From distress to detachment: exploring how providing care for stigmatized patients influences the moral development of medical trainees

Lisa X. Liu1 · Mark Goldszmidt1 · Sara Calvert1 · Sarah Burm1 · Jacqueline Torti1 · Sayra Cristancho1 · Javeed Sukhera2

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Abstract
In acute hospital settings, medical trainees are often confronted with moral challenges and negative emotions when caring for complex and structurally vulnerable patients. These challenges may influence the long term moral development of medical trainees and have significant implications for future clinical practice. Despite the importance of moral development to medical education, the topic is still relatively under-explored. To gain a deeper understanding of moral development in trainees, we conducted a qualitative exploration of how caring for a stigmatized population influences their moral development. Data were collected from 48 medical trainees, including observational field notes, supplemental interviews, and medical documentation from inpatient units of two urban teaching hospitals in a Canadian context. Utilizing a practice-based approach which draws on constructivist grounded theory, we conducted constant comparative coding and analysis. We found that caring for stigmatized populations appeared to trigger frustration in medical trainees, which often perpetuated feelings of futility as well as avoidance behaviours. Additionally, hospital policies, the physical learning environment, variability in supervisory practices, and perceptions of judgment and mistrust all negatively influenced moral development and contributed to apathy and moral detachment which has implications for the future. Recognizing the dynamic and uncertain nature of care for stigmatized patients, and addressing the influence of structural and material factors provide an opportunity to support moral experiences within clinical training, and to improve inequities.

Keywords Medical education · Moral development · Stigma
Introduction

Supporting the moral development of medical trainees is an essential aspect of contemporary medical curricula. The concept of moral development has been extensively described by previous authors (Gibbs, 2013; Gilligan, 1989; Hoffman, 2000; Kohlberg, 1981), and is commonly conceptualized as the gradual reconciling of self-interest with that of others in our society through the maturation of moral decision-making, including moral reasoning and other related processes (Garrigan et al., 2018). Over time, individuals become capable of defining moral principles that guide their actions independent of pressure from social norms. Medical education seeks to develop trainees’ knowledge and skills while shaping their professional attitudes and fostering respect for patients. Yet, existing research suggests that medical trainees undergo little change in their expected moral development throughout the course of their training and at times may even demonstrate regression (Branch, 2000; Lind, 2000; Murrell, 2014; Patenaude et al., 2003; Yavari, 2016). Although the hidden curriculum and negative role modelling have been implicated in such regression (Berger, 2014; Branch, 2000; Kumagai, 2008), there is a limited understanding of why some clinical learning activities may enhance moral development while others hinder it (Olthuis & Dekkers, 2003). A deeper understanding of moral development is long overdue.

One area that may provide insight into moral development is the care of stigmatized patient populations. Trainees may find care for such populations uniquely challenging, often due to the potential for negative role modeling and efforts to advance equity and reduce stigma and discrimination. For example, a particular group of stigmatized individuals cared for in acute hospital setting are people who inject drugs (PWID). Medical professionals frequently report that they lack adequate knowledge to care for PWID (Johansson & Wiklund-Gustin, 2016), and caring for such populations is often perceived to be challenging by both trainees and their clinical supervisors. For medical trainees, challenges while working with PWID may include witnessing resentment towards such patients expressed by their colleagues or experiencing similar feelings of resentment themselves (Christodoulou-Fella et al., 2017; Rectho et al., 2020). The difficulties experienced by trainees are further compounded when their supervising physicians report their own struggles and knowledge gaps related to caring for PWID.

Challenges intrinsic to the care of patient populations such as PWID are particularly salient for staff and trainees working in acute inpatient units, sometimes known as clinical teaching units (CTU). Within these units, medical trainees are often responsible for the daily aspects of care, and experience difficulties due to complexities unique to such patient populations. Although reasons for their medical admission may vary (Binswanger et al., 2000; Haber et al., 2009; Stein & Sobota, 2001), PWID patients often have complex medical needs which are challenging to address because of resource constraints such as high bed occupancy rates, heavy patient acuity, and staffing shortages (Chu & Galang, 2013; Monks et al., 2013). Previous researchers found that over time, frustrations experienced by the healthcare team can contribute to feelings of helplessness, which may in turn lead to staff members becoming hypervigilant or avoidant as a form of self-protection (Johansson & Wiklund-Gustin, 2016). In addition, the frustration felt by staff may aggravate and fuel the development of negative and harmful stereotypes (Ahern et al., 2007; McLaughlin et al., 2000; Miller et al., 2001; Monks et al., 2013).

