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Everyday ethics in internal medicine resident clinic: an opportunity to teach

Joseph A Carrese[1,2], **Erin L McDonald**[1,3], **Margaret Moon**[1,4], **Holly A Taylor**[1,5], **Kiran Khaira**[6], **Mary Catherine Beach**[1,2], and **Mark T Hughes**[1,2]

[1]Johns Hopkins Berman Institute of Bioethics, Johns Hopkins University, Baltimore, Maryland, USA

[2]Division of General Internal Medicine, Department of Medicine, Johns Hopkins School of Medicine, Baltimore, Maryland, USA

[3]Child and Family Services Agency, Washington, DC, USA

[4]Department of Pediatrics, Johns Hopkins School of Medicine, Baltimore, Maryland, USA

[5]Department of Health Policy and Management, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, Maryland, USA

[6]National College of Natural Medicine, Portland, Oregon, USA

Abstract

OBJECTIVES—Being a good doctor requires competency in ethics. Accordingly, ethics education during residency training is important. We studied the everyday ethics-related issues (i.e. ordinary ethics issues commonly faced) that internal medical residents encounter in their out-patient clinic and determined whether teaching about these issues occurred during faculty preceptor–resident interactions.

METHODS—This study involved a multi-method qualitative research design combining observation of preceptor-resident discussions with preceptor interviews. The study was conducted in two different internal medicine training programme clinics over a 2-week period in June 2007. Fifty-three residents and 19 preceptors were observed, and 10 preceptors were interviewed. Transcripts of observer field notes and faculty interviews were carefully analysed. The analysis identified several themes of everyday ethics issues and determined whether preceptors identified and taught about these issues.

RESULTS—Everyday ethics content was considered present in 109 (81%) of the 135 observed case presentations. Three major thematic domains and associated sub-themes related to everyday ethics issues were identified, concerning: (i) the Doctor–Patient Interaction (relationships; communication; shared decision making); (ii) the Resident as Learner (developmental issues; challenges and conflicts associated with training; relationships with colleagues and mentors;

Correspondence: Joseph Carrese, 5200 Eastern Avenue, Mason F Lord Building, Center Tower Suite 2300, Baltimore, Maryland 21224, USA. Tel: 00 1 410 550 2247; Fax: 00 1 410 550 3403; jcarrese@jhmi.edu.

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interactions with the preceptor), and; (iii) the Doctor–System Interaction (financial issues; doctor–system issues; external influences; doctor frustration related to system issues). Everyday ethics issues were explicitly identified by preceptors (without teaching) in 18 of 109 cases (17%); explicit identification and teaching occurred in only 13 cases (12%).

CONCLUSIONS—In this study a variety of everyday ethics issues were frequently encountered as residents cared for patients. Yet, faculty preceptors infrequently explicitly identified or taught these issues during their interactions with residents. Ethics education is important and residents may regard teaching about the ethics-related issues they actually encounter to be highly relevant. A better understanding of the barriers to teaching is needed in order to promote education about everyday ethics in the out-patient setting.

INTRODUCTION

Because every encounter between a doctor and a patient has a moral dimension, competency in ethics is essential to being a good doctor.[1,2] Every interaction with a patient involves ethical and professional duties, and all clinical decisions require consideration of the values of those involved, including patients and their health care professionals. Accordingly, ethics education, especially during training, is vital and should be optimally conceived and implemented.

One strategy for enhancing ethics education is to base it on issues trainees actually encounter during their clinical work.[3] This could be accomplished by having faculty staff recognise and teach about these issues when they are educating residents (qualified doctors receiving training in a specialty).

