ETHICAL DECISION-MAKING AS AN INTERVENTION FOR MORAL DISTRESS EXPERIENCED BY PSYCHIATRY RESIDENTS

A Thesis
Submitted to
the Temple University Graduate Board

In Partial Fulfillment
of the Requirements for the Degree
MASTER OF ARTS

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May 2024

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ABSTRACT

Moral distress in the healthcare field includes feelings of frustration, anger, guilt, anxiety, depression, despair, and powerlessness to carry out ethically appropriate actions to patients in line with personal values in the setting of external constraints. Psychiatry residents are particularly vulnerable to experiencing moral distress due to the coercive aspects of psychiatric treatment, constraints in the medical system, and the internal conflicts caused by a resident's identity as a trainee physician and competing duties to an individual patient, healthcare organizations, health care professionals, and society. Psychiatrists make complex assessments that often cannot be made with absolute certainty, but regardless, they are tasked with the duty to identify and ultimately act on their risk assessments. These unrealistic societal expectations are especially difficult for psychiatry residents who have not yet had the experience to grow their knowledge and confidence in their decision-making skills yet still must make difficult decisions in their new role as physicians. Ethical decision-making can be used to alleviate moral distress, and a consistent utilization of an ethical decision-making framework can help guide decisions that are both objective and thoughtful. The ethical framework proposed includes considerations of the patient's capacity to consent or refuse medical treatment, the urgency of the medical condition, the feasibility of the actions needed to address the medical condition, and the countertransference of the treatment team. This framework helps guide clinicians by ensuring they understand and address the ethical considerations involved in treating patients and the moral distress that arises from these difficult choices.

ACKNOWLEDGMENTS

I would like to thank my advisor, Dr. Nora Jones, and my mentors, Dr. Pietro Miazzo, Dr. Ellen Gluzman, Dr. Mary Morrison, and Dr. Jenny Lugo, for all of their guidance and wisdom that they shared with me. I would also like to thank my family and friends for their endless support and encouragement. Lastly, I would like to thank and express my gratitude to my patients. I have learned so much from them.

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CHAPTER 1

INTRODUCTION

Psychiatrists have a duty to serve and treat patients who cannot always advocate for themselves. At times, this includes involuntarily committing a patient to a psychiatric hospital if they are a harm to themselves, a harm to others, or they are unable to care for themselves (Ganzini et al., 2004). These actions follow the ethical principles of beneficence but need to be balanced with the duty to respect a patient's autonomy in the context of, historically, a very paternalistic field. Thus, capacity and coercion are important considerations to be mindful of when making clinical decisions. During my psychiatry residency training, I have encountered cases where there was not a clear-cut answer on what to do when a patient with an acute psychiatric condition affecting their capacity needed urgent, but not emergent, evaluation for medical concerns. This led to feelings of moral distress in me, wanting to give the best care I could provide but not having the guidelines and structure to make the exact "right" decision.

In the inpatient setting, involuntarily committed patients are not allowed to leave the unit unless discharged by the mental health court system or deemed appropriate for discharge by the treatment team, and so their range of treatment options and choices is restricted, similar to the prison setting. We need to ensure that these patients are still getting the care they can access in the community, which means that we should treat not only their psychiatric conditions but also their medical conditions. In this thesis, I introduce the concept of moral distress and its impact on patient care, discuss common causes of moral distress and the reasons why it is prevalent in psychiatry residency, and discuss interventions to alleviate moral distress, including the utilization of an ethical

decision-making framework. In doing so, I hope to help other psychiatry residents feel more confident in making ethical clinical decisions and alleviate some moral distress prevalent in this field.

CHAPTER 2

MORAL DISTRESS OF PSYCHIATRY RESIDENTS

An Introduction to Moral Distress

Moral distress was originally described by philosopher Andrew Jameton in a 1984 study about nurses who morally disagreed with a treatment decision but felt obligated to participate (Herschkopf, 2021). These nurses were described as having an emotional reaction, termed moral distress, when institutional constraints made it nearly impossible to pursue what they believed to be the right course of action (Bader & Herschkopf, 2019). The term moral distress has since expanded to include feelings of frustration, anger, guilt, anxiety, depression, and despair due to a threat to one's moral integrity, and in the healthcare field, feelings of powerlessness to carry out ethically appropriate actions to patients in line with personal beliefs and core moral values in the setting of external constraints such as institutional limitations, lack of resources, and competing duties to an individual patient and to health care organizations, other health care professionals, family members, or society as a whole (Austin et al., 2008; Bader & Herschkopf, 2019; Herschkopf, 2021; Hamric et al., 2012; Perni, 2017).

Others have more recently noted the vulnerability of students and trainees to experiencing moral distress: "Medical students and junior practitioners may be particularly challenged by morally distressing situations. Their development into attending physicians involves a process that is complex intellectually, sociologically, and culturally, and is no less complex in its moral dimensions" (Berger, 2014, p. 395). Residency training can also be a time of high stress, long work hours, sleep deprivation, isolation from loved ones, and there is an increased incidence of depression (Hoop,

2004). In this setting, when external constraints make it difficult or impossible to act according to one's moral principles, those experiencing moral distress can also experience burnout, which includes poor coping mechanisms such as moral disengagement, blunting, denial, and interpersonal conflict (Perni, 2017).

Moral distress should be distinguished from ethical dilemma distress, burnout, and post-traumatic stress disorder (PTSD). What distinguishes moral distress from these other concepts is that there is a distress that comes from a belief that one has failed to act ethically; there is a moral conflict as one has been made to act in a way that compromises their moral integrity and values (Austin et al., 2008; Hamric et al., 2012). In an ethical dilemma, one has to decide what the right thing to do is between more than one ethically justifiable action without a clear, correct answer. However, in moral distress, one does know what the ethical action is but cannot act on it (Austin et al., 2008; Bader & Herschkopf, 2019). Burnout is a state of mental, emotional, and physical exhaustion caused by demands in the workplace - including but not limited to high expectations, intensive working hours, administrative requirements limiting time spent with patients, and billing and productivity requirements - with symptoms of malaise, fatigue, frustration, cynicism, inefficacy, depersonalization, and a diminished sense of personal accomplishment (Dean et al., 2019; Sales et al., 2021). Burnout is also essential to recognize and prevent, as it can lead to work dissatisfaction, increased medical errors, and reduced quality of care (Sales et al., 2021). Burnout and moral distress are not mutually exclusive, and burnout can be associated with moral distress which then puts providers at risk of "[…] withdrawal from the moral dimensions of patient care, conscientious objection, or leaving the profession altogether" (Hamric et al., 2012, p. 1).

When an individual experiences moral distress repeatedly, the effects can be cumulative and long-lasting. This is called moral injury. Moral injury was first described in a group of veterans returning from the Vietnam War with symptoms that were similar to PTSD but did not respond to PTSD treatment. This group was experiencing moral injury. It was found that unlike in PTSD, where the triggers include experiencing a threat to their mortality during the war, this group had been forced to act on orders that were contrary to their beliefs, such as killing civilians (Dean et al., 2019). “Moral injury occurs when we perpetrate, bear witness to, or fail to prevent an act that transgresses our deeply held moral beliefs" (Dean et al., 2019, p. 400).

Moral Distress and Moral Injury in Psychiatry

Moral distress and moral injury are particularly prevalent in the healthcare field. Physicians take the Hippocratic oath and are taught to always put the needs of a patient first, yet in reality, their workload increasingly is burdened with taking care of the needs of the healthcare system, and thus spend less time directly with patients (Dean et al., 2019). Healthcare providers will continue to experience moral distress if they are taking care of their patients in a system where constraints outside of their control force them to act against their personal moral values (Sales et al., 2021).

Moral distress is especially applicable to Psychiatry as ethical considerations are prevalent in this field, and the nature of a psychiatrist's role has conflicting duties. Psychiatrists are responsible not only for acting in the patient's best interest but also for balancing their duties to the patient and to other healthcare team members and society (Austin et al., 2008; Bader & Herschkopf, 2019; Hundert, 1987). Take into consideration a psychiatrist's ability to involuntarily commit a patient in the setting of a primary

psychiatric disorder that would benefit from inpatient psychiatric hospitalization. This action takes away a patient's autonomy, but is morally justified if it is trumped by beneficence, i.e. to protect the patient from themselves or to protect others in society.

