

Sources of Ethical Conflict in Medical Housestaff Training: A Qualitative Study

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PURPOSE: Despite increased emphasis on medical ethics and professionalism in medical education, concern about unethical and unprofessional behavior by physicians is widespread. This study sought to identify and classify the range of work-related ethical conflicts experienced by medical house officers.

METHODS: We performed a qualitative study using data from in-depth interviews conducted in 2001 with 31 internal medicine residents in one traditional and one primary care residency. Using the constant comparative method, we explored work-related experiences during housestaff training that involved ethical conflict with patients or colleagues.

RESULTS: The interviews revealed five categories of ethical conflict: concern over telling the truth, respecting patients' wishes, preventing harm, managing the limits of one's compe-

tence, and addressing performance of others that is perceived to be inappropriate. Conflicts occurred between residents and attending physicians, patients or families, and other residents. Many of the conflicts were exacerbated by the function of the hierarchical structure in residency training.

CONCLUSIONS: This study provides a classification of work-related ethical conflicts that houseofficers experience, which may be used to improve the working environment for residents and support their professional development. By attending to the challenges that residents face, particularly previously under-emphasized conflicts concerning competence and performance, this framework can be used to enhance education in ethics and professionalism. *Am J Med.* 2004;116:402-407. ©2004 by Excerpta Medica Inc.

Since the 1980s, many people and organizations have increasingly emphasized the role of medical ethics and professionalism in the education and training of physicians (1-4). In response, many medical schools have developed programs to teach these topics to new physicians (5-9). Despite these efforts, both the public and the profession have been concerned about recent reports of unethical and unprofessional behavior by resident physicians (10-17). Little is known about the experiences that house officers face during their training that may lead to such behavior.

Previous studies exploring the ethical challenges of residency have focused primarily on disagreements with attending physicians. This work consists of individual per-

sonal accounts or case studies (18-21), or the results of closed-ended surveys (14,22,23). Despite their value, these methods are limited because they generate either anecdotal information or data constricted by the survey instrument used; they do not provide the systematic breadth and depth of more open-ended techniques.

To support the ethical and professional development of new physicians, it would be useful to understand the full range of experiences that cause ethical conflict. A deeper understanding of the personal and professional challenges may provide insight into whether and how these experiences may lead to compromised behavior in the future. Identifying the full range of sources of conflict for the residents will create opportunities to address problems, improve the efficacy and relevance of educational interventions, and promote a more effective working environment. In this study, we interviewed internal medicine residents to identify work-related ethical conflicts. By categorizing these experiences, we aimed to improve understanding of the types and sources of these conflicts.

METHODS

Study Design and Sample

We interviewed residents from Yale University traditional and primary care internal medicine residency programs. These residents train at four hospitals in Connect-

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Supported by a grant from the Yale University Interdisciplinary Bioethics Project. The study was completed while Dr. Rosenbaum was a Robert Wood Johnson Clinical Scholar at Yale University School of Medicine. In both cases, there was no involvement of the grantors in the design or conduct of the study, data collection or analysis, or manuscript preparation.

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Manuscript submitted September 11, 2003, and accepted in revised form September 18, 2003.

icut, including an urban tertiary care center, a Veterans Affairs hospital, and two community hospitals, which serve as the sites of inpatient and the majority of outpatient experiences.

Residents were selected through purposeful sampling, as is typical in qualitative research (24,25). The initial group was selected randomly from residents who would be more likely to be available for interviewing, including residents on elective, ambulatory, or consult rotations. Additional participants, including chief residents, were selected to ensure breadth and to include a diverse representation of residents. The Human Investigation Committee of Yale University School of Medicine and the Institutional Review Board at St. Mary's Hospital in Waterbury, Connecticut approved the study.