Although navigating the complex challenges related to stigmatized populations likely contribute to a trainee’s moral development, there is a paucity of research on its complexities. Existing studies regarding medical trainees and patients with substance use disorder...
are limited in scope, mixed in results, and have largely focused on trainee’s perception of competency in treating these patients (Cape et al., 2006; Clark et al., 2020; Koyi et al., 2018; Ram & Chisolm, 2016; Wakeman et al., 2013). Such research has tended to focus on the impact of role modeling on ethical or unethical behavior (Branch, 2000; Feudtner et al., 1994) and on the development of empathy (Neumann et al., 2011; Yuguero et al., 2019). Research on empathy and moral development is relevant due to the relationship between empathy, ethical behavior, clinical outcome, and both patient and health professional satisfaction (Wong, 2020; Yuguero et al., 2019). However, research also suggests that trainees struggle with conforming to norms within the clinical learning environment when these norms conflict with their own moral values (Yavari, 2016). In such moments of distress, learners’ moral development and moral reasoning may be under significant strain (Berger, 2014), and may contribute to the stagnancy or failure in moral development that is persistently observed in medical trainees (Murrell, 2014; Sheehan et al., 2015). In a recent study by Thurn and Anneser (2020), the majority (84%) of medical students felt medical school did not prepare them well to handle moral distress. These struggles prompt further investigation and insight into moral development in trainees, especially when learners experience distress.

Observing how medical trainees navigate the process of caring for stigmatized patient populations may provide a unique opportunity to better understand moral development. Care for such patients involves complex moral decisions in the context of potential distress. Through deepening our understanding of how trainees navigate moral and ethical challenges for stigmatized patients, we may also improve our understanding of how care for such patients influences moral behaviour, empathy, and growth in trainees themselves. Therefore, we conducted an observational study to explore how working with a stigmatized patient population such as PWID may influence the moral development of medical trainees.

**Method**

**Theoretical framework**

Moral development and the interdependence of cognitive and affective processes

Research into moral development has historically been informed by different theories and perspectives, with varying definitions and usages of moral terms. Our study is informed by the work of authors who addressed the relationship between both cognitive and affective aspects of moral development. We define moral development as the maturation of moral decision-making, where moral decision-making refers to “any decision, including judgements, evaluations, and response choices, made within the ‘moral domain’.”(Garrigan et al., 2018). While cognitive-development theorists historically posited cognition as the main driver of moral decisions, Hoffman (2000) argued that affective empathy, when bonded with moral principles, gives the principles motive force, and emphasized socialization as a process by which morals are internalized. Building on Hoffman’s work, Gibbs (2013) suggested the interdependency of cognitive and affective processes. Gibbs proposed that moral development can be conceptualized as schemas, rather than stages. Schemas are knowledge structures regarding moral events in long-term memory that help facilitate information processing, which may become activated, gradually reorganized and refined.
over time, adapting to and depending on situational factors (Garrigan et al., 2018; Gibbs, 2013). In addition to the work of Hoffman and Gibbs, our study was guided by Kumagai’s framework (2018), in which learning is considered a transformative process for physicians-in-training that occurs on a cognitive, affective, and experiential level. We viewed moral development as a complex process that is shaped through the dynamic interactions between formal education, role-modelling, informal conversations, implicit and explicit expectations, and social norms.

**Empathic and moral distress**

Moral development is constrained when learners experience distress. Therefore our work was also informed by theories of empathic and moral distress. In the context of clinical care, empathy has been defined as “a predominantly cognitive attribute that involves an understanding (rather than feeling) of experiences, concerns, and perspectives of the patient, combined with a capacity to communicate this understanding, and an intention to help” (Hojat, 2016). Research suggests that in face of distressing events and suffering, empathetic arousal may lead to positive emotional regulation, resulting in healthy empathic concern that leads to compassionate action (Wong, 2020). However, empathy may be impeded when negative empathic arousal becomes overwhelming, leading to empathic distress, which triggers self-focused behaviour to relieve the distress (Wong, 2020).