A decade ago, Fetters and Brody argued for an empirical approach to identify ethics-related issues encountered in clinical settings.[4] They reasoned that an epidemiological approach might, among other contributions, provide a starting point for developing more relevant and targeted ethics education. Yet, in the past decade, few empirical studies have focused on ethics-related issues encountered in the practice of internal medicine.[3,5–8] Even fewer studies have examined the extent to which faculty staff are able to identify and then teach about ethics and professionalism issues during their interactions with residents in clinical settings.[9]

It has been noted that ethics-related issues differ by setting.[5] Empirical studies conducted in internal medicine typically have been executed in the in-patient setting.[9] Although there has been some attention in the literature to issues confronted in the primary care setting,[9–14] this setting has been relatively neglected.[4,10] Rarely have studies had both an out-patient focus and an explicit intent to have study findings inform educational efforts.[10]

With the goal of educating our residents more adequately about the ethics and professionalism issues they encounter in ambulatory settings, we conducted a study to describe common `everyday ethics' issues faced by internal medicine residents in their out-patient clinic (i.e. ordinary ethics-related issues commonly faced in that setting). We were also interested in learning to what extent teaching about these issues occurred during faculty preceptor–resident interactions.

METHODS

Design

This was a multi-method qualitative study. We directly observed faculty preceptor–resident interactions in the resident clinic and conducted brief interviews with faculty preceptors after the clinic sessions. The study participants represented a convenience sample of faculty

preceptors and residents (the term `resident' in this paper includes first-year interns) who were in the respective clinics during the observation period.

The focus of this study was `everyday ethics' issues in the out-patient setting, defined as ordinary ethics-related issues commonly faced in the practice of out-patient medicine. We defined `everyday ethics' broadly, as situations involving values, virtues, obligations, ethical principles (such as respect for persons) or manifestations of these principles (such as truth telling and confidentiality), as well as conflicts between any of these, although conflict was not required. In addition, we included matters relating to professionalism and associated responsibilities. This definition of ethics extends beyond definitions that exclude professionalism or require the presence of conflict. However, our ultimate interest lies in applying the findings of our study to resident education, and a major aspect of the curricular agenda is to teach residents that every doctor–patient encounter has a moral dimension. From an educational perspective, therefore, there is utility in taking advantage of the functional overlap between ethics and professionalism and addressing issues related to ethics and professionalism that extend beyond conflict.

Setting

The study was conducted in the out-patient resident clinics of two internal medicine training programmes affiliated with a large academic medical institution (referred to as Clinic 1 and Clinic 2). Both clinics are conducted in an urban setting and are hospital-based. Clinic sessions were comprised mostly of continuity visits, but some acute care visits occurred. Patients receiving care at Clinics 1 and 2 are typically elderly and have many chronic medical problems, and a large proportion have either Medicare (50% and 46%, respectively) or Medicaid (30% and 31%, respectively) insurance.

Data collection

Observations occurred during 10 half-day clinic sessions, five at each of the two clinic sites, during a 2-week period in June 2007. This resulted in approximately 40 hours of direct observation.

Study investigators gathered data by sitting in the clinic preceptor area (one investigator at each session) and quietly observing one-to-one interactions between preceptors and residents. Investigators recorded field notes of these observations, attempting to capture everything they observed, without making real-time judgements about what qualified as `everyday ethics'. Typically, residents would first see patients and then go to the preceptor room to discuss cases with a preceptor. Sometimes preceptors and residents would leave the preceptor area to see a patient together in the patient examination room. Interactions that took place outside the preceptor area were not observed.

Preceptor interviews were conducted to supplement observations. Interviews took place immediately following the clinic session; therefore it was difficult to interview more than one preceptor per session. Preceptors were invited to reflect on the clinic session just completed and comment about any everyday ethics issues in the cases presented to them.

Data analysis

Observers' handwritten field notes and audiotaped preceptor interviews were transcribed without identifiers. Each transcript was carefully read and coded by at least two investigators using an editing style of analysis.[15] A preliminary coding template was generated by reviewing several field note transcripts. This template was used to code subsequent transcripts and was revised by the team periodically as coding progressed. This

content analysis led to the identification of themes and sub-themes related to everyday ethics issues.

If a preceptor–resident interaction was judged to include any aspect of the definition of everyday ethics described earlier in this section, that interaction was counted as including everyday ethics content. Judgements about whether an ethics issue was present in a preceptor–resident interaction, and how to categorise an issue once identified, although admittedly subjective, involved a process which required multiple coders to reach consensus.