Data Collection

In-depth, open-ended interviews were conducted in person over a 6-month period in 2001. After informed consent was obtained, each interview was conducted in person by 1 researcher (JRR). Interviews ranged from 18 to 60 minutes with a median duration of 38 minutes. All interviews were audiotaped and transcribed by independent professional transcriptionists. The sessions were conducted privately, and all identifiers were coded on study documents and tapes to ensure confidentiality.

For all interviews, a standardized interview guide was employed with probes for clarification and to gather additional detail. The interviewer asked each resident, "Have you ever done something, or failed to do something, involving a patient or colleague that made you uncomfortable?" Questions were also asked about specific experiences that the resident felt were improper, wrong, unethical, or unprofessional. For all questions, respondents were encouraged to elaborate on their experiences with examples and specific stories.

Data Analysis

Transcribed data were analyzed by a team with expertise in qualitative research and with training in internal medicine, public health, and epidemiology. The team used common coding techniques and the constant comparative method of qualitative data analysis (25,26). Each transcript was read line-by-line by at least 2 researchers, and key themes and ideas were abstracted. Data from initial transcripts were organized into a code structure to keep track of and analyze the data. According to constant comparative techniques, as new transcripts were reviewed and coded, new quotes were compared with previous quotes within an evolving category in an iterative process. Investigators examined all of the experiences that the residents reported, including experiences that caused discomfort and those that they characterized as improper, wrong, unethical, or unprofessional.

At two points during the concurrent interviewing and analysis, the entire research team reviewed the coding

Table. Demographic Characteristics of Participants Compared with Residents in Training Program*†

Characteristic	Participants (n=31)	Total Residents (n=195)
	Number (%) or Mean ± SD	
PGY-1	6 (19)	84 (43)
PGY-2	9 (29)	55 (28)
PGY-3	12 (39)	47 (24)
Chief residents	4 (13)	9 (5)
Traditional program	23 (74)	118 (61)
White race	13 (42)	103 (53)
Male sex	15 (48)	97 (54)‡
Age (years)	30.4 ± 3.6	29.4 ± 3.1

* Three residents refused to participate: a white PGY-2 woman from the traditional program; a PGY-2 woman from the traditional program who did not identify race/ethnicity; and an Asian PGY-3 man from the primary care residency. The first resident did not participate because she refused to be taped. The other residents refused because they did not want to discuss the topics of the study.

† The characteristics of the residents who did not respond to their pages did not differ from the characteristics of the residents overall.

‡ Sex data were available for only 181 residents. Age data available for 182 residents.

PGY = postgraduate year.

structure, and consensus was reached among all members regarding its logic and breadth. Revisions to the coding structure were based on new insights and relations that emerged within categories during analysis. The research team reviewed and accepted a final coding structure. All transcripts were coded according to this final structure with differences in interpretation in coding resolved by consensus. Coded data were entered into a software package for qualitative data (NUD*IST 5; Sage Publications Software, Thousand Oaks, California) to assist in reporting themes, links between the themes, and demonstrative quotations. New residents were interviewed and their data analyzed until thematic saturation (24,25) was reached (i.e., successive interviews did not produce new themes). This occurred after the 31st interview.

Several steps were taken to enhance the reliability and validity of the methods, as recommended by experts in qualitative research (27–30). These included purposeful sampling to ensure a theoretically broad range of experience, multiple coding of the data by at least 2 researchers, and analysis of deviant cases. We enhanced our systematic approach through the methodical use of the discussion guide and the creation of an audit trail to document analytic decisions.

RESULTS

Eligible residents were contacted by pager and invited to participate. Overall, we paged 51 residents, of whom 3

refused to participate. The 31 participants in the study were similar to the residents in the Yale medicine residencies in terms of sex, race, ethnicity, and program (traditional or primary care) (Table). Because of our preference for residents who were on less time-intensive rotations, the participants were more likely to be further along in training. Seventeen residents who were contacted failed to schedule interviews because of time constraints or scheduling difficulties, and their characteristics were also similar to those of the residents overall.