Related to empathic distress is the concept of moral distress, the cognitive-emotional dissonance that arises when one feels compelled to act against one’s moral requirements (Berger, 2014). Like moral decision-making, moral distress varies in its definition in different research approaches. Nevertheless, Jameston’s original definition (Jameston, 1984) and other recent literature (Hamric, 2014; McCarthy, 2013; Morley et al., 2019) highlight five key components: (1) complicity in wrongdoing, (2) lack of voice or power to change the situation, (3) wrongdoing associated with professional rather than personal values, (4) repeated experiences of morally distressing situations adding to previous levels of moral residue, and (5) root causes found at the patient, unit, and systemic level (Epstein et al., 2019). In addition to empathic distress, moral distress has been correlated with secondary traumatic stress and burnout, with the highest incidence found in surgical and medicine subspecialties (Austin et al., 2017; Wong, 2020). For trainees and young physicians, moral distress may contribute to diminished empathy (Leiter et al., 2009), a decline which may begin during medical school (Branch, 2000; Murrell, 2014; Patenaude et al., 2003; Yavari, 2016). Overall, our study sought to explore how the distress experienced by learners when caring for a stigmatized patient population influenced their moral development.

**Approach**

While conducting a larger observational study exploring how care is enacted for PWID patients in acute inpatient setting (Calvert et al., n.d.), we observed that medical trainees within acute inpatient units appeared to be experiencing moral challenges. We therefore developed a separate study focusing on moral development and empathy in trainees. Our approach was informed by principles of practice-based research (Gherardi & Rodeschini, 2016) which examines care in situated practices through rich descriptions of everyday life. These principles guided us to develop detailed analyses through a sociomaterial lens which incorporated both human (e.g. professionals, patients, and families) and non-human elements (e.g. technology, work, and organizations), and allowed a deeper exploration of the
complex, non-linear relationships that occurred between social practices and materials in the clinical environment (Burm et al., 2019; Fenwick & Landri, 2012; Gherardi & Rodeschini, 2016; Goldszmidt, 2017). Practice-based approach (Gherardi & Rodeschini, 2016) also draws on key steps from constructivist grounded theory (CGT) described by Charmaz to enhance rigor, through inductive analysis of themes via iterative cycles of data collection, constant comparative analysis, and theoretical sampling (Charmaz, 2014).

Data collection

Data were collected from internal medicine units from two acute-care hospitals in a mid-sized Canadian city from June 2019 until September 2020, with majority of data collected between June 2019 and January 2020. Due to the COVID19 pandemic, observational data collection was paused. However, we continued follow-up interviews until the spring and summer of 2020 with participants who had been previously observed. Participants were identified as any medical trainee caring for PWID patients. PWID patients were identified as those who: (1) had a current or recent history of injection drug use; (2) were assessed to be competent in making informed medical decisions; and (3) were proficient in English communication. To recruit participants, an email was sent to supervising medical staff explaining the purpose and nature of the study. Trained researchers (SC and LL1) then attended morning rounds at both sites to introduce and explain the study in a more fulsome manner, while answering any questions potential participants may have had. Those who provided informed consent to participate were during their clinical rotations, each of which was typically one month in duration. A total of 48 individuals consented to participate in the study. Participants included 14 medical students on their core clerkship in medicine, 18 first year residents, 15 second- or third-year medicine residents, and one physician assistant (PA) student. Of the junior residents, 13 were training in Internal Medicine while five were training in Family Medicine. All senior residents were training in Internal Medicine. Ethical approval was received from the Western University Health Science Research Ethics Board prior to data collection.

Data included 150 h of direct observation of all 48 participants, field interviews, and follow-up interviews. In addition, relevant field notes and clinical documentation such as electronic admission and discharge notes and handwritten daily progress notes were included in our analysis. Field notes were derived from observing interprofessional rounds, medical team rounds, morning and afternoon handovers, as well as direct observations of bedside interactions between patients and the trainees. During rounds, we observed for team communications, attitude, and behaviours; senior to junior interactions; and interprofessional interactions between medical trainees and other providers regarding the care of PWID. Additionally, we focused on material influences that affected the day to day care of these patients. Observation notes were followed up with brief field interviews whenever an observed incident required clarification and explanation from those observed. This approach provided researchers with an opportunity to obtain clarifications and gain a deeper understanding of what they had observed in real time so to minimize recall bias. When field interviews were not possible due to constraints in the participants’ schedule, semi-structured follow-up interviews were arranged instead. The combination of observations augmented by interviews and documents allowed researchers to generate the rich descriptions of everyday life necessary to examine situated practices within the lens of practice-based approach (Gherardi & Rodeschini, 2016). A total of 157 min of interviews were conducted, which included 2 senior residents, 3 junior residents, 2 medical students,
and 1 PA student. One senior resident, who had been a junior resident at the time of initial observation, was approached in a follow up interview to comment on key observed findings.

