees' protection. Further, the degree to which this type of protection is essential to promoting and developing professionalism is explored.

There are four fundamental bases for the assertion that the existence of this process must be available on demand. Each reason is persuasive in its own right, and in combination they are compelling. The importance of the principles underlying these bases override any administrative or philosophical barriers.

The most important basis for the availability of review on demand is that making moral evaluations and objecting to unethical behavior is what a physician *should* do. Every physician has a fiduciary and ethical duty to protect patients. This is the most basic responsibility that a physician has to a patient, often articulated as "first do no harm." Equally as important is that physicians have affirmative moral obligations inherent in their position. The philosophical basis for the moral duties of physicians can be considered within the context of beneficence, paternalism, nonmalificence, or virtue ethics. The basis of this obligation as it relates to issues of review in instances of conflict is best defined in terms of virtue.

Pellegrino and Thomasma have written extensively on virtue ethics in medicine.[2] Ultimately, virtues are a group of desirable characteristics, the acquisition of which is the goal of medical training and professional development. These character traits arise from a common moral purpose among physicians and encourage the development of a moral character capable of practicing medicine in a manner consistent with that common moral purpose. Willingness and ability to object to objectionable care are character traits that further the goals of beneficence and nonmalificence. This virtue, best described as moral courage, is essential to fulfilling the obligations of the physician as a fiduciary of the patient. The physician holds the patient's best interest in trust and has the duty to act in the patient's best interest. This virtue of moral courage facilitates the accomplishment of that duty. Further, this virtue promotes accountability and integrity, both of which are characteristics that further the moral aims of medicine.

Another basis is society's expectations. Our culture expects that physicians will be morally centered. The average person knows generally of the Hippocratic Oath and believes that it sets moral boundaries for physicians. The general public is also aware of the mandate "first do no harm." There is an expectation that physicians will practice within a moral framework that protects patients and respects them as people. For physicians to honor this trust, every physician must have the authority to act in the interest of patient safety. When any member of the profession is not given full license to protect patients then the profession as a whole fails to adequately protect patients' interests.

This cultural expectation is reflected in the standards of the Accreditation Council of Graduate Medical Education (ACGME), the council that accredits its residency programs. The ACGME has six general competency areas that outline the skills and knowledge that should be universal to all physicians graduating from ACGME-accredited residencies.[3] One of these six areas, professionalism, is defined to include commitment to ethical principles, responsiveness to needs of patients that supercedes self-interest, respect, compassion, and integrity. These skills are fundamental requirements of training because they are fundamental to what a doctor is and are essential to preparing residents to perform to the expectations of their patients and society.

This review principle is important to the philosophy of training and the development of standards of professionalism in trainees. Medical training includes the acquisition of standards of ethics and professionalism. Residency programs have responsibilities to teach professionalism and to promote professional development as part of training. Encouraging and respecting critical moral analysis is crucial to professionalism. As physicians in training confront ethical concerns, they need to be encouraged to critically reflect on those concerns. Physicians in training need to be encouraged to act on their own moral and ethical standards. Acknowledging this right encourages physicians to actively enforce their own ethical standards. Physicians have promoted internal regulation of the profession as the only workable form of professional regulation. This creates a duty to train professionals who understand and uphold the duty to regulate their colleagues internally. Residents need to have the freedom to begin the process of critical analysis for purposes of regulation and upholding standards of professionalism.

Finally, our concept of justice in the Western world includes a right to fair process. This opportunity to initiate

review is analogous to the concept of due process. Due process in the law applies only to the government in interactions with citizens, but the principles involved are generalizable. A person is entitled to due process when a right is affected by the government. This applies to the criminal sphere because the right to freedom is threatened. Due process attaches to government jobs, welfare benefits, and a variety of government-related interactions. Due process itself is the right to a hearing. The formality of the hearing varies according to the importance of the rights implicated and the likelihood that formalized proceeding will generate a fair result.

In this analogy the same principles apply. A hearing or an opportunity for review is essential because the issues implicated are the moral integrity and sense of ethical duty held by the resident physician, as well as the safety and protection of patients. These are two of the most compelling interests in all of medicine, and that necessitates a formal process with inherent assurances of fairness. As long as the procedure prioritizes fairness, there is a high likelihood that it will generate a fair result. Review is inherent in societys' formulation of justice, and justice requires that residents' ethical concerns be fairly and seriously addressed.

