

**THE ETHICAL CHALLENGES
ASSOCIATED WITH MEDICAL
INTERNSHIP AND RESIDENCY**

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ABSTRACT

Internship and residency are the first years following graduation from medical school. Interns and residents work in hospitals as the junior members of hierarchical medical teams. To date there has been little systematic philosophical work that focuses specifically on this group. Instead, in ethical discussions, interns and residents tend to be included either with medical students or with their more senior colleagues. In this thesis, I argue that interns and residents differ from both medical students and more experienced doctors in ethically important ways. Their working context requires them to play multiple roles simultaneously, including doctor, subjugate team member, learner, and hospital employee. The demands of these multiple roles create a set of ethical challenges for junior doctors that is unique to their professional stage. Further, the potentially conflicting demands of these multiple roles limit the ways in which junior doctors can act in response to the ethical difficulties that they encounter. I thus propose that the ethical challenges associated with medical internship and residency can be fruitfully understood as role virtue conflicts.

Aiming to produce a work of empirically-informed moral philosophy, I investigate junior doctors' ethical issues using a combination of literature review, semi-structured interviews, and philosophical analysis. In-depth interviews with fourteen Melbourne-based junior doctors formed a central element of this project, in order to ensure the project's focus on pressing practical issues. On the basis of these interviews and my review of research findings about junior doctors across various disciplines, I develop a typology of the kinds of ethical challenges associated with internship and residency. These include being involved in treatment perceived as futile, seniors discouraging disclosure of errors, and reporting unrostered hours. In addition to the typology of ethical issues, I develop and use a role-based framework as a way of analysing the ethical challenges faced by interns and residents. The method of ethical analysis that I propose conceptualises the good junior doctor as good qua four roles, each with a differing set of role virtues. I argue that this role-based framework both reflects and

engages with junior doctors' specific position of agency and thus captures a fuller range of moral considerations than do other possible modes of analysis.

DECLARATION

This is to certify that

the thesis comprises only my original work towards the PhD,
due acknowledgment has been made in the text to all other material used, and
the thesis is less than 100,000 words in length, exclusive of tables,
bibliography, and appendices.

Rosalind McDougall

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INTRODUCTION

You will be faced with many new challenges during the course of the year. Most of these will be exciting and positive. You will be working with people who understand that you are still learning...Enjoy the year ahead (from *A guide for interns in Victoria*, Medical Practitioners Board of Victoria, 2005, p.3).

Having spent the last four years researching junior doctors' experiences, I now cannot read the above quote without hearing it in a slightly ominous tone. The positive aspects of their early postgraduate years that junior doctors have described to me in the course of this project – engaging with patients, being a real doctor, finally applying their knowledge – are coloured also with their stories of powerlessness, lonely fear, intense frustration, and overwhelming responsibility.

I first became interested in the ethical challenges faced by junior doctors when I was hearing these types of stories from friends working as interns or residents. At the time, I was writing an honours and then a masters thesis in philosophical bioethics, both of which looked at moral questions prompted by new medical technologies. I had also begun doing some tutoring with medical students. It struck me that both the bioethics discussions that I was participating in and the medical ethics curriculum that I was teaching were not engaged with the kinds of ethical issues that my friends were experiencing. Their ethical challenges seemed much more everyday. They described disagreeing with their seniors' approaches to particular patients, responding to making misdiagnoses, and the difficulties of coping with patients alone in isolated hospitals.

It was from this concern about the separateness of my work from theirs that the research question and approach of this thesis developed. It seemed to me that closer interaction between philosophers and healthcare practitioners had the potential to be very useful from the perspective of both groups: the result could be relevant, well-informed ethical analysis of urgent practical issues.

THE RESEARCH QUESTION

This project investigated the following question:

What kinds of ethical issues are associated with medical internship and residency, and how are these issues best conceptualised for ethical analysis?

The research question positions interns and residents together as a group. In Australia, interns are doctors in their first year after graduation from medical school and residents are doctors in their second or third postgraduate year. All work in hospitals. Throughout the thesis, I use the term ‘junior doctors’ to refer to interns and residents. (In some other contexts, the term ‘junior doctors’ also includes doctors in later postgraduate years.) I chose to consider internship and residency together, despite the relatively greater clinical experience of residents, as it is generally either an intern or a resident who is the most junior member of the medical team in the hospital setting. Whether it is an intern or a resident filling that role in a particular team depends on the type of unit. It is this ‘most junior doctor’ role that is the focus of this study.

I took two perspectives on the word ‘kinds’ in the research question. The first perspective was to think in terms of the content of the issues individually. What *are* junior doctors’ ethical challenges? I aimed to identify the issues that junior doctors face, thinking in terms of generating a list that drew on the standard medical ethics menu of confidentiality, futility, truth-telling etc. However, I also wanted to think more broadly about junior doctors’ ethical issues as a set. This second perspective took ‘kinds’ in the sense of common features of the issues identified. Is there an overall nature to the ethical issues that interns and residents face? What can be said about these issues as a group?

Wanting to discover and analyse pressing real-life ethical issues in current medical practice, I chose to interview junior doctors as a central element of the project. Considering that the project grew from my observations of close friends, I was positioned to be quite sympathetic to the junior doctors I interviewed. From the

outset, I already viewed internship and residency as challenging and ethically-complex time. I understood – at least secondhand – the intense demands placed on junior doctors and the potential effects of these demands on their wellbeing. This sympathetic starting point was undoubtedly reflected in my conduct as an interviewer and has also shaped my analysis throughout the course of this research.

OUTLINE OF CHAPTERS

The first three chapters of the thesis provide the background to the project. In chapter one I argue for a broader conception of philosophical bioethics, one that looks beyond the standard fare of dramatic technology-driven dilemmas and issues in the doctor-patient relationship to capture in addition the everyday ethical challenges that my junior doctor friends were describing. The second chapter describes the project's method. I argue for empirical research as an essential resource for philosophers working on questions in medical ethics. I outline the way in which my research question is addressed using a combination of literature review, interviews with junior doctors, and ethical analysis. I also describe in detail the qualitative method employed in the interview component of the study. Chapter three describes the organisational setting in which junior doctors work, and reviews existing studies of junior doctors in order to put forward an initial typology of the kinds of ethical challenges associated with internship and residency. I suggest that junior doctors are positioned in multiple roles by their work context – simultaneously responsible health professionals, subjugate learners, and hospital employees – and that this multiple-role position influences both the content of the particular set of ethical issues that they face and their options for negotiating these challenges. As a starting point for the typology, I use the categories suggested by the qualitative research of Rosenbaum and colleagues (Rosenbaum et al., 2004). I then add further issues and examples from existing literature and, in a later chapter, refine the typology further on the basis of the interviews that I conducted with Melbourne-based junior doctors.

Chapters four, five and six focus on the findings of the interview component of the study. All three develop the idea that junior doctors differ from medical students and more senior doctors in ethically important ways, relating to the multiple roles that junior doctors play. In chapter four, I discuss ways in which participants' views on internship and residency invite refinement of the concept of the multiple-role position put forward in chapter three, revealing additional complexities and further roles such as teacher and competitor. Chapter five presents ways in which participants' stories of their ethical difficulties both reflect and challenge the initial typology of issues. From the data, I identify three new kinds of ethical challenge that were not apparent in the literature review. Participants' stories also show that some of the ethical challenges involved in junior doctors' work are not ethical problems in the standard sense of difficulties in identifying the appropriate action option. The crucial moral question in these stories is not 'what *should* I do?' but rather 'what *can* I do now about this problem?', indicating the importance of agency limitations in junior doctors' ethical challenges as a whole. The issues and stories presented in chapter five are essentially about 'doing', focusing on junior doctors' action. However, some participants also talked about issues of 'being', raising questions about what kind of people or doctors they should be or were becoming through their internship and residency experiences. These concerns about character are discussed in chapter six.

Chapters seven, eight and nine develop and use a role-based framework as a method of ethical analysis that reflects and engages with junior doctors' specific position of agency. In chapter seven, I argue that the good junior doctor can be conceptualised as being good in respect to four different roles: doctor, medical learner, team member, and employee. I suggest that there are specific virtues associated with each of these four roles, but also that there is potential for debate about the components and nature of each set of role virtues. I propose that many of the ethical challenges associated with internship and residency can be understood as role virtue conflicts. By analysing one of the new ethical issues that the data identified – seniors discouraging disclosure of errors – I argue that thinking about junior doctors' ethical challenges in this role-based way enables important moral considerations that are overlooked by other

frameworks to be included in ethical analysis. In chapters eight and nine, I employ this role-based framework to analyse two other ethical challenges that were highlighted as important by the interview data. Chapter eight discusses a second new ethical difficulty identified by this project: junior doctors recording their actual hours worked even when unrostered. The focus of chapter nine is junior doctors' involvement in treatment that they perceive to be futile. This was a particularly prominent ethical challenge in the experience of the group of junior doctors who participated in this study and one that many had found deeply troubling. These two ethical challenges represent the spectrum of ethical issues that junior doctors face: from the mundane and administrative to life-and-death situations of obvious ethical complexity.

I conclude by suggesting some implications for ethics education, both for medical students and for junior doctors, which arise from the study. I also offer specific answers to the research question, from the two perspectives on 'kinds of ethical issues' as described above. I reflect on the typology of ethical challenges associated with internship and residency that the project generated, and outline two key concepts that relate to the set as a whole: playing multiple roles and limited agency. These concepts are encapsulated in the main original contribution of this thesis: a role-based framework of ethical analysis that recognises the particular institutional position occupied by junior doctors and the constraints on their action that this position implies.

CHAPTER 1: BROADENING THE SCOPE OF PHILOSOPHICAL BIOETHICS

In this chapter, I develop and argue for the conception of bioethics that underlies this project. I outline an understanding of bioethics as a subject investigated by various disciplines (rather than a specific discipline in itself), and suggest that the range of issues currently considered by philosophers to constitute bioethics ought to be significantly broadened. Consideration of the content of key texts in philosophical bioethics indicates a prevailing understanding in philosophy that bioethics is primarily constituted by issues in the doctor-patient relationship and dramatic technology-driven dilemmas. I claim that this is too limited a conception for various reasons, particularly the wider applicability of the conceptual tools provided by moral philosophy and the complex nature of the modern healthcare sphere. Understanding bioethics in a broader way produces a conception of the area that is more inclusive than the standard view in at least two dimensions: the mundane events in the healthcare sphere receive philosophical attention alongside the dramatic, and relationships beyond that between doctor and patient are also considered.

Throughout this project, I take the term ‘bioethics’ to be essentially interchangeable with both the term ‘medical ethics’ and the term ‘health ethics’, setting aside arguments that bioethics encompasses a broader range of topics, beyond the healthcare sphere (Harris, 2001b, pp.3-4; Kuhse & Singer, 1998a, p.4; Reich, 1978, p.xix). In this chapter, I generally use the term ‘health ethics’ rather than ‘medical ethics’, as the argument relates to the healthcare sphere broadly and includes issues faced by health professionals other than doctors. In later chapters, in which I discuss junior doctors’ situation specifically, I use ‘medical ethics’ instead.

BIOETHICS AS A SUBJECT RATHER THAN A DISCIPLINE

The nature of bioethics has consistently been debated since the reinvigoration of this area of scholarship in the 1960s. Early questions about the role of philosophers and theologians in responding to scientific developments and medical issues were replaced with a continuing debate about the disciplinary nature of bioethics (Jonsen, 1998; Callahan, 1973). In this thesis, I follow Sulmasy and Sugarman, taking bioethics to be a set of issues investigated from various disciplinary perspectives rather than a specific disciplinary approach in itself. Sulmasy and Sugarman write that

[m]edical ethics is a single field of inquiry of great interest to many disciplines, not a discipline in its own right. What medical ethicists share is a common subject matter, not a common disciplinary mode of investigating that subject. Their common subject matter is the normative aspect of healthcare...[h]owever, they view it through the eyes of a wide variety of disciplines (Sulmasy & Sugarman, 2001, p.5).

Perusing any recent issue of *Bioethics* or the *Journal of Medical Ethics* bears out this view that bioethics is best understood as a group of issues rather than as a particular method of investigation. A wide variety of articles appear in health ethics journals, investigating topics involving value and health using a range of disciplinary methods. For example, a recent issue of the *Journal of Medical Ethics* includes work employing sociological (Dierckx de Casterle et al., 2006), philosophical (Dawson & Garrard, 2006), legal (Bjorkman & Hansson, 2006), and historical (Bishop, 2006) methods.

The disciplinary approach taken by this thesis is philosophical. Philosophical bioethics can be understood as work that uses systematic argument based in ethical theory to investigate the moral justifiability of various aspects of healthcare. Unlike most philosophical work, this project included the gathering of empirical data. The relationship between philosophical bioethics and empirical investigation is discussed in detail in chapter two. The figure below encapsulates the understanding of bioethics that Sulmasy and Sugarman describe and indicates the place of this project in that understanding.

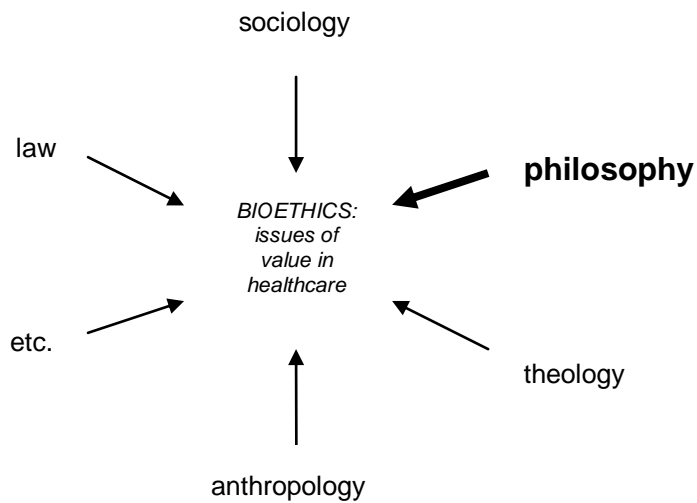


Figure 1: Bioethics as a subject rather than a discipline

The remainder of this chapter focuses on philosophers' understanding of the content of the hub in the figure above; what subject matter do philosophers take to constitute bioethics and is that conception justified?

THE CURRENT CONCEPTION

Komesaroff writes that

the subjects covered by the bioethical literature are already familiar...Terms like *euthanasia*, *confidentiality*, *autonomy* and *paternalism*, *genetic engineering*, and *in vitro fertilization* are not only well known today and easily employed in ordinary language but have come to be identified as the whole subject matter of medical ethics (Komesaroff, 1995, p.65, italics in original).

Looking at key texts of philosophical bioethics, a clear picture emerges of the standard understanding of this area. In this section, I argue that, as Komesaroff's list suggests, bioethics is typically understood by philosophers to be constituted by dramatic technology-driven dilemmas (such as euthanasia, genetic engineering, and

IVF) and issues arising in the doctor-patient relationship (such as confidentiality, patient autonomy, and medical paternalism). I question the justifiability of this limited understanding, suggesting that the flexibility of the resources provided by moral philosophy and the complexity of the contemporary healthcare sphere indicate that a far broader understanding of the scope of health ethics ought to be adopted.

Dramatic technologies and the doctor-patient relationship

Analysis of the content of key texts indicates that the prevailing understanding amongst philosophers working in bioethics is that the subject primarily consists of two types of issues: dramatic technology-driven dilemmas and issues in the doctor-patient relationship. The content of three texts substantiates this claim: *Principles of biomedical ethics* (Beauchamp & Childress, 2001), *Bioethics* (Harris, 2001c), and *A companion to bioethics* (Kuhse & Singer, 1998b). *Principles of biomedical ethics* is arguably the most influential text of modern bioethics (Spriggs, 2005, p.39; Jonsen, 1998, pp.24,333). Holm claims that it is “the most read bioethics textbook in the USA (and probably the world)” (Holm, 2001b, p.494). Beauchamp and Childress put forward a framework of four principles, arguing that bioethical debates can be structured around these four key philosophical concepts of respect for autonomy, nonmaleficence, beneficence, and justice. Harris’ *Bioethics* is an edited collection of influential articles by prominent moral philosophers and, of the three texts, is the most explicitly positioned within the discipline of philosophy. In his introduction, Harris describes bioethics as “a distinct and important branch of philosophy...not another thing altogether” and posits this anthology as aiming to make available “the best possible introduction to the range, importance, and interest of the area” (Harris, 2001b, p.1). The anthology edited by Kuhse and Singer is less exclusively philosophical, but the majority of contributors (including the editors) are from that disciplinary background and the book is part of the series ‘Blackwell Companions to Philosophy’. Unlike the Harris anthology, this book is made up of pieces written specifically for the collection. It is a successful and widely-read text, currently in its

fourth reprint. The following table indicates the substantive topics covered in these three books (setting aside methodological discussions and ethical theory).

Beauchamp and Childress	Harris	Kuhse and Singer
Euthanasia Advance directives Severely disabled newborns Killing/letting die distinction Withdrawing or withholding life-sustaining technologies/treatments Artificial nutrition and hydration Futile treatment	Euthanasia Advance directives Severely disabled newborns Killing/letting die distinction	Euthanasia Advance directives Severely disabled newborns Brain death
Resource allocation Organ donation Quality of life Regulation of drugs Access to healthcare	Resource allocation Organ donation Quality of life	Resource allocation Organ donation
Autonomy Consent/refusal Truth-telling Confidentiality Nursing ethics Paternalism Surrogate decision-making Privacy Conflicts of interest	Autonomy Consent Truth-telling Confidentiality	Autonomy Consent Truth-telling Confidentiality Nursing ethics
Mother-foetus conflict Surrogacy	Screening for disability Abortion	Screening Abortion Mother-foetus conflict Population growth Artificial reproductive technologies
Dual roles of physician and researcher		Research ethics
		Genetic technologies
		AIDS

Table 1: Issues covered in three key texts of philosophical bioethics

Although topics such as resource allocation and research ethics are also addressed in these books, the majority of the material focuses on the doctor-patient relationship

and on issues involving life-or-death decisions, often in association with new biomedical technologies. In terms of substantive issues addressed, all three of the books are dominated by scenarios involving high stakes decisions and/or technology-driven dilemmas, with discussion of issues such as futile treatment, surrogate decision-making, and organ donation. Historically, discussion of the doctor-patient relationship was central to bioethics (Kuhse & Singer, 1998a, pp.4-5; Jonsen, 1998, pp.6-7) and, as the three books described indicate, discussion of issues such as patient autonomy, informed consent, and confidentiality continue to be standard fare. Beauchamp and Childress' *Principles of biomedical ethics* can be seen as having a particular focus on the doctor-patient relationship, with three of their four fundamental principles relating directly to the one-on-one relationship between doctor and patient. Beneficence, nonmaleficence, and respect for autonomy are all presented as ethical obligations of doctors towards their patients (as well as of researchers towards their participants).