All participants described experiences with patients or colleagues that they considered uncomfortable or that they considered wrong, improper, unethical, or unprofessional. Almost all of the residents (90%, $n = 28$) described situations in which they had been directly involved. Three respondents (10%) did not report uncomfortable experiences in which they had been involved but did describe conflicts they had witnessed or heard about involving colleagues.

We classified the experiences into five broad categories: concern over telling the truth, respecting patients' wishes, preventing harm, managing the limits of one's competence, and addressing performance by others that is perceived to be inappropriate. Ethical conflicts involving these five categories occurred between residents and their attending physicians, residents and other residents, and residents and patients or their families. Residents also experienced internal conflict in which they struggled with themselves to decide the appropriate course of action. The types or descriptions of conflicts did not vary markedly by sex or year of training.

Five Categories of Ethical Conflicts

Telling the truth. Residents reported having to compromise in telling the truth. This involved many ways of manipulating information, including delaying, framing, or omitting information. At times it also involved lying. Some residents reported that this behavior was due to pressure from attending physicians; others described pressure from families, patients, or peers. The types of information about which residents failed to tell the truth ranged from diagnoses and prognoses to how experienced they were with specific procedures. Conflicts arose from disagreements over how much information to disclose, who should disclose, and when to disclose.

In an example of delaying the sharing of information, a resident said, "The biopsy came back that he had lung cancer . . . our attending wanted to wait until his primary attending came back a week later before telling him. We . . . myself and my intern, felt very uncomfortable waiting . . . he [the patient] kept asking us, 'Do you know the results?' . . . and we'd have to tell him . . . 'we're waiting for the results.' Even though we knew."

This resident framed information to guide a patient toward a particular decision: "The resident did not want

the patient to undergo the procedure . . . they would really bias the wording that they would use when portraying the risks and benefits from the procedure . . . using language that no one would end up giving consent for this procedure."

In an example involving omitting information, a resident said, "It's obviously frightening to do it [a procedure]—because you are very aware of your own abilities, whereas the patient is not. And I don't think that I've always told the patient, 'This is my third time doing a central line' . . . patients may think that you do this every day, when you don't."

To illustrate an example of lying, a resident said, "The patient says 'Hey doc! Where are my, where are my meds [prescriptions]?' I was like, 'I called them in.' At that time I actually had not called them in."

Respecting patients' wishes. Residents desired to respect the patients' autonomy by learning their wishes and by making efforts to ensure that their treatment decisions were respected, often regarding decisions near the end of life. Sometimes they were unable to ensure that the patient's wishes were being respected because the medical team, patient, or family did not agree on what those wishes were or whether they were in the patient's best interest. One resident stated, ". . . they [the patient] pretty much had said that they probably don't want to be intubated again. And the family wanted it done . . . as the day went on there was an ongoing discussion of 'Should we intubate? Should we not? Does the patient really want this? They probably don't but the family probably does.' And whenever you have that situation it's kind of tense." Another resident said, ". . . I kind of felt like I got strong armed [by the attending physician] into putting a PEG [percutaneous endoscopic gastrostomy] in this guy when I really thought it was the wrong thing to do. And not that it was just my personal decision, but I had spent a lot of time talking to the family . . . and this is a new attending who just showed up. He had never spoken to the family. . . ."

Preventing harm. Several residents mentioned experiencing conflicts when patients were harmed by the care provided by the residents. One aspect of this distress stemmed from residents confronting the inherent risks of medicine, including adverse events or side effects of necessary, although risky, treatments or procedures. One of the residents said, "It felt difficult for us to live with the fact that we had done something to her that had killed her. . . . Sometimes I just feel really evil. Doing things to people. That's my way of saying it. But I feel, a lot of times, we do different procedures to people that are—putting in lines or whatever—in their so-called best interest. I just wonder a lot of times whether it really is."