Field notes were also analysed to determine whether preceptors identified and taught about the everyday ethics issues present. Findings were placed into one of four categories: no identification or teaching; implicit identification but no teaching; explicit identification but no teaching, and explicit identification and teaching. `Implicit identification' occurred when, in the judgement of the investigators, the preceptor did not explicitly identify or teach about an everyday ethics issue that was present, but seemed to indirectly acknowledge its presence. NVivo 8 (QSR International Pty Ltd, Doncaster, Vic, Australia) qualitative research software was utilised for data management and to facilitate analysis.

Human subjects protection

This study was approved by an institutional review board. Written informed consent was obtained from each faculty preceptor and verbal consent was obtained from the observed residents.

RESULTS

Demographic information

Table 1 presents demographic information about the training programmes, their trainees, the preceptors and the observed interactions. Twenty-eight of the residents observed were in the Clinic 1 training programme and represented approximately half of the cohort in that programme. Twenty-five of those observed were in the Clinic 2 programme and represented approximately a quarter of the cohort in that programme. A relatively high percentage of observed case presentations were judged by investigators to have everyday ethics content (109 of 135 case presentations [81%]). Just over half of the preceptors observed were interviewed.

Thematic findings

Content analysis of the observer field notes and preceptor interviews revealed findings that were organised into three major thematic domains: (i) Doctor–Patient Interactions; (ii) the Resident as Learner, and (iii) Doctor–System Interactions. Below, and in Table 2, we present findings from each of these three domains and their associated sub-themes. Representative examples taken from the field notes and preceptor interviews are used to illustrate each major theme. Once cases were chosen from the field notes for presentation, relevant portions of the preceptor interviews were identified to add information about the case, the resident's experience and the resident–preceptor interaction.

Frequency data for the themes are presented in Table 2. Such data should not be regarded as definitive; rather, we present frequencies to give readers a general impression of what we observed in the clinics. Some of the observed cases were coded as belonging to more than one thematic domain.

Data on faculty preceptor teaching about everyday ethics are also presented and are included in Table 1.

Doctor–Patient Interaction

Themes associated with Doctor–Patient Interaction were determined to be present in about two-thirds of the observed cases. The major sub-themes associated with this domain were: *relationships* (e.g. interacting in and ending relationships with difficult patients); *communication* (e.g. communication challenges related to sensitive information or cultural differences), and *shared decision making* (e.g. responding to patient preferences that deviate from the standard of care or are not supported by the medical facts; respect for patient autonomy when motivating or persuading patients to change behaviour).

The following example from the Doctor–Patient Interaction domain refers to the *communication* sub-theme and deals with issues of honesty and disclosure. It involves a patient who wanted the doctor to prescribe a medication to help her sleep, and a doctor who was concerned the patient was depressed and wanted to treat her for that:

`Patient reports problems sleeping… Believes it is stress-related… thinks sleeping through the night will help with stress. The preceptor asks about depression assessment, noting that disrupted sleep is pathognomonic for depression. Patient reports being on an SSRI [selective serotonin reuptake inhibitor] in the past; says she is not depressed now – just wants medication for sleep. The preceptor advises screening her for depression, noting she might not want the diagnosis. “She may catch on to what you are doing but we want to get a sense of her mood… Could go with trazodone which is mildly sedating. Could tell the patient that the drug is often prescribed for depression but also used to help folks sleep.”' (Field notes)

`I thought the biggest ethical issue was Doctor A had this patient who we thought might be depressed. And so I think he was on the fence with how truthful he should be with telling her that what he was giving to her was an antidepressant. And so I tried to gently correct him and I said to him specifically, “Tell her it's used for depression but it is also used for sleep,” so he could be honest with her and get that out there…' (Preceptor interview)

This case raises the question of whether it is ever defensible to be less than completely honest with a patient or, for that matter, deceive him or her. Being completely honest with this patient (about prescribing an antidepressant for depression) might have the unintended consequence of reducing her compliance with the recommended therapy.