In articulating this prevailing conception of the subject matter of philosophical bioethics, I do not mean to suggest that philosophers have reflectively and actively set these limits on the content of bioethics or that this conception is shared by all philosophers working in this area. When I articulate specific features of a broader conception of bioethics in a later section of this chapter, I draw on the work of a number of philosophers who have argued that our understanding of bioethics ought to be broadened in various ways. The standard conception focusing on dramatic technologies and the doctor-patient relationship is implicit in the body of philosophical bioethics literature, presumably arising by default rather than being the product of deliberate reflection.

Why the limitations?

Why is it that healthcare issues of other types receive little philosophical attention, falling on the periphery or beyond the scope entirely of philosophical bioethics as it currently exists? Considering the widely accepted view that scientific developments played a key role in creating modern bioethics discourse (Jonsen, 1998, pp.11-19;

Kuhse & Singer, 1998a, p.3), it is perhaps unsurprising that biomedical advances and the healthcare dilemmas that they create continue to occupy philosophers working in this area. Similarly, the idea of patients as vulnerable and doctors as in a position of significant power (see for example Beauchamp & Childress, 2001, p.60) has long motivated philosophical interest in the primary relationship in the healthcare sphere, that between doctor and patient.

However, while the current limitations on the scope of bioethics are understandable in terms of the area's historical trajectory, it is less clear that persisting in focusing philosophical attention on only these traditional issues is justifiable. Why should philosophers continue to limit their study to these particular topics? The resources at their disposal are far more widely applicable. There is no obvious reason why the content and methods of moral philosophy can only be fruitfully applied to dramatic technology-driven ethical dilemmas and aspects of the doctor-patient relationship.

Those from disciplinary backgrounds other than philosophy, including health professionals themselves, have recognised the ethical complexity of aspects of the contemporary healthcare sphere beyond those classified by philosophers as bioethics. Health professionals' codes of ethics provide evidence of this recognition, with a variety of issues addressed that fall outside the scope of standard philosophical bioethics. For example, the code of ethics put forward by the Australian Medical Association clearly implies that ethical practice cannot be fully defined by an ethically-appropriate relationship between a doctor and each of his or her patients. The preamble states that the code of ethics aims to "guide doctors' conduct in their relationships with patients, colleagues and society", and the code contains ethical guidance relating to the doctor's role as researcher, clinical teacher, colleague, businessperson, employee, and citizen (Australian Medical Association, 2004). The document both recognises the doctor as playing diverse interconnected roles and, by presenting its guidance in terms of responsibilities, patient trust, and mutual respect, frames these roles as each involving ethical considerations.

Medical educators have similarly implicitly indicated a broader understanding of the issues constituting bioethics. Teachers of medical ethics in Australia and New Zealand have put forward a core ethics curriculum for undergraduate medical courses (Braunack-Mayer et al., 2001), following similar developments in the UK (Ashcroft et al., 1998). Although dramatic technology-driven dilemmas and the doctor-patient relationship (particularly the latter) are well-represented in these and other core curricula (Lewin & Goodman, 2004, p.S39; Braunack-Mayer et al., 2001, p.207; Miyasaka et al., 1999, pp.517-8; Ashcroft et al., 1998, pp.189-90), these documents also posit a variety of other types of ethical issue. Indicating the recognition that healthcare situations need not be dramatic to be ethically important, Goldie writes in his review of medical ethics curricula that

[t]he focus of medical ethics has been broadened from classical dilemmas and determining ethical ‘correctness’, to examining ethical behaviour under the constraints of actual practice, placing more emphasis on ‘everyday ethics’, i.e. the issues that routinely arise in daily medical practice (Goldie, 2000, p.111).

Further evidence of this broader understanding among medical educators is provided by the Australasian core curriculum which posits the doctor as being involved in ethically important relationships beyond the patient. The ethical importance of communication with other health professionals and promoting “the interests of colleagues through professional relationships” is highlighted (Braunack-Mayer et al., 2001, p.207). The doctor’s relationship with the employing institution is also raised, with the challenge of powerlessness in the face of the medical institution put forward as an ethical concern (Braunack-Mayer et al., 2001, p.207). Other issues such as the commercialisation of medicine and responding to clinical error, which have attracted little philosophical attention, are posited as core ethical content in this context (Braunack-Mayer et al., 2001, p.207). The UK core curriculum similarly takes a broader view of health ethics, with its inclusion of topics like inter/intra professional conflicts and whistle-blowing (Ashcroft et al., 1998, p.189-90).

Philosophers interested in bioethics have the disciplinary resources similarly to address a more complete range of issues. By looking beyond the entrenched classic topics, the content of philosophical bioethics could much better reflect the huge variety of ethically-charged situations that arise in the healthcare sphere.

TWO DIMENSIONS OF A BROADER UNDERSTANDING

What would this broader-scope bioethics look like? How would a wider understanding of the issues constituting bioethics differ specifically from the conception currently in the philosophical literature? In this section I put forward the wide definition of ‘ethical issues’ that will be employed in this project, and describe two particular features of a broader conception of health ethics: inclusion of the mundane alongside the dramatic and an interest in health professionals’ interactions with those other than patients. As mentioned earlier, a number of authors have argued for broadening in various dimensions that which counts as bioethics for philosophers. The work of these thinkers, particularly Komesaroff with his concept of “microethics” (Komesaroff, 1995), serve as a starting point for articulating some specific features of a broader understanding of bioethics.

Defining ethical issues

Writing on health professionals’ ethical decision-making, Holm provides one wide definition of ethical issues. He claims that

a consideration is...classified as an ethical consideration if it: a) refers to a non-legal or not solely legal norm, duty, obligation or right; or b) refers to consequences (well-being, happiness etc.) for some specifiable person or groups of persons; or c) refers to what kind of person one ought to be or what virtues one ought to have (Holm, 1997, p.85).

Holm’s understanding could perhaps be critiqued as being too wide a definition of *ethical* considerations specifically. It seems to include, for example, norms of etiquette and fashion not just ethics, as well as *all* consequences. However, it is a

useful starting point in articulating a wider scope for the concerns of philosophers working in bioethics. We can take Holm's insight about breadth but modify his definition somewhat, in line with the concerns of moral philosophy as a discipline, and define ethical issues in the following way: *an issue is an ethical one if it involves persons' rights, duties, and obligations and/or consequences that are beneficial or harmful to people and/or the development and exercise of virtues.* This will be the definition used throughout this thesis.

This definition attempts to capture a range of theoretical positions on the nature of moral action. The way in which one defines the concept 'ethical issues' seems unavoidably determined by the normative theory one has adopted. For example, if we understand the ethical action in any situation as the action that has the best consequences in terms of minimising harm and maximising benefit, then ethical issues are those that involve potential harm and benefit. Similarly, if we take ethical action as action in accordance with duty, then ethical issues are necessarily defined as those that involve our duties. As discussed in detail in the methodology chapter, I adopt a pluralist approach in this project, taking the position that there are a number of irreducible types of consideration that contribute to determining the moral status of an action. Thus the definition of ethical issues outlined above aims for comprehensiveness by including deontological, consequentialist, and virtue ethics considerations. The definition does however (in contrast to some consequentialist views particularly) limit ethical issues to those involving people. This is because my focus is on the healthcare sphere where those acting and affected are people. Also, the definition implicitly includes both the personal and the public or professional level. Although the rights, consequences, and virtues that matter morally are not limited to those associated with one's professional role, I focus particularly on role-related considerations in this project. This is a result of the project's focus on the actions of healthcare professionals as a group of agents facing specific job-related ethical challenges.

Ethical considerations on this definition are clearly involved in a huge variety of situations in the healthcare sphere beyond those traditionally considered by philosophers. Interns' long working hours, the way in which bad news is delivered to a patient's family, the treatment of nurses by senior doctors, a hospital administration's procedures for dealing with medical errors – all of these issues are ethical ones on this definition.

The mundane

If we take all healthcare situations involving ethical considerations as potential foci for philosophical analysis, day-to-day interactions in the healthcare sphere will be included in the subject matter of bioethics alongside the familiar dramatic scenarios. It is not only situations of life-and-death decision-making in which issues of value arise; considerations around rights, obligations, harm and character are similarly involved in a huge variety of other healthcare situations. Braunack-Mayer, interviewing general practitioners about their ethical problems, has identified that mundane frequently-occurring situations can constitute significant ethical challenges in some healthcare professionals' perceptions (Braunack-Mayer, 2001). On the definition of ethical issues suggested above, issues such as the way news is broken to a patient, the structuring of staff rosters, and patient time spent waiting to be seen by a doctor would all count as ethical issues potentially warranting philosophical consideration.

Worthley, in his book *The ethics of the ordinary in healthcare* (Worthley, 1997), argues for the inclusion of the everyday in the scope of bioethics. He claims that

[t]he recent literature on healthcare ethics is striking in its emphasis on the more cosmic and redoubtable dimension of healthcare and on its relative silence regarding the mundane and the humdrum. The books, articles and essays that have been written over the past decades deal predominantly with the great and recognised dilemmas that healthcare professionals face (Worthley, 1997, p.1).

Worthley argues for increased ethical attention to the “micro dimension of healthcare provision” (Worthley, 1997, p.2), claiming that the vast numbers of people affected by healthcare professionals’ day-to-day activities make this aspect of health ethics as important as the analysis of the traditional more dramatic situations:

[h]ealthcare ethics should be vitally concerned with probing the ethical significance of such seemingly inconsequential, routine, professional healthcare situations and actions, to raise the level of recognition of “micro” responsibility, and to help healthcare professionals use their power sensitively and responsibly within the hectic, pressured contexts of their daily chores. When one considers that the exercise of this “administrative” power affects nearly everyone with whom the health professional interacts (whereas macropower affects primarily those few involved in a clearly intense situation), the subject of microethics can take on striking significance (Worthley, 1997, pp.4-5).

Interestingly, Worthley explicitly positions his work as “phenomenological” rather than “philosophical”, emphasising the “actual experience of the healthcare professionals who deal daily with an ethical dimension on the front lines” (Worthley, 1997, pp.34-6). In my view, such an emphasis does not however exclude work from being philosophical. The phenomena of lived experience, mundane or otherwise, are of great import to philosophical ethics. Worthley’s emphasis on everyday experiences should be incorporated by philosophers into their understanding of the content of bioethics.

Like Worthley, Komesaroff has argued for the inclusion of mundane situations in the scope of bioethics, positing what he calls “microethics” in contrast to contemporary philosophical bioethics (Komesaroff, 1995). Komesaroff’s position is that philosophical bioethics is too far removed from the practical challenges facing clinicians, and that practitioners would be better served by philosophers understanding every clinical interaction and decision as involving ethical issues. He sees philosophical bioethics as dominated by a set of issues, assumptions, and methodological conventions that abstract issues from their clinical context (Komesaroff, 1995, pp.64-6), and thus claims that it

is deficient because it is unable to provide an adequate account of day-to-day decision making in medicine, as a result of which it cannot provide any substantial guidance for medical practice (Komesaroff, 1995, p.65).

He argues for a radical broadening of philosophers' understanding of health ethics, writing that "[t]he domain of ethical issues in medicine is much larger and more diverse than is generally accepted within the paradigms of conventional bioethics" (Komesaroff, 1995, p.72). For Komesaroff,

medical ethics is not just about the dramatic questions that are discussed widely in the popular media or in the philosophical texts. *Ethics is what happens in every interaction between every doctor and every patient* (Komesaroff, 1995, p.68, italics in original).

He calls these constant ethical issues faced by the doctor "microethical decisions", giving examples such as the way in which a physical examination is conducted, the investigations sought by the clinician, the manner in which the patient is questioned, and the type and delivery of information (Komesaroff, 1995, pp.68-9). Komesaroff's claim is one about both the content and the methods of philosophical bioethics. He advocates a far broader understanding of the types of issues constituting the area, and argues that medical ethics discourse ought to be situated not in abstracted dilemmas but rather in specific clinical situations, focusing on particularity, human interaction, and practical action (Komesaroff, 1995, pp.73-4).

Komesaroff's argument about the content of philosophical bioethics is a persuasive one, but his methodological point is more problematic. Paralleling Worthley, Komesaroff's methodological point relies on an unnecessarily dichotomous contrast between microethics and philosophical bioethics. In terms of content, it seems clear that doctors' day-to-day clinical interactions with patients have very real consequences for patients' experiences of illness and healthcare, and thus are ethical issues worthy of philosophical consideration as Komesaroff suggests. But in setting up microethics as a methodological alternative to philosophical bioethics, Komesaroff posits too radical a split between philosophers' bioethical thinking and microethical

thinking. Philosophical bioethical thinking, abstracted to some degree from a single specific clinical situation, need not be extremely theoretical and irrelevant to the clinical context in the way that Komesaroff suggests, applicable only to rare and dramatic dilemma situations. Although Komesaroff is right to highlight the limited clinical usefulness of highly abstracted reflection, the implication that any work at a level beyond a specific practical decision-making context lacks applicability to clinicians is problematic. Thinking systematically about types of cases with the aim of generating principles to guide action need not produce results irrelevant to the clinical context. Komesaroff underestimates the flexibility of the methods of philosophical bioethics when he writes that “[t]he job of the clinician...cannot be formulated in terms of broad principles, bioethical or otherwise, but only as a series of practical tasks” (Komesaroff, 1995, p.62). Principles need not be rigid and abstract rules of ethical conduct. A well-formulated principle will be pitched at an appropriate level of generality and maintain reasonable flexibility in response to contextual particulars. Philosophers can acknowledge the crucial importance of the clinical context and the fact that clinicians’ ethical issues are extremely practical ones, while still seeing prior systematic ethical thought encapsulated in a general principle to be a helpful starting point for clinicians’ decisions about how to act in a specific ethically-charged situation. Day-to-day aspects of clinical encounters can (and should) be taken as issues in bioethics, without abandoning standard forms of philosophical argument that aim to generate principles specifying morally justifiable action.

Relationships beyond doctor-patient

By highlighting the ethically-charged nature of day-to-day medical interactions, Komesaroff’s work indicates one key way in which health ethics is broader than is standardly assumed in philosophical contexts: mundane situations can be as ethically important as dramatic ones. However, from another perspective, Komesaroff’s work falls *within* the standard conception of bioethics as his focus is very much on the doctor-patient relationship. An understanding of bioethics as encompassing all issues in the healthcare sphere that involve ethical considerations would also include, for

example, analysis of relationships *between* health professionals and between health professionals and institutions (such as the hospitals that employ them) alongside an interest in doctor-patient relationships. Three justifications can be put forward for seeing these other types of relationships as part of bioethics. The first two relate to the influence of these relationships on patient well-being, and the third relates to the intrinsic value of health professionals themselves.

If, as many philosophers imply, one aim of their work in bioethics is to protect and promote patients' well-being, then the relationships of health professionals with their colleagues and employers are relevant. These relationships can have an impact on patients' experiences in two ways. The first is that poor relationships with colleagues or institutions can have direct negative physical effects on patients. This point is well-illustrated by a tragic case reported in the Melbourne press in 2006. A junior doctor at a paediatric hospital ordered medication be administered at ten times the appropriate concentration to a baby with a stomach upset, resulting in severe brain damage to the infant. The surgeon had prescribed an intravenous solution including five percent dextrose, but the junior doctor believed that the baby was to be given a fifty percent solution. The junior doctor was reported as saying that

she thought the prescription was "unusual" and checked Professor Dewan's [the surgeon's] orders with nurses rather than with a medical consultant because she did not want to bother the consultant...[S]he found senior staff at the hospital intimidating and that there was "an element of fear to approach them"...[T]here was a culture at the hospital in which questions or lack of knowledge was frowned on (Miletic, 2006).

Here, the nature of a junior doctor's relationship with a more senior colleague has had a highly detrimental physical impact on a patient. The surgeon's being unapproachable from the junior doctor's perspective has had disastrous health consequences for the baby being cared for. Similar stories of intraprofessional interactions impacting on patient care are common in doctors' narratives, although in the majority of cases the impact on patients' well-being, while negative, has not been

as horrific as in the case described (see for example Kushner & Thomasma, 2001, pp.183-5).

As well as physical harm, patients can also suffer harms of disrespect or lack of compassion as a result of a health professional's poor relationship with colleagues or the hospital administration. Issues such as doctors' health status and morale can have a significant impact on patients' experiences, and are determined to a large degree by the relationship between health professionals and their employing institution. For example, the way in which administrators design the roster will to some extent determine doctors' ability to care sensitively and compassionately for their patients. Where junior doctors are overly tired from long shifts, the way in which they relate to patients is likely to be compromised. Similarly, it seems reasonable to expect that junior doctors who have themselves been treated disrespectfully by senior colleagues would be more likely to treat patients disrespectfully. The way that colleagues relate to one another creates a moral culture in which patients are also involved. An interest in patients' well-being, both physical and more broadly, thus clearly justifies philosophers working in bioethics looking beyond the immediate doctor-patient relationship to consider also the doctor's relationships with colleagues and institutions.

A third reason that philosophical bioethics ought to include health professionals' relationships with colleagues and with institutions is that these relationships affect health professionals' *own* well-being, autonomy, and rights. These are values often overlooked in existing bioethics discussions. In the context of doctors' well-documented limitations in terms of their own self-care, Rogers writes of

this delusion that we are 'doctors' and not 'people whose occupation is doctoring'...[T]his stereotype marginalise[s] the real, imperfect, vulnerable men and women whose job is doctoring (Rogers, 2001).

Rogers' distinction is a useful one in the context of ethical discussion. Thinking of doctors as people with particular professional responsibilities rather than exclusively in terms of their profession emphasises the intrinsic worth of health professionals

themselves. The reasons that underlie concern for patients' well-being and the avoidance of harm (aside perhaps from the specific vulnerability that comes with being unwell) similarly justify concern for health professionals themselves; people's well-being and rights matter, and healthcare professionals, like patients, are people.

From this perspective, it is clear that health professionals' ethically important relationships are not only those that they have with their patients. Their relationships with their colleagues and with institutions have the potential to cause them harm. For example, revisiting the incorrect medication case outlined above, the junior doctor involved has described the incident as personally and professionally "devastating" (Miletic, 2006). Here then is a catastrophic example of an intraprofessional relationship whose nature had enormously harmful consequences for a health professional, an example that could be supplemented by description of many less drastic experiences of stressful, demeaning, or upsetting interactions with colleagues. The health professional-institution relationship also clearly has the potential to harm health professionals. For example, the negative social effects for a junior doctor of being constantly rotated through a wide geographical range of hospitals can be significant. Thus, whether the focus is on patient well-being (physical or holistic) or on the avoidance of harm to all involved in the healthcare sphere, various professional relationships beyond those between doctors and patients ought to be considered by philosophers working in bioethics.