In other instances, the concern was about harm to the patient resulting from the educational process. Some-

times the residents perceived incentives to do procedures to gain experience, which involves the inherent risks of the procedure as well as the risks due to the limited experience of the resident performing the procedure. A resident said, "It's that whole tension between what I need to do to become a better resident, which was I had to get through a certain amount of procedures. . . . I don't know that I would have known that there would be these situations where my learning would happen maybe somewhat at the expense of the patient."

Managing the limits of one's competence. The house officers also reported discomfort related to feeling inadequately prepared to perform their duties and how to handle this discomfort. The residents' concerns over their own competence were exacerbated by concerns about whether patients, peers, or attending physicians viewed them as competent. Due to concern over the perception of others, especially the superiors who evaluated them, residents described pressure to act as though they were more experienced than they perceived that they were. Some residents reported realizing their limitations but having difficulty admitting their shortcomings.

A resident expressed this concern about external perceptions of competence: ". . . I'm transferring them [a patient] to somebody and meeting resistance, just feeling uncomfortable because they [co-resident] say, 'why didn't you do this?' or 'why didn't you do that?' or 'they're not really appropriate for me right now. You called me too soon.' Just feeling like I'd been inadequate, inadequately working up the patient and why would I call them prematurely. I feel that, actually, a lot."

Another resident gave this example of difficulty admitting shortcomings: "I've done in the past procedures on patients that I wasn't necessarily comfortable doing, with not a whole lot of supervision. But when someone asks me, you know, 'Do you need me to stand here? Do you need me here while you do this?' And I said, 'No.' And that was probably not the right answer."

Addressing the performance of others that is perceived to be inappropriate. Residents experienced conflict when they thought a peer's or attending physician's performance was inappropriate or inadequate. Several residents described the tension of balancing their professional responsibility to challenge, intervene, or report the inappropriate or inadequate behavior with the need for approval and acceptance by colleagues. One resident stated, "When you think that one of your colleagues, for example, may be not doing something that they're supposed to be doing and you feel you should tell them something about that. It's, I'm not quite sure how to intervene." Another said, "There are a couple of residents, a couple of interns that I had that were really horrible and I did not write an evaluation . . . I think that's a bad quality [of mine]."

This conflict was reported as especially stressful in working with attending physicians, who often were in charge of evaluating the resident. Some residents described acquiescing to the superior's wish, often subjugating their values to the attending physician's demands. One resident said, ". . . there are times I've done stuff that I didn't necessarily think was necessary. I mean because the attending wanted this or that done and I didn't . . . agree with them . . . Not that they were wrong but just that I didn't personally feel this person needed an LP (lumbar puncture) or whatever . . . why bother torturing somebody?"

DISCUSSION

Nearly all residents reported ethical conflicts in their work experiences. These included conflicts between the residents and attending physicians, residents and patients or families, residents and their peers, or internal conflicts in which the residents grappled over the appropriate course of action, which we were able to classify into the five categories.

These concerns are reflected in varying degrees in the recent promulgations of professional organizations regarding professionalism. The recent Charter on Medical Professionalism reaffirms the principles upon which the medical profession is based (31). The Charter is a joint effort of international professional organizations, including the American College of Physicians–American Society of Internal Medicine, the European Federation of Internal Medicine, and the American Board of Internal Medicine. The principles include a set of professional responsibilities: honesty with patients, patient welfare, professional competence, and professional responsibility, including the self-regulation of peers. In addition, postgraduate medical training programs are now expected to demonstrate how they evaluate their learners' performances around six competencies, including the domain of professionalism (32).

Our study demonstrates the difficulties that the residents sometimes faced in trying to reach these ideals, despite a common understanding of the importance of these professional responsibilities. Sometimes, compromises were necessary between two competing professional values (e.g., potentially harming a patient to learn a procedure for the sake of future patients). At other times, despite agreement on the meaning of a principle, different interpretations of how to implement the principle led to conflict (e.g., how and when to disclose a diagnosis). In addition, residents sometimes felt pressure to act according to a separate set of priorities that might be valued differently within the hierarchical training system, including efficiency, respect for authority, and collegiality. Although the strong organizational structure of medical

training provides organization and efficiency, the hierarchy may make the residents feel as if they sometimes must compromise their core professional responsibility to patients in order to succeed.