Prior literature has explored this double-bind further, noting that the assessments required of psychiatrists, including an assessment of a person's state of mind and the risk of harm to self or others, are complex and often not able to be made with absolute certainty but regardless, psychiatrists are tasked with the duty to identify and ultimately to act on these risk assessments (Austin et al., 2008; Bader & Herschkopf, 2019). As psychiatrists are only able to make psychiatric evaluations and risk assessments, and cannot predict the future with absolute conviction, it can be an unrealistic demand for psychiatrists to make the one "right" decision each and every time. This expectation from society and the legal system pressures psychiatrists "[...] to act in ways that are inconsistent with their own estimation of medical knowledge, skills and responsibilities. In trying to uphold their professional obligations to society, psychiatrists are placed in intolerable and morally distressing situations" (Austin et al., 2008, p. 95).

These competing responsibilities can lead to feelings of moral distress in many clinical cases. In Emergency Psychiatry, patients who do not meet the criteria for inpatient hospitalization and are recommended to follow up in an outpatient setting may not be able to if they are also experiencing homelessness and have difficulty accessing care. Should these social barriers be a reason to admit the patient? With a finite amount of inpatient beds this is not always possible, especially when there are so many patients that do require inpatient admission. This is not to say that the patient would not benefit at all from admission but that other patients may “need it more”. However, discharging a

patient like this can be challenging and morally distressing for the resident who makes this decision. Seeing the same patients return repeatedly because they cannot access adequate care further compounds this distress. In the Inpatient Psychiatry setting, patients are generally started on psychotropic medications for stabilization. What if a resident is treating a patient who declines to take any medications and asks to be discharged, who then does not improve during their hospital course but suffers from feeling their liberty taken away? Is hospitalization when this patient is not benefiting from the proposed treatment truly in the patient's best interest? In Outpatient Psychiatry, a resident meeting with their first psychotherapy patient may feel they do not have the clinical experience to help the patient and may feel guilty knowing that their patient may not know this. Perhaps this patient can only use the resident clinic as they have been on the wait-list for other clinics for months and cannot afford the out-of-pocket costs of a private clinic. These feelings can lead to moral distress for the resident, who also might feel the patient is being coerced to be used as a training tool for them. I will further explore the common causes of moral distress experienced by psychiatry residents later in this thesis.

I have discussed the prevalence of moral distress in Psychiatry and the vulnerability of students and trainees to moral distress. One can then conclude that psychiatry residents are particularly set up to experience moral distress. On top of the difficult training experience where trainees work long hours with acute and complex patients, psychiatry residents must learn how to balance the needs of patients and society (Herschkopf, 2021). This is especially difficult when there are unrealistic societal expectations of psychiatrists, and they have not yet had the experience to grow their knowledge and confidence in their decision-making skills yet still have to make difficult

decisions in their new role as physicians. As previously discussed, repeated instances of moral distress lead to moral injury, which impacts personal well-being and can negatively impact patient care. We do our best work when we are physically and mentally well. Thus, it is a part of good clinical care to address moral distress and moral injury.

It is important to understand moral distress and injury so that residents can recognize and address it in themselves and others. Moral distress is associated with feelings of frustration, anger, guilt, anxiety, depression, despair, and powerlessness. These experiences may also engender feelings of cynicism and dissatisfaction in their roles as physicians, which can persist and cumulatively add to higher baseline levels of distress with more experiences of moral distress (Berger, 2014; Sales et al., 2021). Clinicians may also have diminished empathy and engage in depersonalization, blunting, denial, and gallows humor to cope and protect them from experiencing further distress (Berger, 2014; Sales et al., 2021). These feelings and experiences can lead trainees to feel guilty and ashamed, making it especially difficult to talk about with others. I encourage psychiatry residents to check in on their internal states and to check in with each other. They should not blame themselves and instead recognize that they feel this way due to external constraints that have been put upon them and their patients.

Common Causes of Moral Distress in Psychiatry Residents

I will now discuss common factors that engender feelings of moral distress in psychiatry residents, including gaps in medical education and training on ethical principles and moral distress, coercive aspects of psychiatric treatment, and lack of resources in the medical system. I will especially focus on exploring the internal conflicts of trainees that make moral distress prevalent in psychiatry residency.

Gaps in Medical Education and Training on Ethical Principles and Moral Distress

Unfortunately, there are often no clear-cut answers for what decisions should ultimately be made. Complex cases require difficult decisions, and even when a physician is confronted with impossible scenarios from which to choose, a decision still must be made. This is another factor that leads to moral distress, especially for psychiatry resident trainees who are new to the field, who have suddenly become directly responsible for the care of their patients, and who may not yet have the experience to be confident in their decisions.

This cause of moral distress is especially applicable to psychiatry residents involved in capacity consultations through the Psychiatry Consultation Liaison service. Psychiatry trainees, despite having less experience, are often at the forefront of difficult conversations with patients, families, and medical teams. They also bear the weight of carrying out the directions of senior residents or attending physicians with whom they may disagree with and may feel the emotional weight of making an ultimate decision. These factors, taken together, increase the likelihood of moral distress (Bader & Herschkopf, 2019).

Additionally, psychiatry residents often do not have the ethics training that would help navigate these difficult decisions. The literature explores this further by noting the lack of formal ethics education in the clinical years of medical education and the importance of teaching ethics alongside clinical decisions (Berger, 2014; Hundert, 1987). Psychiatry residents should, of course, be taught the basics of bioethics, including Beauchamp and Childress' four principles of biomedical ethics—autonomy, beneficence, nonmaleficence, and justice. They should also be taught about moral distress, how to

recognize it in themselves, and how to address it. They should also be taught this in a way that integrates clinically relevant information on ethics with everyday medical activities and decision-making (Roberts et al., 1996).

Coercive Aspects of Psychiatric Treatment

Another factor that often leads to the experience of moral distress in psychiatry residents is the coercive elements of psychiatric treatment. These elements can be both overt and covert, and in the history of a paternalistic field, all psychiatry residents should be cognizant of the existence and potential for coercion and act to ensure ethical treatment of psychiatric patients.

When deciding to commit a patient involuntarily, a psychiatry resident must balance a patient's autonomy with beneficence and nonmaleficence. That is, they must decide whether involuntarily committing a patient, which takes away their liberty, is justified in order to prevent harm from happening if the patient poses a risk to themselves or others (Herschkopf, 2021). Involuntary commitment to the inpatient psychiatric unit then leads to feelings of coercion as the patients are not allowed to leave when they want to, and they are not allowed to discontinue their treatment at times, even if they are unhappy with their experiences on the inpatient unit (Katsakou et al., 2010). Coercive measures include physical restraint, forced medication, and seclusion, which are at times unavoidable. However, the way these acts are delivered, negotiated, and explained affects how the patients perceive these measures and these measures need to be justified and considered when no less restrictive alternatives are possible (Chieze et al., 2021). The literature recommends ensuring patient participation in treatment decisions and effective communication among team members and patients to lessen feelings of coercion and

increase feelings of understanding and acceptance of treatment decisions (Chieze et al., 2021; Katsakou et al., 2010).

Constraints in the Medical System

Though not unique to the field of Psychiatry, barriers to accessing care and the lack of resources in the medical system are significant causes of moral distress experienced by all healthcare team members. Healthcare workers work in a strained and broken system. Part of good clinical care is addressing the social determinants of health, and people need to have their basic needs met first to engage in mental health treatment. This is not possible for many people. There is a lack of homeless shelters, a lack of walk-in mental health centers, and limited bed availability in mental health facilities and substance use treatment centers. Even when patients are able to make it to an emergency room or a crisis center, they may be stuck waiting there for days for placement. In the long wait, many patients will ask to be discharged. Patients cannot take their medications if they cannot afford them, their insurance will not cover them, or if there is a shortage of those medications. They cannot access outpatient psychotherapy or psychiatric medication management when there are months-long wait-lists or even no openings, if they are not able to pay the out-of-pocket fees of private practices, if they have limited coverage from their insurance provider and cannot find a clinic that accepts their insurance, if they do not have a phone or internet access to call the clinics, or they do not have a way to get to these clinics. They cannot access effective treatments, for example, electroconvulsive therapy for treatment-resistant depression, exposure response and prevention therapy for obsessive compulsive disorder, or dialectical behavioral therapy for borderline personality disorder, if these resources are not accessible in the

community. Treatment decisions are no longer based solely on clinical information in these situations as they now have to account for the limitations of the system.

