The ethical junior: a typology of ethical problems faced by house officers

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Summary

Although many studies have explored the experiences of doctors in their first postgraduate year, few have focused on the ethical issues encountered by this group. Based on an extensive literature review of research involving house officers, we argue that these doctors encounter a broad range of 'everyday' ethical challenges, from truth-telling to working in non-ideal conditions. We propose a typology of house officers' ethical issues and advocate prioritizing these issues in undergraduate medical ethics and law curricula.

Introduction

Although many studies have explored the experiences of doctors in their first postgraduate year,[1–3] few have focused on the ethical issues encountered by this group. Traditionally called 'house officers', they are now referred to as F1 in the UK and 'interns' in North America and Australia. In this paper, we propose a typology of house officers' ethical challenges based on an extensive literature review and examine the implications of our classification for medical training. We adopt a broad definition of what counts as an ethical issue. Following bioethicist Soren Holm, in the context of this paper an ethical consideration refers to:

> *'a) a non-legal or not solely legal norm, duty, obligation or right; or b) consequences (well-being, happiness etc.) for some specifiable person or groups of persons; or c) what kind of person one ought to be or what virtues one ought to have.'*[4[85]]

Methodology

Sociologists, and particularly ethnographers, have long been interested in medical internship.[5,6] Studies of postgraduate medical training offer fascinating insights into the processes of professionalization and the moral development of junior doctors.[7,8] As medical education and the organization of internships evolve with time and as our primary concern was to develop a typology of ethical challenges faced by today's house officers, we chose to focus on recent research. We defined, rather arbitrarily, recent research in this area as work published from 1994 onwards.

To construct the typology, we identified relevant publications using three major electronic databases: Web of Science, Medline and Philosophers' Index. In Web of Science and Medline, the search terms used were 'intern' and 'resident', constructed inclusively (to capture, for example, 'internship'). Articles from non-Western settings or published before 1994 were excluded. Searches were also conducted using the term 'ethics' together with 'junior doctor' and 'house officer' to ensure that relevant literature was not being overlooked due to terminological differences between countries. The search in Philosophers' Index used the term 'intern or resident' (again constructed inclusively) together with 'ethics' (or 'ethical') and 'medicine' (or 'medical'). Much of the literature did not explicitly aim to investigate ethical issues, but was nonetheless relevant in understanding the ethical challenges faced by house officers.

A typology of ethical challenges

The work of Rosenbaum *et al*. served as the starting point for our typology.[9] Based on in-depth interviews with thirty-one junior doctors in their first,

Table 1
A typology of ethical challenges faced by house officers

Type of ethical issue	*Specific examples*
Telling the truth	• To patients and relatives about diagnosis and prognosis • To patients about lack of experience • To consultants about tasks performed • To colleagues about a patient's condition when seeking tests
Respecting patients' autonomy	• Respecting patients' wishes about treatment, including at the end of life • Maintaining confidentiality • Seeking informed consent
Preventing harm	• Dealing with potential harm to patients associated with their treatment • Avoiding harm to patients when involving them in the educational process
Managing the limits of one's competence	• Coping with feeling inadequately prepared for their responsibilities • Negotiating lack of supervision/role modelling by superiors • Making mistakes
Addressing the inappropriate behaviour of others	• Dealing with peers' mistakes/ incompetence • Conflicts between views of junior doctors and superiors – subjugating own opinions and values to superiors' demands • Observing the unethical behaviour of others • Demeaning humour about patients • Compromised superiors • Superiors handing risky tasks down the hierarchy ('passing the buck') • Dealing with verbal or physical abuse by patients or superiors, including sexual harassment
Conflicts of interest	• Ability to treat family and friends • Offers of gifts or hospitality from drug companies
Setting interpersonal boundaries with patients	• Dealing with sexual advances or romantic intentions • Treating disliked, difficult, or dangerous patients • Controlling compassion
Impact of working conditions	• Dealing with transience • Working long hours • Feeling unsupported by hospital administration • Working when unwell or exhausted • Lack of cover for absent colleagues

second or third postgraduate year, these authors suggested five categories of ethical conflict faced by junior doctors:

(1) concern over telling the truth
(2) respecting patients' wishes
(3) preventing harm
(4) managing the limits of one's competence and
(5) addressing performance of others perceived to be inappropriate.

We drew on the literature review to construct a more comprehensive typology of the ethical challenges faced by house officers.

Table 1 presents eight broad ethical issues, with more specific examples in the second column. Some of the examples transcend several categories. For example, making mistakes could fall under 'preventing harm', 'conflicts of interest' and 'managing the limits of one's competence'. As the typology is derived from existing research, its scope is limited to aspects of house officers' experiences that have already been studied; further ethical issues may emerge as more empirical research is conducted with this group.

