Ethics Education for Psychiatry Residents

A Mixed-Design Retrospective Evaluation of an Introductory Course and a Quarterly Seminar

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Introduction

Bioethics education for medical specialty residents is important so that they can address ethical issues involved in clinical practice and research. Although informal ethics education in a clinical context is invaluable,[1] formal medical ethics education is increasingly considered important.[2] The experience of informal education may (1) vary among residents and (2) not necessarily provide systematic knowledge and skills in ethics. Formal ethics education may involve various challenges. First, a comprehensive literature review indicates two different goals for medical ethics education. One is to develop virtuous clinicians, and the other is to enhance knowledge and skills to address ethical dilemmas. However, there is no consensus about which should be the primary goal.[3] Second, it is unclear whether the ethics sensitivity and reasoning of medical students and residents improve as a result of their professional education.[4] Third, there are conflicting findings and arguments in the literature regarding gender differences in ethical attitudes and behaviors.[5]

Even the undergraduate medical ethics curriculum, which is more developed than the postgraduate curriculum, seems to vary across medical schools, for example, in Canada and the United States.[6] According to a survey in the United Kingdom, the content of ethics education at medical schools does not sufficiently cover the areas recommended by the experts on medical law and ethics.[7] Ethics education for undergraduate medical students also remains an ongoing project.

These issues pertaining to the undergraduate level may be more serious for postgraduate ethics education. Most educators of residents have no formal ethics education and hence are not ready to develop curricula and teach ethics pertinent to each specialty.[8] Considering the need to address ethical issues involved in clinical practice, residents' need for ethics education may be more pressing than that of undergraduate students. Also, researchers have pointed out that empirical data to guide the development of curricula may be required concerning (1) the content needed for residents,[9] (2) the most effective method, including optimal time allocation,[10] and (3) evaluation of the outcomes.[11]

Psychiatry is no exception in terms of postgraduate ethics education. For example, the Royal College of Physicians and Surgeons of Canada (RCPSC) does

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not present any specific training requirements for psychiatry residents' ethics education, although some guidance is provided in its "Accreditation Committee Discussion Paper on Biomedical Ethics" for all specialties.[12] Bloch and Green indicate from their review of such education in the United States, the UK, Canada, and Australia that despite requirements by national training associations, (1) education has been rather sporadic, (2) a few programs may hold promise as future models, (3) various training associations provide no more than the opportunity to develop programs, and (4) reports of specific educational programs have been sparse. They argue that this may be ascribed to the wide scope and elusiveness of the goal of ethics education, although more than a single goal may be acceptable. They conclude that the outcome of ethics education may suffice if the residents (1) obtain a certain amount of knowledge in ethics, (2) can identify ethical issues involved in clinical practice, and (3) acquire the skills to address ethical issues.[13]

There are few studies discussing ethics education for psychiatry residents. Roberts and others proposed a six-step strategy for clinical ethics training in psychiatric supervision, which identifies ethical issues and conflicts of values and explores further information and expertise if needed.[14] As part of their formal education, Tsao and Guedet proposed a monthly 90-minute case presentation seminar for senior residents (including students in postgraduate year [PGY] 3 and 4 and also Fellows). The presentation is based on clinical cases that encompass topics for psychiatrists in relation to end-of-life care, geriatrics, children, adolescents, perinatal care, addiction, genetics, forensic medicine, psychotherapy, consultation, and research. However, they indicate that this approach involves challenges, such as residents' hesitation in speaking about the issue, the lack of faculty with relevant expertise, disagreement about the selection of topics, and time and funding constraints.[15] A survey on ethics education and professionalism by Lapid and others demonstrated that psychiatry residents, despite their training in relationships and boundaries, perceive a need for additional relevant training, particularly in managing mistakes in clinical practice, reacting to impaired colleagues, and reporting medical errors.[16] Hoop focused on dilemmas due to the conflicting roles that psychiatry residents must perform. Residents are required to find a balance between being a physician and a learner, a physician and a supervisee, and a physician and an employee of the institution. These multiple, conflicting roles and possible vulnerabilities may affect residents' decisionmaking.[17] As illustrated, psychiatry residents' ethics education is still an underdeveloped area without consensus regarding the goal(s), content, method, and evaluation of outcomes.

The objective of our study was to retrospectively evaluate an ethics education program for psychiatry residents at a Canadian university. This program consists of an introductory course and quarterly seminars. Our study's qualitative research questions were as follows:

1) Did the seminar reports by the residents demonstrate understanding of psychiatric ethics; that is, did they (a) identify the ethical issues involved and (b) apply relevant ethical theories to reach solutions?
2) What ethical and other issues were addressed in the seminar reports?
3) What is the nature of the residents' feedback about the introductory course and the seminar?