Working in this setting can lead not only to frustration with the medical system but also to feelings of hopelessness and ineffectiveness. Psychiatry residents directly witness the suffering of patients who often present when they are most vulnerable. The residents may feel they are not doing enough to serve their patients and apologetic for the constraints of the medical system that are outside of their control.

In the time of electronic medical records, psychiatry residents are spending a significant amount of time and mental energy on documentation and especially learning how to document to cover themselves from a legal perspective (Hamric et al., 2012; Sales et al., 2021). They have to focus on meeting insurance reimbursement requirements and following hospital policies, all of which must be done in a timely manner while working as a trainee in a residency program that comes with its own duties, including actively engaging in didactic lectures, meeting training requirements, responding to messages, working on research projects and extracurricular activities, and keeping up with the literature. All of this takes away from time spent directly with their patients and adds to the feeling of moral distress.

Internal Conflicts

The internal conflicts experienced by psychiatry residents also contribute to the moral distress prevalent in this field. I discuss how psychiatry residents' identity as trainees and their conflicting duties to their patients, supervisors, the institutions they are employed by, and society in general cause these internal conflicts.

Identity as a Trainee Physician

A psychiatry resident's identity as a trainee can lead to moral distress due to their position on the lower end of the medical hierarchy, their lack of experience and clinical expertise leading to self-doubt, and concerns about being evaluated by attendings they are working with (Perni, 2017). Having just graduated from medical school and earned their medical degree, these trainees go through a significant transition by starting their residency as physicians with direct responsibilities for patient care. This transition can be difficult for new graduates and it is important to be prepared for it as they "[...] may fail to internalize their accomplishments during times of transition and struggle with self-doubt and the fear of being exposed as a fraud. The "impostor syndrome" has been associated with comorbid depression, anxiety, job dissatisfaction, and burnout" (Sales et al., 2021, p. 4).

This transition also happens in the context of having endured many years of schooling, exams, and various extracurricular activities to be competitive applicants until they have finally met their goal of becoming a physician. They have been told that medicine is not just a job but a privilege and feel lucky and thankful to have matched into a residency spot. Their identity as a physician can become all-consuming in this manner, but each resident is an individual with their own unique life experiences, perspectives, and values. All individuals deserve compassionate care, not just our patients.

Furthermore, medical students and trainees can become indoctrinated to believe that the patient must always come first, even at the cost to their own well-being, and this identification to their work can cause difficulties in recognizing flaws in the medical system that lead to stress and moral injury (Sales et al., 2021). On top of this, they may

feel they are doing a disservice to their patients due to their lack of clinical expertise and feel guilty for engaging in learning practices that treat the patient as an educational tool.

The hierarchical nature of medicine puts the new residents at the bottom, having to do things they may not feel qualified to do yet or defer treatment decisions to more senior team members and attending physicians, even if they may not agree with the decision (Herschkopf, 2021). They may also feel afraid to speak up about their ethical concerns for fear of poor evaluations, retaliation, or threat to their residency spot that they have worked so hard for and feel "privileged" to have.

Conflicting Duties

Psychiatry residents not only have to balance a patient's right to autonomy by respecting their values and decisions and beneficence by acting in the best interest of the patient, but they must also balance the competing duties they have to society, their training program, and the health care system they are a part of. As a result of balancing these competing and at time conflicting ethical responsibilities, psychiatry residents experience internal conflicts (Hoop, 2004).

Hoop (2004) distinguishes dual roles of physician and learner, physician and supervisee, and physician and employee of a training institution. Psychiatry residents undertake the responsibility of learning how to best care for their patients, but to do that, they must get further training in their specialty and this involves learning “[...] from current patients in order to adequately provide for future ones, and it stems from the benefits society receives by producing fully trained clinicians" (Hoop, 2004, p. 2).

Psychiatry residents are supervised by attending physicians during their training, and the attendings hold the ultimate legal responsibility for a patient's care. The

supervising attending is also responsible for assessing the resident's abilities and delegating increasing responsibility to the resident as they become more clinically experienced. Residents will also have an assigned attending(s) as their supervisor during their residency training. Residents routinely meet with their supervisors to discuss patient cases, treatment plans, and research papers, and it is meant to feel supportive. In this setting, a psychiatry resident may feel conflicted when they have to balance the duty to their patient with the duty to their supervisor whom they may disagree with (Hoop, 2004).

Lastly, psychiatry residents are paid employees of hospital systems and thus bound by institutional policies. Conflicts arise when the residents must follow the rules of the institution they work for, even if they do not agree with the policies or believe them to be unethical (Hoop, 2004). All of these internal conflicts, created by the dual roles of psychiatry residents, can lead to moral distress and moral injury.

Ethical Decision-Making in Difficult Cases

Psychiatry residents often encounter challenging cases that can make ethical decision-making difficult and give rise to moral distress.

Countertransference Reactions

The term countertransference was first used by Sigmund Freud in 1910 and is typically used in the modern day to refer to all reactions, emotional or behavioral, conscious or unconscious, a clinician has toward their patient (Herschkopf, 2021; Rao et al., 1997). Countertransference is clinically useful as it can be used to understand the patient better, though it is important to understand that countertransference reactions can lead to unethical decision-making, especially in difficult cases.

Unethical decision-making happens when clinicians do not follow ethical principles and base their treatment decisions instead on personal values and feelings. Complex clinical cases are especially vulnerable to this. For example, residents working in an Emergency Psychiatry setting will often see the same patients come in repeatedly. A subset of these patients may be manipulating the system for secondary gain. A patient may present for suicidal ideation and then later reveal that they had feigned their suicidality in order to get shelter and food. Seeing this over and over again when there are already limited resources, as discussed earlier, a limited amount of time to see each patient in a busy clinical setting with many more patients to see, and when the residents are already over-worked can engender increasingly negative feelings of apathy, anger, and even hate. This can make a resident push for discharge or put minimal effort into their care. Another example that can cause distressing feelings is the treatment of patients with borderline personality disorder who have chronic suicidality and many other patients who have chronic emotional suffering that are "not getting better." This is often difficult to treat and can cause clinicians to feel hopeless or view their patients as a hopeless cause. These patients can also remind clinicians of loved ones who have refused to get help for their mental health problems and cause the clinicians to unconsciously react negatively toward these patients. In the Inpatient Psychiatry setting, patients who become agitated and may verbally or physically abuse other patients or staff members may invoke feelings of anger and malice in a clinician that may lead them to use excessive amounts of medications or restraints that, upon further analysis of their reasoning, can be comprehended as a way to punish those patients.

For physicians who have been entrained to put the patient's best interests first and in other settings would not act this way towards their patients, this can lead to feelings of moral distress. It is important to note here that clinicians are not robots. It is expected that they will feel emotions toward their patients, and I argue that there is an additional influence of constraints in the medical system that compounds feelings of moral distress.

These are negative countertransference reactions to patients, but even positive countertransference reactions can lead to unethical decision-making. For example, imagine an elderly, ailing patient who reminds a psychiatry resident of their beloved grandparent. They may suggest more aggressive treatment plans because subconsciously, they want their grandparent to stay in their life as long as possible, even if the patient values treatments that improve quality of life but may not necessarily prolong their life.

Ways to mitigate countertransference reactions that lead to unethical decision-making include being aware of one's values and biases, recognizing when one is experiencing a strong feeling or preference regarding a treatment decision, and asking for a second opinion from peers with differing values to prevent mistaking the physician's preferences for the patient's (Howe, 2009; Kontos et al., 2015).

Capacity Evaluations

Capacity evaluations done in the Consultation-Liaison setting can lead to moral distress in several ways. Typically, these are consults to assess a patient's capacity to refuse treatment. Ideally, the psychiatry resident would be able to equally balance ethical principles of autonomy, beneficence, nonmaleficence, and justice to assess decision-making capacity in all cases, but in reality, this does not commonly happen, and difficult decisions must be made.

Capacity assessments have important legal, social, and ethical implications, and in the context of Western society's emphasis on liberty and autonomy, it can be difficult to navigate cases when a patient's treatment choice is not aligned with treatment recommendations from the treatment team. The team is following ethical principles of beneficence, i.e., to do what is in the patient's best interest, and nonmaleficence, i.e., to protect the patient from harm. However, this conflicts with their duty to respect the patient's right to make autonomous choices for their care (Bader & Herschkopf, 2019; Herschkopf, 2021; Kontos et al., 2013; Navin et al., 2019).