In this chapter, I have argued that philosophers' current conception of bioethics ought to be significantly broadened beyond the standard topics of the doctor-patient relationship and dramatic technology-driven dilemmas, to encompass also day-to-day aspects of the healthcare sphere and health professionals' relationships with colleagues and institutions. It is this broader conception of philosophical bioethics that informs my investigation into the ethical challenges faced by junior doctors, the method of which is outlined in the next chapter. The broader understanding of bioethics that I have described informs this project in two ways. Firstly, it justifies taking junior doctors' working lives as the subject of a philosophical investigation.

Because of their lowly position in the medical hierarchy, junior doctors lack the authority to make some types of serious decisions. Thus members of this group rarely face the classic technology-driven dilemmas on which philosophers typically focus. Junior doctors do not themselves make decisions about turning off life support machines or allocating scarce transplant organs. But, if we look beyond the dramatic decisions with obvious ethical import to include also the more mundane aspects of the healthcare sphere as I have advocated, many aspects of junior doctors' working lives are potentially worthy subjects of ethical investigation. Secondly, the broader understanding of bioethics that I have outlined determines the particular aspects of junior doctors' experiences that will be understood as potentially involving ethical issues. The two elements described in this chapter – the mundane and relationships other than doctor-patient – will both be understood as potentially involving ethical challenges for junior doctors.

CHAPTER 2: METHODOLOGY

This thesis addresses the following research question: what kinds of ethical issues are associated with medical internship and residency, and how are these issues best conceptualised for ethical analysis? In this chapter, I describe and justify my approach to investigating this question, in light of the previous chapter's argument for a broader scope bioethics. In the first section, I argue for empirical research as an essential resource for philosophers working on questions in bioethics. I posit three crucial roles for empirical research in this kind of work, including identifying issues for philosophical attention from the vast range in the healthcare sphere and ensuring the practical usefulness of philosophical work in bioethics. These claims about the importance of empirical research to philosophical bioethics are reflected in the design of this specific study, which I describe in the second section of the chapter. I outline the way in which the above question is addressed through a combination of literature review, interviews with junior doctors, and ethical analysis. In the third section of the chapter, I focus specifically on the method employed in the interview component of the study.

THE IMPORTANCE OF EMPIRICAL RESEARCH TO PHILOSOPHICAL BIOETHICS

Empirical work has had an increasing presence in health ethics literature since the 1980s (Borry et al., 2006; Sugarman et al., 2001; Hope, 1999). Drawing on existing work on this “empirical turn in bioethics” (Borry et al., 2005; Ashcroft, 2003), in this section I argue that empirical data ought to play an integral multifaceted role in specifically *philosophical* work on problems in bioethics. I outline three ways in which empirical data is important in philosophical bioethics: agenda-setting, the introduction of information relevant to the plausibility of an argument, and input into the practical viability of a concept or piece of action guidance. I argue that, if we

accept that philosophical work in bioethics aims to establish the moral justifiability of acts and to have an impact on practice, then empirical data must play far more than a peripheral role as an optional extra in this type of work.

The three roles I describe are not intended as a comprehensive account of the appropriate relationship between bioethics and empirical research. There is a large literature debating this relationship, particularly between bioethics and the social sciences, at an interdisciplinary level (DeVries et al., 2006; Hedgecoe, 2004; Alvarez, 2001; Nelson, 2000; Birnbacher, 1999; DeVries & Subedi, 1998; Hoffmaster, 1990). As philosophers and others working in bioethics have begun to recognise the value of empirical data, social scientists have questioned being allocated “the ‘handmaiden’ role of simply providing the facts” to these other disciplines (Haines, 2002, p.89), arguing that social science has a more important contribution to make to questions about value in healthcare. Rather than entering this debate by suggesting the blurring of disciplinary boundaries or the transformation of moral philosophy in the direction of sociology (for examples of such arguments see Parker, 2007; Zussman, 2000; Hoffmaster, 1992), my argument is limited to advocating an empirically-informed moral philosophy. I understand moral philosophy in this context as a type of argumentation that draws on ethical theory, and thus my claim about the importance of empirical research to philosophical bioethics conceptualises empirical research as feeding into, rather than defining, this type of work. I am not arguing that empirically-informed moral philosophy is the only appropriate relationship of social science and philosophical bioethics. Rather, I am making the more limited claim that philosophical bioethics should be empirically informed, leaving open the broader question of the optimal disciplinary constitution and approach of bioethics as a whole. My investigation of junior doctors’ ethical challenges is a philosophical one and thus the scope of this chapter’s argument is limited to considering the ways in which empirical data ought to contribute to this type of work.

This section’s argument relates to philosophical bioethics overall as a body of work, rather than to every individual piece of research. The distinction between these two

levels is at times unclear in the work of those advocating a crucial role for empirical data in philosophical bioethics. For example, Hedgecoe's argument for a "critical bioethics" refers at times to characteristics of "a piece of work" while at other times seeming to be a claim about the contents of the discipline as a whole (Hedgecoe, 2004, pp.135,143). I am not claiming that every philosopher working in bioethics must use empirical work in every piece of writing in the ways that I outline. Rather, the argument is about what needs to be present in the philosophical bioethics literature as a whole.

Aims of philosophical bioethics

There is a degree of consensus around the aims of philosophical bioethics. These widely-accepted aims provide a basis for considering the role that empirical data ought to play in this type of work. One aim is to establish moral justifiability, that of particular actions, kinds of action, agents, policies, or practices. With the "topic of right and wrong action [being]...perhaps the most important single issue in the discipline [of moral philosophy]" (Slote, 1995, p.591), philosophers working on issues in bioethics aim to put forward rigorous arguments showing the moral justifiability of various aspects of the healthcare sphere.

A second widely-accepted aim of philosophical bioethics is to have an impact on practice. I do not mean to suggest that all work aims (or ought to aim) to have an impact on practice directly, but rather that philosophical discussions in bioethics are focused ultimately on increasing morally justifiable action in the health sphere. As Holm argues, "(at least part of) the purpose of bioethics is to affect changes in the way healthcare is delivered, and to minimise the number or gravity of unethical acts toward patients" (Holm, 1997, p.27). Harris similarly argues for bioethics as intrinsically practically-orientated, writing that

[b]ioethics has its roots in medicine and in the ethical issues raised by the practice of medicine. It must therefore have something useful to say to the health professionals who care for patients. It must, among other things, be able to help with decisions to

be made about managing the care of ‘Mrs Jones in Ward 5 at 4.10 in the afternoon’
(Harris, 2001b, p.14).

Brody and Birnbacher both concur, arguing that health ethics should always aim to have an impact on practice (Birnbacher, 1999, pp.320-1; Brody, 1990, p.162). Thus, throughout the following discussion, I will assume that philosophical bioethics aims not only to establish what the morally justifiable course or courses of action *are*, but also to facilitate these in fact *occurring*.

Empirical data in philosophical bioethics

Before considering what these consensus aims imply about the role of empirical data in philosophical bioethics, it is important to clarify what is meant by ‘empirical data’ in this context. I will take empirical data to be any information derived from observation or research intervention, using quantitative or qualitative methods. This includes data generated by work in bioethics using disciplinary methods from the social sciences, such as an ethnography of a neonatal intensive care unit or a sociological study of nurses’ attitudes to euthanasia. Empirical data generated by researchers outside bioethics, such as work in the biological sciences, will similarly be included in the wide understanding of empirical work employed here. Borry and colleagues rightly emphasise the importance of philosophers drawing on *high quality* empirical studies. They write that identifying such work can be “an especially difficult task because they [philosophers] are usually not trained in the methodology of empirical research” and these writers thus advocate philosophers’ “greater cooperation with epidemiologists, statisticians or other empirical scientists” (Borry et al., 2004, p.48). Although my emphasis is on systematic studies, information gathered more informally is also included in my understanding of empirical data. Philosophers can be informed in significant ways by their personal impressions and by stories they are told, and can justifiably use this information in appropriately circumscribed ways in their theorising.

One type of empirical information that is peripheral to the argument in this chapter is moral judgements, as invoked in the Rawlsian notion of reflective equilibrium

(Rawls, 1972, pp.48-51). According to Rawls, “considered” judgements are those moral judgements made when the agent has “the ability, the opportunity and the desire to reach a correct decision” (Rawls, 1972, p.48). Considered judgements are part of the bidirectional process of reflective equilibrium that Rawls posits as the appropriate method for assessing moral theories: possible moral principles are tested for their alignment with our considered judgements and “we may want to change our present considered judgments once their regulative principles are brought to light” (Rawls, 1972, p.49). (It is worth noting that Rawls is working at a particular abstract level, constructing big-picture moral theory. The study of junior doctors’ ethical challenges is far more specific and hence reflective equilibrium is not a central method in this project.) Considered judgements could certainly be viewed as empirical data, particularly when they are collected and recorded systematically. However, considered judgements are not the type of empirical information to which the argument in this chapter refers. Considered judgements are differentiated from the various other types of empirical data mentioned above by the explicit ethical reflection that produces them. Qua empirical data, our thoughtful moral judgements are highly atypical in that they already encapsulate ethical reflection. This chapter’s argument for the use of empirical information in philosophical bioethics focuses on data that is derived from observation or research intervention rather than that which is the product of ethical reflection.

Arguments about the relevance of various types of empirical data to philosophical bioethics could refer to many different levels of debate, from argument about a specific case through to more generalised thinking about a health ethics issue, all the way up to discussion about the most attractive ethical theory for application in the health sphere. Although empirical data could be seen to be relevant at all of these levels, my argument relates primarily to the more specific end of this spectrum, namely the relevance of empirical information to philosophical argument about cases and issues. I focus here because it is this level of debate to which this thesis contributes. This project analyses junior doctors’ stories both as individual cases and

as starting points for generating moral insights into the particular kinds of ethical issues that interns and residents encounter.

In the context of the increasing presence of empirical data in bioethics, there has been significant debate about the role of different types of empirical data in investigating ethical issues. Various typologies and models of existing and possible relationships between empirical data and ethical argument have been put forward (see for example Sokol, 2006, pp.127-32; Solomon, 2005; Borry et al., 2004; Sulmasy & Sugarman, 2001, pp.10-5; Holm, 1997, pp.25-6). Drawing on these discussions, I will argue that empirical data is integral to effective philosophical bioethics, rather than merely an interesting optional extra. Using empirical data in at least three ways, I suggest, is essential to the fulfilment of the aims of philosophical bioethics, assuming the disciplinary goals outlined. My aim is not to describe comprehensively all possible ways in which empirical data could contribute to philosophical argument about issues in health ethics, nor to outline the full range of ways in which empirical data is actually invoked in such work. Instead, I aim to outline three roles empirical data *ought* to play in philosophical bioethics if we assume this body of work to be endeavouring both to establish moral justifiability via rigorous ethical argument and to increase ethical action in the healthcare sphere.

Role 1: Agenda-setting

Having suggested in the previous chapter that philosophical bioethics could usefully include a far greater breadth of issues than those currently dominating philosophers' thinking, a pressing question then arises: if all situations involving value in healthcare are potential targets for philosophical analysis as I have argued, how ought philosophers to choose which topics to study in the context of this suddenly vast range of bioethics issues? Hedgecoe claims that "[t]he problems, dilemmas and controversies analysed [should] come from looking at a particular setting (e.g. the clinic), talking to participants and taking note of what they say" (Hedgecoe, 2004, pp.135-6). His claim seems well-justified in light of the aim of having an impact on practice. In the context of this aim, it seems that philosophers ought to look to

empirical research about the healthcare context in order to determine issues for their attention, rather than continuing to be drawn primarily to dramatic situations involving obvious conflicts of values.

Holm has argued that “numerical considerations” alone indicate that philosophers should draw on empirical work to set their bioethics agenda. His idea is that, to best fulfil the aim of increasing ethical practice, philosophers ought to work on the most common problems (Holm, 1997, p.27). Aside from this arithmetical justification, a further reason that empirical data ought to inform philosophers’ agenda in this area is the fact that health professionals tend to be the agents facing bioethical dilemmas. As Sulmasy and Sugarman highlight, “medical ethics is, in large part, about what *these people* [those practising the healing professions] ought to do” (Sulmasy & Sugarman, 2001, p.5, italics in original). Thus, in order to increase ethical action in the healthcare sphere, it is important that philosophers work on issues confronting and concerning practitioners.

Empirical work can most effectively identify these issues. Brody makes a strong version of this point, writing that

[i]f the field of bioethics is to have the appropriate impact on the actual provision of healthcare..., and it should always aim to have that impact..., it is necessary that it address ethical questions actually arising in the provision of healthcare...Only empirical investigations can reveal to us the major problems actually faced by healthcare providers (Brody, 1990, p.162).

This is not to say that only those issues *identified* by practitioners as ethically troubling ought to be the focus of philosophical investigation. Those outside the health professions may be better placed to identify some ethical issues arising in healthcare than those deeply involved and long-socialised into particular contexts. The perspectives of outsiders, including philosophers, can generate valuable insights as they are more likely to question features taken for granted by healthcare industry insiders.

The experiences and concerns of patients and relatives, alongside those of healthcare professionals, ought also to inform philosophers' bioethics agenda. Patients and their families are also in the position of actually making the difficult ethical decisions about healthcare. If philosophical bioethics aims in part to have an impact on decision-making and action, then empirical data investigating the context and concerns of practitioners and patients ought to play a key role in determining which topics are worked on.

Various types of empirical work could (and currently do) play this agenda-setting role. Real life case studies have long been used as a stimulus for ethical discussion in various ways (see for example Levine, 1989; Higgs & Campbell, 1982). Case studies are discussed as concrete problems requiring articulation of a morally justifiable way of proceeding, as situations potentially revealing something about more abstract ethical issues, or to sensitise an audience to the existence of ethical considerations in a particular practice or situation. Empirical research investigating attitudes and practices can also function in this agenda-setting role. For example, a study indicating the prevalence of euthanasia being practised by doctors despite its illegality (such as Kuhse et al., 1997) or highlighting distinctions between philosophers' and practitioners' use of ethical concepts about end-of-life (such as Dickenson, 2000) points to the need for greater philosophical consideration of these issues. Although studies of this type cannot establish moral justifiability, they highlight topics warranting ethical reflection. Empirical work that is not explicitly focused on an ethical issue can also play an agenda-setting role. For example, a psychological study showing that consecutive night shifts significantly impede medical interns' performances (such as Rollinson et al., 2003) could stimulate philosophical reflection on the moral justifiability of long working hours, particularly in relation to impacts on patient care.

Role 2: Introduction of information relevant to the plausibility of an argument

In addition to agenda-setting, a second role that empirical work should play in philosophical bioethics is as a source of information relevant to the plausibility of an argument (Sulmasy & Sugarman, 2001, p.11). As Borry and colleagues have highlighted, “there are empirical data relevant to almost every debate that takes place in the field of bioethics” (Borry et al., 2005, p.51). A philosophical argument for the moral justifiability of an action will often involve an empirical claim. This will necessarily be the case in work that uses a consequentialist framework (Birnbacher, 1999, p.323). As Zussman has argued, “a good deal of medical ethics is based on consequentialist claims that social scientists are well equipped to assess” (Zussman, 2000, p.9). Thus, without knowledge of the relevant empirical work, philosophical bioethics cannot fulfil its aim of putting forward strong arguments about moral justifiability.

The way in which empirical data is relevant to the plausibility of an argument will differ, making this role a broad one, playable in various ways. (Of course, in all cases, the argument itself must be well-formed in order for the empirical data to support it.) In some arguments, empirical data functions to establish the plausibility of a claim about direct causation on which the argument depends. For example, the argument that interns’ long working hours are morally problematic because patient care is compromised requires empirical data linking shorter hours with improved patient care (such as Privette et al., 2009). In a similar vein, empirical data could be relevant to gauging the likelihood of a posited slippery slope in fact occurring (Borry et al., 2004, p.47; Sulmasy & Sugarman, 2001, p.12). Take, for example, the argument that voluntary euthanasia is morally impermissible because it will lead to non-voluntary euthanasia being practised. This argument could be weakened by empirical work investigating health professionals’ perceptions of euthanasia (such as Kuhse & Singer, 1993), particularly data indicating that health professionals perceived a clear and fundamental moral difference between the two types. While data here could not support or undermine the argument as decisively as the right data

could in direct causation arguments, empirical information could nonetheless have a significant impact on the plausibility of the proposal. A further way in which empirical data could determine an argument's plausibility is when an ethical principle applies under particular conditions. Empirical information will be necessary to establish whether the relevant conditions apply in the situation that is the focus of the argument (Sulmasy & Sugarman, 2001, pp.11-12). Thus, depending on the type of argument being made, empirical data will be relevant to its plausibility in different ways.

In all cases, as Borry and colleagues argue, "a critical attitude should be adopted with respect to research results being described" (Borry et al., 2004, p.51). Empirical research itself is also value-laden, involving norms, assumptions and judgements which philosophers must recognise and assess in their use of the data generated.

Role 3: Input into the practical viability of philosophical concepts and action guidance

A third role that empirical data should play in philosophical bioethics is as a source of information about the practical viability (relative to the alternatives) of the concept or action guidance being proposed. While role two refers to empirical claims *within* arguments, role three refers more to the *endpoints* of philosophical argument or reflection, for example a recommended action option, a model for generating a morally justifiable decision in the relevant circumstances, or a framework for thinking about a particular type of ethical problem. The compelling idea that 'ought implies can' (discussed further in the later section on ethical analysis) requires philosophers to seek empirical details about the type of situation under analysis. (This is the case for all philosophers but is particularly important for philosophers working on bioethical questions with their aim of having an impact on practice.) The idea that 'ought implies can' suggests that a practically infeasible piece of action guidance is necessarily a bad one. That which is morally appropriate must be something that the agent in that situation can achieve. As with action guidance, the concepts or theories put forward by philosophers in bioethics must also be practically applicable. Various

authors have identified that empirical data can be important in indicating a concept's practical feasibility. Hedgecoe, for example, advocates a "critical bioethics [that] tests its theories in the light of empirical experience, *and changes them as a result*" (Hedgecoe, 2004, p.137, italics in original). Borry and colleagues emphasise the "concrete context[s]" in which moral questions arise and the importance to effective ethical analysis of asking the "reality-revealing questions" that illuminate these contexts (Borry et al., 2004, p.44).