The brief summaries below elaborate on some of the issues in Table 1. Since the aim of this paper is to present a systematic overview of ethical issues, rather than propose solutions to them, we do not attempt to analyse or resolve the problems. We leave this daunting task to the ethicists and educators.

Telling the truth

Like all doctors, house officers experience truth-telling dilemmas. However, their unique position in the medical hierarchy and their dual roles as clinician and learner bring additional problems. Should they tell patients about their lack of experience? Is it acceptable to stretch the truth with superiors to save face? Some house officers deceive consultants about figures or tasks they are expected to know or perform.[10,11[279]] In one study, 14% of participants (doctors in their first, second or third postgraduate year) indicated that they were likely to fabricate a laboratory value to a consultant to avoid being humiliated.[10] House officers may also lie to colleagues, such as radiographers or laboratory technicians, about a patient's condition in order to obtain tests ordered by a consultant.[11[281–2]]

Respecting patient autonomy

To respect patient autonomy, doctors must provide information without manipulation or coercion. In one study, nearly a third of junior doctors reported intentionally influencing patients to accept or reject procedures.[12] On occasion, junior doctors struggle to respect patients' wishes about treatment: while they may be aware of the patients' wishes, they may be unable to respect them when their superiors are unreceptive to the patient's requests.[13[59]] Finally, house officers can breach patient confidentiality, often inadvertently, by disclosing information without the patient's permission or by looking at the medical notes of hospitalized friends or colleagues.[12,14]

Preventing harm

House officers' duty of non-maleficence (avoiding net harm to patients) can be difficult to fulfil when involving patients in the educational process. Furthermore, inexperienced house officers can be distressed by intrusive procedures and adverse patient outcomes, even when the treatment was necessary and competently performed.[9]

Managing the limits of one's competence

Many house officers report being asked to perform tasks which they deem beyond their clinical competence.[1,3,15] Some also report difficulties around accessing support from more senior doctors due to a variety of factors, including superiors' workloads, absence on leave or unwillingness to assist, as well as house officers' fear of verbal abuse or disapproval.[3,13] This could lead to negative outcomes for patients, particularly when a house officer's limited competence is coupled with inadequate supervision. The stress experienced by house officers can also be considerable; as newly qualified professionals, some feel ill-prepared for their responsibilities and struggle to cope.[13,16,17] These difficulties can be compounded by the absence of role models to serve as moral and practical guides.[14]

Addressing the inappropriate behaviour of others

Some house officers will suspect or know that a doctor's competence is compromised or that a colleague's behaviour is unethical.[18] Dealing with this knowledge can be morally distressing, particularly in the context of house officers' dependence on their superiors for assessment and career advancement. How should house officers handle conflicts between their own beliefs and the views or demands of their superiors? How should they behave if they hear colleagues making inappropriate comments about patients?

Conflicts of interest

Questions arise about the appropriateness of house officers treating and giving medical advice to their friends, their relatives or themselves. There are also moral issues around accepting gifts and hospitality from drug companies.

Setting interpersonal boundaries with patients

Junior doctors report difficulties around negotiating the appropriate level of empathy, compassion and involvement with their patients. This is perhaps unsurprising given the erosion of compassion often associated with medical school (sometimes referred to in the literature as 'ethical erosion').[19,20] Issues relating to treating disliked, aggressive or infectious patients and dealing with patients' sexual advances or romantic intentions also fall under this category of 'boundaries'.[21,22]

Impact of working conditions

House officers tend to rotate jobs or placements every few months. The lack of stability and the emphasis on efficiency can contribute to a lack of reflection and empathy, and an undue deference to

authority.[23] Transience also has a negative impact on house officers' personal lives, creating social isolation and making it difficult to pursue interests outside medicine. Furthermore, the long working hours, although more reasonable than in times past, can adversely affect their personal lives and, in turn, patient care. Some junior doctors feel unsupported by hospital administration.[3,24] They feel dissatisfied with arrangements for covering absent or sick colleagues. House officers may thus feel obliged to work even when unwell, with potentially negative consequences for their own well-being and the quality of patient care.