Our study's quantitative hypotheses were as follows:

1) The introductory course contributes to the improvement of the residents' knowledge of general and psychiatric ethics as represented in the score change between the pretest and posttest.
2) There is no difference between men and women regarding (a) pretest scores, (b) score change between the pretest and posttest, and (c) seminar scores.

Ethics approval of this study was obtained from the Health Sciences Research Ethics Board at the University of Western Ontario, which approved a waiver of informed consent (the residents' data were in part anonymous and in part deidentified).

Method

Setting and Participants

Since 2005, the Department of Psychiatry at the University of Western Ontario has held a one-day (approximately six-hour-long) introductory ethics course for first-year (PGY 1) psychiatry residents in the first month of their residency. This course covers basic topics in general and psychiatric ethics through interactive lectures and class exercises, such as case discussions, guided literature search, and role playing. The objectives of the course are to enhance awareness of ethical issues in psychiatry, increase knowledge of ethics in psychiatry, improve problem-solving skills regarding ethical issues in psychiatry, and enforce attitudes that facilitate ethical conduct in psychiatry. Subjects covered include fundamental general ethics and bioethics; issues of autonomy (constraints and impairments of autonomy, privacy and confidentially, truth telling and disclosure, informed consent, decisional capacity/competence, and rational suicide); and issues of beneficence and nonmaleficence (involuntary hospitalization and treatment, substitute decisionmaking, advance directives, conflicts of interest, boundary transgressions, and quality improvement).

The pretest is taken at the beginning of the course, and the posttest is taken at the end of the course for course evaluation (not for grading purposes). Both tests are anonymous, and their objective is conveyed to the residents. The pretest and posttest are identical and consist of 10 questions (Table 1). The first 8 questions were used for analysis, as the ninth question is context dependent and the tenth question concerns the residents' self-evaluation.

In this residency program, all residents participate in a quarterly seminar that consists of two resident presentations (each of which is 45 minutes long, including discussions). The resident prepares the presentation with instructor (last author) feedback and submits a seminar report within a month after the seminar. The preparation, presentation, and report are graded by the instructor. Full scores are 25, 25, and 50, respectively, with a total score below 50 requiring remediation.

All residents were aged in their twenties or thirties. Twenty-eight residents (12 men, 8 women, and 8 individuals of unknown gender, who were excluded from the gender analysis) participated in the introductory course. Residents' feedback (n = 12) on the introductory course was systematically collected for the years 2010 and 2011. Twenty-four residents (10 men and 14 women, 4 PGY 1–3 and 20 PGY 4–5) did their seminar presentation and report (n = 23; two residents did them jointly). The vast majority of the discussed cases were from the residents' experience, except for one hypothetical case and two other presentations that did not

Table 1. Pre- and Posttest for the Introductory Course

1. Moral dilemmas address good vs. bad values:	yes/no
2. Madrid declaration is WPA code of ethics:	yes/no
3. Informed consent should always be explicit:	yes/no
4. Decisional capacity is situation-specific:	yes/no
5. Beneficence entails treatment:	yes/no
6. Psychotherapy has no conflicts of interests:	yes/no
7. The Tarasoff case refers to the duty to treat:	yes/no
8. Telepsychiatry reflects justice considerations:	yes/no
9. Psychiatric research with placebo is justified:	yes/no
10. I understand ethics in psychiatry:	yes/no

discuss any specific clinical case: one discussed ethical issues involved in psychiatric diagnosis and the other discussed ethical issues related to the clinical duties of pregnant residents.

Measures and Analysis

Statistical analysis with an alpha level of 0.05 was performed to test for a pre- to posttest score change and for gender differences regarding the pretest score, pre- to posttest score change, and seminar score. Residents' ratings about the introductory course were statistically described. Residents' seminar reports were qualitatively analyzed to identify (1) ethical and other issues addressed and (2) ethical theories applied. Thematic analysis,[18] informed by adult education theory that distinguishes knowledge, skills, and attitudes,[19] was conducted on the seminar reports.

Results

Quantitative Analysis

The mean score improved significantly from pretest to posttest ($p = 0.00$). There was no significant difference between men and women in relation to the pretest score ($p = 1.00$), the score change from pretest to posttest ($p = 0.95$), and the seminar score ($p = 0.14$). Residents rated their satisfaction in relation to the introductory course highest (93%) for the objectives and lowest (83%) for the presentation.