The following example from the Doctor–Patient Interaction domain refers to the *shared decision making* sub-theme and involves the challenge involved in respecting patients when their preferences may put their well-being at risk. The case involves an elderly woman with gait problems, who is at risk for falling and who declines suggested interventions:

`Frail. Can live independently but needs help. Physical therapy recommended for fall prevention. DEXA [dual energy x-ray absorptiometry] scan and vitamin D level ordered to see whether results can convince the patient to get assistance. Challenge: breaking through to a stubborn patient.' (Field notes)

`So I think this is probably the most gut wrenching moment for the residents. The lady with the autonomy issues and a resident trying to deal with her… You know this lady is going to have some sort of bad outcome. You could see it when you watched her walk, she was going to fall and she was probably going to break her hip. And what do you do with that kind of a patient? And the resident, she knows all the right things to do, she knows all the right resources to help this lady reduce her risk of falling. So she had a very respectful approach

and the ethical issue was front and centre and it was acknowledgement that this lady is fiercely independent and she is competent and she is probably going to have a bad outcome… We are going to keep trying to find some other way to convince her that it is in her best interests to have someone make sure she does not fall. But she did not want to have anything to do with that.' (Preceptor interview)

This case portrays a patient who refuses to consider acting on recommendations the clinician believes to be best for her. The doctors involved are therefore torn between their obligation to respect the patient's autonomy and their duty to protect her from harm.

The Resident as Learner

Resident as Learner themes were determined to be present in about half of the observed cases. The major sub-themes associated with this domain were: *developmental issues* (e.g. recognising the limits of personal knowledge; addressing the tension between enacting the role of learner and providing the best care for the patient); *challenges and conflicts associated with training* (e.g. completing residency and leaving patients; competing and simultaneous responsibilities); *relationships with colleagues and mentors* (e.g. situations involving respect, differences, conflict, mistakes; helping one another), and *interactions with the preceptor* (e.g. the preceptor as a role model of compassion and patient-centredness; the preceptor modelling how to prevent and manage ethics-related problems).

The following example from the Resident as Learner domain refers to the challenges and *conflicts associated with training* sub-theme and involves a situation that arises when trainees complete residency and leave their patients as the training period ends:

`One resident was checking the schedule and asked another resident whether he needed help seeing patients, since he was done. The other resident declined, noting that all his patients were having their last visit with him so he wanted to see them.' (Field notes)

`So there was one interesting thing which is totally specific to this time of the year – quite a few third-year residents who are finishing up and are seeing a lot of their patients for the last time and sort of feeling the patient abandonment and attachment to patients that they particularly like (and some that they are happy to be done with!). But always, “Who will take care of this patient?” It is always interesting to see residents pick specific interns or second-year residents to hand off the patient and you can see how people fit the personality of the patient with the person that they pick. And that is a great end of the year specific topic that has a lot of ethical things: hand-offs and who will take responsibility for this patient when I leave?' (Preceptor interview)

The ethics and professionalism issues involved in this situation, which are experienced by all trainees, include: the need to be respectful and considerate when preparing patients for this transition; the need to be thoughtful and careful when executing hand-offs with colleagues; the need to comfort patients who may be experiencing loss and grief as the relationship ends, and the need to recognise that trainees themselves can experience loss and grief and that being self-aware and reflecting on this can contribute to professional development.

The next example from the Resident as Learner domain refers to the *developmental issues* sub-theme and addresses the tension that can occur between the trainee's role as learner and the obligation to deliver the best care possible to patients:

`Discussion of techniques for a punch biopsy that the resident was to perform. The resident asked questions about tools and appropriate technique, and expressed some familiarity with

the technique, but had not done one since internship. The preceptor offered further explanation… After conducting the procedure, the resident discussed the mechanics of her biopsy technique and noted that there was more bleeding than expected…' (Field notes)

One issue raised by this case is that the resident's desire to perform the procedure in question, in order to become more skilled and professionally competent, may conflict with the goal of having the most qualified person carry out the procedure.