Data analysis

Data collection and analysis occurred concurrently at both sites and unfolded in an iterative fashion consistent with a constructivist grounded theory informed approach. Throughout the process of data collection, researchers (SC and LL) continuously maintained reflective and theoretical field notes and met weekly with (JS) and (MG) in order to compare initial codes; to discuss ways in which our own personal perspectives were shaping what we noticed, explored and interpreted; as well as to direct future data collection. Data were analyzed manually by highlighting and open coding (Charmaz, 2014). Preliminary analysis included regular consultations with JS and MG. In addition, team meetings were held at monthly intervals to discuss preliminary findings, to assess goodness of fit of categorization, and to analyze accuracy of themes. Theme mapping and case narratives were adopted to help create connections between cases. Definitions of codes and themes continued to be refined throughout data collection and analysis, until theoretical sufficiency was achieved (Charmaz, 2014).

Reflexivity

The research team included a diverse group of clinicians, researchers, and scientists representing a range of specialties and fields of study, which enabled us to approach our data with an interdisciplinary lens and to enhance the rigor of our study through investigator triangulation (Carter et al., 2014). Senior members of our team included two practicing physician-scientists – a child and adolescent psychiatrist (JS) and an internist (MG)—each with extensive experience in qualitative research and doctoral degrees in health professions education. A medical student (LL) and a registered nurse (SC1), both of whom have masters level education in research, were responsible for primary data collection and coding. Detailed reflective notes were kept on all observation notes and interviews. Other members of the team included an undergraduate student (MR) and four experienced qualitative health profession education researchers (SB, SC2, LC, and JT), all of whom were involved in the analysis of results and development of the paper. The diverse backgrounds of team members provided a range of perspectives and enabled rich analytical discussions through which differences were resolved by consensus and final decisions were made by LL and the senior author JS.

Results

Caring for PWID appeared to trigger a sense of frustration in trainees that compounded through the course of their training over time and was distinct from their experience caring for other patient populations. Frustration often perpetuated a sense of futility which further contributed to observed changes in senior trainees that could be viewed as adaptive or problematic. For example, trainees began emotionally distancing themselves from PWID and engaged in physical avoidance as a protective mechanism to preserve their ability to continue providing adequate care despite the moral challenges they were experiencing. We
describe this avoidance as “moral detachment.” Additionally, there were also material factors in the physical environment which influenced moral development, including hospital policies and electronic chart documentation.

**Cycles of frustration and moral tension**

Care for PWID patients was often perceived as cyclical. Almost all PWID patients that were admitted to CTU were previously known to the team through the experience of their colleagues or through extensive documentation of past hospital visits. Common causes of repeat admission were infections such as skin abscesses and endocarditis. Through our interviews and observed interactions amongst team members it became evident that caring for PWID patients led to a sense of helplessness. At the heart of this was a perceived inability to make a difference and “actually solve” the problem (HCP015). Frustration and helplessness were further exacerbated by a sense that attitudes of patients and their unwillingness to help themselves were part of the cyclical problem:

*There’s definitely a perception that people who inject drugs don’t really care about their health and there’s a lot of patients who are repeats patients who come in and out of hospital but not only that, they leave against medical advice and then, it’s quite frustrating trying to provide care for them because, you know that they’re going to leave hospital again* (HCP002).

The frequency with which PWID left the hospital against medical advice (AMA) created additional challenges to providing them consistent care and perpetuated frustration for trainees. Reasons for such outcomes varied, including inadequate pain management and social obligations outside of the hospital (Calvert et al., n.d). Unlike other patients of CTU, many of whom were bed bound due to mobility concerns, PWIDs were often medically stable enough to stroll in the hallways, go to the cafeteria, or even leave hospital premise. These absences could be at times quite prolonged, leaving the trainees uncertain about their patient’s whereabouts. When trainees could not locate their patient after a significant amount of time, they would often be discharged as AMA. Some did not return, yet many would later present to the emergency department again requiring readmission (Case 3 Observation Notes).

Trainees also expressed that a patient’s prolonged absence from the unit posed barriers to their ability to care for the patient. They felt they were unable to perform necessary assessments and administer diagnostic tests yet had to devote addition time and resources searching or rechecking on their patients, even when the patient may never return after their absence. In cases of AMA, trainees perceived the course of antibiotics that would remain unfinished due to the patient’s abrupt departure as a wasted opportunity. Such examples also contributed to a sense of futility (Field Interview HCP004).