Substituted judgement is often cited as an example of a philosophical concept shown empirically to be practically problematic (see, for example, Sulmasy & Sugarman, 2001, pp.13-4; Holm, 1997, p.31). Buchanan and Brock's theory that substituted judgement respects incompetent patients' autonomy (Buchanan & Brock, 1989) was problematised by empirical evidence indicating that hypothetical treatment decisions made by surrogates supposedly in line with patients' values did not in fact align consistently with the decisions patients themselves would have made (such as Sulmasy et al., 1994). The existence of implementation problems does not, of course, imply that a philosophical concept should automatically be jettisoned. This will depend on the answers to questions such as 'is the concept's feasibility, though not completely successful, good enough?', 'are there other options available?', and 'are they more feasible?'. Practicality will always be relative amongst the range of feasible options.

Available empirical information about the issue's real life context should be used in the *development* of the concept or action guidance, not just to test its plausibility after development. Existing information about the practical context provides constraints that philosophers ought to acknowledge. This is not to say that philosophers must view bioethics situations conservatively, never attempting to alter people's thinking or advocating organisational change. Rather, the idea is that the actual empirical situation ought to play a significant part in philosophical thinking about morally justifiable action in that scenario. Detailed consideration of the relevant context enables the idea put forward to be implementable.

Using empirical information in this way is necessary for philosophical bioethics to achieve its aim of practical impact. As Birnbacher argues, “any serious attempt to influence practice...requires consideration of the pragmatic conditions” to which the theory relates (Birnbacher, 1999, p.320). Sokol similarly argues that

[m]edical ethicists are more likely to offer practical guidance that will impact on the practice of medicine if they are aware of the realities of clinical practice and take these into account in formulating their advice (Sokol, 2006, p.124).

Unless philosophers produce ideas fitted to a sufficient degree to the empirical contours of the situations for which the ideas are proposed, their ability to make a practical impact will be compromised.

Thus the disciplinary aims of philosophical bioethics imply that empirical data should play an integral multi-faceted role in this type of work. If the posited aims are accurate, philosophical discussions in bioethics ought to use empirical data in at least the following ways: to identify problems warranting attention, to inform arguments, and to ensure that the ideas put forward will be practically feasible in light of what is known about the context in which they apply. The first and third of these ways enable the goal of practical impact to be met, and the second facilitates the goal of putting forward rigorous arguments about moral justifiability. There may well be further roles for empirical data in philosophical bioethics, but, if we accept the posited set of aims for philosophical bioethics, then at least the three roles described are essential to philosophical discussion of issues in the healthcare sphere. In my investigation of the ethical issues associated with internship and residency, I endeavoured to use empirical information in all three of the posited roles, as is clear from the study design described in the next section.

STUDY DESIGN

Research question

To reiterate, the research question addressed by this study is ‘what kinds of ethical issues are associated with medical internship and residency, and how are these issues best conceptualised for ethical analysis?’. In line with the agenda-setting role articulated, this question was stimulated by existing empirical information about the healthcare context. As will be discussed in detail in chapter three, various empirical studies from a range of disciplines indicate the existence of ethical issues in junior doctors’ professional lives, particularly when we understand ‘ethical issues’ in the broad way described in chapter one. Falling outside the standard limited conception of the issues constituting bioethics, junior doctors’ ethical challenges have failed to attract substantial philosophical attention. This project aimed to begin to address the need for systematic philosophical work on these problems, particularly as a potential source of additional knowledge for junior doctors and for those who educate and support them.

Overall, the method used to investigate this question was an empirically-informed moral philosophy. Within the context of an essentially philosophical project, I drew extensively on existing empirical research involving junior doctors and also conducted an empirical study, interviewing fourteen Melbourne-based junior doctors about their experiences. My empirical study focused on the first part of the research question (“what kinds of ethical issues are associated with medical internship and residency?”), although the data collected also provided some insight into the second element of the question (“how are these issues best conceptualised for ethical analysis?”). Overall, my approach to this project involved three basic stages, each of which is detailed below: a literature review, collection of data by interview, and ethical analysis. In line with the argument made in the previous section, I used empirical information (particularly the interview data) to identify particular ethical issues for detailed ethical analysis and as a source of knowledge about junior doctors’

context which I used in my theorising about the ethical issues associated with internship and residency.

Literature review

The first stage of the project was a literature review which served three purposes: to generate an understanding of Australian junior doctors' professional context, to establish an initial typology of the set of ethical issues associated with internship and residency, and to survey existing normative positions on these issues. Literature relevant to the research question came from a variety of disciplines. Thus the review was not limited to philosophical or even overtly health ethics literature, but rather encompassed sociological, anthropological, psychological and education-focused studies of junior doctors, as well as non-academic literature from various hospitals and professional bodies involved in junior doctors' working lives.

To source academic literature relating to junior doctors, a number of electronic databases were used. These were Web of Science, Medline, and Philosophers' Index. In Web of Science and Medline, the basic search term used was 'intern or resident' in an article's title, constructed so as to capture any of 'interns', 'internship', 'residents', or 'residency'. I also limited the search to articles mentioning the words 'medical' and 'hospital' in order to exclude articles relating to other spheres with their own interns and residents. From the results of the searches, I excluded most work from non-Western settings because of the significant differences in medical training and culture compared with the Australian context; this type of work was not relevant to generating an understanding of Australian junior doctors' professional context. I did include the few articles from non-Western settings that focused specifically on junior doctors and ethics as these utilised similar ethics paradigms to those prominent in Australia. I focused the review on articles about junior doctors' experiences (rather than, for example, particular postgraduate curricula or the development of a specific clinical skill). The exception to this was where the work was Australian-based. In these cases, all articles relating to junior doctors were reviewed in order to gather information about the context in which the doctors interviewed worked. Articles

published before 1994 were included only if they made specific reference to ethics. I considered articles about junior doctors' context that were published more than fifteen years ago to be out of date in relation to this study (conducted 2006-9) due to the constantly changing nature of the hospital environment, including the way in which internship and residency are structured. The search in Philosophers' Index was slightly different as here I was seeking work on junior doctors that specifically framed itself as ethical investigation. Here I used the term "intern or resident" (again constructed inclusively) together with "ethics" (or "ethical") and "medicine" (or "medical"). All the articles found were reviewed.

The non-academic literature was primarily sourced from the websites of various organisations. I also attended a "Medical Careers Expo" aimed at final year medical students in June 2006, at which a number of Victorian hospitals and professional bodies had information stands. This event and the literature distributed at it proved excellent sources of information about junior doctors' professional context. The time I spent in hospitals recruiting and interviewing participants and talking about the study was also invaluable in terms of establishing an understanding of junior doctors' working environment. Personal contacts working in or familiar with the hospital environment were able to answer many of my questions about the hospital environment and terminology, particularly in relation to junior doctors' career trajectories and the structure of the hierarchical medical teams in which they work.

The results of the literature review are reported in chapter three. From the studies reviewed, a table was generated that summarised an initial typology of the kinds of ethical challenges associated with medical internship and residency as well as various more specific examples of each kind of issue. I included in this typology any issue that a researcher framed as an ethical one, alongside other issues that the literature indicated were having a significant negative impact on a group's well-being or on junior doctors' development into ethical professionals. This decision to be wide-ranging in the issues included was made in the light of the definition of ethical issues put forward in the previous chapter (that is, that an issue is an ethical one if it involves

persons' rights, duties, and obligations and/or consequences that are beneficial or harmful to people and/or the development and exercise of virtues).

Interviews

This typology was then used as a basis for the interview component of the study. Semi-structured individual interviews were conducted with fourteen Melbourne-based junior doctors from six different hospitals. (The method of the interview component of the study is discussed in detail in the third section of this chapter.) In line with the broad conception of bioethics advocated in chapter one, the interviews explored junior doctors' experiences with patients, colleagues, and the hospital administration. The emphasis was on the day-to-day aspects of their professional lives. Informal discussion and observation had repeatedly indicated that junior doctors do not tend to perceive themselves as involved in ethical issues in the hospital. To this extent, junior doctors could be said to share philosophers' limited conception of the issues constituting health ethics. For this reason, the study was presented to participants primarily as exploring junior doctors' experiences, rather than their ethical challenges. I hoped to record junior doctors' stories of ethically-challenging situations without relying on their interpretation of whether these experiences involved ethical issues. Participants were asked about the issues that the literature review had highlighted as well as open questions about junior doctors' difficulties in general.

I aimed to achieve four objectives with the interviews:

1. to test the initial typology generated by the literature review,
2. to capture other ethical challenges for junior doctors that may not have emerged from that process,
3. to select real pressing issues relevant to practitioners for detailed philosophical reflection (in line with the agenda-setting role for empirical data advocated in the first section of this chapter), and

4. to collect rich detailed narratives about junior doctors' ethical challenges.

The interview data fulfilled the third role for empirical data outlined in the previous section; the interviews enabled me to better ground my ethical analysis in the practical realities of the situations analysed. The extensive contextual detail that the participants provided, both about specific challenges and about the hospital context in general, facilitated philosophical reflection that was far more closely aligned with the practical realities of the situations than would otherwise have been the case. Although my analysis remains that of someone positioned outside the clinical context, I was able to generate more practical conclusions as a result of gathering this empirical information.

The interviews were conducted to direct and inform philosophical reflection, rather than as a basis for sociological theorising. Although I aim to accurately represent what I was told by this group of junior doctors, I make no claim to be telling a comprehensive story of the ethical challenges faced by Melbourne's junior doctors nor to be presenting an interpretation of the experience of being a junior doctor. I did not have the sociological aim of interpreting and explaining junior doctors' ethical challenges in terms of how they play out in real life and why. The study was not a phenomenology; my aim differed from representing the lived experience of internship and residency in participants' own terms. Rather, the data gathered by the interviews was intended to enable philosophical reflection on the ethical issues associated with medical internship and residency; the ultimate aim was well-informed philosophical analysis. Therefore, having gathered accounts from participants of their experiences, I took a more distant perspective on the data, seeing participants' actions and interpretations as potentially open to ethical question in my analysis. As is clear in all the parts of the thesis where I engage in detail with individual participants' stories, the actions and interpretations of the junior doctors I interviewed were understood as legitimate targets of ethical investigation and critique.

Arguably, qualitative methods other than interviewing could have generated the empirical information required for this project. Ethnography is an obvious possibility.

A study of junior doctors in their working context would have generated extensive and rich data about the ethical issues associated with their position. However, I chose interviews for a number of reasons. Participants from a variety of hospitals, units and year levels could be included, in a way that would have been significantly more difficult if ethnographic methods had been employed. Interviews also avoided the potential for my “ethicist” presence to affect the types of challenges junior doctors in the study encountered or the way in which issues were dealt with. As well, interviewing revealed more of junior doctors’ *thinking* whereas observation would have only captured their behaviour. Also, I hoped individual interviews would create the privacy necessary for participants to feel comfortable in talking freely about experiences that may have been personally difficult or professionally compromising. Further, interviews generally enable detailed reflections and extended narratives to be collected. This was particularly appropriate given the way in which I intended to use junior doctors’ stories as a basis for ethical analysis.

Ethical analysis

Theorising about the nature of junior doctors’ ethical challenges and detailed analysis of two specific ethical issues faced by participants formed the final stage of the project. Although I have been describing the project as a sequence of three stages, the ethical analysis phase did not begin only after completion of all of the interviews. Initial reflection began at the early stages of interviewing, which enabled later interviews to explore in depth the particular ideas and issues that were emerging as likely foci. This approach is consonant with the iterative methodology of grounded theory (Liamputtong & Ezzy, 2005, pp.265-73), but I was not working towards producing a grounded theory in the strict sociological sense. Ultimately, I developed a framework for understanding junior doctors’ ethical issues and explored the potential of this framework to generate action guidance for junior doctors in various ethically-difficult situations.

Moral pluralism

I took a moral pluralist perspective in this project. Moral pluralism refers to the doctrine that “there are a number of distinct and irreducible basic duties or moral principles, all of which can be relevant in determining whether some action is right”; this is in contrast with unitary accounts of what makes right actions right, epitomised by utilitarianism and the Kantian categorical imperative (McNaughton, 2002, p.76). Pluralist analyses are both familiar and prominent in health ethics, with Beauchamp and Childress’ influential principlism an obviously pluralist approach (Beauchamp & Childress, 2001). Beauchamp and Childress specifically invoke Rossian pluralism, presenting their framework of principles in terms of Ross’ notion of prima facie obligations (Beauchamp & Childress, 2001, pp.14-5). Another prominent pluralist approach is that of Gert who articulates ten moral rules that he sees as the basis of common morality (Gert, 2004, p.20) and a two-step procedure for assessing whether a violation of the rules is justified in a specific situation (Gert, 2004, pp.58-76). Gert posits his framework as specifically applicable to health ethics issues (Gert et al., 2006), and his approach has been applied to various areas of health ethics including genetics (Gert et al., 1996).

Pluralist frameworks are attractive in that they capture the intuition that various kinds of considerations all matter morally, and that this plurality of considerations need not be unified by a single underlying justification. The fact that each of the prominent unitary theories is supported by well-informed, well-motivated people suggests to me that each has significant plausibility and something insightful to contribute to the moral description of a situation. Adopting a pluralist approach enables this multiplicity of intuitively important moral considerations to be included in the analysis, while avoiding the problematic implications of rigid adherence to any one monistic principle. I find intuitively highly compelling Ross’ idea that “in principle there is no reason to anticipate that every act that is our duty is so for one and the same reason” (Ross, 1930, p.24). In a pluralist framework, considerations around maximising the good, obeying moral rules, and cultivating virtue can all count in our ethical decision-making in their own right, without the theoretical difficulties

associated with committing to one as the fundamental justification for the ethical importance of the others. Although I ultimately propose a role virtues framework for thinking about junior doctors' ethical challenges, I put forward this framework as a way of capturing various types of moral concerns rather than as a strictly virtue ethics approach. My claim is that junior doctors need to be good qua various roles and that junior doctors' ethical challenges can usefully be understood as role virtue conflicts, rather than the virtue ethics claim that the action of the virtuous junior doctor *defines* good action.

Stories

By basing my philosophical reflection on stories told to me during the interviews, I aimed to produce a theoretical framework grounded in clinical reality and, relatedly, action guidance that was both relevant to and implementable by junior doctors themselves. Particularly when analysing the two specific ethical issues investigated in chapters eight and nine, participants' stories were used as starting points. Guillemin and Gillam argue that beginning ethical analysis by engagement with first-person narratives enables us to

see the ethical dimensions of real clinical practice; not just one clearcut ethical dilemma, but many interwoven ethical considerations, issues, questions, concerns, and possibilities...[as well as] the messiness of real practice, where ethical issues are not neatly delineated from other issues, and do not come labelled for ease of consideration...[We see] the constraints, both personal and institutional that limit and direct the options that are, or appear to be, open to people (Guillemin & Gillam, 2006, p.30).

The features of stories that Guillemin and Gillam highlight resonate with the roles for empirical data discussed earlier, particularly the role of ensuring the practical viability of theories and action guidance. My decision to use junior doctors' stories (rather than, for example, hypothetical scenarios or abstract questions about an act's moral justifiability) was thus made for a number of reasons. Structuring philosophical reflection around real stories aligns both with the commitment to generating

practically feasible concepts and action guidance and with the aim of addressing issues genuinely relevant to those in healthcare contexts. By addressing real events in all their messy contextual detail, philosophers working in health ethics are more likely to produce compelling analyses relevant to the agents facing the ethical issue in question.

In chapters eight and nine, I analyse two specific ethical issues using the role-based way of understanding junior doctors' ethical challenges developed in chapter seven. From the interview data, two particular ethical challenges were chosen for detailed ethical analysis: junior doctors recording their actual hours worked even when unrostered, and junior doctors' involvement in implementing treatment that they perceive to be futile. I selected these issues for various reasons. The issue of reporting overtime had not been identified by the literature review process and thus represented a new finding from this study. The issue of involvement in futile treatment had been previously reported, but was a particularly prominent issue amongst the group of junior doctors interviewed and one that many participants had found highly distressing. Together, these two issues reflect the broad conception of bioethics advocated in chapter one, involving everyday challenges and difficulties with colleagues. They also reflect the spectrum of ethical issues that junior doctors face, from the everyday to the dramatic. In addressing these two issues using the framework developed, I aimed not to put forward rigid rules of ethical conduct for junior doctors but rather to offer an ethically reliable starting point for interns and residents to draw upon when they face a similar situation. In taking this perspective, I do not mean to downplay the significance of features of the organisational context and the actions of others in creating the ethical issues that interns and residents face. Rather, I aim to acknowledge that junior doctors must act in some way in the face of these issues, regardless of the longer term need for structural change.

While accepting that the practical issues of what to do need to be addressed, Guillemin and Gillam reject the idea of ethical analysis that aims to produce a "solution to the problem, or a guide for what to do next time a similar situation arises"

(Guillemin & Gillam, 2006, p.38). They argue instead that ethical analysis, should focus on the production of “ethical mindfulness”, a set of abilities and predispositions that enables sensitivity to and analysis of ethical considerations as well as self-awareness and courage in ethically-challenging situations (Guillemin & Gillam, 2006, pp.30-3). While far from denigrating the value of ethical mindfulness, I do not share Guillemin and Gillam’s view that analysis ought not to aim for concrete guidance for future action. There is, inevitably, a role for judgement in relation to ethical action in any *specific* situation. However, in my view, thinking systematically about the kinds of ethical considerations involved in a certain *type* of situation, in this case through detailed consideration of a particular narrative instance, provides a necessary starting point from which such judgement is then appropriately exercised. In this sense, my view reflects that expressed by Nagel; non-codifiable judgement comes into play “provided one has taken the process of practical justification as far as it will go” (Nagel, 1979, p.135). Adopting the approach that Nagel advocates – “a mixed strategy, combining systematic results where these are applicable with less systematic judgement to fill in the gaps” (Nagel, 1979, p.139) – seems to me more likely to generate philosophical reflection that is useful to practitioners while still acknowledging the ethical relevance of specific contextual detail and thus the role for individual judgement in any particular situation. Therefore, when generating action guidance, I viewed the results as a preliminary basis for the agent’s own final judgement about the right thing to do in any specific instance of that type of ethical challenge.