Conclusion

The typology shows the wealth of ethical challenges faced by house officers. To deal adequately with these challenges, house officers and medical students should receive appropriate and problem-specific training at the undergraduate level and during the first years of clinical practice. The issues in Table 1 tend to fall within what has been called the 'ethics of the ordinary' rather than the more dramatic ethical problems which, although fascinating, may be far removed from the realities of life as a house officer.[25] Although the proposed core curriculum in medical ethics and law in the UK incorporates several of the issues identified in our typology, it also includes topics such as the ethics of the new genetics and aspects of resource allocation which are of secondary importance to most medical students.[26] We suggest that undergraduate medical ethics curricula, necessarily constrained by the demands of other subjects, should give priority to the real-life issues that students will encounter in their first years of practice. A strong emphasis on the types of ethical problems we have described, rather than the classic bioethical dilemmas, would best equip graduates for the challenges of life as a junior doctor. Our typology can serve as a useful resource for teachers of medical ethics and law and for educators involved in curriculum development.

References

1 Finucane P, O'Dowd T. Working and training as an intern: a national survey of Irish interns. *Med Teacher* 2005;**27**:107–13

2 Daugherty SR, Baldwin DC, Rowley BD. Learning, satisfaction, and mistreatment during medical internship – a national survey of working conditions. *JAMA* 1998;**279**:1194–9

3 Goldacre MJ, Davidson JM, Lambert TW. Doctors' view of their first year of medical work and postgraduate training in the UK: questionnaire surveys. *Med Educ* 2003;**37**:802–8

4 Holm S. *Ethical problems in clinical practice: The ethical reasoning of health care professionals.* Manchester: Manchester University Press, 1997

5 Mumford E. *Interns: From Students to Physicians.* Cambridge, MA: Harvard University Press, 1970

6 Miller SJ. *Prescription for Leadership: Training for the Medical Elite.* Chicago: Aldine, 1970

7 Bosk C. *Forgive and Remember: Managing Medical Failure.* 2nd ed. Chicago: University of Chicago Press, 2003

8 Cassell J. *Life and Death in Intensive Care.* Philadelphia: Temple University Press, 2005

9 Rosenbaum JR, Bradley EH, Holmboe ES, Farrell MH, Krumholz HM. Sources of ethical conflict in medical housestaff training: a qualitative study. *Am J Med* 2004;**116**:402–7

10 Green MJ, Farber NJ, Ubel PA, *et al.* Lying to each other – when internal medicine residents use deception with tumor colleagues. *Arch Intern Med* 2000;**160**:2317–23

11 Sinclair S. *Making doctors: an institutional apprenticeship.* Oxford: Berg, 1997

12 Green MJ, Mitchell G, Stocking C, Cassel CK, Siegler M. Do actions reported by physicians in training conflict with consensus guidelines on ethics? *Arch Intern Med* 1996;**156**:298–304

13 Paice E, Rutter H, Wetherall M, Winder B, McManus IC. Stressful incidents, stress and coping strategies in the pre-registration house officer year. *Med Educ* 2002;**36**:56–65

14 Clark PA. What residents are not learning: observations in an NICU. *Acad Med* 2001;**76**:419–24

15 Lambert TW, Goldacre MJ, Evans J. Views of junior doctors about their work: survey of qualifiers of 1993 and 1996 from United Kingdom medical schools. *Med Educ* 2000;**34**:348–54

16 Bruce CT, Thomas PS, Yates DH. Health and stress in Australian interns. *Intern Med J* 2003;**33**:392–5

17 Bellini LM, Baime M, Shea AJ. Variation of mood and empathy during internship. *JAMA* 2002;**287**:3143–6

18 Baldwin DC, Daugherty SR, Rowley BD. Unethical and unprofessional conduct observed by residents during their first year of training. *Acad Med* 1998;**73**:1195–1200

19 Feudtner C, Christakis DA. Do clinical clerks suffer ethical erosion? Students' perceptions of their ethical environment and personal development. *Acad Med* 1994;**69**:670–9

20 Testerman JK, Morton KR, Loo LK, Worthley JS, Lamberton HH. The natural history of cynicism in physicians. *Acad Med* 1996;**71**:S43–S45

21 O'Rourke A. Dealing with prejudice. *J Med Ethics* 2001;**27**:123–5

22 Kushner TK, Thomasma DC, editors. *Ward ethics: Dilemmas for medical students and doctors in training..* Cambridge: Cambridge University Press, 2001

23 Christakis DA, Feudtner C. Temporary matters: the ethical consequences of transient social relationships in medical training. *JAMA* 1997;**278**:739–43

24 Goldacre M, Stear S, Lambert T. The pre-registration year: The trainees' experience. *Med Educ* 1997;**31(Suppl 1)** :57–60

25 Worthley JA. *The ethics of the ordinary in healthcare: concepts and cases.* Chicago: Health Administration Press, 1997

26 Doyal L, Gillon R. Medical ethics and law as a core subject in medical education. *BMJ* 1998;**316**:1623–4