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# Moral angst for surgical residents: a qualitative study

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**KEYWORDS:**
Surgical education;
Ethics;
Moral angst;
Moral distress

**Abstract**

**BACKGROUND:** The ethical dilemmas that residents experience throughout their training have not been explored qualitatively from surgical residents' perspectives.

**METHODS:** Grounded theory methodology was used. All University of Toronto surgical, otolaryngology, and obstetrics and gynecology residents were invited to participate. Twenty-eight face-to-face interviews were conducted. Interviews were transcribed and analyzed by 3 reviewers.

**RESULTS:** Five encompassing themes emerged: (1) residents prefer operating with another resident while the staff watches; (2) residents felt that patients were rarely well informed about their role; (3) residents develop good relationships with patients; (4) residents felt ethically obliged to disclose intraoperative errors; and (5) residents experience ethical distress in certain teaching circumstances.

**CONCLUSIONS:** Residents encounter ethical dilemmas leading to moral angst during their surgical training and need to feel safe to discuss these openly. Staff and residents should work together to establish optimal communication and teaching situations.

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The resident–patient relationship is immensely important to the dynamics of teaching hospitals. Although staff physicians are responsible for the patients' care overall, it is the residents who primarily care for patients. Patients often see the residents more than they see their staff surgeon. Furthermore, it is the residents who are called first at all hours of the day and night to care for emergencies. If the case is beyond their level of expertise they call the staff physician. This is the structure of care on the wards, designed to give residents autonomy under supervision such that they can evolve into capable independent physicians.

In the surgical world, this dynamic extends into the operating room. To forge skilled surgeons, residents must have hands-on experience. Consequently, it is common practice for surgeons to allow residents to perform portions of surgical cases depending on their level of training. Although this system is designed to forge competent surgeons, it may also place trainees in situations of stress and perhaps even moral distress.

Other areas of medicine such as nursing are replete with studies examining the level of comfort and decision-making skills of trainees versus experienced nurses.[1–5] Such studies have confirmed that trainees, due to their lack of experience, report more moral angst in difficult situations and they rely on didactic teachings rather than experiential judgment in moral decision-making.

In other nonmedical professions, such as firefighting, law enforcement, and commercial piloting, graded responsibility also exists.[6] In all of these fields, trainees are exposed to distressing situations in a controlled environment with supervision before exposure to real-life situations alone. Despite the controlled environments, such trainees may still experience trepidation and hesitation in ethically distressing situations.[7]

Such ethical matters have not been explored in the surgical literature, especially not from the perspective of the trainees themselves. The purpose of this study was to explore

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ethical concerns and distress that surgical residents may encounter as a result of their being "on-the-job trainees."

## Methods

### Design

This was a qualitative study using grounded theory methodology to explore ethical issues with surgery residents. An e-mail was sent to all University of Toronto surgery, otolaryngology, and obstetrics and gynecology residents by the office of their respective departments. Residents responded directly and privately to the interviewer (A.G.) if they desired to participate.

### Setting, participants, and sample size

Potential participants were all surgery, otolaryngology, or obstetrics and gynecology residents at the University of Toronto (approximately 300). We intended to complete approximately 30 interviews as this is usually well beyond the number where "saturation" is reached in qualitative studies. Saturation is the point at which information begins to be repetitive with each additional subject.[8]

### Data collection

Face-to-face interviews were conducted with residents who responded to the e-mail requesting their participation in the study. Interviews were based on a study guide (Figure 1). Themes not outlined on the guide were explored when

Preamble:
Thank you for agreeing to participate in this study. The purpose of this study is to determine how the resident-patient relationship is impacted by the patients' discovery that the residents have been involved in their operations. A number of open-ended questions will be asked around this topic. Your privacy will always be respected. Please feel free to answer the questions in any way you please.

1. How often do you operate with the staff surgeon?

2. How often do you operate with another resident and the staff surgeon is scrubbed and supervising?

3. How often is the staff surgeon unscrubbed and supervising while you and another resident operate?

4. How often does the staff surgeon leave the room while you and another resident operate?

5. Under what conditions does the staff surgeon leave the room while you operate and when does s/he return (ie at what part of the operation does the staff surgeon leave and return)?

6. How often do you introduce yourself to the patient prior to operating on her/him?

7. How often do you meet a patient for the first time post-operatively?

8. How often do you feel that the patient has been informed of your role in their care prior to you meeting them?

9. How often do you feel that the patient is aware that you operated on them?

10. How do patients react when they meet you? (ie. Are they happy, upset, inquisitive, or suspicious?, do they ask many questions about how you will be involved in their operation?)

11. If you meet the patients pre-operatively, what do you tell patients when they directly ask you whether you will do their operation?

12. If you only meet the patient post-operatively, what do you tell patients when they ask if you 'did' their operation?
- do you tell them the explicit details of their operation including where the staff surgeon was the entire time?

13. How do unknowing patients react to finding out that you were involved in their operation?

14. Do patients ever request to have the staff surgeon because they do not feel that you are their 'real' doctor?
If so, how do you handle this situation?

15. How would you describe your relationship with the patients under your care?

16. Do you feel that the resident-patient relationship changes when patients find out the residents have operated on them without their knowledge?
- how does it change?

17. With the increased media dramatization of residents operating on patients in the absence of staff surgeons, do you find that patients treat you differently?

18. Of the following scenarios which do you feel provides you with the best educational experience and why?
i. assisting the staff surgeon during a case.
ii. Doing the case with another resident while the staff surgeon looks on unscrubbed?
iii. Doing the case with another resident while the staff surgeon is not in the operating room?

19. If you made a consequential error while the staff surgeon was absent from the operating room and the patient was not aware of your presence, would you tell the patient after the operation?
- Why or why not?

20. Do you have any further comments regarding this study?

21. Do you have any questions or concerns?

Thank you for participating in this study. Your time is greatly appreciated.

**Figure 1** Structured interview guide used during the interviews with the residents.

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