Ought implies can

A third idea that informs the ethical analysis is the principle that ‘ought implies can’. This notion, originally put forward by Kant, is regularly invoked in moral philosophy. (For a collection of the passages in which Kant is taken as stating the principle in a number of his texts, see Stern, 2004, pp.53-5). Frankena argues that the principle can plausibly be understood in three different ways:

1. that moral judgements presuppose that that the agent is able to act as proposed,
2. that the “point of uttering” moral judgements disappears if the agent is not able to act as proposed, and
3. that it would be “morally wrong to insist that an agent ought to do a certain action” if he is unable to do it (Frankena, 1958, p.60).

A fourth interpretation is that “we should focus on the [psychological] capacities of agents in moral theorising and action, and adjust our accounts of what is right and wrong accordingly” (Stern, 2004, p.44. Stern critiques this interpretation which he attributes to Griffin among others.)

I use the idea of ‘ought implies can’ in the first of these senses, deliberately limiting the action guidance proposed to actions that are possible for a junior doctor to perform. There are, of course, a number of ways of understanding the concept of possible action. Some actions are physically impossible for junior doctors. These include actions that are physically impossible for all human agents, such as being in two places at the one time, as well as actions impossible for junior doctors specifically, such as performing complex surgery. I take this type of action to be excluded from the realm of the possible. In this project I also take actions prohibited by formal institutional constraints within the hospital as similarly excluded for junior doctors. These would be actions such as ordering a procedure that can only be authorised by a senior doctor, undertaking an operation without any formal consent, or refusing to work in the allocated ward. These institutionally-prevented actions represent the range of action options that are physically possible for junior doctors but that are nonetheless unavailable to them because of their professional position. Throughout the thesis I argue that the formal institutional constraints faced by junior doctors place real and unique limits on the action options available to them and therefore require systematic consideration when analysing the ethical challenges faced by this group. Importantly however, I consider actions that offend cultural norms of the medical profession to fall within the realm of the possible. While questioning

one's seniors or requesting payment for one's overtime may contradict entrenched cultural norms among doctors and thus entail significant costs for junior doctors, these action options are available to them. Thus, in this project, physical limits and formal institutional constraints are taken as precluding actions but the norms of medical culture are not. In the junior doctor context, the principle 'ought implies can' means that junior doctors cannot be morally required to act in ways that are physically or institutionally impossible but may be obliged to undertake actions that are very much 'not the done thing' currently amongst their medical colleagues.

METHOD OF THE EMPIRICAL COMPONENT

Having given an overview of the project's design, in this section I outline in greater detail the method of the interview component specifically. The Human Research Ethics Committee of the hospital from which I recruited granted ethics approval for the study overall and the project was also registered with the HREC at the University of Melbourne. The interviews were conducted during the period October 2006 to September 2007.

Sampling

Melbourne-based interns and residents (defined for recruitment as doctors who had been working for three or fewer years since graduation) were sought to participate in the study. Both school-leaver and postgraduate entrants to medicine were recruited.

As Liamputtong and Ezzy articulate, "sampling in qualitative research is not concerned with ensuring that findings can be statistically generalised to the whole population" but rather with generating data of sufficient richness to support the kind of analysis envisaged (Liamputtong & Ezzy, 2005, pp.44-9). The sample's characteristics in this type of study therefore need not reflect the characteristics of the whole population of interest. As the study was not aiming to produce a generalisable account of medical internship and residency but rather to feed into philosophical reflection about the kinds of ethical challenges that interns and residents can face,

capturing a statistically representative sample was not imperative. A sample of approximately fifteen in-depth individual interviews with junior doctors from different hospitals was predicted to achieve sufficient richness in this project. Similar sample sizes have been used in other qualitative studies with healthcare professionals (for example Coombes et al., 2008; Braunack-Mayer, 2001). I also aimed to validate the data and my interpretation of it, an important element of qualitative research involving small numbers of participants (Pyett, 2003), through feedback to participants, presentations to junior doctors, and discussion with other health professionals and researchers.

In light of the finding that “there is considerable, and consistent, local variation in working practices, and in the treatment of doctors in training” (Bligh, 2002, p.2), ensuring that a geographical variety of experiences was captured by the interviews was important. I decided to source participants from a variety of hospitals in order to achieve this. Collecting data from doctors based at various different sites also had the advantage of decreasing the likelihood of participants being identified. Participants came from hospitals that are diverse in terms of their geographical positions, regional connections, and university affiliations.

One limitation of the sampling strategy was that only junior doctors based in metropolitan Melbourne were recruited. Although restricting the participant group in this way made the study feasible in the timeframe, it did mean that the experiences of junior doctors currently based in hospitals in rural and regional areas were not explored. However, junior doctors are a mobile population, undertaking country rotations and often changing locations after a year-long position. Therefore, even in a Melbourne-based sample, a significant geographical variety of experiences was captured.

Recruitment

Participants were recruited in three ways: through one hospital, via the Australian Medical Association’s Council of Doctors-in-Training (AMACDT), and snowballing.

Participants were recruited via one hospital's weekly email to junior doctors from the Chief Resident. Two rounds of recruitment were undertaken at this hospital, the first in late 2006 and the second in early 2007. (A new cohort of junior doctors begins work each January/February). In the first round, as well as the email, I also attached fliers to noticeboards in the hospital and left a pile in the junior doctors' common room. In addition, I spoke briefly about the project and distributed fliers at two of the lunchtime education seminars held for the junior doctors. As all first round participants responded as a result of the Chief Resident's email, this was the only method used for the second round of recruitment.

Participants were also recruited via the AMACDT. This group functions within the Australian Medical Association (the professional association for Australian doctors) and advocates in relation to issues faced by junior doctors, such as safe working hours, postgraduate training, and work-life flexibility. Because the AMACDT's email network includes a large number of junior doctors based in a wide variety of hospitals, I chose to recruit via this group rather than through two more individual hospitals as I had originally envisaged. Also, after my experience recruiting from the hospital site, I was aware of the increased effectiveness of a recruitment request coming from a source trusted by potential participants rather than from myself as an unfamiliar researcher. The recruitment information was included in the AMACDT's email newsletter in April 2007.

Snowballing recruitment was also utilised. At the conclusion of each interview, the participant was provided with fliers with a description of the project and my contact details to distribute to any other junior doctors that he or she thought might be interested in participating in the study. I also gave my contact details whenever I gave a seminar about the project and personal contacts gave my details to doctors they thought might be interested in participating in the project.

The text used in the flier and advertisements is included in Appendix D. The forms of recruitment used generated a participant group that is potentially different in at least two ways from junior doctors as a whole population. Firstly, the recruitment

information specifically indicated that the researcher was interested in “both good and bad experiences”. However, interns and residents with particular concerns would presumably be more likely to volunteer for an interview than those doctors who had found their early years of practice unproblematic. Indeed several participants arrived at the interviews with troubling stories that they were clearly keen to share and have recorded. Secondly, the majority of the participants were women. As discussed further below, it was obvious from the recruitment information that the researcher was a woman and this may have resulted in a female-dominated sample.

The participants

All the participants in the interview study were junior doctors based at hospitals in Melbourne, Australia. Fourteen junior doctors were interviewed: eight interns, five residents (three in their second postgraduate year and two in their third postgraduate year), and one registrar (in her fourth postgraduate year). My original intention was to interview only interns and residents, but when the registrar volunteered through a friend, at a time when recruitment was proceeding frustratingly slowly, I decided to include her. We primarily discussed her internship and residency experiences, and her role as a registrar now supervising more junior doctors provided some important insights into this key relationship. It is also worth noting that some of the residents interviewed had already been accepted onto specialty training programs. A small minority of participants were therefore undertaking Basic Physician Training or Basic Surgical Training, the first differentiating step to specialisation. Although this affects the kinds of rotations they undertake, essentially their position is the same as their peers who are yet to embark on these programs; in the hierarchy of the medical team, they still play the junior role.

The majority of participants were women, with only three men in the participant group. Men and women are approximately equally represented in medical courses in Australia (Australian Medical Workforce Advisory Committee, 1997, p.xii), and thus the gender breakdown in this participant group is far from representative of the junior doctor population as a whole. One possible explanation is my being female, which

was clear from the recruitment information. Considering that I was seeking to discuss experiences that were in many cases quite personal and confronting for participants, perhaps female junior doctors were more comfortable in discussing these situations with another woman. The gender imbalance in the participant group may mean that the issues highlighted by the interviews relate to being a female junior doctor specifically. However, there are various indications that the data is not substantially biased in this way. Most of the stories told by participants were not gender-specific; the junior doctors involved could have been either male or female. Also, participants often noted the way in which the issues they were discussing affected their peers as well, implying that both men and women encounter the various challenges raised. Further, the correlation between the issues that this group of junior doctors encountered and the issues discussed in the existing literature suggests that these junior doctors' experiences were not particularly female-specific.

Twelve of the fourteen participants had studied at either Monash University or the University of Melbourne, the two largest and most prestigious universities in Melbourne. The remaining two participants had studied medicine at prominent universities in other Australian states. Overseas-trained doctors were deliberately excluded from the study due to the distinctively more complex nature of their internship and residency experiences. At the time when participants were studying, the University of Melbourne and Monash University were the only universities in Victoria offering medicine. Since then, three further medical programs have begun being offered as part of government initiatives to address workforce limitations, particularly in regional areas. (These programs are Deakin University's graduate entry course based in the regional city of Geelong, a graduate entry course at a new regional medical school run by Monash in Gippsland in the state's east, and a "rural cohort" at Monash's main campus who will complete their clinical placements in northern Victoria). These new programs aim particularly to attract students from these regional areas who, it is hoped, will remain in these areas once qualified (Hall, 2007; Abbott & Bishop, 2006).

Eleven participants had studied medicine immediately after finishing secondary school. The other three had studied medicine as tertiary graduates from other courses. These three doctors had studied either science or health science disciplines before embarking on medicine. Each had followed his or her first degree immediately with a medical course. It is worth noting that graduate entry medical courses are becoming increasingly common in Australian universities. The Australian Medical Workforce Advisory Committee now estimates that fifty percent of those students completing Australian medical courses entered as tertiary graduates (Committee of Deans of Australian Medical Schools, 2005, p.47). Several universities accept only tertiary graduates while others, including Melbourne and Monash, offer both undergraduate and postgraduate places. (From 2011, the University of Melbourne will join the ranks of Australian universities offering medicine only as a graduate degree.) Universities' educational rationale for this move towards graduate entry medical courses relates to the perceived greater maturity of postgraduate students and, relatedly, to their putative broader educational background and high level of self-motivation (Geffen, 1991).

The experiences of participants in this study remain relevant, even in this context of moves towards more non-city-based medical education and a majority of medical students studying as postgraduates, trends not reflected in the group of junior doctors interviewed. It is reasonable to assume that students trained in the medical programs in regional areas will experience their early postgraduate years in substantially similar ways to their city-based counterparts. Their experiences will presumably involve some additional ethical issues such as working in small communities with patients known to them from other non-medical contexts, and the moral justifiability of bonding students to working in particular areas in exchange for fee remission during their studies. Also, despite the universities' rationale for increasing graduate entry, it is questionable whether graduate cohorts will in fact differ substantially from school-leaver cohorts. The majority of graduate students enter medicine directly following a three or four year undergraduate course and thus complete medicine at a similar age and having had similar educational experiences to school-leavers who have undertaken the traditional six year undergraduate medical program. The continuing

moves towards graduate medical courses thus seem unlikely to change significantly the population of interns and residents and, associatedly, their experiences of their early professional years. The ethical issues that graduate cohorts face seem likely to be similar to those identified in this project.

Throughout the thesis, features of participants' quotes have been altered where these were potentially identifying. As well as allocating a pseudonym to the protagonist of each story, I have in some cases changed ward-types, characteristics of patients, and participants' and others' genders. In each case, I have attempted to alter features in ways that do not affect the crux of the story or the participant's point. All references to specific hospitals have been removed.

Method

A semi-structured individual interview of approximately one hour's duration was conducted with each participant. The interviews were semi-structured to allow individuals' varying experiences to be explored. Interviews took place in each participant's own time and at a location chosen by the junior doctor. These included hospital cafeterias, one participant's home, local cafes, the University of Melbourne, and a ward office. Offering this choice was intended to enable junior doctors to take part in the study without their colleagues' knowledge if this was their preference.

Before commencing the research interviews, I conducted two pilot interviews with friends who were former junior doctors to test and refine the questions. The resulting schedule of interview questions is included in Appendix A. In the research interviews, the exact questions asked depended on that individual participant's responses to early questions. Emergent ideas from earlier participants' responses influenced the questions asked of later participants, particularly in terms of the different roles that junior doctors play. However, each interview explored to some degree the participant's relationships with patients, with colleagues, and with the hospital administration. At the beginning of the interview I emphasised that the project was looking at junior doctors' experiences broadly, including all the mundane

aspects, and that I was particularly interested in stories and examples from his or her experience. At the conclusion of each interview, I provided the participant with handouts outlining support services available to junior doctors. Each participant was invited to phone or email me in future if he or she thought of something further that he or she would like to contribute to the study, which several participants did. A one page overall summary of the project's findings was sent to all participants.

Analysis

All of the interviews were audio-recorded and transcribed. Rather than conducting all of the interviews before beginning transcription and analysis, analysis of early interviews proceeded concurrently with later interviews. This feature of the analysis again draws on notions from grounded theory (Liamputtong & Ezzy, 2005, pp.265-73).

I primarily focused on three aspects of each interview, looking at the data in terms of particularly the following questions.

- What does the participant identify as the main challenges associated with being a junior doctor? Are these ethical challenges?
- Are there other experiences described that seem to involve ethical issues, even if these are not identified as such by the participant?
- What stories does the participant tell?

The interview data was considered in the context of the initial typology, looking for overall consistencies or key differences with the set of ethical challenges generated by the literature review. Specific stories were collected as potential bases for the chapters analysing individual ethical challenges.

I also conducted a systematic thematic analysis of the interview data as a way of feeding the types of ethical issues that this group of junior doctors had encountered into the typology of ethical issues associated with internship and residency. The

thematic analysis comprised initial coding of transcripts, then grouping into themes. The initial typology of junior doctors' ethical challenges assembled during the literature review was used as a starting point for grouping codes into themes. The themes from the literature review were used as an aid for organising the codes into groups. Where a participant or participants described a situation that was not clearly captured by an existing theme from the literature review, a new theme was named and the issue added to the typology.

Insights from the interview data are primarily presented in chapters four, five, and six. In the next chapter, I discuss the findings of the literature review both in terms of the organisational setting in which junior doctors work and the ethical issues identifiable from existing studies of this group.

CHAPTER 3: THE JUNIOR DOCTOR'S PROFESSIONAL SITUATION - RESPONSIBLE CLINICIAN, SUBJUGATE LEARNER, HOSPITAL EMPLOYEE

In order to investigate the ethical issues associated with internship and residency, it is necessary to understand the basic structures and features of junior doctors' work context. In this chapter, I briefly describe the organisational setting in which junior doctors work, and draw on existing studies of junior doctors to put forward an initial typology of the ethical issues associated with this group. Throughout the chapter, I suggest that the junior doctor is uniquely positioned by his or her work context compared to medical students and more senior doctors. The junior doctor is simultaneously responsible health professional, subjugate learner, and hospital employee. This positioning influences both the content of the set of ethical issues associated with internship and residency, and junior doctors' options for negotiating the ethical challenges that they face.

The first section of this chapter outlines the organisational setting in which junior doctors work. I describe the process of applying for internship positions, the nature of the hospital medical team, the rotations system, and the actual tasks undertaken by junior doctors. As the participants in the empirical part of this project were from Melbourne hospitals, my focus in this section is on the Australian (particularly Victorian) context, but I refer also to both the UK and the US situations where parallels can usefully be drawn. I argue that some features of their organisational setting position junior doctors as responsible clinicians while others position them as subjugate learners or as human resources. In the second section, I propose that occupying this position creates a set of ethical issues for junior doctors that is different to the sets experienced by medical students or more senior doctors. From existing research, both within and outside ethics, I develop an initial typology of the

ethical issues associated with internship and residency. These include truth-telling, respecting patient autonomy, preventing harm, managing limited competence, dealing with colleagues' inappropriate actions, conflicts of interest, setting interpersonal boundaries with patients, and difficult working conditions. Each of the three different roles involves different issues for junior doctors, and occupying multiple roles itself creates some ethical challenges; overall, junior doctors' three-role position creates a set of ethical issues specific to this group. In the third section, I discuss the very limited amount of ethical work addressing this set of problems. Ethical issues only encountered by junior doctors, such as long hours and transience, have attracted almost no attention from moral philosophers. A great deal of moral philosophy has been written on the issues within the set that more senior doctors also face, such as truth-telling about diagnoses and respecting patient wishes at the end of life. Similarly, the issues that are also encountered by medical students are increasingly the subject of systematic philosophical attention. However, in line with the understanding of 'ought implies can' outlined in the previous chapter, I argue that the applicability of these analyses to junior doctors is limited by the group's specific professional position. The three-role position not only determines the *content* of the set of ethical issues faced by junior doctors, but also the *kinds of actions* junior doctors can take in the face of these challenges, limiting the relevance of normative work that does not recognise their particular position. In order to deal well with the range of ethical issues that junior doctors' particular professional situation generates, much thinking about how these issues ought morally to be negotiated remains to be done.

THE ORGANISATIONAL SETTING IN WHICH JUNIOR DOCTORS WORK

Getting an internship

After completing his or her medical degree, an Australian graduate wanting to practise medicine in Australia must spend a year as an intern in a hospital. (The

requirements for overseas-trained doctors to practise in Australia are different.) Internship has been the subject of much detailed sociological and anthropological work over recent decades (Marion, 1997; Miller, 1970; Mumford, 1970), being well-recognised as a crucial period in a doctor's professional development. It is seen as "the physician's most significant rite of passage", the transition from being a student to being a doctor (Coombs et al., 1986, p.79).

In the Australian state of Victoria, internship involves at least forty-eight weeks of supervised clinical experience in a hospital, including at least ten weeks in medicine, at least ten weeks in surgery, and at least eight weeks in emergency medicine (Medical Practitioners Board of Victoria, 2005, p.5). Students apply for Victorian intern positions during the final year of their undergraduate education. Intern positions, like most junior doctor jobs, are usually for twelve months duration beginning in January or February each year. The Medical Practitioners Board of Victoria grants only provisional registration to medical graduates to enable them to undertake internship, emphasising their continuing status as learners. Completion of an accredited internship satisfactorily, as certified by the Medical Director of the intern's employing hospital, is necessary for the granting of general unconditional registration (Medical Practitioners Board of Victoria, 2005, p.5). The UK's General Medical Council has an equivalent system of provisional registration for first year graduates, as do state medical boards in the US.