**Disconnection and mistrust**

Over time, authors perceived that trainees’ empathy eroded due to a lack of trust and rapport between trainees and the PWIDs they cared for. This in turn posed substantial barriers to providing efficient and adequate care. One trainee revealed in an interview, “the difficult thing is building that rapport with the patient and trying to find common ground with them. […] They have more kind of a defensive wall that’s harder to get through” (HCP003). Difficulty establishing shared care goals often led to patients refusing proposed management plans by the
team. When this happened, trainees were observed to experience significant increase in frustration, especially if multiple members of the team, seniors and juniors alike, had attempted but failed to establish rapport with the patient. In one incidence, a senior resident exclaimed, “how are we supposed to help them when they won’t cooperate with us” (Case 4 Observation notes).

Difficulty establishing common care goals was particularly notable when pain medication was discussed. The general trend observed on CTU was that pain was inadequately managed, where the amount of pain medication requested by patients was more than often less than what the team was comfortable prescribing (Multiple Observation Notes). In this regard, trainees reported feeling more hesitant to believe a PWID patients’ reported pain if patients’ own account of substance use did not match their previous hospital documentation: “If they say they don’t [use substances], and then I look at a chart, […] and they’ve previously tested positive, well then, that trust is broken” (HCP014). Fear of contributing to PWID’s addiction by over prescribing medication played an important role in inhibiting the formation of a trusting therapeutic relationship (Case 2 Observation Notes).

We also observed that trainee’s difficulty establishing rapport was in part influenced by supervisory practices of their attending physicians. During their rotation, trainees were supervised by multiple physicians, each with their own style of communication and approach to treating and caring for PWID. Supervising consultants and senior residents rarely demonstrated approaches to communicating with PWID that trainees perceived as effective or trauma-informed. For example, a junior trainee was asked to stay behind by another team member to provide a more detailed explanation of MRSA + status (methicillin-resistant Staphylococcus aureus positive) to the distressed patient, because the senior resident who had conveyed the message previously had not taken the time to fully understand the patient’s concern (Case 1 Observation Note). When interviewed by researchers regarding that encounter, the same trainee had shared, “Some providers don’t like to take the time to explain […] and some of them kind of just brush them off and then other providers are excellent and also take the time to explain” (HCP 002).

Rapport was further hindered by trainees’ limited ability to commit focused time with an individual patient. In another instance, a supervising physician described a PWID patient with a history of mental illness by stating, “They need TLC. You need to take your time with them or don’t even bother” (Case 17 Observation Notes). Such assertions were perceived as indifference by trainees who noted that they were learning to “let them leave” if they wanted to. Yet, the supervising physician in the above scenario recognized that establishing rapport with the PWID population required significant time investment, empathy and patience. What we have observed, over the course of months, was that it was often extremely challenging, if not impossible, for trainees of any level to “take their time” when caring for patients of CTU. Acute inpatient units carried a heavy patient load at any given time, both in the number of patients the team was caring for and the medical complexity of these patients. More than an issue of mistrust and poor role-modelling, time acted as a major barrier to creating the connection between trainees and PWIDs necessary for optimal care outcome. Over time, trainees became complacent with the expectation that good rapport could not be achieved.

**Material pressures and influences**

In addition to time, several other material entities enacted upon trainees in ways which hindered empathy and moral development. Heavy patient load of acute inpatient units not only posed time constraints for working trainees but also created an ever-present pressure
to discharge patients in order to free up beds for other patients waiting to be admitted from the Emergency Department. PWIDs’ propensity for prolonged absence from the unit meant that they were often discharged as AMA when the team faced mounting bed pressures. One trainee said:

*I understand that, in this particular population, we should be increasing the threshold to discharging them against medical advice, but at the same time, it’s a hospital resource issue. They have a full ER unit needing to mobilize.* (HCP015).

Although discharge pressures were also evident for non PWID patients, elderly patients that experienced discharge planning challenges were perceived as too unwell to leave, while PWID patients without mobility limitations were justified as being more appropriate for discharge, despite their treatment course not being complete.

Communication between teams via electronic documentation also contributed to perpetuating negative perceptions, mistrust, and poor rapport. Electronic documentation review of admission, progress and discharge notes demonstrated documentation of PWID being labelled as “belligerent” or “aggressive” or with mention of them being “pleasant” in a manner that was surprising to the trainee who wrote the clinical note. Once documented, stigmatizing labels further perpetuated stigmatizing treatment. We found multiple instances where clinical documentation contributed to a healthcare professional’s perception of the patient before they even met the patient in person, since trainees are taught to study their patients’ charts ahead of time. As one trainee (HCP 019) said during field observation (Observation Note Case 8), members of the medical team spent most of their time reading the chart and “talk to the patient for a minute”.