Doctor-System Interaction

Themes relating to Doctor–System Interaction were determined to be present in about half of the observed cases. The major sub-themes associated with this domain were: *financial issues* (e.g. attending to the needs of patients, especially those with limited resources, in a fragmented, expensive health care system); *doctor–system issues* (e.g. schedule-induced time limits with individual patients); *external influences* (e.g. factors affecting doctor behaviour, such as relationships with industry representatives), and *doctor frustration related to system issues* (e.g. disagreement about the division of labour; tracking down results of studies conducted elsewhere).

The following example from the Doctor–System Interaction domain refers to the *financial issues* sub-theme and involves an attempt by doctors to provide optimal care for a patient under suboptimal circumstances:

`The resident presented a patient with chronic liver disease who has no insurance… The lack of insurance impacts his care. The resident says she manages him by phone so he doesn't have to pay for visits… They discussed emergency Medicaid – it might pay for hospitalisations, but not for chronic care or the liver transplant he will eventually need. The resident notes he has Grade 1 encephalopathy with evidence of confusion, but to monitor this by following ammonia levels is too expensive. She considered using lactulose to see if it helps. She will use propranolol for his portal hypertension since it is cheap and effective.' (Field notes)

`Yeah, that was the most complex issue of the entire morning because we are left with feeling like we are inadequately treating his portal hypertension, his disease… But the trade-off for treating him appropriately is leaving him thousands of dollars in debt… how do you decide what is more important? So to treat him as best you can but not destroy him financially…' (Preceptor interview)

This case involves tension between the duty to provide a standard of care to patients and the duty to be sensitive to the patient's financial circumstances and larger life context.

Teaching about everyday ethics

Everyday ethics issues were explicitly identified by preceptors (but not taught about) during their interactions with residents in only 18 of the 109 (17%) case presentations judged by investigators to have ethics or professionalism content. Teaching about identified everyday ethics issues, with explicit reference to the ethics or professionalism considerations involved, occurred in only 13 (12%) interactions. Implicit identification of an ethics-related issue occurred in a much larger percentage of cases (40%).

Both of the case vignettes presented to illustrate the Doctor–Patient Interaction domain show a preceptor's implicit identification of an everyday ethics issue, but not explicit identification or teaching. Interestingly, for each of these two cases, in the post-clinic session interviews, the preceptors involved demonstrated exemplary awareness, sensitivity and knowledge with respect to the relevant everyday ethics issues present in the cases they precepted.

Below is an excerpt from the field notes demonstrating the explicit identification of and teaching about an everyday ethics issue by a preceptor. The case involved a 48-year-old man with mild cognitive disability and congestive heart failure whose social situation was complicated and for whom adequately managing his medical problems was very challenging:

`This led to a discussion between the faculty preceptor and the resident about the responsibility of patients for their own care versus the limits of the doctor's responsibility for helping patients in general, and, in particular, patients like this who may be compromised in some way. For example, with mild mental retardation or with difficult social circumstances, helping patients like this get things done. The question raised was: what's the threshold for our responsibility and what's the right thing to do under these circumstances? Should more of an effort be made to reach out to someone like this, and/or to reach out to someone in their social universe to help facilitate care for the patient? Also, should an extra effort be made to educate the patient by spending more time with them to help them understand their situation?' (Field notes)

DISCUSSION

Direct observation of preceptor–resident interactions in two internal medicine resident clinics revealed that everyday ethics issues arose commonly in these settings and that a variety of issues were encountered.

We had several reasons for initiating this study and for conducting it as we did. Firstly, one of our stated goals is to educate trainees about the ethics-related issues they encounter in the out-patient setting. The first step in accomplishing this goal is to document what those issues are and whether they are being taught. Secondly, it is over two decades since any study has examined ethics-related issues in an internal medicine out-patient setting with the explicit intent of using study findings for educational purposes.[9] We thought it was time to revisit this territory to see if the landscape has changed. Thirdly, we are not aware of any other study that has attempted to identify the ethics-related issues that arise in an internal medicine resident clinic by observing interactions between preceptors and residents.