In Victoria (as in New South Wales and the US), applicants are allocated to internship positions via a computer matching process that aims maximally to fulfil both the candidates' and the hospitals' preferences. Matches developed in order to control competition among hospitals for good students. Before the process was centrally administered, students often had to accept or reject offers before knowing which other offers would be forthcoming (Roth, 2003). The Victorian internship match is administered by the Postgraduate Medical Council of Victoria (PMCV) on behalf of the state government Department of Health. The PMCV describes itself as "the organisation concerned with hospital medical officer training, professional

development, support and workforce issues” (Postgraduate Medical Council of Victoria, 2004, p.5).

Applicants for internships register on the PMCV’s website, including submitting a candidate priority list ranking hospitals at which they would like to work. Simultaneously, they submit applications to these various hospitals. Victorian hospitals are divided into networks, so in applying for a position candidates are essentially applying to a particular group of hospitals. Although each intern is appointed and administered by a Melbourne “parent” hospital, he or she is expected to undertake one or two rotations (of two to three months duration) to affiliated “rotating” hospitals, some of which are in regional locations (Medical Practitioners Board of Victoria, 2005, p.4). For example, an intern appointed by the Royal Melbourne Hospital could expect to be allocated a rotation at (at least one of) Ballarat, Wangaratta, and Wimmera Hospitals (The Royal Melbourne Hospital, 2006). These hospitals are located in towns 110, 235, and 300 kilometres respectively from Melbourne.

Hospitals generate a ranked list of candidates in the hospital’s order of preference, based on applicants’ academic results, referees’ reports, and performance at interview. Both candidates and hospitals are forbidden from investigating each others’ preferences, in an attempt to render all rankings independent and confidential. The PMCV describes the matching process that ensues as follows:

[t]he matching process starts by looking at the first hospital/health service on the Priority List of each candidate and making a match if the candidate appears within the quota boundary of the Preference List of that hospital/health service...After all the appointments possible have been made when considering the first priority only of each candidate, the next pass considers second priorities - and later passes lower priorities...The matching process continues until all hospital/health service quotas have been filled, or all of the candidate’s lists have been processed down to their lowest priority choice and no further appointments can be made (Postgraduate Medical Council of Victoria, 2006c).

Any unmatched candidates are provided with a list of unmatched positions for follow up. Graduates of Victorian medical schools who are also Australian citizens or permanent residents are the first to be placed in the computer match process. There are generally more internship positions available than can be filled by members of this group. The competition is thus for prestigious hospitals rather than for internships per se. The remaining positions are filled by other types of applicants such as temporary residents (i.e. fee-paying international students who studied at Victorian medical schools) and graduates of medical schools in other states.

Hospitals and candidates agree to abide by the outcome of the match on threat of exclusion from future matches. Hospitals are obliged to appoint and candidates to accept the positions as generated by the matching process (Postgraduate Medical Council of Victoria, 2006d). A graduate's provisional registration allows him or her to work only in an accredited intern post in the hospital to which he or she is allocated (Medical Practitioners Board of Victoria, 2005, p.5). These features of the Victorian match suggest that part of its function is workforce distribution, ensuring doctors are available where they are required.

The medical team

Having secured a position via the match, interns begin work in the context of hierarchically structured medical teams. Hospital patients are cared for by teams of doctors. One intern in the empirical part of this study summed up the hierarchy neatly in describing his intended career trajectory:

there's a very strongly understood kind of set of rungs on the medical ladder. You understand 'I'm an intern now, I'll be a resident next year, I'd like the year after to be in whatever training program, I'll do my exam, I'll be an advanced trainee, I'll be a consultant' (Interview 14, p.9).

A simplified version of a standard Victorian team is represented below.

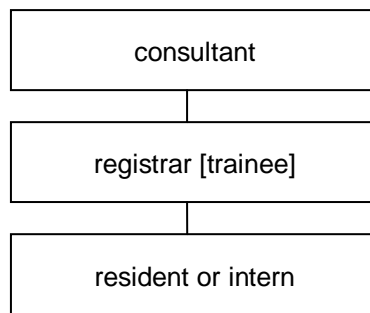


Figure 2: The standard Victorian medical team

At the top of this hierarchy is the consultant, who has ultimate clinical responsibility (although not complete legal liability) for the patient's treatment. Patients are sometimes referred to as "belonging" to a particular consultant. Consultants tend to mix public hospital work with private practice and many also hold university positions. They generally see their hospitalised patients fairly briefly, and not necessarily every day. Under the consultant is the registrar, who sees the patient at least daily. The registrar is either in the process of training for specialty exams (a junior registrar) or has recently passed these exams (a senior registrar or advanced trainee). Registrars are the day-to-day supervisors and teachers of the residents and interns.

There are of course numerous variations on the simplified structure I have described. Firstly, a fellow may be involved in the team, at a level between the consultant and the registrar. Fellows have undertaken specialty training, and are researching for a PhD in their area. A fellowship is a standard way of progressing from a senior registrar level to a consultant position, which tend to become available only rarely with many consultants spending decades in their posts. The fellow advises the registrar in the absence of the consultant. Secondly, in some contexts there may be multiple individuals at a particular level in a single team, such as both a junior and a senior registrar, multiple consultants working alternate weeks, multiple residents, multiple interns, or both an intern and a resident (although this latter situation is rare in Victorian hospitals). Where this is the case, a more complex hierarchy exists, for

example with the intern and the resident both instructed by the registrar but with the intern being expected to do the more menial of the allocated tasks. An intern or resident may also be under multiple registrars. For example, when working overnight on the wards, a resident may be supervised by one registrar dealing with inpatients and another registrar responsible for admitting new patients.

As mentioned in the introduction chapter, this thesis considers interns and residents together, despite the relatively greater clinical experience of residents. This is because the intern or resident is the most junior member of the team; it is this 'most junior doctor' role that is the focus of this study. Whether it is an intern or a resident filling that role in a particular team depends on the type of unit.

On medical and surgical wards, the intern or resident takes part in daily ward rounds with the registrar, and the entire team comes together for the consultant's ward rounds which occur about three times a week. During these rounds, the intern or resident is expected to concisely present a patient's history and clinical details to the other doctors present. The consultant questions the junior doctor about the patient's condition, and makes decisions about the patient's treatment. Sinclair, a hospital ethnographer, writes that ward rounds are the occasion on which "housemen's [interns'] work become[s] visible to consultants, who report that it was often on housemen's performance on ward rounds that they based their assessment of them" (Sinclair, 1997, p.273). As well as having an impact on their assessment, ward rounds also involve the more immediate possibility of public exposure of ignorance or incompetence and thus can be a particularly stressful time for junior doctors.

In an emergency department, doctors are still in hierarchical teams but work more independently compared to working on a medical or surgical ward. Each doctor, including interns and residents, individually sees the next waiting patient. A more senior doctor would not re-examine a patient seen by a junior doctor unless something goes wrong with the patient or the junior doctor has a major question. An exception is young children, who are generally also examined by a more senior doctor if seen by an intern or resident.

Terminology

The terminology around junior doctors is varied and, to some degree, vague. While the term ‘intern’ is used universally in Australia to refer to doctors in their first year out of university, residents are referred to as Resident Medical Officers (sometimes with a prefix of Junior or Senior, indicating years since graduation) and/or House Medical Officers (sometimes with a suffix of PGY2 or PGY3+, again indicating years since graduation; PGY stands for postgraduate year). The term House Medical Officers is sometimes taken to include interns as well as residents. In some hospitals, the term ‘junior doctors’ or ‘junior medical staff’ refers to all doctors at a level below consultant, while in other contexts the same phrases are used in a more limited way to refer only to interns and residents. ‘Doctors-in-training’ is another synonym for junior doctors. This phrase is sometimes intended to include medical students as well and also, at times, registrars. As mentioned in the introduction, throughout this thesis I will use the term ‘junior doctors’ to refer to interns and residents specifically.

Terminology also varies between countries, in relation to both junior doctors and the more senior members of the medical team. The table below indicates the main terms used in the UK and the US, and their Australian equivalents.

Australia	UK	US
intern	pre-registration house officer (PRHO) foundation year (F1) junior house officer houseman	intern
resident	senior house officer	junior resident assistant resident
registrar trainee	registrar	fellow senior resident [chief resident]
consultant	consultant	attending

Table 2: Medical team terminology in Australia, the UK, and the US.

In the US, the term ‘residency’ includes the internship year. I will use Australian terminology throughout this thesis, except when quoting directly from authors reporting on other countries.

Rotations

As well as fulfilling a set role in a hierarchical medical team, junior doctors’ professional lives are further structured, temporally and spatially, into a series of rotations. There are four or five rotations in a Victorian junior doctor’s year. In Victoria, the PMCV accredits intern positions, requiring each position to involve medical, surgical and emergency rotations. These are considered “core” rotations (or terms). The remaining rotation(s) will be in a different area of medicine or surgery, or in other areas such as anaesthesia, psychiatry, paediatrics, rehabilitation medicine,

palliative care or geriatrics. At least one rotation must be undertaken in a regional location (Postgraduate Medical Council of Victoria, 2006b).

In contrast to the necessarily general nature of internship, residency positions can be specialised to some degree. Residency positions can be medical, surgical, paediatric or mixed. Within each stream, the resident will rotate through various units. For example, a paediatric resident might undertake rotations in neurosurgery, emergency, respiratory medicine and general medicine. Medical, surgical, and mixed residency positions would generally involve at least one rotation outside the parent hospital. A resident may also be rostered as 'relieving' for up to several weeks. This means that he or she will work wherever in the hospital ill or absent peers need to be covered. Currently, no organisation accredits residency positions in Victoria, although the PMCV is trialling a framework for this purpose (Postgraduate Medical Council of Victoria, 2006a).

As an indication of the range of rotations available to junior doctors at a large teaching hospital in Melbourne, table three on the following page outlines the rotations available at the Royal Melbourne Hospital. Interns at this hospital undertake five rotations of ten to eleven weeks, and residents four rotations of thirteen weeks.

Applicants apply for internship or residency positions without knowing the exact rotations that they will be allocated. Each junior doctor submits preferences for pre-existing fixed sets of rotations, but his or her rotations are ultimately set by the employing hospital. Rostering is usually the responsibility of a manager working in medical administration.

Interns	Residents
Aged Care	Aged Care
Emergency Medicine	Anaesthetics/Emergency
General Medicine	Cardiology
General Surgery	Cardiothoracic
Infectious Diseases	Emergency
Medical Assessment Planning Unit	Ear, Nose, Throat/Ophthalmology
Stroke	Intensive Care
Vascular Surgery	Gastroenterology
Orthopaedics	Endocrinology
	Infectious Diseases/Dermatology
	Medical Oncology
	Medical Oncology/Rheumatology
	Nephrology
	Neurosurgery
	Orthopaedics
	Plastic Surgery
	Surgical Oncology
	Psychiatry
	Rehabilitation
	Relieving
	Respiratory Medicine
	Short Stay Assessment Care Unit
	Trauma
	Urology

Table 3: Rotations at the Royal Melbourne Hospital (The Royal Melbourne Hospital, 2006)

Work

On every rotation, junior doctors have significant patient care responsibilities in contrast to their time spent on wards as medical students. The specifics of a junior doctor's work vary depending on the rotation he or she is doing, particularly the nature of the unit and the time of day that he or she is on duty. An intern working on a ward is expected to have between ten and twenty-five patients at any one time (Medical Practitioners Board of Victoria, 2005, pp.12-5) and unlike the consultants ultimately managing patients' care, the junior doctors are engaging with their patients at least daily. According to the PMCV, the tasks of a intern on a core medical rotation should include taking histories, ordering and interpreting tests, communicating with referring doctors, maintaining the patients' medical records, and formulating discharge plans. Indicating the types of hands-on tasks that interns undertake, the PMCV expects interns to be competent in performing the following procedures by the end of the medical rotation: insertion of intravenous and nasogastric tubes, insertion of urinary catheters, venipuncture, and taking blood (Medical Practitioners Board of Victoria, 2005, p.14). During a core surgical rotation, an intern should also prepare patients for surgery, suture, and manage wounds.

One of the participants in the study described the junior doctor's typical day as follows:

I guess a typical day for an intern on the ward job is that you come in in the morning, check all the results from things that were done overnight, like overnight blood tests and things like that which, you know, takes you fifteen, twenty minutes. And then you do a ward round, and so you go around and see every patient with your registrar, and you make a plan for each patient for the day. So then basically the intern's job for the day is to carry out those plans, make sure everything gets done. They'd be a few patients needing x-rays or other imaging, they'd be a few patients that needed blood tests, needing new drips. There's referrals [that] need to be made to other units. There's patients going home, so they need plans sorted out for going home. And that might involve calling the GPs, making referrals to outpatient type things, liaising with the physios and speech therapists and all that type of thing. There's new patients coming in. [You] just sort them out, and you, it's sort of shared between you

and your registrar, and it's variable throughout the jobs as to who actually admits the patients, but you often do a fair bit of that too. You've got to do all your discharge summaries, which is a summary of their, what's happened in their admission. So, and then, you may or may not have an outpatient clinic to do. Some units do make the interns do that and some not, so there's those types of jobs. And there's, I guess, you know, there's a number of things that need to be done early, like referring patients to other units, for other units to come and see them and give an opinion. It's pretty rude to call them at five o'clock and say 'we need a' [laughs]. So there's, there's some things that need to be done more urgently than others and some things that will take you a really long time. And then there's also patients and families that you need to speak to. You'll get a number of pages in the day saying 'So-and-so's family wants to talk to you', and those things often take the most time. So, yeah, it's just a matter of juggling all of that (Interview 3, pp.13-4).

Hours

Junior doctors tend to work extremely long hours, anecdotally up to a hundred hours per week in Victoria (Fyfe, 2006; Buck, 2006; Nader, 2006). Participants in this study described forty to fifty hour weeks as standard. They noted that it was often the length of individual shifts rather than the total number of hours per week that most affected their performance at work.

In response to concern about the effects of long hours on patient care and on doctors' health, the Australian Medical Association (AMA) developed a national voluntary code of practice which recommended minimising shifts greater than ten hours, ensuring that breaks between shifts enabled a minimum eight hours sleep, and at least twenty-four hours free of work in a seven day period (Australian Medical Association, 1999, p.16). However, a 2001 study of junior doctors' rosters indicated that working hours remained a problem. The working hours of eighty percent of intern and resident respondents fell into the "significant risk" or "higher risk" categories constructed by the AMA to indicate extent of misalignment with the recommendations (Australian Medical Association, 2001, p.5). A similar audit of working hours conducted in 2006 found "minor improvements" over the 2001 data. The working hours of sixty-one percent of the intern and resident respondents were

classified as significant or higher risk (Australian Medical Association, 2006, p.8). The AMA's conclusion however was that the "riskiest work patterns are still commonplace" (Australian Medical Association, 2006, p.3). These studies indicate that although Australian hospitals are committed to the code's principles at a policy level, this commitment is not reflected in junior doctors' experiences.

A similar situation exists in the US, where guidelines put forward by the Accreditation Council for Graduate Medical Education (ACGME) stipulate that junior doctors work no more than eighty hours per week, with at least one day in seven off, and maximum shifts of thirty hours (Accreditation Council for Graduate Medical Education, 2004). Unlike the Australian code which is voluntary, failure to adhere to the ACGME guidelines can result in the removal of a training program's accreditation. However, at least one comprehensive recent study indicates that noncompliance with the requirements is common (Landrigan et al., 2006). In the UK, the European Working Time Directive dictates that doctors in training cannot work more than fifty-eight hours a week, further reduced to forty-eight hours a week in 2009 (Jagsi & Surender, 2004, p.2182). The extent to which this regulation is adhered to is unclear at this stage. It has however been suggested that implementation of the regulation has not solved the problem of junior doctor fatigue, with the new restrictions resulting in junior doctors working poorly designed rosters (Royal College of Physicians, 2006).

The multiple-role position: responsible clinician, subjugate learner, employee

In her classic ethnography of internship at two contrasting hospitals, Mumford observes that interns are required to play two roles simultaneously, namely competent physician and learner. She writes that

[t]he intern may have to act as the technically competent authority for a patient who is the age of his father, but at the same time he must learn a technique and learn competence through work with the patient (Mumford, 1970, p.119).

I suggest that the above description of the organisational setting in which junior doctors work supports and extends Mumford's contention about multiple roles. It indicates that members of this group are positioned simultaneously in three roles by their professional context: as well as being responsible clinicians and subjugate learners, they are also positioned as employees. Junior doctors' responsibility for clinical tasks with a real impact on patients' care and well-being positions them as responsible clinicians. Yet other features of their working context – provisional registration, accreditation of internship positions, core internship rotations, ward rounds with their superiors – emphasise that they remain students, with a body of knowledge still to be learnt. Their location at the bottom of the overtly hierarchical medical team reinforces their situation as subjugate learners. Further aspects of their organisational setting position junior doctors as employees or human resources. The obligations involved in the job match, the lack of control over their rotations, and the long hours they are required to work position junior doctors as a resource to be distributed for the maximal benefit of the hospital network and ultimately the patient community. Thus junior doctors are positioned in three roles simultaneously by their working context: responsible clinicians, subjugate learners, and employees. In the second section of this chapter, I argue that this multiple-role position generates a unique set of ethical issues, one that is different to those faced by either medical students or by more senior doctors.

JUNIOR DOCTORS' SPECIFIC SET OF ETHICAL ISSUES

In their influential article 'Ethics in a short white coat: the ethical dilemmas that medical students confront', Christakis and Feudtner argue that medical students face a specific set of ethical challenges because of their position in the medical team, and that ethics education ought to focus more attention on these challenges (Christakis & Feudtner, 1993). The discussion in the previous section suggests that the same insight may be applicable to junior doctors. They too have a particular position in the medical world. Ethics work building on 'Ethics in a short white coat' tends to include junior doctors with medical students (for example Kushner & Thomasma, 2001;

Hundert et al., 1996). In this section, in contrast, I argue that existing research indicates that junior doctors encounter a set of ethical issues that is specific to their professional stage and generated by the multiple-role position they occupy.

I begin with the work of Rosenbaum and colleagues which provides a useful starting point for a typology of the ethical issues faced by junior doctors. Rosenbaum and colleagues suggest that this group faces five categories of ethical issue: truth-telling, respecting patients' wishes, preventing harm to patients, managing their own limited competence, and addressing the inappropriate actions of others (Rosenbaum et al., 2004). Empirical evidence from other studies (across multiple disciplines, locations, and methods) supports Rosenbaum's contention that junior doctors face these types of issues, as well as highlighting additional challenges faced by this group. I use this research to modify and extend Rosenbaum's categories to build an initial typology of the ethical issues associated with internship and residency.