Trainees’ sense of futility was further perpetuated by the perception that PWID patients were likely to be lost to follow up in the community, since many patients within this population faced additional social challenges such as homelessness and unemployment. Often, trainees reported feeling frustrated because they knew their efforts were ultimately futile if it could not be maintained post discharge, as demonstrated by this trainee who commented on outpatient follow up for PWID: “We’re trying our best but, in a way, it’s kind of stupid because, um, we’re doing this knowing that she doesn’t have a set family doctor or pharmacy” (HCP 004). Trainees’ frustrations are shared by their supervising consultant and members of the interdisciplinary team, who through experience found that PWID patients often sought non-medical support which the hospital system did not have the capacity to provide (Case 6 Observation Notes). Overall, futility, helplessness, and anticipation of poor outcomes led interdisciplinary teams to deny and deflect PWID patients who requested social or housing supports (Case 6 Observation Notes).

**Adapting and adjusting**

The cyclical nature of caring for PWIDs, difficulty building rapport, and constraints posed by variable supervisory practices and resource issues contributed to the development of frustration, feelings of futility, and negative perception towards the PWID population. Though junior trainees attempted to resist negative labelling and maintain optimism, we observed their attitudes shift over time. For example, one medical student stated, “It’s frustrating for any health care [staff] when [PWID] refuse certain tests or certain procedures, but on the whole […] I find [PWIDs] fairly pleasant to talk to most days and not really different than other patients” (HCP 002). In the senior residents which we observed, this sentiment was not observed to be shared. Additionally, attitude shifts against PWID patients were observed to begin to take
place in junior trainees as well. One junior trainee expressed their frustration regarding the frequent interruptions in care and shared in an interview that due to the patient’s absence, they felt that “resource and that time we allocated for [the PWID patient] was wasted” (HCP 004).

We also found that junior and senior trainees tended to approach PWID differently, suggesting a gradual process of labeling, stigmatization, detachment, and avoidance. We found that senior trainees tended to perceive PWID in stereotyped ways such as seeking shelter and resources from hospitals, which was different from junior trainees (Case 2 Observation Note). During morning rounds, one senior resident addressed the concern that limited system resources would be further stretched by patients who “abuse” such resources (HCP 018, Observation Note Case 2). Such stereotypes also contributed to an anticipatory sense of futility even before treatments were delivered. A senior resident stated that they anticipated the treatment course being prescribed would not be completed due to their perception that the patient would likely be discharged AMA (HCP 015). For many senior trainees, they seemed to have given up on efforts to convince PWID patients to stay, accepting their loss to follow-up as an intrinsic part of their care. Similarly, senior trainees noted a strong sense of apathy. Although junior trainees demonstrated more visible distress and engaged proactively with PWID in an attempt to convince them to stay, such distress was less evident in senior trainees who stated that the patient’s premature discharge no longer caused them distress. One senior resident stated, “my experience is that convincing them probably hasn’t worked…there are just a lot more other things we can be doing, and they’ll probably come back anyways.” (HCP017). They went on to say:

I’ve reflected on it a lot, and I think to me the way that you deal with that is to say: the patient is the one with the disease and all I can do is [...] [be] kind to them, give them pretty equitable treatment and I’m not responsible for the results of [them leaving].

This resident also rationalized their detachment, noting that it was necessary to protect themselves against “empathy burnout” (HCP017).

We also observed that feelings of frustration and futility led to avoidance behavior in certain trainees. Avoidance manifested in different ways, such as keeping distance between oneself and the patient, not entering fully into the room to speak with the patient, or the passing of responsibility to another member of the team. During one observation, a junior trainee explicitly refused to take on a PWID patient they had seen the day before, stating that after a prior altercation, they had lost the rapport that they had had with the patient (Case 14 Observation notes). The team sympathized with the trainee’s struggles and did not force the matter, and the patient was assigned to the senior resident. Multiple instances were seen of trainees distancing themselves from PWIDs both physically and emotionally, a phenomenon we have termed as moral detachment. The adoption of moral detachment by medical trainees was viewed by trainees as protective in nature against burnout, so that they may continue to provide adequate care for future PWID patients that they would inevitably encounter throughout their training.