In this setting, consultation requests for capacity evaluation can be viewed as a way to address ulterior goals of deferring difficult ethical and legal decisions (Bader & Herschkopf, 2019; Herschkopf, 2021; Kontos et al., 2013). The psychiatry residents may feel moral distress when they feel pressure from the primary team to make a decision that aligns with the team's recommendation (Bader & Herschkopf, 2019). These types of capacity evaluations may be utilized even if there is no overt suspicion about decision-making capacity (Kontos et al., 2013). For example, if a team wants to discharge an irritable, verbally abusive patient who is demanding to leave against medical advice, an assessment of having capacity in this situation would allow the treatment team to be rid of this patient. In another example, if a team has a patient who frequently presents to the emergency room with a breakthrough seizure as they decline to take anti-epileptic medications, an assessment of lacking capacity in this situation would perhaps allow the patient’s autonomy to be overridden even if the patient is able to state to their treatment team clearly why they do not take their medications. Rather than being consulted for their professional evaluation, the psychiatry residents may feel pressured and left with the

moral burden of making clinically and emotionally difficult decisions outside of their scope of practice (Bader & Herschkopf, 2019).

CHAPTER 3

ADDRESSING MORAL DISTRESS THROUGH ETHICAL DECISION-MAKING AND OTHER INTERVENTIONS

Ethical Decision-Making Framework

I propose that ethical decision-making can be used to alleviate moral distress. I have discussed that internal conflicts, dual roles, complex cases, and limitations of the medical system all lead to moral distress. In this setting, when residents are still asked to make the ultimate decision in very difficult cases and when they also have self-doubt due to a lack of clinical experience and knowledge, the consistent utilization of an ethical decision-making framework can help guide them to a decision that is both objective and thoughtful.

From the literature review and my own experiences during psychiatry residency training, I propose a framework on which to guide ethical clinical decisions for cases where there are concerns regarding a lack of decision-making capacity or a need for treatment over objection. Treatment decisions in these cases can be particularly distressing due to the complex balancing of ethical principles that carry different moral weights for each patient and each clinician. It is also ethical from a justice standpoint to use a standard framework for treatment decisions: "[…] some clinicians could be more conscientious than others in providing information or more skilled at communicating in a way that patients can easily understand" (Ganzini et al., 2004, p. 265). Ethically, a rigorous and consistent approach must be employed for each capacity assessment.

Capacity evaluations are also commonly requested for patients that belong to vulnerable groups, such as people with cognitive impairment, people with intellectual

disability, people with acute psychiatric concerns, and children (Berghmans & Widdershoven, 2003). Generally, in capacity evaluations a balance needs to be made between beneficence and autonomy. When there is a compromised ability for a patient to comprehend their illness, such as in these vulnerable groups, the patient's autonomy can be diminished (Lyckholm & Aburizik, 2017), though it is important to note that membership in this group does not automatically mean the patient lacks capacity. I will speak more on this later in this thesis.

The literature also expands on the moral significance of capacity assessments, noting that they are meant to protect both a patient’s autonomy to make decisions that affect their own health and also to protect a compromised patient who lacks decision-making capacity from their decisions (Baruth & Lapid, 2017; Berghmans & Widdershoven, 2003).

I have adapted this framework from Fischkoff et al.'s Classification Tree (Fischkoff et al., 2021) and Rubin and Prager's Seven Core Questions approach to guiding decisions on treatment over objection (Rubin & Prager, 2018). The framework includes considerations of the patient's capacity to consent or refuse medical treatment, the urgency of the medical condition, the feasibility of the actions needed to address the medical condition, and the countertransference reactions of the treatment team. I also include accompanying considerations to address throughout the decision-making process of maximizing the patient's understanding, considering the patient's values and emotions, and making decisions in the presence of acute psychiatric disorders that cause a decreased capacity to value. These considerations need to be taken in together and balanced against each other. The weight assigned to each consideration will be case-

dependent. This, of course, is only meant to be a guideline, prompting areas of consideration to explore, to assist with making difficult decisions, and to offer a framework on *how* to make the decisions, not *what* the decisions should be. I will now discuss the specifics of the framework I propose and refer to Figure 1 for a decision tree model of this framework.

Step 1: Assess the Patient's Capacity to Consent or Refuse a Medical Treatment

Informed consent is needed for a patient to consent to treatment. When there are concerns that a patient is unable to give informed consent, capacity is assessed by the treating physician. The most commonly used, accepted, and standard principles of evaluating decision-making capacity have already been discussed in depth in the literature (Baruth & Lapid, 2017; Berghmans & Widdershoven 2003; Berkowitz & Trevick, 2024; Ganzini et al., 2005; Kontos et al., 2015; Zhong et al., 2019) and are generally attributed to Appelbaum and Grisso's "Four Abilities" model of capacity. For the purpose of this thesis, I will only paraphrase them below:

1. Ability to communicate a clear and consistent choice
2. Ability to understand the relevant information
3. Ability to appreciate the situation and its consequences
4. Ability to reason about treatment options

These principles are in line with the American Medical Association Code of Medical Ethics on Informed Consent (2001).

The literature has called for an expansion of the "Four Abilities" model to include considerations of a patient's values and emotions that also influence decision-making,

instead of only cognitive factors (Berghmans & Widdershoven, 2003; Berkowitz & Trevick, 2024; Howe 2009; Kontos et al., 2015): "[...] what is missing is a mechanism by which to incorporate and weigh how a patient's emotional state, ability to value, authenticity of values driving decisions, and ability to envision a future influence their decision-making" (Berkowitz & Trevick, 2024, p. 3).

Decision-making capacity is affected by a person's emotional state (Howe, 2009; Kontos et al., 2015). A patient may be using their emotions to inform their judgment. In overwhelming situations, their emotional state can even override previously held values and instead prioritize independence or avoidance of pain, or cause them not to be able to participate in meaningful discussions needed to assess capacity (Kontos et al., 2015). The way patients prioritize their values can also change over time and not align with the treatment recommendation. For example, a patient with opioid use disorder who is admitted to the hospital for an infection can be in extreme discomfort from opioid withdrawal. They may be frustrated that their provider is not giving enough pain medication and the provider may not realize that the patient has a higher tolerance to opioids. In the acute sense, pain control may be more important than antibiotic treatment for their infection, and they may decide to leave against medical advice (AMA). This then triggers a capacity assessment to ensure the patient has the capacity to make the decision to leave AMA. The patient should get adequate pain control and withdrawal treatment as this may prevent them from engaging in a full capacity discussion. They may also be prioritizing this value of pain control over infection treatment when they would not if they were not in active opioid withdrawal. When the risks and benefits are weighed, it is more important and beneficial to control their pain, which may allow them

to stay in the hospital to get care, rather than not treat their pain and discharge them AMA. If possible, the capacity assessment should be done after they are more comfortable.

It is also important for the evaluating physician to consider the patient's previous life choices (Kontos et al., 2015). For the clinical example mentioned, previous encounters can be looked through to see if this patient was willing to stay for medical treatment in the past. This would give more evidence that their capacity is likely affected by their current state, with their reasoning clouded by pain. If instead, previous encounters note that they have had full discussions where they have declined further care and instead preferred to follow up as an outpatient, allowing the patient to leave AMA may be more justifiable. This is not to say that emotions should be disregarded as an irrational approach to decision-making; it is an important source of knowledge that allows further understanding of the goals and values a person considers important (Berghmans & Widdershoven, 2003). Thus, open and non-judgmental discussions between the providers and the patient are important for uncovering these values-based reasoning and compassionately coming to a decision together (Kontos et al., 2015).

Taking this into consideration, in the ethical decision-making framework I propose, I change the wording of the first point in the "Four Abilities Model" to: Ability to communicate a clear and consistent choice *that aligns with a patient's values*. I also recommend considering a patient's emotional state to assess decision-making capacity comprehensively.

Step 2: Consider the Urgency of the Medical Condition

When there is an urgent situation and the patient is unable to give informed consent due to a lack of decision-making capacity for the specific treatment intervention, a surrogate decision-maker can make a decision based on the patient's preferences and values, which is the substituted judgment standard (American Medical Association, 2001; Berkowitz & Trevick, 2024; Rubin & Prager, 2018). This standard should include considerations of "(ii) the patient's views about life and how it should be lived; (iii) how the patient constructed his or her life story; (iv) the patient's attitudes toward sickness, suffering, and certain medical procedures" (American Medical Association, 2001).