Qualitative Analysis

In the seminar reports, a wide range of ethical issues were addressed, such as a patient's decisionmaking, involuntary admission, treatment refusal, drug and substance misuse, suicide, sexuality of geriatric patients, rights of caregivers, consultation-liaison psychiatry, professional obligations, access to healthcare information, and placebo-controlled trials. In addition, issues besides ethical issues, such as other medical conditions, cultural differences, family relationships, unemployment, social isolation, and institutional and financial restrictions, were mentioned in relation to ethical issues. Most residents applied principlism to address the ethical issues involved in their case report. Besides principlism, utilitarianism, deontology, care ethics, and virtue ethics were also applied or referred to in some reports.

Thematic analysis of the residents' seminar reports identified three themes: a resident's (1) knowledge of ethical theories or principles, and his or her skills to apply these theories or principles, (2) attitudes regarding ethical issues involved in the presented case, and (3) views on ethics education.

1) *Residents' knowledge and skills*: A few descriptions concerning knowledge and skills in ethics were incorrect. First, a resident who identified forced treatment as harm misused nonmaleficence in a treatment refusal case by saying that "not withholding treatment would constitute nonmaleficence." Second, terms that are associated with but distinct from autonomy, such as capacity assessment and informed consent, were confused with autonomy. A resident wrote that he wanted to highlight the "importance of autonomy assessment in every patient" instead of capacity assessment.
2) *Residents' attitudes*: This theme was classified into eight subthemes: (a) autonomy, (b) beneficence or desirable consequence, (c) social justice, (d) other justice, (e) uncertainty tolerance, (f) peers and ethics, (g) doctor-patient relationships, and (h) psychiatry as ethically unique among medical specialties. The attitudes reported are those of the presenting (and reporting) resident, or of the residents who participated in the discussion as quoted by the reporting resident.
    a) Attitudes in favor of autonomy were identified much more often than those against autonomy. With respect to geriatric patients, a resident supported geriatric assent: "Patients with reduced capacity may still be able to express their preferences and desires consistent with long held values and prior wishes." In contrast, only a few attitudes against autonomy were identified; these occurred particularly in relation to mental illness. A resident said that "in psychiatry we often feel we must take a more paternalistic approach to protect patients from acting in ways that they would otherwise not if they were not suffering from a mental illness."
    b) Quite a few attitudes in favor of beneficence or desirable consequences from the healthcare professional's viewpoint were identified, whereas attitudes that are clearly against beneficence were not identified. In the discussion of a dual-role dilemma, a resident applied utilitarianism and concluded that "when faced with several morally 'right' acts, a physician must consider which one will yield the greatest possible balance of good vs. bad consequences."
    c) Attitudes concerning social justice, that is, equitable resource allocation and rectification of disadvantages, were identified. During the seminar, regarding discrimination against comorbidly addicted physically ill patients, residents "shared their personal stories of perceived inequalities in organ distribution based on questionable factors such as methadone [heroin replacement] treatment in a patient."
    d) Positive attitudes concerning justice other than social justice were identified. A resident discussed justice in preventing multiple suicide attempts: "Hospitalization is unjust from the perspective of the patient who believes that involuntary treatment violates his personal rights"; however, justice also requires protection of other people from "negative impacts

such as property damage and witnessed trauma."

e) Largely positive attitudes concerning uncertainty tolerance were identified. In the discussion of discharge against medical advice, a resident stated that there is no definite way to settle such ethical issues and that "the physician should use clinical judgment and consider his/her obligations as a physician to establish a reasonable approach." Another resident argued for a case-specific approach regarding sexuality of geriatric patients; however, the resident added that "facilities should have ethics policies regarding sexual expression by patients in order to guide the decision making of staff members."

f) Residents' attitudes toward peers' decisions on ethical issues were mostly critical. Regarding a consultation-liaison psychiatry case in which the patient died from a physical disorder unexpectedly, a resident criticized the attending physician's practice because the patient's "psychotic illness led to suboptimal care; most people would have undergone a full workup including CT scan." In contrast, in a geriatric case in which patient abuse by the family was suspected, the resident endorsed the decision made by the geriatric team because the patient's "autonomy was maintained by not making extreme interventions" and because "beneficence was also maintained through continued support" provided by the team.

g) Across various ethical issues involved in each case, residents appeared to value the relationship between the clinician and the patient and/or family. In a case in which the patient was suspected of driving under the influence of alcohol, the clinical team faced a dilemma as to whether they should immediately report the patient to the ministry of transportation to protect society, which may result in the patient losing the driver's license necessary for her work. During the seminar discussion, a resident pointed out that "it might be favorable to include her [the patient] in the discussion and decision making process, to better preserve the therapeutic relationship."

h) Residents expressed a view that psychiatry is unique among other medical specialties in terms of ethical aspects involved in practice and expectations as a professional. A resident said that "while normativity is not absent in other areas of medicine, ethical issues appear to be more prevalent in psychiatry." Another resident said that "a large role for mental health professional[s] is that of advocacy."