Discussion

Our findings suggest that caring for stigmatized patients such as PWID influences the moral development of medical trainees in ways that have potentially significant and long-lasting implications for how they care for stigmatized patients in the future. Similar to previous research, we found that modelling and inconsistent support from senior members of the team clearly influenced moral development. Additionally, we found that these forces
also contributed to detachment and avoidance of stigmatized patients, which was further impacted by structural forces within the system of care.

Caring for stigmatized patients such as PWID consistently triggered frustration in medical trainees which was not typically experienced with other patient populations and which compounded over time. The cyclical nature of admission, discharge, and repeated admission contributed to worsening frustration, futility, and helplessness. Over time, trainees appeared to develop a set of fixed assumptions around how care would unfold, and they would protect themselves by engaging in avoidance and detachment. A lack of teaching on effective communication with PWID patients and inconsistent modelling from consultants and supervisors further led to trainees’ detachment.

**Empathy, moral distress, and moral erosion**

Previous work describes moral development as both the process of gradual transmission of norms and values that become internalized (Hoffman, 2000), and the maturation of moral decision making through reorganization and refining of moral schemas depending on situational factors (Gibbs, 2013). In the context of medical education, transformative learning happens on a cognitive, affective and experiential level, and is achieved through both formal education and informal teaching and expectations (Kumagai, 2008). In our study, we found that moral development was negatively impacted by multiple forces, both human and non-human. Though supervising faculty play an important role in influencing perceptions of empathy and compassion (Berger, 2014), we found that the lack of effective role modelling by supervisors increased distress and eroded moral development. Workload expectations within acute clinical settings were also perceived as barriers to developing empathy. In addition, the cyclical nature of caring for PWIDs and the unique challenges managing complex emotions contributed to feelings of frustration and futility. These further contributed to negative beliefs towards PWID as well as the demonstration of greater apathy over time.

When physicians encounter a distressing event, emotional dysregulation may occur as a result of overwhelming negative empathic arousal, leading to empathic distress (Hoffman, 2000; Rushton et al., 2013; Wong, 2020) To alleviate these negative emotions, physicians often turn to self-focused behaviours rather than compassionate actions that arise from positive emotional regulation and empathetic concern (Wong, 2020). Self-focused behaviours include frustration, avoidance, or freezing/numbing responses, which are congruent with the findings of our study. Both senior and junior trainees vocalized their frustration and feelings of futility and demonstrated avoidance and numbing behaviours as a means of self protection.

Similar behaviours of avoidance and blunting have been previously noted as maladaptive strategies for medical trainees experiencing moral distress (Berger, 2014). A key feature of morally distressing situations is that they tend to occur repeatedly over time, adding to previous moral residue and creating a crescendo effect (Epstein et al., 2019). In this study, we observed that senior trainees who had more exposure to caring for PWID patients through the course of their training, were more vocal with their negative emotions and feelings of frustrations. Comparatively, junior trainees were perceived to be more optimistic and initiated greater effort to establish a human connection with their patients, even though feelings of frustration and avoidance behaviour were nevertheless seen to manifest at all levels. This is also congruent with the idea of desensitization, that empathy is hindered through habituation to others’ distress (Hoffman, 2000), and supports existing literatures.
that suggest medical trainees experience a decrease in empathy and increase in cynicism as they transition through residency and with progressively more clinical experience (Bellini, 2002; Chen et al., 2012; Neumann et al., 2011; Newton et al., 2008; Stratta et al., 2016; Underman & Hirshfield, 2016). We noticed that this decline in empathy and increase in cynicism also contributed to detachment and avoidance, which has potential implications for the quality of care that stigmatized patients receive.

In addition, our finding that medical trainees experienced more futility and apathy as they progress further in their training is related to the concept of moral erosion and detached concern. Previous authors suggest that there is a gradual erosion in morals that occurs outside of a learners’ awareness (Kleinman, 2006). Throughout our study, we found that trainees distanced from their patients as a form of coping with frustration and helplessness without anyone explicitly instructing them to do so. They seemed, however, to be aware of their behaviour in this regard. The moral detachment we observed was also distinct from previous literature on detached concern, which was deliberately taught and encouraged in the past. In the context of greater attention to the emotional wellbeing of learners, the development of moral detachment from stigmatized patients as a potential maladaptive coping strategy for distress has significant implications for both trainees, patients, and overall patient care.