The best interest standard is utilized when there is an emergent situation, that is, when a patient presents with immediate danger of loss of life or limb, and the patient is unable to give informed consent, the patient's preferences and values are not known and cannot reasonably be inferred, there is no advanced directive, and there is not enough time to search for a surrogate decision maker (American Medical Association, 2001; Berkowitz & Trevick, 2024; Rubin & Prager, 2018). This means for a physician to act in a way a reasonable person would want done for themselves under a similar circumstance (Palmer and Iserson, 1997) and should be based on "(i) the pain and suffering associated with the intervention; (ii) the degree of and potential for benefit; (iii) impairments that may result from the intervention; (iv) quality of life as experienced by the patient" (American Medical Association, 2001). The physician can proceed without consent in these emergency situations and they must use their professional knowledge and act according to the principles of beneficence in this best interest approach. These standards are in line with the American Medical Association's Code of Medical Ethics section on

"Decisions for Adult Patients Who Lack Capacity" (2001), which also recommends consulting an ethics committee and institutional policies when there is no surrogate available, there are disagreements on who the appropriate surrogate is, there are disagreements on treatment decisions that cannot be resolved, or there is concern that the surrogate's decision is clearly not what the patient would want or not in the patient's best interest.

There are, of course, challenges when the cases are not emergent. In these situations, one must consider how much time a patient has before they decompensate and how the treatment decision will affect the patient. Would acting now prevent irreversible, fatal outcomes or lead to a significant recovery of functionality, and if so, at what cost to the patient and the therapeutic alliance? Forced measures involving physical restraints, chemical sedation, and surgical procedures that alter a patient's body are particularly traumatic and distressing, making these decisions less ethically justifiable (Fischkoff et al., 2021; Rubin & Prager, 2018). I will go over considerations for ethically deciding on treatment over objection further in Step 5 of the proposed framework. Ultimately, the treatment team should include the urgency and lethality of the clinical case as considerations in ethical decision-making.

Step 3: Consider the Feasibility of the Actions Needed to Address the Medical Condition

The treatment team should also consider the feasibility of the actions needed to address the medical condition. The literature stresses that even if there are ethical justifications to proceed with treatment over objection, logistical challenges can make this unreasonable or even impossible, especially when long-term efficacy relies on patient

cooperation and adherence (Berkowitz & Trevick, 2024; Fischkoff et al., 2021; Rubin & Prager, 2018). Additionally, the potential harms of forcing treatment onto patients can cause "[…] psychological and emotional distress, decreased trust in individual doctors and/or the wider medical profession, may have enduring negative effects on the therapeutic relationship" (Berkowitz & Trevick, 2024, p. 11) and thus, may be less ethically justifiable than an alternative treatment that may not be as clinically recommended but may be more realistically feasible.

For example, if a patient is believed to need more urgent evaluation in the emergency room but is refusing to be transported down, the team would have to consider the feasibility of how they would bring the patient down. Would this involve physical restraints, chemical sedation, or utilization of a wheelchair or a stretcher/medical bed? Similarly, if a patient refuses a physical examination of a subacute condition, would it be feasible to force this examination, undermine their autonomy, and cause acute distress for the sake of beneficence? Another example is if a patient refuses to give lab work or undergo imaging studies. Again, what steps would be needed to have a patient go through with this against their will? Suppose a patient declines to be still enough for lab work or imaging. In that case, this will not lead to any significant data and chemical sedation would likely be needed, but again, it would have to be balanced against the urgency of the medical condition. The same principles apply to a patient declining their anti-epileptic medications for a seizure disorder or blood sugar monitoring and insulin for diabetes. Because these situations require daily or multiple interventions, the patient would need to be forced to comply each time. The feasibility could be even more difficult for chemotherapy for cancer or dialysis for chronic kidney disease. Is it realistic to strap

someone down and force them to get these treatments that may prolong their life but can also lead to a decrease in quality of life?

An assessment of logistical barriers should include how likely a patient is to cooperate with the proposed treatment, how often the proposed treatment would occur, and how difficult the proposed treatment would be for a patient to maintain (Fischkoff et al., 2021). If the intervention recommended is not feasible, the discussion should then focus on finding an alternative that aligns with the patient's preferences and values and respects autonomy (Howe, 2009). As a part of this concept, the team should ensure that other acceptable and reasonable alternatives are explored and offered to the patients (Simon, 2007). For example, if a patient refuses to get lab work done but would be agreeable to getting their vital signs measured, that would provide more useful information than having no objective data at all.

Step 4: Complete a Psychiatric Evaluation and Identify Countertransference of the Treatment Team

In Consult-Liaison Psychiatry, it is also important to understand the treatment team's countertransference reactions regarding difficult situations. Internal conflicts may arise when a patient refuses the team's recommendations, leading to frustration and anger that may negatively affect patient care. Even when a patient does not appear to lack clinical decision-making capacity, a consult for a capacity evaluation may be placed due to conflicting views on the "right" course of action or ulterior motives as Kontos et al. (2015) describe: "In many of these cases, it is suspected that the capacity evaluation request is really a "euphemism for physicians' frustration in managing some patients who are unable to progress smoothly"" (Kontos et al. 2013, p. 103). Just because a patient

does not agree with the physician's recommendation does not mean they have to comply. Patients are allowed to make their choice even if it goes against what the physician wants for the patient. To avoid misunderstanding their own values for the patient's, as their own values should not be a part of decision-making, and not respecting the patient's autonomy, the treatment team should acknowledge their biases and analyze their countertransference and how these may impact their treatment recommendations.

The psychiatry resident, acting in the liaison role, can help not only to identify any underlying psychiatric disorders present, but can help to facilitate communication and understanding through their knowledge and skillset in understanding patients' values, effectively communicating, utilizing de-escalating techniques, and identifying and managing the underlying interpersonal dynamics of a clinical situation (Bader & Herschkopf, 2019; Kontos et al., 2013).

Step 5: Ethically Decide Whether to Carry Out Treatment Over Objection

Rubin and Prager's 2018 paper "Guide to Considering Nonpsychiatric Medical Intervention Over Objection for the Patient Without Decisional Capacity" offers a thoughtful approach that addresses medical, logistical, and psychosocial issues to decide on treatment over objection when the patient lacks capacity. They state that treatment over objection is more ethically justified when there is a greater severity of harm, imminence of harm, and efficacy of the recommended treatment. They also state that treatment over objection is less ethically justified when the treatment is more invasive, the outcomes are less certain, there is a greater likelihood and severity of emotional distress and complications of the treatment, and when there is more reason employed by a patient regarding their refusal (Navin et al., 2019; Rubin & Prager, 2018).

There is a duty to make these complex decisions based on ethical principles. It would not be ethically justifiable to have the clinician's own beliefs and values influence these weighty decisions or used to coerce a patient to make a decision, and it would not be in line with the principles of equity as "[…] an outcome based on a psychiatrist's moral view would not be justifiable because the outcome would be arbitrary" (Howe, 2009, p. 16).

It is also part of the ethical decision-making process in these situations to seriously take into account a patient's preferences, even when they lack the decision-making capacity to refuse the treatment. We respect the patient as a person by working through these complex considerations before deciding to treat a patient against their wishes (Hundert, 1987; Navin et al., 2019). Clinicians can experience distress in these settings, worrying that maybe they could have done more or even believing that a bad outcome was a result of a decision they made wrongly. These clinicians can reflect that they did what they could and based their decisions on ethical principles. A thorough evaluation had been done before a clinically and emotionally challenging decision was made. Let that give us some solace from moral distress.

Optimizing Decision-Making Ability and Clinician Understanding

It is important to optimize the patient's decision-making ability and the clinician's understanding of the patient throughout a capacity assessment. This can be accomplished by facilitating the patient's best performance as capacity can change over time (Baruth & Lapid, 2017). For patients whose cognitive ability is temporarily incapacitated (ex. developing medical conditions, mental health disorder, delirium), capacity should be regularly reassessed and, if possible, important discussions should be delayed until their

capacity is restored - while treating the underlying condition - or timed to correspond to periods when the patient is capable of making those decisions themselves (Baruth & Lapid, 2017; Fischkoff et al., 2021; Ganzini et al., 2004; Zhong et al., 2019).

Strategies that can help the team communicate with the patient and improve the patient's understanding of the clinical situation include repeating the clinical information, allowing time for the patient to process the information and possibly consult with their loved ones who can provide more information to clarify the patient's concerns, beliefs/values, and treatment preferences, using alternative forms of communication (ex. visual/video aids, oral and written information), and simplifying the information (ex. using the appropriate reading level) (Baruth & Lapid, 2017; Ganzini et al., 2004; Howe, 2009; Roberts et al., 1996; Zhong et al., 2019).