Many of our findings are consistent with those in other accounts that have characterised clinical ethics over the past few decades,[5,7,16–21] particularly taxonomies of out-patient ethics issues.[4,12,22] Specifically, some of the major thematic categories described in this paper are well established (e.g. the doctor–patient relationship and communication, and doctor–system interactions). Similarly, some of the specific issues we identified have been described by others (e.g. treatment refusal).[7,11,12,23] However, many of the findings in our Resident as Learner thematic domain and some of the findings in our Doctor–System Interaction domain are not included in existing taxonomies of out-patient ethics-related issues.[4,12,22] For example, the ethical and professional considerations involved when residents conclude their training experience, such as the ending of relationships with continuity patients and the handing over of these patients to colleagues, are not found in the previously cited taxonomies. Teaching about these issues seems especially important at a time when a variety of hand-offs are increasingly common in medical practice.[24] Similarly, doctor frustration with systems issues is rampant,[25–27] yet is not typically listed as a distinct issue in clinical ethics taxonomies. Teaching about the ethical and professional considerations associated with such frustration, including the associated moral distress,[28,29] is important because trainees must grapple with these issues.

Many authors have pressed the notion that ethics education informed by empirical findings has the potential to be more relevant for learners.[4,10,30–33] Our approach allowed us not only

to capture and describe actual cases encountered by residents, but also to identify specific topics that can be taught. These cases can serve as clinical material for teaching, whether `in the moment' or at some later point during a designated conference session.

Previous work has established that ethics-related issues can vary by setting and subspecialty.[5,34,35] Several authors have argued that ethics-related issues encountered in the out-patient setting may differ from those that arise in the in-patient setting and that appropriate attention should be directed to the ambulatory setting.[4,22,36] Given the traditional focus of ethics education on in-patient issues, studying what is happening in the out-patient setting is important, especially in view of the increased emphasis on the out-patient experience for both trainees and practising doctors.[37] Our study contributes to the goal of developing a deeper awareness and appreciation of the ethics-related issues trainees and practising doctors face in ambulatory settings.

Another objective of the study was to examine how faculty preceptors responded when everyday ethics issues arose and, specifically, to determine whether they were identifying and teaching about these issues during their interactions with residents. Our findings indicate that faculty preceptors explicitly identified ethics or professionalism issues infrequently and taught about these issues even less frequently. Importantly, it is clear that at least some of the time faculty preceptors were, in fact, quite aware of, sensitive to and knowledgeable about the everyday ethics issues involved, yet did not take the step of explicitly sharing this knowledge with their learners during the precepting interaction. There are several possible explanations for why preceptors did not address these issues. One concerns the considerable amount of other precepting work to be accomplished in a limited amount of time, which may compete with the discussion of everyday ethics issues. Secondly, about 40% of the time, preceptors made some comments that could be interpreted as implicitly addressing the relevant everyday ethics issue. Perhaps faculty members assume that an indirect, passing reference to an issue will be clearly understood by trainees and that such communication is sufficient in terms of identification and teaching. Burack *et al.* have pointed out that such assumptions are often unfounded and that trainees may misunderstand the intended message.[9] Thirdly, faculty staff may conclude that explicit focus on ethics-related issues is not germane to the patient's management. Fourthly, faculty staff may feel under-prepared to teach about these issues even if they recognise them. Finally, faculty members may not recognise ethics and professionalism issues; recognition is necessary in order to mention and subsequently teach about these issues.

Further studies might examine which factors are responsible for the relatively low level of explicit teaching about everyday ethics issues that occurred in our resident clinics. Specific strategies might then be developed to address barriers to teaching. It is possible that simply making faculty staff aware of these data would enhance their frequency of teaching. Other strategies might include encouraging faculty members to explicitly share what they already know, developing and disseminating helpful tools to facilitate teaching,[38] and urging faculty staff to keep a log of everyday ethics-related cases to be shared with the `ethics faculty', who might, in turn, teach about these issues in designated conferences. Finally, it would be helpful to have a more effective overall model of precepting that assists preceptors in addressing and balancing the multiple concerns and agendas that arise in a complex and demanding environment.