Implications and Procedural Elements

This process of immediate external review must be available on demand without limit or qualification. The resident must be free to initiate review at any time for any issue that he or she feels creates a moral conflict. Review must be automatic upon request. Discretionary review is insufficient to protect an interest of this magnitude. The process of initiating review should be formalized by every residency program, and the process must ensure that there will be no adverse consequences. The department must have a vocal and visible commitment to supporting residents' efforts to develop and protect their own professional integrity. Further, the mechanism of resolution of disputes should be formalized.

Review must also be immediate. In instances where the conflict may affect a patient's care, both the resident and the patient have a right to immediate review. To have any value, this process must resolve the situation before the clinical decision will have an impact on the patient. Retrospective review fails to protect either the resident or the patient. Given that clinical situations may develop and progress rapidly, review must be immediate and available at any time. Absent these qualities the review process is meaningless because it does not have the power to offer prevention of the harm at issue.

Review must be meaningful. Review cannot be merely a formality where the designated reviewer hears the initial issue and makes a decision without looking into it. The reviewer should not have the discretion to dismiss the issue without addressing it in a way that the resident is comfortable with. This must involve some independent information gathering and clinical judgment by the reviewer. If the reviewer simply relies on the supervisor's judgment without exercising any additional clinical judgment, no review has taken place. The supervisor's judgment has merely been rubber-stamped under the label of review. When residents identify a conflict that is important enough for them to initiate review, then independent, fact-based judgment must be exercised by an experienced neutral party to resolve the conflict.

Finally, review must be fair. There must be a genuine commitment on the part of the reviewer to achieve a result that is ethical, that values the concerns of all parties involved, and that treats the parties as equals for purposes of the review. Reviewers, whether as individuals or in a group, must understand that their purpose is to reach a fair and just result without dismissing any concerns or issues brought to the table by any party. In this review the ethical integrity of the resident must be given equal weight to that of the supervising physician. The supervising physician should be given the respect and deference warranted by superior clinical knowledge but is ethically on equal footing with any other member of the healthcare team. Thus, in terms of ethical review, there is no clinical hierarchy.

Resolution must include the opportunity for the resident to be excused from providing or participating in care that he or she objects to on ethical grounds. This is a commonly recognized right in medicine. No one is obligated to provide care they object to ethically. If, after review, no change in the care plan or issue of concern is deemed necessary, the resident should still have the option to withdraw from participation. This recognizes that moral concerns have a subjective component, and that subjective component is valid. A resident's subjective moral objection may not be borne out in the review process, but the resident is still entitled to hold that moral position. The failure to recognize this would imply that the reviewing party is a higher moral authority with the power to brand certain positions as morally "wrong." This review mechanism does not replace the existing safeguard that enables providers to remove themselves from providing care they object to.

When objective review is completed, the substantive opportunity to external review that the resident has to ensure protection of his or her own integrity and the patient's safety has been satisfied. As long as the review is meaningful, no further system remedy is required beyond what is recommended as a result of the review. This is to say that a meaningful, immediate review conducted by a truly neutral third party is sufficient to protect residents. It is sufficient to promote professional development of ethical principles and is sufficient to respect the moral judgment of the resident. However, the resident should not be required to participate in care that he or she finds subjectively objectionable. This final element demonstrates basic respect for an individual's moral assessment that requires no additional validation to be internally relevant.

The fundamental issues are fairness and respect for the moral integrity of the resident physician. No one would argue that the resident physician is unworthy of fair treatment or respect. However, when issues arise and passions are inflamed, process becomes an important element of ensuring fairness. A predetermined process of review allows the parties to be confident that their current positions have not dictated the scope of the nature of the review. This ensures adequate substantive protection for residents' ethical beliefs as well as encouraging residents to explore and exercise their moral integrity.

Notes

1. American Medical Association, Council on Ethical and Judicial Affairs, policy E-9.055 Disputes Between Medical Supervisors and Trainees, adopted December 1993. *JAMA* 1994;272:1861–65.
2. Pellegrino ED, Thomasma DC. *The Virtues in Medical Practice*. New York: Oxford University Press; 1993.
3. ACGME Outcomes Project, available at www.acgme.org/outcome/comp/compMin.asp (accessed Oct. 28, 2002).