Effective conversations can also lead the treatment team to understand the reasons for refusing care and address patient concerns (Kontos et al., 2015; Roberts et al., 1996). They may learn that other concerns may prevent the patient from agreeing to care, such as pain or other discomfort, financial concerns, or insufficient knowledge about their condition, which the team can work to address (Simon, 2007; Zhong et al., 2019). An example of this is understanding that a patient is worried about staying in the hospital longer because they are worried their family cannot afford the hospitalization.

Considering Incapacity in the Setting of Psychiatric Diagnosis

Several papers in the literature have commented on the decision-making capacity of people with psychiatric diagnoses. Importantly, a patient with a psychiatric disorder should not be automatically presumed to lack capacity and thus not able to make the choices affecting their life. It has been found that capacity is preserved in the majority of

psychiatric patients and a patient's diagnosis alone does not indicate whether they lack decision-making capacity (Baruth & Lapid, 2017). Cognitive impairment, in which there can be a deficit in understanding and reasoning, was found to be most correlated with incapacity: in patients with schizophrenia, incapacity was more often correlated with cognitive impairment than with positive or negative symptoms, and in patients with mania, incapacity was more often correlated with cognitive impairment than with grandiosity and impulsivity (Baruth & Lapid, 2017; Kontos et al., 2015).

Though cognitive impairment can be a part of major depressive disorder (MDD), it is more likely the depressive biases that affect decision-making capacity and lead to ego-syntonic medical decisions including refusal of life-sustaining treatment (Kontos et al., 2015). Depression can impair a patient's ability to value their medical situation and treatment options, compromise the ability to appreciate the possibility of positive outcomes or a return to a non-depressed state, and decrease their self-concern, without affecting the factual understanding of their illness (Berkowitz & Trevick 2024).

In these situations, the literature recommends the importance of authenticity in understanding if the patient's decisions are based on pathologic values that come from MDD rather than truly based on a patient's preferences and values that are not held by the patient when they are not experiencing major depression (Berghmans & Widdershoven, 2003; Berkowitz & Trevick, 2024; Kontos et al., 2015). To do this, a restorative representation approach is utilized. In this approach, the surrogate decision maker bases decisions on the patient's "truest self" by focusing on the patient's history of treatment preferences and values while euthymic (Berkowitz & Trevick, 2024; Kontos et al., 2015). For example, if there is documentation that the patient had consistently refused treatment

relevant to the current situation even when they were not depressed, there would be more ethical justification to decide that the patient has the capacity to refuse treatment.

Of note, this would be ideal but not always possible in practice. The patients we work with often lack surrogates,"[...] particularly when they are homeless, elderly, mentally ill, or substance users" (Rubin & Prager, 2018, p. 826). When there is no surrogate decision maker that can provide information about the patient's life and values or no documentation found regarding this, it can be difficult to make a decision based on a restorative representation model, which makes ethical decision-making more difficult for our most vulnerable members of society that have been let down by the current medical system.

Difficulties also arise when a patient’s condition is more chronic and becomes a large part of their identity, as in some cases of substance use disorders, eating disorders, and personality disorders (Kontos et al., 2015). When these patients' identity is chronically affected and perhaps shaped by these disorders, the patient's authentic values may be indistinguishable from their "pathologic values". Psychiatric advanced directives can help in these situations (Berkowitz & Trevick, 2024). Psychiatric advanced directives are not commonly used, perhaps because many clinicians and patients do not know they exist. I encourage psychiatry residents and psychiatrists to discuss them with their patients to prevent unethical decisions from being made.

Ultimately, psychiatry residents should understand that they are not the ones making the ultimate decision and the moral burden should not fall on just them. Through shared-decision making, as described in this framework, the moral burden is shared between all involved. The team recommending the treatment is responsible for doing a

comprehensive capacity assessment, which involves discussing the risks and benefits of their proposed treatment, alternative treatments, and no treatment, taking emotions and values into thoughtful consideration, working to improve their patient's understanding, and communicating with the surrogate decision-maker, families, and friends if applicable (Ganzini et al., 2004). It is up to the surrogate decision maker or a court-appointed legal guardian to make the final decisions.

Other Interventions to Address and Alleviate Moral Distress for Psychiatry Residents

I have discussed how to utilize ethical decision-making as a way to alleviate moral distress for psychiatry residents who are often presented with difficult decisions to make for reasons I have stated above. I will now present interventions, some that can be structured into psychiatry residency programs and some that are self-directed, which if adopted and implemented, could promote a culture where we are aware of moral distress, can recognize it in ourselves and in our trainees, and can work together to lessen moral distress for the sake of all involved.

Structured Interventions for Moral Distress in Psychiatry Residency Programs

Clinical Ethics Teaching in Residency

Psychiatry residents should have early and repeated access to education and training on ethical issues in Psychiatry. Didactic lectures should expand on the basic principles of biomedical ethics that trainees are taught in undergraduate courses and medical school and explore ethical principles, ethical considerations specific to the subspeciality settings (ex. Inpatient Psychiatry, Outpatient Psychiatry, Emergency

Psychiatry, Consult-Liaison Psychiatry, etc.), ethical decision making, and moral distress. Junior residents should also be informed about the internal conflicts they may encounter due to their conflicting duties (Hoop 2004). The literature has highlighted several ways the ethics curriculum can be integrated into psychiatry residency training, including through case-based ethics education sessions, difficult patient cases debriefings, didactic programs on medical and professional ethics, and skill-building workshops on mediation, communication, and conflict management (Berger, 2014; Perni, 2007; Scher & Kozlowska, 2020).

Supervision

Supervision is structured into psychiatric residency training and, when adequate, can be an effective way for trainees to not only discuss clinical cases but also explore ethical considerations. Supervision is an ideal place for ethics teaching as it is a structured time to focus on the care of individual patients and reflect upon one's perceptions and behavior in caring for patients, and because the supervisor would already know the institutional culture of the training program and any constraints on treatment decisions (Roberts et al. 1996). In this structured setting, ethical dilemmas may be clarified, moral distress can be identified, and supervisors can address moral distress by providing a safe space for trainees to share their feelings and problem-solve together ways to work on these conflicts (Bader & Herschkopf, 2019). For psychiatry residents who bring up ethical concerns about treating a patient as a trainee, a supervisor can encourage the resident to inform their patients that they are a trainee and discuss how being treated by a resident in a training program can affect their treatment (Hoop, 2004).

Supervisors can help recognize and identify moral distress by being attuned to the feelings of the residents they supervise. They should gently ask their trainees if they have had clinical encounters or patient experiences that have left them feeling "[...] puzzled? disappointed? concerned? angry? confused? shaken? upset? challenged? surprised? delighted?" (Scher & Kozlowska, 2020, p. 331). If these questions are not asked, "[...] the residents' professional and personal growth will be, to that degree, compromised" (Scher & Kozlowska, 2020, p. 331). This also helps with the discussion of countertransference reactions, which can be challenging for both supervisors and residents to talk about, as reactions can include annoyance, frustration, anger, and hostility, which can inspire feelings of shame in physicians.

Supervisors can also help with moral distress by sharing their own experiences of moral distress and sharing the moral burden. In discussing complex and difficult patient cases, the supervisor not only can help identify ethical concerns and moral distress but also offer empathic support and share personal ways they have coped in similar situations (Roberts et al., 1996). They can also share the moral load of difficult decisions by emphasizing that the resident is making the decision with the supervisor, and in cases of complex capacity evaluation consults, with the primary team and surrogate decision makers as well (Herschkopf, 2021).

All of this can only be achieved if the resident feels they are speaking with an attending they can trust. The resident must feel that the supervisor sees their concerns as valid, important, and reflective of systemic issues in Medicine and not a sign of personal weakness, and works to address their concerns appropriately (Herschkopf, 2021; Scher & Kozlowska, 2020; Roberts et al., 1996). Therefore, supervision should be adequate by

ensuring supervisors are educated on the importance of exploring ethical elements of cases and the moral distress of the residents they supervise.

Process Groups

Process groups (also known as T-groups, training groups, or experiential groups) can be an effective and valuable part of residency training offerings. Process groups should start early in residency training and be part of protected time. In these groups, a class of residents is brought together in a safe and confidential space and led by a group facilitator to discuss any concerns, feelings, and challenging or sensitive experiences in a supportive environment of their peers. This process helps to promote feelings of trust, connection, and a sense of solidarity for residents who may feel alone and lost, especially at the start of residency (Herschkopf, 2021; Rao et al. 1997).