**Material influences**

The feelings of futility and frustration experienced by our participants were in a very large part influenced by the materials which impacted their everyday function. Whether it was through the influence of labelling transmitted through the electronic health record that inhibited empathy before meeting patients or struggling with the ability to provide sensitive and empathic care within the context of a busy clinical service, material influences appeared to perpetuate distress and detachment. In addition to this, we found that trainees are considerably restrained by the limited physical capacity of the hospital institution and were under constant pressure to discharge.

Our results were consistent with existing research that suggests time pressures, increasing level of clinical responsibility, fatigue secondary to workload and stress, greater emphasis on evidence based medicine, advancements of medical technologies, and the lack of empathetic role models in more senior clinicians can contribute to distress and moral erosion. (Dyrbye et al., 2005; Hojat et al., 2009; Murray et al., 2018; Neumann et al., 2011; Newton et al., 2008; Thirioux et al., 2016). However, our findings also demonstrate that material influences such as the organization of clinical care in the context of socioeconomic structures may also play an important role in shaping moral development for medical trainees. It elaborates on previous research conducted in the U.S which showed that attitudes towards patients correlated with economic conditions within hospitals (Reich, 2014).

**Implications for the future**

The implications of our work for the education of medical and other health professionals underscore that when it comes to stigmatized or vulnerable patient populations, teaching communication skills and providing empathic modeling is not enough. The issue lies in how the system delivers what it views as ‘good care’. Using routine practices is part of the problem. Despite recognizing the unique needs and struggles of
stigmatized patients, current clinical practice continues to streamline them into general high turn-over units and manage their needs with the same expectations and parameters as the average hospitalized patient. When this invariably leads to negative outcomes, the blame is placed on patients for being uncooperative and for whom successful care is deemed difficult if not impossible. This solution not only fails such patients, but it hinders trainees’ development by subjecting them to cycles of frustrating and futile care that eventually leads to moral detachment. Understanding this issue thus invites us to consider care not as a rigid set of standards and guidelines, but as nuanced, materially heterogenous actions always specific to each situation.

Our results suggest that in order to support trainees in their learning and preventing moral erosion and detachment, it is thus crucial for medical educators to address the nuance and uncertainty inherent in care. We should strive to guide trainees to redefine success as providing care in all its messy and every-changing ways, instead of merely abiding by strict routines to which we have grown accustomed. Additionally, there should be space and time for trainees to discuss and process how material elements like institutional policies perpetuate inequity, and how trainees can respond in a manner that increases their agency instead of becoming helpless and hopeless. These conversations should ideally start early in medical training, priming trainees to be prepared for clinical learning, and continue into later years. Most importantly, our findings suggest that educators must make space for learners to process and discuss their experiences of distress and discomfort. Leaning in to such distressing moments can encourage learners to critically examine their beliefs and values that may contribute to these emotions (Boler & Zembylas, 2003). Kumagai and Naidu (2015) suggest that such conversations should be safe, confidential, intentional, and critically informed. Our findings build upon such recommendations and suggest the importance of being trauma informed and sensitive to the deep emotional and moral distress that learners experience. Making space is crucial to expose and explore negative emotions and frustrations in an open and accepting environment, so to prevent the erosion of empathy over time.

**Limitations**

Despite our efforts, we recognize that our team was limited in our ability to follow and observe all interactions relevant to our research topic throughout every hour of the day. For instance, overnight call for trainees of acute medicine was anecdotally described to be busy and stressful, and this was often also the time when PWID patients are admitted through the Emergency Department. Due to researcher’s availability and schedule, these periods were not included in our observations. Moreover, the unexpected circumstances of the COVID-19 pandemic required us to conclude observations early and to shift to solely phone interviews distantly. This limited our ability to continue with further theoretical sampling. We hope that our findings may help generate reflection and discussions amongst peers so that we may explore new and innovative solutions for the complex challenges described in this study.
Conclusion

Fostering empathy through moral development in medical trainees has become a crucial aspect of clinical training, as important as mastering technique skills and acquiring bioscientific acumen. Yet, despite the best efforts of medical curricula to teach communication and empathy, trainees continue to struggle with apathy, moral distress and moral detachment, particularly when caring for marginalized patients with complex psychosocial needs. Our findings suggest that negative role-modelling alone cannot fully explain why trainees continue to struggle with empathy. Rather, emphasis is needed to recognize the dynamic and uncertain nature of care and the role materials have in shaping it, and at times, in a detrimental way. For stigmatized populations like PWID, we need to reframe the way in which we define successful care and to be mindful of the structural and institutional forces which are at play.

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