3) *Residents' views on ethics education*: Regarding the seminar, one resident described a positive experience: "The questions from the residents were in the beginning to clarify the dilemma about that patient" and the course instructor "helped me to focus my question and reframe it." However, some residents expressed dissatisfaction: "Group discussion regarding the case and presentation was brief due to the time constraints." Concerning ethics education in general,

one resident indicated that the "key to preventing boundary violations lies largely in education."

Discussion

The introductory course may improve residents' ethics knowledge and skills in general and in psychiatric ethics, as demonstrated in the test score improvement after the course participation. The residents' feedback about the introductory course indicated relatively high satisfaction on the part of the residents. The slight gap between the evaluation of the presentations and the other components, that is, objectives, reading materials, and lecturer, may suggest that the level of difficulty and the length of the presentation may require adjustment to better meet the residents' needs. For example, it may be better to set aside two half-days (to reflect on the contents and come back with questions and comments) rather than one day for the course. As residents' background in ethics may differ, their needs could be diverse. However, as an introductory course, it should be focused on the basic level but be flexible enough to expand depending on participants' interests.

In relation to gender, neither the introductory course test scores nor the quarterly seminar report scores indicated any difference between men and women. These results mainly concern the acquisition of knowledge and skills in ethics, which may be influenced by moral orientation and motivation to learn. Gender differences in relation to ethics have been studied in various areas and settings, with contradictory findings across studies.[20] A survey with medical students and residents (PGY 1–3) in the United States indicated that women expressed a greater need for ethics education in all the topics surveyed (bioethics principles, informed consent, and care of special populations) and across training levels.[21] Although gender differences in terms of ethics education should be further studied, our findings suggest that gender-specific ethics education may not be required for psychiatry residents.

Most of the issues discussed in the seminar reports, such as treatment refusal, dementia, access to healthcare information, and ethical issues involved in the physician-patient relationship, pertain to all specialties. Issues such as involuntary admission and drug and substance misuse may be rather specific to psychiatry. Some of the topics listed among Tsao and Guedet's proposal[22] were not identified in the seminar reports. Examples of missing areas are end-of-life care, perinatal psychiatry, forensic psychiatry, psychotherapy, and psychiatric genetics. This may be due to the residents' less frequent exposure to these areas during their training. Also, as the program's educational approach allows residents to choose any topic as long as it involves ethical dilemmas, it may be difficult to systematically cover all relevant areas. However, a resident may be more motivated to present on the issues that he or she has encountered and considered controversial. Also, this approach may enable the program to capture important issues that could not have been captured otherwise. The selection of topics may require further discussion.

The majority of the reports discussed conflict or balancing of different ethical principles in principlism, particularly autonomy versus beneficence. Some reports discussed autonomy versus justice. Other ethical theories were applied only in limited cases. Principlism may encompass multiple ethical theories, as it involves two major ethical theories: utilitarianism through the principles of beneficence and justice and deontology through the principles of autonomy and justice. Some critics have indicated

that principlism may result in a mere checklist for identifying ethical issues and thus may not lead to problem solving,[23] which may be true depending on the way in which principlism is employed. Nonetheless, principlism may be advantageous in giving structure to the discussion of ethical dilemmas, even if correct application of principlism may not necessarily guarantee sufficient understanding of ethical issues.

The qualitative analysis of the seminar reports revealed themes concerning the residents' learning in relation to ethics knowledge, skills, and attitudes. These themes and subthemes are discussed in the order of their appearance in the previous results section.

Most residents seemed to have a correct understanding of ethical theories, particularly principlism. However, the principles of nonmaleficence and autonomy were not correctly used by a few residents. As the principle of beneficence arguably may encompass the principle of nonmaleficence, principlism may be better introduced to residents with three principles, that is, autonomy, beneficence (as a balance of benefit and harm), and justice. Regarding autonomy, it may be necessary to emphasize a clear definition of this concept and its relationships with other terms that are often used in close association with autonomy.