Balint Groups

Unlike Morbidity and Mortality conferences, where residents typically discuss a patient case that led to a poor outcome and identify medical errors or a unique teaching case to improve patient care, Balint groups offer a supportive space for discourse and reflective practice. Peers share and process difficult, challenging, complicated patient cases together. This allows a focus on the emotional impact patient cases have on the residents and the moral distress they may feel in the process of caring for their patients.

This is important to talk about and share with each other. Psychiatry residents should not have to face this alone. There is healing in sharing their experiences with moral distress with each other (Austin et al., 2008). This also reduces the feeling of personal shame and guilt when residents hear that their peers struggle with similar feelings and experiences. There is also the importance of discovering, understanding, and

addressing ethical concerns in Psychiatry. If not done, these concerns go unnoticed and do not get addressed, "[...] and on both the institutional and personal levels, an opportunity for discovery, knowledge, improvement, and growth would have been lost" (Scher & Kozlowska, 2020, p. 331).

I encourage psychiatry residency programs to adopt Balint groups as part of the training and education offered to residents. Balint groups should be carved into protected time for residents so that they do not have to choose between a free hour to work on notes and engagement in an effective way to process moral distress.

A Culture of Openness

The psychiatry residency program administration should make it a priority to foster a culture of openness among the administrators, attendings, residents, and other healthcare teams in the hospital system. There needs to be support and protection from the hospital administration to report substandard behavior and unethical practices and to voice concerns when patient care is at stake (Hoop, 2004). Without encouragement and support, trainees may feel they are powerless to speak up for fear of repercussions or due to deference to their supervisors and attendings. Voicing concerns should be viewed as a moral action taken in the patient's best interest, which is important for alleviating moral distress and improving the health care system (Perni, 2017).

Having an open, supportive, and non-judgmental culture combined with respectful communication between all staff and trainees improve patient care and safety by allowing trainees to feel more comfortable voicing their concerns and feelings of moral distress. Addressing moral distress will enable trainees to perform their clinical duties more effectively without their distress having a negative impact on the quality of

care they provide. To add to this type of culture, I encourage attendings to always remember that they were once medical students and residents themselves and support their trainees as future colleagues.

Wellness Initiatives

Residency-structured wellness initiatives can be helpful, but it is important to remember that one size does not fit all. Residents must be able to engage in personally meaningful and beneficial activities, or else well-meaning initiatives can become another burden. I propose that residency programs consider this by hosting a diverse range of offerings throughout the year, limiting email fatigue, and understanding that residents would benefit from flexibility and grace.

Self-Directed Interventions

Personal Psychotherapy

Learning the name of what I had been experiencing during my psychiatry residency, moral distress, has been helpful to me. Identifying these feelings is the first step in healing. When confronted with feelings of moral distress, trainees can turn those feelings inward, leading to self-doubt and shame. It is important that they instead take a moment to acknowledge their feelings, identify where these feelings come from, and practice self-compassion. Personal psychotherapy can be a very effective way to explore thoughts and feelings, gain a deeper understanding of oneself, and improve well-being.

Personal psychotherapy has also been a general recommendation for psychiatry residents to use as a training tool to become better psychiatrists. Personal psychotherapy can also be a place for residents to explore and work through their individual resistances

and countertransference in a safe space that they may not be able to in supervision or a process group (Rao et al., 1997).

Well-Being Practices

Psychiatry residents can benefit from their own recommendations to their patients. They should engage in practices that bring joy, meaning, and fulfillment, including but not limited to spending time on hobbies, enjoying time with friends and family, and getting good nutrition, exercise, and rest. It is important to have a good work-life balance and engage in well-being practices. Residents should not feel guilty for taking care of themselves. Engaging in creative outlets can also improve personal well-being. Writing this thesis has helped with my own moral injury I experienced during my psychiatry residency training. I share this to contribute to a culture of openness and normalize this experience as a reflection of external constraints in a difficult specialty, rather than have residents suffer with guilt and shame, believing that what they are feeling is a reflection of personal faults.

Support Networks

It is important for psychiatry residents not to feel alone, as this can give rise to feelings of shame, guilt, and hopelessness. Psychiatry residents should find peers and mentors to support them and spend time with their loved ones to remind them they are not just cogs in a machine. Meaningful connections with peers build a sense of community, which can help to alleviate moral distress overall.

Moral Resilience

During residency training, psychiatry residents will become more accustomed through their clinical experiences to the moral distress prevalent in this field. Over time, they will develop moral resilience, which involves a cognitive restructuring, an understanding that there is not usually one "right" action to be made and by taking the time to consider the complex aspects of a case, they can make decisions that preserve their moral integrity and do justice to their patient (Bader & Herschkopf, 2019; Herschkopf, 2021). Moral resilience helps to manage moral distress in this way, but it takes time to develop and involves "[...] being realistic about one's limitations, seeking meaning in situations that feel senseless, and cultivating an ability to self regulate" (Bader & Herschkopf, 2019, p. 510).

Psychiatry residents are taught to become adept at listening, observing, and interviewing their patients to better understand the patient and the clinical picture. We should also apply this unique skill set to ourselves and regularly engage in critical thinking, recognize and analyze our emotions, and understand our moral principles and values as a part of building moral resilience.

Engagement in Advocacy

Long-term solutions to moral distress will need to include changes to the current healthcare system (Dean et al., 2019; Herschkopf, 2017). Upstream changes can address the systemic issues that lead to moral distress. Psychiatry residents should feel supported in reaching out to their administrators and legislators, uniting together, and engaging in advocacy groups. We need to take care of the physicians who take care of the community, and this ultimately will lead to better care for all.

CHAPTER 4

FUTURE DIRECTIONS

To further investigate factors that lead psychiatry residents to experience moral distress and potential interventions for this, a qualitative study may be done by surveying trainees from different psychiatry residency programs regarding their experiences. The trainees can give anonymous, open-ended answers regarding what has led them to experience moral distress, what has helped them, and what changes they would like to see to feel better supported in their residency program. These responses could then be compiled and analyzed to form a guide of the most common factors of moral distress and identify potentially key interventions that can be utilized by psychiatry residency programs. It would be interesting to see how the results would differ between residency programs in different areas (ex. responses from trainees in residency programs located in rural versus urban areas or in the United States versus other countries with different health care systems like Canada or the United Kingdom).

CHAPTER 5

CONCLUSION

In conclusion, an ethical framework to guide clinical decisions can be utilized to address moral distress experienced by psychiatry residents. The framework I propose includes considerations of a patient's capacity to consent or refuse medical treatment, the urgency of the medical condition, the feasibility of the actions needed to address the medical condition, and the countertransference of the treatment team. When deciding on treatment over objection, I have discussed ways to optimize decision-making ability and clinician understanding. I have also discussed the importance of understanding a patient’s values and respecting a patient’s preferences, even when they lack the decision-making capacity to refuse treatment, as a part of ethical care. This framework serves to help guide clinicians by ensuring they understand and address the ethical considerations involved in treating patients and the moral distress that arises. Though I have also discussed that moral distress and moral injury reflect external constraints and a broken system, if a resident feels they are making ethical decisions when feeling lost, doubtful, and presented with difficult choices, perhaps that will alleviate some of the moral distress prevalent in this field.

REFERENCES

American Medical Association (2001). 2.1.1 Informed Consent. Chapter 2: Consent, Communication & Decision Making. *AMA Principles of Medical Ethics: I,II,V,VIII.* AMA Code of Medical Ethics. Adopted June 1957; revised June 1980; revised June 2001.

American Medical Association (2001). 2.1.2 Decisions for Adult Patients Who Lack Capacity. Chapter 2: Consent, Communication & Decision Making. *AMA Principles of Medical Ethics: I,III,VIII*. AMA Code of Medical Ethics. Adopted June 1957; revised June 1980; revised June 2001.

Angelos, P. (2021). Classic Ethical Dilemma: When Is it Acceptable to Treat Patients over Their Objection? *Journal of the American College of Surgeons*, 233(4), 515–516. https://doi.org/10.1016/j.jamcollsurg.2021.07.683

Appelbaum, P.S. (2007). Clinical Practice. Assessment of Patients' Competence to Consent to Treatment. *N Engl J Med.* 2007 Nov 1;357(18):1834-40. doi: 10.1056/NEJMcp074045. PMID: 17978292.