This study has several limitations. It was conducted at two different clinics that are part of the same institution and ethics-related issues in different settings (both within and outside the study institution) may not be the same. However, these training programmes and their residents are similar in many respects to other internal medicine training programmes and residents in the USA and therefore we suspect these findings will resonate with others

elsewhere. A second limitation is that resident-patient interactions were not directly observed. It is possible that these interactions involved ethics-related issues that were not discussed in the observed resident-preceptor interactions and were therefore not captured. In some cases, because a portion of the resident-preceptor interaction occurred away from the preceptor area, we were not able to observe the entire interaction. A third limitation is that the observation window was 2 weeks in duration and took place at a particular time of the year. A longer period of observation that included observations at several different times in the academic year might have yielded different or additional findings. However, it was not our intent for the findings of this study to generate an encyclopaedic list of topics that might form the basis for a comprehensive ethics curriculum. Rather, we hoped to take a snapshot of what our residents were commonly encountering and to determine whether they were being taught about these issues.

One strength of our study is that it involved more than one method of data collection. The two approaches used in our study, direct observation and interviews, complement one another and increase the trustworthiness of our findings.[39]

In conclusion, this study of faculty preceptors and residents in the out-patient clinics of two internal medicine training programmes revealed that everyday ethics issues arose commonly as residents cared for patients in these settings, and that a variety of issues were encountered. Preceptor awareness of the ethics-related issues encountered by trainees can facilitate the integration of ethics education into the discussion of routine clinic cases. However, faculty preceptors infrequently explicitly identified or taught these issues during their interactions with residents. A better understanding of the barriers to teaching about these issues is needed in order to develop strategies to promote their discussion during precepting sessions. Residents may consider that learning about the challenges they are actually facing is highly relevant to their education. Future studies in other out-patient and in-patient settings might help to expand the empirical basis for ethics education in internal medicine.

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Table 1

Characteristics of training programmes, trainees, preceptors and observed interactions

Residents on programme, *n*	Clinic 1: 46 (20 male, 26 female)
	Clinic 2: 106 (55 male, 51 female)
Residents observed, *n*	Clinic 1: 28
	Clinic 2: 25
Preceptors	Clinic 1: 10/5
observed/interviewed, *n*	Clinic 2: 9/5
Cases discussed during the observed interactions, *n*	135
Cases with everyday ethics content, *n*	109 (81%)
Explicit identification and teaching by preceptors	13 of 109 cases (12%)
Explicit identification (without teaching) by preceptors	18 of 109 cases (17%)
Implicit identification by preceptors	44 of 109 cases (40%)

Table 2

Information about major thematic domains and associated sub-themes*

Domains and sub-themes	Cases, *n*	Proportion of cases involving everyday ethics (*n* = 109)
1 Doctor–Patient Interaction	85	78%
Relationships	54	50%
• Interacting with difficult patients		
• Ending relationships with difficult patients		
Communication	12	11%
• Challenges involving sensitive information or cultural differences		
Shared decision making	64	59%
• Responding to patient preferences when they deviate from the standard of care or when they cannot be supported by the facts		
• Respecting patient autonomy when motivating or persuading patients to change behaviour		
2 Resident as Learner	62	57%
Developmental issues	28	26%
• Recognising personal limits of knowledge		
• Addressing tension between learner role and best care for patient		
Challenges and conflicts associated with training	8	7%
• Completing residency and leaving patients		
• Competing and simultaneous responsibilities		
Relationships with colleagues and mentors	26	24%
• Respecting one another		
• Managing differences and conflict		
• Dealing with one's own and others' mistakes		
• Helping one another		
Interactions with the preceptor	27	25%
• Preceptor as a role model of compassion and patient-centredness		
• Preceptor modelling how to prevent and manage ethics problems		
3 Doctor-System Interaction	47	43%
Financial issues	19	17%
• Attending to the needs of patients, especially those with limited resources, in a fragmented, expensive health care system		
Doctor-system issues	22	20%
• Schedule-induced time limits with individual patients		
External influences	15	14%
• Factors affecting doctor behaviour, such as relationships with industry representatives		
Doctor frustration related to system issues	4	4%
• Disagreement about division of labour		
• Tracking down results of studies done elsewhere		

* Bulleted examples of sub-themes are illustrative rather than exhaustive