In looking to existing research for answers to the question of junior doctors' ethical issues, I am seeking to identify not only issues that junior doctors *perceive* as ethically challenging but ethical issues on the broad understanding developed in chapter one. Recall the definition of an ethical issue put forward in that chapter: an issue is an ethical one if it involves persons' rights, duties, and obligations and/or consequences that are beneficial or harmful to people and/or the development and exercise of virtues. Based on particularly the second part of this definition, any aspect of junior doctors' professional situation that creates suffering for patients or for junior doctors themselves can be regarded as an ethical issue.

It is worth noting that the work discussed in the remainder of this chapter is based variously on the experiences of junior doctors in the UK, US, Ireland, Switzerland, France, Denmark, and the Netherlands. Database searches using Web of Science and Medline did not reveal any research that explicitly investigated Australian interns' and residents' ethical issues. Kuflik however, writing in the *Australian Journal of Professional and Applied Ethics*, has argued that the traditionally long hours worked by junior doctors are unethical (Kuflik, 2001). The majority of work on Australian

junior doctors focuses on their mental well-being (Heredia et al., 2009; Markwell & Wainer, 2009; Willcock et al., 2004; Bruce et al., 2003; Grace, 2002), specific competencies (Barton et al., 2003; Gaughwin et al., 2000; Rolfe & Pearson, 1994), career choice determinants (Dunbabin et al., 2006; Hume & Wilhelm, 1994; Piterman & Silagy, 1991), and learning opportunities (Dent et al., 2006; Lack & Cartmill, 2005). A recent survey conducted by Dent and colleagues on aspects of junior doctors' learning implicitly highlights as pertinent in the Australian context several of the ethical challenges discussed in this chapter: specifically, coping with feeling inadequately prepared for their responsibilities and negotiating a lack of supervision by superiors. Only a minority of respondents felt prepared for clinical emergencies or performing procedures, and approximately four fifths wanted more formal instruction from their registrars and consultants (Dent et al., 2006). Smith's study of the difficulties facing junior doctors in rural areas highlights similar issues (Smith, 2005). The lack of existing research on Australian junior doctors' ethical challenges means that the empirical data collected as part of this study contributes to addressing a significant gap in research in the Australian context, as well as facilitating philosophical analysis.

Rosenbaum's categorisation

Rosenbaum and colleagues argue that junior doctors face five types of ethical issue. Their study is unlike the majority of research involving junior doctors, in ways that make it a very useful starting point for generating an understanding of the ethical issues associated with internship and residency. Firstly, the researchers explicitly investigated *ethical conflicts* experienced by junior doctors, rather than their perceptions of their overall experience of internship or residency. Secondly, these researchers looked broadly for ethical challenges faced by junior doctors, rather than focusing on a specific ethical issue of interest and investigating its prevalence. Thirdly, the investigation involved a qualitative methodology (rather than the more popular questionnaire approach), enabling the collection of rich data on the topic. The open nature of the questions used enabled the participating doctors to discuss the

experiences that they perceived to be relevant and important. On the basis of in-depth interviews with thirty-one junior doctors from four US hospitals, these authors put forward five categories of ethical conflict faced by junior doctors, each with various specific examples, summarised in the following table.

Type of ethical issue	Examples
Telling the truth	To patients about diagnoses and prognoses To patients about lack of experience To patients about risks and benefits of a procedure
Respecting patients' wishes	About treatment at the end of life
Preventing harm	Dealing with harm to patients intrinsic to their treatment Harming patients through involving them in the educational process
Managing the limits of one's competence	Coping with feeling inadequately prepared for one's responsibilities
Addressing the performance of others that is perceived to be inappropriate	Dealing with peers' mistakes/incompetence Subjugating own opinions/values to superiors' demands

Table 4: Rosenbaum and colleagues' categorisation of the ethical challenges faced by junior doctors (Rosenbaum et al., 2004)

The existence of several of the ethical issues that Rosenbaum and colleagues identify is well-supported by others' work. Koh's study with Korean residents, for example, indicates that truth-telling about diagnoses and prognoses is an ethical issue faced by junior doctors. Only five percent of respondents in his study saw themselves as "routinely truthful with their patients about serious medical problems" (Koh, 2001, p.298). Similarly, various studies highlight respecting patients' wishes at the end of life as an ethical issue for junior doctors (Gorman et al., 2005; Koh, 2001; Muller, 1992). The issue of managing the limits of one's competence is also regularly invoked in studies of junior doctors' perceptions of their early professional experience. These consistently report the group's dissatisfaction with the expectation that they perform tasks that they perceive to be beyond their clinical competence (Finucane & O'Dowd, 2005; Luthy et al., 2004; Goldacre et al., 2003; Lambert et al., 2000). With respect to addressing others' inappropriate performance, a study documenting the extent of unethical conduct observed by interns in a range of US

hospitals indicates that this is clearly an issue, with over ninety percent of respondents claiming to have observed at least one of the types of unethical conduct put forward in the survey (Baldwin et al., 1998, p.1196).

In developing an understanding of the ethical issues associated with internship and residency, it is important to keep in mind that the interview questions used in Rosenbaum's study mean that only those experiences perceived as problematic by junior doctors were captured in the categorisation. Participants were asked "[h]ave you ever done something, or failed to do something, involving a patient or colleague that made you uncomfortable?" and further questioned "about specific experiences that the resident felt were improper, wrong, unethical, or unprofessional" (Rosenbaum et al., 2004, p.403). Questioning participants in this way means that the five issues that emerge are limited firstly, to experiences involving patients and colleagues and secondly, to experiences which participants themselves found troubling. Challenges involving junior doctors' interactions with hospital administration are not captured. Similarly, if the ethical considerations in a situation were not perceived by the junior doctor, the situation will not be recounted to the interviewer. Rosenbaum and colleagues' five categories thus provide a useful but limited basis for a typology of the ethical issues faced by junior doctors.

Extending Rosenbaum's categorisation: issues from other literature

A second US study captured ethical issues faced by junior doctors beyond those that the participants themselves saw as problematic, and thus can be used to extend the schema put forward by Rosenbaum and colleagues. Green and colleagues administered a questionnaire to a random sample of American junior doctors, asking about ethical decision-making in areas addressed by the American College of Physicians ethics manual (Green et al., 1996). The types of ethical issue investigated were thus dictated by the content of the published guidelines rather than by junior doctors' feelings of discomfort or ethical unease. In fact, one particularly interesting finding that emerged from Green's study was that a large proportion of junior doctors

who reported acting contrary to the ethics guidelines did not perceive the relevant situation as involving an ethical difficulty. (In the context of my project, it is important to note that, unlike Rosenbaum's study which included only doctors in their first, second or third postgraduate year, thirty-six percent of the respondents in Green's study were in their fourth or later postgraduate year. It is also worth highlighting that the response rate in Green's study was only forty percent.)

As well as providing further empirical evidence for the pertinence of some of the issues identified by Rosenbaum and colleagues (such as truth-telling about inexperience), Green's study points to various additional ethical challenges faced by junior doctors. **Maintaining confidentiality** is one such challenge. Forty-five percent of the respondents indicated that they had released information about a competent patient to the patient's friends or relatives without the patient's permission, and forty percent reported discussing patients' problems in public places. A third had looked at the medical chart of a hospitalised friend or colleague. Clark's ethnographic work supports the contention that maintaining confidentiality is an ethical issue for junior doctors. He reports junior doctors' inadvertent confidentiality breaches on ward rounds where information was regularly presented in the presence of other patients and their relatives (Clark, 2001, pp.422-3). **Seeking informed consent** is another ethical challenge highlighted by Green's study. Expanding Rosenbaum's finding on the challenge of telling patients the truth about the risks and benefits of a procedure, Green and colleagues found that twenty-nine percent of participants reported having intentionally manipulated a patient to accept or reject a procedure or test.

Their findings also indicated that some junior doctors lie to consultants. Thirty-seven percent of participants reported lying to a consultant about something they had neglected to do. This suggests an additional facet to the truth-telling category put forward by Rosenbaum and colleagues which discussed the issue only in relation to patients. **Lying to consultants** is a phenomenon also described by Sinclair. On the basis of his ethnographic observations of interns in a UK hospital, Sinclair argues that the high stakes associated with interns' answers to consultants' questions on ward

rounds – the necessity of demonstrating their own professionalism to the consultant, their coaching by registrars, the import of the answers to clinical decision-making – means that they are tempted “to ‘bullshit’ and answer confidently as if they know the answer to questions, sometimes even making them up” (Sinclair, 1997, p.279). Sinclair also reports junior doctors **lying to the technicians who carry out tests**; when technicians question the necessity of a test for a particular patient, the junior doctor may lie about the patient’s condition in order to get the tests that the consultant has ordered (Sinclair, 1997, pp.281-2). Sinclair’s claim about junior doctors lying to consultants is supported by a finding from a later study, also led by Green, in which fourteen percent of residents surveyed indicated that they were likely to fabricate a laboratory value to a consultant to avoid being humiliated; women were found to be particularly likely to act in this way (Green et al., 2000). Other ethical challenges that Green’s study highlights are junior doctors’ **involvement with drug companies**, and their **treatment of friends and family** (see also Aboff et al., 2002; Steinman et al., 2001). These are framed as involving conflicts of interest. Publication of a recent review of curricula on relationships between junior doctors and the pharmaceutical industry (Montague et al., 2008) indicates the increasing awareness amongst clinicians and educators that drug company involvement in hospitals can pose an ethical challenge for junior doctors, as well as for medical students (Rogers et al., 2004) and for more senior staff.

An article by Shreves and Moss highlights another ethical issue faced by interns and residents: **involvement in treatment that they perceive as futile**. This study involved surveying junior doctors about ethical disagreements with consultants, experienced during the previous year (Shreves & Moss, 1996). For eighty-four percent of the junior doctors surveyed, “their most troubling ethical disagreement” involved treatment ordered by the consultant that the junior doctor considered to be futile. I have designated this a different challenge to “subjugating own opinions and values to superiors’ demands”. This is because in some cases around futile treatment, junior doctors do not in fact subjugate their own opinions and values. Shreves and Moss report that thirty-four percent of their participants “had discussed their most

troubling disagreement with the attending physician [consultant]”. Similarly, some participants in my study expressed their views about a treatment’s futility to registrars and consultants and advocated for a different course of treatment. When junior doctors were not successful in changing the course of the patient’s care, as was inevitably the case in the experience of participants in my study, some junior doctors came up with creative ways of avoiding involvement in an attempt to preserve their own integrity. Thus, involvement in futile treatment need not involve subjugation of the junior doctor’s opinions, and therefore potentially constitutes a different sort of ethical challenge.

A further issue that has been highlighted as an ethical challenge associated with being a junior doctor is dealing with the **transience** created by the constant rotations. Christakis and Feudtner argue that this transience necessarily affects the nature of junior doctors’ relationships with patients and with their fellow hospital workers (Christakis & Feudtner, 1997). They argue that junior doctors’ constant movement through different units results in the delivery of care that reflects neither the patient’s nor even the junior doctor’s deeply held values. Instead action is dictated by a set of “medi-centric” values focused on efficiency, safety, and habit. They also suggest that the system encourages the avoidance of intimate or committed doctor-patient interactions, and contributes to the erosion of junior doctors’ empathy. In terms of colleague relationships, Christakis and Feudtner suggest that transient placements result in workers merely fulfilling role expectations, and unreflectively deferring to authority. They also mention the effects on junior doctors’ personal lives, referring to the “social isolation” that the rotation system creates. Dimsdale’s qualitative work with interns supports this contention. Participants in his study “complained of limited friendships and social ties” resulting from their geographical transience (Dimsdale, 1986, p.109). Similarly, Mumford notes the negative impact of transience on interns’ ability to form ongoing supportive friendships with their peers (Mumford, 1970, p.81).

A **lack of supervision and positive role modelling** by consultants has also been put forward as an ethical issue faced by some junior doctors. On the basis of six months observation of doctors in a neonatal intensive care unit, Clark claims that there is “a lack of supervision of the clinical training of interns and residents by attending physicians [consultants]” (Clark, 2001, p.422). This is supported by interns’ sentiments in a study conducted by Marion, one of whom writes “I’m frightened, I’m not getting enough supervision, and I don’t know what to look for. Something bad is bound to happen in a situation like this” (Marion, 1997, p.190). Both Clark and Marion focus on American hospitals, but the situation is similar in Australia with a recent Australian study claiming that “the clinical supervision provided to postgraduate doctors is inadequate” (Hore et al., 2009, p.220). Clark argues that the lack of supervision and positive role modelling results in a range of negative consequences for patients including systematic errors, junior doctors’ inability to deal compassionately with patients’ family members, and the provision of futile treatment. In light of the contention that medical students’ and junior doctors’ behaviour in the hospital context is primarily determined by observation of their superiors (rather than, for example, via formal instruction) (Hafferty & Franks, 1994; Konner, 1987, p.362; Mumford, 1970, pp.156-7), the deficit that Clark highlights becomes all the more ethically significant. It is not only their current patients who will suffer, but also future patients of those junior doctors developing in the absence of positive role models. Although lack of supervision and positive role modelling is not a universal feature of junior doctors’ experience (see for example Goldacre et al., 2003, p.804; Bosk, 2003, pp.41-2), the fact that it is part of some interns’ and residents’ working lives justifies its inclusion in the initial typology of the ethical issues associated with internship and residency.

Several other ethical challenges are highlighted by research that is not explicitly framed as bioethical. For example, there is a large literature specifically addressing the fatigue suffered by junior doctors as a result of their **long working hours**. Numerous psychological and sociological studies indicate that junior doctors experience significant sleep deprivation and, although there is not a universal

consensus that professional performance is compromised, much research documents the negative effects of this extreme tiredness on junior doctors' skills (for reviews see Philibert, 2005; Samkoff & Jacques, 1991). The negative impact of fatigue on junior doctors' attitude towards patients is also well-documented. For example Marion, who has conducted studies involving interns keeping audiotape diaries of their experiences and reflections over the course of their internships and is himself a doctor, writes that

[h]umanism and idealism are good and important traits in young doctors, attributes we should recognise and build upon during their training. But instead of building on them...the process of turning a student into a doctor – the unmercifully long hours, the unforgiving hard work and desperate situations, the misery and depression and death – actually contributes to their destruction. We ultimately come to view the patients we once wanted to help as the enemy; we come to recognise their cries for help as attempts to prevent us from getting to sleep (Marion, 1997, pp.106-7).

His observation of this movement from an altruistic motivation to a self-protection mentality is repeated by various other researchers (Cassell, 2005, pp.41-2; Biaggi et al., 2003; Bissonette et al., 1995; Cousins, 1986; Small, 1986). Alongside the effects of fatigue on patient care, the demanding working hours also impact on junior doctors' personal lives. The extreme fatigue involved in the early postgraduate years and the toll it takes on a junior doctor's personal life and outlook are a consistent theme in doctors' narratives (Marion, 1997; Anonymous, 1986; Shem, 1985; Miller, 1970, pp.186-8). In a number of recent studies documenting junior doctors' perceptions of their overall experience of internship or residency, participants report as unsatisfactory the long hours and associated sacrifices in personal life (Buddeberg-Fischer et al., 2006; Luthy et al., 2004; Goldacre et al., 2003; Lambert et al., 2000; Daugherty et al., 1998). It has also been suggested that fatigue has a negative impact on junior doctors' interactions with other hospital workers (Marion, 1997, pp.74-85).

The vast majority of researchers investigating junior doctors' long hours do not frame their topic in moral terms. However, keeping in mind the broad conception of ethical issues outlined earlier, their work indicates that junior doctors' long working hours constitute an ethical issue. The research described highlights junior doctors' hours as

an issue that clearly involves harmful consequences. The studies document that both patients and junior doctors themselves suffer significantly as a result of the long working hours. This suggests that long hours ought to be included in a conception of the ethical issues associated with internship and residency. Several authors do recognise the ethical implications of junior doctors' long working hours, emphasising the impact of fatigue on doctors' skills and compassionate outlook as well as the potential harms to doctors themselves (Higginson, 2009; Lopez & Katz, 2009; Wiesing, 2007; Kuflik, 2001; Green, 1995).

A further issue highlighted by research outside bioethics is a perceived **lack of support from hospital management** for interns and residents. Junior doctors' perception that they are unsupported by hospital administration is a recurring finding in studies of this group (Finucane & O'Dowd, 2005; Goldacre et al., 2003; Lambert et al., 2000; Daugherty et al., 1998). For example, in a comprehensive study of UK interns, only eight percent of respondents agreed with the statement "I receive good support from hospital management in my current post" (Lambert et al., 2000, p.350). A more recent survey confirmed this sentiment, with respondents contributing comments about hospital management that were "almost universally unfavourable" (Goldacre et al., 2003, p.807). Postulated as contributors to this perceived lack of support are junior doctors' dissatisfaction with arrangements for covering colleagues who are sick or on leave, together with the demanding hours that they are required to work (Lambert et al., 2000, p.353). Studies suggest that problems covering absent doctors result in junior doctors **feeling obliged to work when unwell** (Marion, 1997; Goldacre et al., 1997, p.58; Rosemark, 1986, p.226). This situation has potentially important consequences for the quality of patients' care as well as for junior doctors' own well-being.

Ethnographies and doctors' narratives vividly record **mistakes** made by junior doctors (Bosk, 2003, p.40; Clark, 2001, p.420; Marion, 1997, p.42; Shem, 1985). This phenomenon constitutes another ethical issue faced by junior doctors. Numerous studies have attempted to document the prevalence of junior doctors' errors (Haller et

al., 2009; Mycyk et al., 2005; Borenstein et al., 2004; Larson et al., 2004; Carroll et al., 2003), the ways in which these errors are handled (Schenkel et al., 2003; Hobgood et al., 2000), and possible causes and remedies (Coombes et al., 2008; Jagsi et al., 2005; Mycyk et al., 2005; Volpp & Grande, 2003). This body of research suggests that making mistakes is a significant and ongoing feature of internship and residency. The dire consequences for patients of this aspect of junior doctors' early professional lives are obvious. Less regularly invoked is the suffering that this phenomenon causes junior doctors themselves. A recent American study indicates that residents experience intense emotional responses to errors, usually a combination of distress, guilt/self-doubt, and frustration/anger (Engel et al., 2006). These effects, along with the consequences for patients, justify including errors in the set of ethical issues faced by junior doctors. Further, making an error necessitates a decision about what to do next: ought one to reveal the mistake and, if so, how? Responding to an error is very clearly an ethical issue.