Residents' attitudes mostly upheld a patient's autonomy. However, some residents endorsed a protective or paternalistic attitude toward the patient, considering the patient's mental illness. Also, the residents demonstrated a basically unreserved positive attitude concerning beneficence. These findings may suggest that despite the majority of descriptions in favor of autonomy, residents may tend to be outcome oriented. With respect to social justice, although residents seemed concerned about patients with mental illness being discriminated against, they also demonstrated an overprotective attitude toward these patients, which may involve discrimination against such a population. Particularly for psychiatry residents, it may be desirable to emphasize the problems of protective attitudes toward patients, regardless of the clinician's good intention and concern for the patient's well-being.

Uncertainty tolerance was expressed to varying degrees by residents. Uncertainty tolerance may be valuable in addressing ethical issues, because uncertainties are involved in many cases. It may be preferable to nourish uncertainty tolerance through education, although the risk of confusing uncertainty tolerance with conceptual indifference or theoretical cynicism should be avoided.

The residents' attitudes toward peers were mostly critical. This may result from the selection of cases, as residents could have chosen clinical cases that they considered problematic or controversial. Critical attitudes toward the ethical aspect of colleagues' decisions or conduct may be vital to improve the quality of patient care. That being said, such attitudes may be based on a variety of elements, including misunderstanding and bias, which may suggest the need for better communication within and across specialties and professions.

The doctor-patient relationship seems to be valued by residents and was often addressed by them in their discussion of ethical dilemmas. The relationship tended to be considered as a factor to be balanced against other ethical principles and values. In the dual-role dilemma case, preserving a good relationship with the patient was viewed as one of the major objectives for including the patient in the clinical team's decisionmaking. A strong therapeutic alliance between the healthcare

professional and the patient and/or family members may be indispensable for optimizing patient care. An ethical framework proposed for psychiatry by Bloch and Green employs principlism and care ethics as enunciated by Annette Baier in a complementary manner, because neither rule-based nor character-based ethical theories are sufficient to address ethical issues.[24] Bloch and Green argue that principlism functions as a flexible framework, whereas care ethics speaks to the component of trust in relationships.[25] Such a combination may be identified in our findings, as residents may be applying care ethics more often than they explicitly indicate.

Many residents expressed views that psychiatry is unique among medical specialties because it involves more ethical issues. This view may be controversial, as it is difficult to compare the number of ethical issues involved in each specialty. The idea that a psychiatrist serves as a principal advocate for psychiatric patients, in addition to other attending physicians serving as advocates, may also be contentious. These attitudes may influence the practice of psychiatry residents. They may be more attentive to ethical issues and more empathic toward patients. On the other hand, they may have difficulties in collaborating with other specialties if they perceive themselves as more experienced in addressing ethical issues and more committed to the patient.

The residents' appreciation of feedback from others during the seminar may suggest that residents are satisfied in this regard. However, as most residents did not mention anything about the educational process of the seminar, it may be difficult to grasp their satisfaction or dissatisfaction. One resident's comment on the need for education to address boundary issues may indicate that residents find ethics education necessary and effective and are motivated to participate in such programs.

Our study has limitations. First, this study evaluated a relatively small number of psychiatry residents in one Canadian university. Second, this was a retrospective, uncontrolled study; hence causal inference cannot be strongly made regarding the effect of the program. Third, the questions of the pretest and posttest of the introductory course were not psychometrically tested. Fourth, the seminar reports were written in various formats. The majority consisted of a case report and the discussion thereof, with or without a brief description of the relevant theories employed in the subsequent argument, whereas few reports presented ethical issues not directly arising from a clinical case. This resulted in some lack of structural homogeneity in the reports, hence in some difficulty comparing them for analysis. Fifth, the residents were not interviewed about their views on ethics education. This was attempted, but no resident volunteered to participate in such an interview, possibly due to time constraints or to concern that criticizing the current program may cause a negative reaction toward them.

Conclusion

The introductory course for PGY 1 psychiatry residents may contribute to the acquisition of ethics knowledge. Gender difference was not statistically significant regarding the introductory course test scores and seminar report scores. The seminar report demonstrated that most of the residents have correct knowledge and skills in ethics. Psychiatry residents' attitudes in relation to their discussion of ethical issues and their views on ethics education were identified.

In the future, prospective research with larger samples in other universities in Canada and elsewhere is required. To evaluate educational programs, a reliable, valid, and change-sensitive measure should be developed to enable comparisons across institutions and studies. Finally, residents' participation in research on ethics education programs, which may provide invaluable feedback, should be enhanced by addressing factors that may discourage them from participating.

Notes

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