Austin, W. J., Kagan, L., Rankel, M., & Bergum, V. (2008). The Balancing Act: Psychiatrists' Experience Of Moral Distress. *Medicine, Health Care, and Philosophy*, *11*(1), 89–97. https://doi.org/10.1007/s11019-007-9083-1

Bader, C.S., & Herschkopf, M.D. (2019). Trainee Moral Distress in Capacity Consultations for End-of-Life Care. *Psychosomatics*, *60*(5), 508–512. https://doi.org/10.1016/j.psym.2018.08.001

Baruth, J.M.B. & Lapid, M.I. (2017). Influence of Psychiatric Symptoms on Decisional Capacity in Treatment Refusal. *AMA J Ethics*. 2017;19(5):416-425. doi: 10.1001/journalofethics.2017.19.5.ecas1-1705

Berger, J.T. (2014). Moral Distress in Medical Education and Training. *Journal of General Internal Medicine*, *29*(2), 395–398. https://doi.org/10.1007/s11606-013-2665-0

Berghmans, R.L., & Widdershoven, G.A. (2003). Ethical Perspectives on Decision-Making Capacity and Consent for Treatment and Research. *Medicine and Law*, 22(3), 391–400.

Berkowitz, E., & Trevick, S. (2024). Non-Psychiatric Treatment Refusal in Patients with Depression: How Should Surrogate Decision-Makers Represent the Patient's Authentic Wishes? *HEC forum*: an interdisciplinary journal on hospitals' ethical and legal issues, 10.1007/s10730-024-09522-9. Advance online publication. https://doi.org/10.1007/s10730-024-09522-9

Chieze, M., Clavien, C., Kaiser, S., & Hurst, S. (2021). Coercive Measures in Psychiatry:

A Review of Ethical Arguments. *Front Psychiatry*. 2021 Dec 14;12:790886. doi: 10.3389/fpsyt.2021.790886. PMID: 34970171; PMCID: PMC8712490.

Dean, W., Talbot, S., & Dean, A. (2019). Reframing Clinician Distress: Moral Injury Not Burnout. *Federal practitioner: for the health care professionals of the VA*, DoD, and PHS, 36(9), 400–402.

Fischkoff, D., Prager, K., Dastidar, J., Dugdale, L., Neuberg, G., Nemeth, S., & Fischkoff, K. (2021). Ethical Framework to Guide Decisions of Treatment Over Objection. *Journal of the American College of Surgeons*, 233(4), 508–516.e1. https://doi.org/10.1016/j.jamcollsurg.2021.07.003

Ganzini, L., Volicer, L., Nelson, W., Fox, E. & Derse, A. (2004). Ten Myths About Decision-Making Capacity. *Journal of the American Medical Directors*. 6. S100-4. 10.1016/j.jamda.2005.03.021.

Hamric, A.B., Borchers, C.T., & Epstein, E.G. (2012). Development and Testing of an Instrument to Measure Moral Distress in Healthcare Professionals, A JOB Primary Research, 3:2, 1-9, DOI: 10.1080/21507716.2011.652337

Herschkopf, M.D. (2021). Moral Distress or Countertransference? Addressing Emotional Reactions of Psychiatry Trainees. *Academic Psychiatry: The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry*, *45*(4), 476–480. https://doi.org/10.1007/s40596-021-01443-w

Hoop, J.G. (2004). Hidden Ethical Dilemmas in Psychiatric Residency Training: The Psychiatry Resident as Dual Agent. *Academic Psychiatry: The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry*, 28(3), 183–189. https://doi.org/10.1176/appi.ap.28.3.183

Howe, E. (2009). Ethical Aspects of Evaluating a Patient's Mental Capacity. *Psychiatry* (Edgmont (Pa.: Township)), 6(7), 15–23.

Hundert, E.M. (1987). A Model for Ethical Problem Solving in Medicine, With Practical Applications. *The American Journal of Psychiatry*, 144(7), 839–846. https://doi.org/10.1176/ajp.144.7.839

Katsakou, C., Bowers, L., Amos, T., Morriss, R., Rose, D., Wykes, T., & Priebe, S. (2010). Coercion and Treatment Satisfaction Among Involuntary Patients. *Psychiatr Serv.* 2010 Mar;61(3):286-92. doi: 10.1176/ps.2010.61.3.286. PMID: 20194406.

Kontos, N., Freudenreich, O., & Querques, J. (2013). Beyond Capacity: Identifying

Ethical Dilemmas Underlying Capacity Evaluation Requests. *Psychosomatics*, 54(2), 103–110. https://doi.org/10.1016/j.psym.2012.06.003

Kontos, N., Querques, J., & Freudenreich, O. (2015). Capable of More: Some Underemphasized Aspects of Capacity Assessment. *Psychosomatics*, 56(3), 217–226. https://doi.org/10.1016/j.psym.2014.11.004

Lyckholm, L.J. & Aburizik, A.K. (2017). Ethical Management of Patients with Cancer and Mental Illness. *AMA J Ethics.* 2017;19(5):444-453. doi: 10.1001/journalofethics.2017.19.5.ecas4-1705.b\

Navin, M.C., Wasserman, J.A., & Haimann, M.H. (2019). Treatment Over Objection – Moral Reasons for Reluctance. *Mayo Clinic Proceedings*, 94(10), 1936–1938. https://doi.org/10.1016/j.mayocp.2019.08.011

Palmer, R.B., & Iserson, K.V. (1997). The Critical Patient Who Refuses Treatment: An Ethical Dilemma. *J Emerg Med.* 1997 Sep-Oct;15(5):729-33. doi: 10.1016/s0736-4679(97)00157-1. PMID: 9348069.

Perni, S., (2017). Moral Distress: A Call to Action. *AMA J Ethics*. 2017;19(6):533-536. doi: 10.1001/journalofethics.2017.19.6.fred1-1706.

Rao, N.R., Meinzer, A.E., & Berman, S.S. (1997). Countertransference. Its Continued Importance in Psychiatric Education. *The Journal of Psychotherapy Practice and Research*, *6*(1), 1–11.

Roberts, L. W., McCarty, T., Roberts, B. B., Morrison, N., Belitz, J., Berenson, C., & Siegler, M. (1996). Clinical Ethics Teaching in Psychiatric Supervision. *Academic Psychiatry: The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry*, 20(3), 176–188. https://doi.org/10.1007/BF03341568

Rosenthal, S.M. & Clay, M. (2017). Initiatives for Responding to Medical Trainees' Moral Distress about End-of-Life Cases. *AMA J Ethic*s. 2017;19(6):585-594. doi: 10.1001/journalofethics.2017.19.6.stas1-1706

Rubin, J., & Prager, K.M. (2018). Guide to Considering Nonpsychiatric Medical Intervention Over Objection for the Patient Without Decisional Capacity. *Mayo Clinic Proceedings*, 93(7), 826–829. https://doi.org/10.1016/j.mayocp.2018.04.005

Rzhevskaya, N.K., Ruzhenkov, V.A., Ruzhenkova, V.V., Khamskaya I.S., & Moskvitina, U.S. (2020). Psychiatric Coercion and Violence: Ethical, Legal and Preventive Aspects. https://doi.org/10.5281/zenodo.4265434

Sales, P.M.G., Arshed A., Cosmo, C., Li, P., Garrett, M., & Cohen, M.A. (2021) Burnout

and Moral Injury Among Consultation-Liaison Psychiatry Trainees. *Psychodynamic Psychiatry*. Vol. 49, No. 4. doi: 10.1521/pdps.2021.49.4.543

Scher, S., & Kozlowska, K. (2020). Teaching Ethics in Psychiatry: Time to Reset. *Harvard Review of Psychiatry*, *28*(5), 328–333. https://doi.org/10.1097/HRP.0000000000000258

Simon, J.R. (2007) Refusal of Care: The Physician-Patient Relationship and Decision Making Capacity. *Ann Emerg Med*. 2007 Oct;50(4):456-61. doi: 10.1016/j.annemergmed.2007.04.016. Epub 2007 Jun 20. PMID: 17583381.

Zhong, R., Sisti, D.A., & Karlawish, J.H. (2019). A Pragmatist's Guide to the Assessment of Decision-Making Capacity. *The British Journal of Psychiatry*: *The Journal of Mental Science*, 214(4), 183–185. https://doi.org/10.1192/bjp.2019.17

APPENDIX A

FIGURE 1: ETHICAL DECISION-MAKING FRAMEWORK