The principles of honesty, nonmaleficence, and respect for patients' autonomy have received a great deal of attention in the literature on ethics and in education (1,5). Similarly, competence and self-regulation are considered cornerstones of professionalism (3,31,33). However, less attention has been paid to how to manage the limits of one's competence and how to implement professional self-regulation in the day-to-day setting. For example, if a resident believed that a colleague had acted inappropriately, the resident reported little guidance about how or when to provide effective constructive criticism or when to seek assistance from a superior. Even when they judged that they should have notified a superior, some residents were uncomfortable doing so out of a concern about the possible consequences for themselves and their colleague. As the medical profession attempts to reassert its professional authority, issues of self-regulation will become even more important (34,35). Especially given the growing attention to medical errors and the quality of health care (32,36), the profession must clarify how this kind of self-regulation should proceed and then teach this process to physicians in the beginning of their careers.

This study suggests that there is still much progress to be made regarding how to ensure that ethical and professional principles are effectively translated into appropriate behavior. There are three levels at which such efforts can be targeted. First, education can focus on analytic skills to enable residents to identify and adjudicate the ethical and professional principles that are relevant in particular situations. Such education can also impart skills of conflict resolution and effective patient advocacy without compromising residents' positions in the medical hierarchy. Second, faculty development regarding the prevalence and management of these conflicts during residency may relieve some of the tension and deleterious outcomes, both in terms of house officer stress and patient care. Third, the effective translation of principles into practice will necessitate addressing the institutional context in which these conflicts occur. This may involve attending to a culture and hierarchy that may hinder reflective criticism, as well as other desirable ethical behaviors. Professional, institutional, and educational leadership will be key in identifying and addressing systematic and cultural barriers that deter avoiding or resolving conflicts with minimal negative effect on the involved parties, especially on patients.

Our analysis was based on interviews with internal medicine residents at two programs. It is possible that the empirical findings regarding their uncomfortable experiences and values conflicts are particular to this group. However, we attempted to sample the residents to ensure

that they were diverse and representative of medical residents generally. Because many of the findings are related to values that are deeply held by the profession or are reflective of the hierarchies that are an inherent part of medical training, it is probable that similar conflicts would be discovered in other groups of trainees.

We used qualitative methodology to explore an area that had not previously been subject to systematic research, specifically to illuminate the types of ethical and professional challenges that the housestaff faced. The 31 residents were selected through purposeful sampling until thematic saturation was reached. Residents were not asked to recall each incident to gain a sense of prevalence nor to tell us even their most difficult experience. Because of the sampling and questioning technique, we are only able to report meaningfully the range of experiences. Quantitative data that we might report on the relation among year of training, sex, or race and the ethical and professional experiences would be at most suggestive because of the type of methodology we employed. Our findings can be used in future studies that describe the frequencies of these experiences or, with hypotheses generated by our findings, in studies that explore the reasons that these phenomena exist.

Although each of these experiences caused conflict for the residents, some experiences may cause discomfort that leads to appropriate ethical and professional responses and growth. Others, however, might lead to more deleterious effects. With the description of the range of these experiences, we can begin to understand how residents differentiate between experiences that are difficult but developmentally important and those that violate basic ethical standards. To positively influence ethical and professional development, we must ensure that residents understand when compromises in ethical standards might be acceptable and when they are not.

ACKNOWLEDGMENT

We wish to thank Ann Senick, MSW, for her research assistance, and Nancy Angoff, MD, David Berg, PhD, and Helena Hansen for their comments on the manuscript. We also appreciate the generous support of the Yale University Interdisciplinary Bioethics Project and the Robert Wood Johnson Clinical Scholars Program. Finally, we especially appreciate the housestaff who participated in this study and thank them for their time and candor.

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