An initial typology

Taking Rosenbaum's categorisation as a basis then drawing on the other research described, both within and outside bioethics, an initial typology of the ethical issues associated with internship and residency can be generated. This is represented in the following table.

Type of ethical issue	Specific ethical challenges
Telling the truth	To patients and relatives about diagnoses and prognoses To patients about lack of experience To consultants about tasks performed To colleagues about a patient's condition when seeking tests
Respecting patients' autonomy	Respecting patients' wishes about treatment, including at the end of life Maintaining confidentiality Seeking informed consent
Preventing harm	Dealing with potential harm to patients associated with their treatment Avoiding harm to patients associated with involving them in the educational process
Managing the limits of one's competence	Coping with feeling inadequately prepared for one's responsibilities Negotiating lack of supervision/ role modelling by superiors Making mistakes
Addressing the behaviour of others that is perceived to be inappropriate	Dealing with peers' mistakes/incompetence Subjugating own opinions/values to superiors' demands Involvement in treatment perceived as futile Observing the unethical behaviour of others
Conflicts of interest	Treating family, friends, and self Offers of gifts or hospitality from drug companies
Impact of working conditions	Dealing with transience Working long hours Feeling unsupported by hospital administration Working when unwell Lack of cover for absent colleagues

Table 5: Initial typology of the ethical challenges associated with internship and residency

Not all of the ethical challenges described are unique to junior doctors. For example, issues around telling the truth to patients about diagnoses and prognoses, and maintaining confidentiality are faced by doctors at all professional stages. There are also significant commonalities with the set of ethical challenges faced by medical students. Issues like honesty about their inexperience, harming patients through involving them in medical education, and subjugating their own values to their superiors are relevant to both groups. However, the *set* of ethical challenges described in this section is specific to junior doctors. Because interns and residents are both subjugate learners (like medical students) and responsible clinicians (like more senior doctors), they encounter a combination of the challenges of the medical student and the more senior doctor, as well as additional difficulties generated by their role as junior employee (such as long hours and dealing with transience).

Some of the ethical challenges that junior doctors face result from tensions between their multiple roles. Hoop has argued, in the context of psychiatric residents specifically, that ethical challenges arise for this group as a result of the conflicting duties associated with being a physician, a learner, a supervisee, and an employee (Hoop, 2004). He cites examples such as “a resident performing a lumbar puncture for the first time, knowing that he is likely to cause the patient unnecessary discomfort and that more skillful hands are readily available”; this is presented as a conflict between the physician’s duty to consider patients as ends in themselves and the learner’s duty to become adequately trained for the benefit of future patients (Hoop, 2004, p.184). Hoop’s insight about conflicting demands is a compelling one, although the issues need not, to my mind, be formulated as conflicts between duties specifically. Further, Hoop’s insight applies to junior doctors beyond just the psychiatric context. Many of the ethical challenges identified are faced by junior doctors because of their position playing multiple roles simultaneously. The challenge of dealing with difficult working conditions, for example, is generated by the conflicting demands of being an employee (expected to contribute long hours and work transiently wherever required) and a clinician delivering optimal patient care. Negotiating a lack of supervision and making mistakes could similarly be seen as

problems created by junior doctors' multiple roles. These challenges result from junior doctors being both responsible clinicians and subjugate learners.

I propose that the notion of junior doctors playing multiple roles deserves far greater prominence in ethical thinking than it currently receives. Junior doctors' multiple-role position produces a set of ethical challenges that are specific to this group, different to the set faced by more experienced doctors or by medical students. In the next section I will argue that the multiple-role position also determines junior doctors' possibilities for action in the face of these challenges and thus ought to play a prominent role in ethical analysis of these issues.

LIMITED EXISTING NORMATIVE WORK

Junior doctors' issues, situation, and experiences have not attracted significant attention from moral philosophers. Few philosophers draw on ethical theory to systematically assess junior doctors' options for action in relation to the issues outlined. Work focusing on junior doctors that is explicitly framed as medical ethics (that is studies appearing in medical ethics journals or explicitly invoking medical ethics concepts) tends to be limited to analysis of appropriate ethics training for doctors in their early postgraduate years and to studies describing the prevalence of particular types of ethical challenge. The descriptive studies on ethical challenges faced by junior doctors usually investigate the current situation empirically (usually in relation to a single ethical issue) without theorising about what ought morally to be done in the circumstances of interest (see for example Gorman et al., 2005; Aboff et al., 2002; Green et al., 2000; Shreves & Moss, 1996; Muller, 1992). In terms of the former type of literature, there is some discussion of the prevalence, content, delivery, and reception of ethics teaching to junior doctors. Broadly, the consensus suggested by this body of writing is that varied experience-based ethics education is necessary at junior doctors' professional stage, but that such education tends to be hindered by attitudinal and logistical barriers in the clinical setting (Gacki-Smith & Gordon, 2005;

Fins & Nilson, 2000; Sulmasy & Marx, 1997; Downing et al., 1997; Strong et al., 1992; Forrow et al., 1991).

Some writers put forward concrete action guidance for junior doctors facing ethical issues, but do not present systematic philosophical arguments that work through the ethical implications of the various options. For example, the work of Green and colleagues on residents' use of deception with one another (which primarily reports the findings of a survey) presents particular kinds of deception as universally wrong (Green et al., 2000). Here the researchers implicitly indicate how junior doctors ought morally to act in the face of a particular ethical challenge, but not via a process of systematic consideration of the ethical implications of the various possible actions. Sokol and Bergson's writing on junior doctors respecting patient autonomy and managing their limited clinical competence are further examples of this type of ethical discussion (Sokol & Bergson, 2005, pp.209-14).

A small number of studies take a more systematic normative approach, attempting to articulate options and to determine via philosophical argument ethical ways to deal with the challenges they discuss. Wiesing's article 'Ethical aspects of limiting residents' work hours', published in the journal *Bioethics*, is one example. He explicitly articulates a normative framework, in this case a version of principlism, and then analyses the implications of both existing long hours and a reduced alternative. He argues that "an institution that allows an avoidable increase in the risk of harm to its patients acts against a constitutive moral principle of the medical profession" (Wiesing, 2007, p.404). The issue of conflicts between a junior doctor's values and those of the consultant has also been discussed in this systematic normative way by a number of writers. Although he draws more on conflict resolution literature than on ethical theory to articulate appropriate actions, Levi nonetheless offers an argument that these conflict situations ought to be dealt with in a particular way, advocating openness and dialogue within the context of maintaining one's own integrity (Levi, 2002). Beckerman and colleagues include a normative aspect in their discussion of these conflicts, arguing that senior doctors ought to "[e]xtend...the principle of "do no

harm” beyond patients to include medical staff”, particularly the junior doctors in their team, on the basis that “there is a significant relationship between care of the staff and care of patients” (Beckerman et al., 1997, pp.37-8). Morris offers a third normative perspective on this issue, characterising it as an intractable ethical dilemma. He describes the problem as “whether the junior doctor should perform an action that the consultant thinks is appropriate, but which the junior doctor thinks is not in the patient’s best interests” (Morris, 1992, p.153). He suggests that the junior doctor is obliged both to serve the best interests of the patients and to respect the superior skill and experience of his or her teachers, creating an impasse for doctors in this situation. In each of these instances, the authors attempt systematically to articulate how agents ought to act in the face of conflicts between junior and senior doctors. There is however no clear consensus on a framework for analysis or on concrete principles for ethical action for agents in these situations.

The most fully developed example of normative analysis of junior doctors’ ethical challenges is Kushner and Thomasma’s edited book *Ward ethics: dilemmas for medical students and doctors in training* (Kushner & Thomasma, 2001). Kushner and Thomasma aim to address the “key ethical dilemmas that student doctors face as they enter the clinical wards” (Kushner & Thomasma, 2001, p.1). They do this by collecting stories from (current and former) medical students and junior doctors, then choosing representative stories from those collected. These representative stories are then grouped into issue-based categories (such as omissions, hierarchy, and blaming the patient). Writers with varying disciplinary backgrounds then respond to the group of stories with an ethical analysis. Via this process, the editors hope to offer readers “a range of reasonable and defensible options with which to inform their own thinking and conduct” (Kushner & Thomasma, 2001, p.3). The focus is not on junior doctors exclusively, but rather on both medical students and junior doctors grouped together.

Looking exclusively at the stories in *Ward ethics* told by junior doctors, these broadly support the typology of ethical challenges put forward in the previous section. However, within the categories articulated, the *Ward ethics* stories point to some

specific challenges not previously included. Numerous additional challenges arise in relation to the issue of addressing the behaviour of others that is perceived to be inappropriate. The majority of junior doctors' stories in the book could be interpreted as versions of this ethical issue. The new examples include demeaning humour about patients, handling superiors whose performance is compromised (for example by substance abuse), superiors passing risk down the hierarchy, and dealing with abuse. The stories also identify a whole new type of ethical issue: setting interpersonal boundaries with patients. Specific challenges in this category include dealing with sexual advances, treating disliked patients, and controlling compassion.

What can we learn from the *Ward ethics* commentaries about how junior doctors ought to deal with the ethical issues that they face? Commentators on the stories put forward a variety of types of ethical analysis. Some offer fairly general abstracted discussion of a key issue or concept raised by the story (for example Mino, 2001; Weisstub, 2001). Others however draw on ethical theory to put forward systematic arguments about the appropriate action(s) for agents facing these issues. A variety of ethical theories are invoked, including consequentialism (Iserson, 2001; Harris, 2001a) and virtue theory (Kane, 2001; Weijer, 2001).

For the majority of the ethical challenges discussed, there is a lack of consensus among the commentators about how agents ought to deal with the difficulty. Managing the limits of one's competence, for example, is one issue on which commentators' normative prescriptions differ. The suggested strategies for dealing with this challenge vary from students standing firm against institutional coercion to treat beyond their capabilities (Andereck, 2001), to acting strictly in the patient's best interests (Larkin, 2001), to reforming ethics education (Huijer, 2001a), to organisational culture change (Holm, 2001a). A similar situation applies with respect to the issue of addressing others' inappropriate behaviour. A wide variety of (potentially compatible) actions are variously suggested as the appropriate way to deal with instances of this type of challenge; junior doctors ought to be speaking out (Harris, 2001a), institutional structures ought to be changed (Rhodes, 2001b), medical

team hierarchies ought to be less linear (Holm, 2001a), junior doctors ought to “work the hierarchy” (Chambers, 2001). One issue on which there is greater consensus about appropriate action is setting interpersonal boundaries with patients. Normative advice around this challenge consistently requires professionalism, empathy, and respect for patients, reflected in dignified treatment, human connection, and the avoidance of sexual contact (Huijjer, 2001b; Martinez, 2001; Rhodes, 2001a).

One reason for the lack of consensus may relate to a crucial point of difference within this group of analyses: some take into account the organisational position from which junior doctors act, while others set aside these contextual considerations in their suggestions about ethical action. Some commentators do not engage with junior doctors’ specific position in the medical world, generating action guidance that abstracts the challenge from junior doctors’ particular social context. For example, Nelson and Hoffman argue that in a case of inexperience and informed consent, the junior doctor “should have discussed the subject with Dr M [the consultant] prior to her [Dr M’s] conversation with the patient” (Nelson & Hofmann, 2001, p.21). This suggestion overlooks the real limitations on junior doctors’ interactions with their superiors. Initiating a discussion with a consultant can be hampered by constraints of distance, time, and the consultant’s attitude. The possibility that their position in the hierarchy might present obstacles to junior doctors acting ethically is also rarely acknowledged. For example, Harris’ suggestion that “[s]enior doctors should certainly be challenged [as]...each doctor must answer first to his conscience and only second to his medical superiors” (Harris, 2001a, p.196) seems short-sighted on this front. Other commentators acknowledge junior doctors’ specific situation but do not take it as potentially constraining junior doctors’ actions. Larkin, for example, in the context of the issue of managing the limits of one’s competence, writes that because patients ought to be seen as ends in themselves “issues of pride, embarrassment, and peer pressure are tertiary [for junior doctors]; their subjugation presents little, if any, moral challenge” (Larkin, 2001, p.39).

In contrast, some commentators take the junior doctor's social setting as fundamental to their normative analysis of the stories presented. Holm's commentary on conflicts between junior doctors' views and those of their superiors clearly articulates this approach. He writes

[f]or all seven cases in this chapter there are two easy solutions that immediately spring to mind: 1. The insensible and unethical superior should mend his or her ways. 2. The junior doctor should be courageous and do what is right, whatever the personal consequences. Both these solutions are obvious and attractive from the point of view of ethical theory, but at the same time problematic as practical solutions to the problems...One of the things the simplistic analysis above leaves out, is that all these cases occur in a very complex social setting, i.e., the modern hospital (Holm, 2001a, p.186).

Holm goes on to look at the issue in the context of the hospital's organisation, discussing how the structure of the medical team prevents junior doctors accessing additional senior points of view, and acknowledging that "[t]he position of junior doctors is complicated by the fact that most of them are in training" (Holm, 2001a, 190). Another writer who acknowledges junior doctors' particular social position is Burack. Writing on the issue of observing the unethical behaviour of others, his ethical advice varies depending on the hierarchical relationship between the observer and the wrongdoer. He argues that concerns such as "self-preservation, professional self-advancement, social acceptance, and reticence" have a legitimate place in junior doctors' deliberations, writing that "it is a counterproductive moralism which claims that concerns about harming oneself or one's teammates have no place in deliberating about one's response" (Burack, 2001, p.90). Awareness of the normative implications of junior doctors' particular situation is also clear, although less explicitly so, in the commentaries of Kane and Schneiderman (Kane, 2001; Schneiderman, 2001).

I argue that normative analysis of junior doctors' ethical issues needs to take their particular social position into account as it has significant implications for the action-options available to these agents. Their professional situation both limits the actual range of options available and determines the personal costs associated with the

various available options. Being a junior doctor places genuine limitations on the possible actions an agent can perform. Institutional protocols prevent junior doctors acting in some ways: they cannot order certain tests and procedures nor choose not to work in particular units. Their lowly position in the team further constrains their possibilities for action. Kushner and Thomasma write of the “frankly limited agency” for subordinates that the hierarchical nature of medicine creates (Kushner & Thomasma, 2001, p.127). Bosk, in his influential ethnography of surgical training, makes the point unequivocally:

in disputes over what a clinical reality is, the attending [consultant] has the last word. He has the right to construct reality as he sees fit. The subordinate is compelled for all practical purposes to accept this definition of reality, however much he may resent it, distrust it, or disagree with it (Bosk, 2003, p.85).

The organisational setting in which junior doctors necessarily work thus limits their possibilities for action in very real ways. The features described in the first section of this chapter – the hierarchical medical team, the rotations system, the job-seeking process – have implications for how junior doctors are able to respond to the ethical challenges that they face. They also determine some of the specific costs to junior doctors associated with available action options, in terms of creating disharmony within the team, offending assessors, or alienating peers. Therefore, for two reasons, junior doctors’ specific social position must be acknowledged by philosophers working on these issues in order for their ethical analyses to be useful and defensible. The first is the principle of “ought implies can” discussed in the previous chapter. The second is that costs to the agent are a legitimate ethical consideration for an agent puzzling through an ethical difficulty. For a junior doctor, these costs are often significantly determined by his or her subordinate status as an intern or resident.

Accepting this claim that normative analysis needs to take junior doctors’ unique position of agency into account implies that a great deal of normative analysis of junior doctors’ ethical issues remains to be done. Firstly, many of the ethical challenges identified in this chapter (such as dealing with transience and feeling

unsupported by hospital management) remain essentially uninvestigated from a moral philosophy perspective. Secondly, if we accept that normative analysis of junior doctors' ethical challenges needs to take their particular professional situation as fundamental, then the usefulness of various types of existing philosophical work on these issues will be limited. This will be the case with, for example, work that focuses on medical students or on issues like respecting patient autonomy in relation to doctors generally or on junior doctors specifically but without engaging with their particular position of agency. Where the discussion of what ought to be done does not engage with junior doctors' organisational setting and the multiple-role position that they occupy within it, it can only be of limited usefulness to this group.

In this chapter I have argued that junior doctors face a set of ethical challenges unique to their professional stage and that this is the result of their being positioned by their organisational context as simultaneously responsible clinicians, subjugate learners, and employees. I have also claimed that junior doctors' positioning determines the way in which these agents can deal with the ethical challenges that they face, highlighting the need for ethical analysis of these issues that takes into account junior doctors' particular professional situation. On the basis of existing research within and outside bioethics, I put forward an initial typology of the ethical challenges associated with internship and residency. In light of the interview data, additions will be made to this typology ultimately to present a fuller picture of the kinds of ethical challenges associated with internship and residency. In the next three chapters I discuss the ways in which these (and other) ethical issues arose in the experience of the group of Melbourne-based junior doctors whom I interviewed. I then undertake ethical analysis in the following chapters that aims to be sensitive to junior doctors' particular situation in the way advocated here.

CHAPTER 4: REFINING THE CONCEPT OF THE MULTIPLE-ROLE POSITION

This chapter is the first of three that focus on the results of the interview study. In this chapter, I present participants' accounts of their work as junior doctors. I use their reflections to refine the concept of the multiple-role position put forward in chapter three. The next chapter then presents various stories told by the interns and residents interviewed that describe the ethical challenges associated with their work. The third of these chapters looks at participants' concerns about character. All three chapters develop the claim that the junior doctor is an ethically unique position, compared with the medical student or more senior doctor.

This chapter is in two sections. I firstly discuss ways in which participants' views on internship and residency relate to the concept developed in chapter three, namely that junior doctors are positioned in multiple different roles by their organisational context and that this limits their possibilities for action as well as creating many of the ethical challenges that they face. I suggest a number of specific ways in which participants' comments invite development of this idea, including refinement of the three roles originally described (clinician, subjugate learner, and employee) and the emergence of additional roles such as teacher and competitor. In the second section, my focus is on the effects of the multiple-role position on junior doctors' actions. I discuss two participants' stories that indicate ways in which the multiple-role position shapes and limits the actions of junior doctors.

REFINING THE CONCEPT OF THE MULTIPLE-ROLE POSITION

Evidence and complexity

In the previous chapter, I argued that junior doctors are positioned by their organisational context in three roles simultaneously: clinician, subjugate learner, and employee. The interview data supported this idea, with participants indicating both that they were so-positioned by others and that they perceived themselves as playing each of those roles.

Participants were clearly positioned by their hospital surroundings as responsible clinicians. The following passage is typical of many participants' discussions ("covers" involves a junior doctor working alone, usually at night, covering a number of wards).

You rock up on day one, everyone expects you to know what to do...They don't know that you've just started...I remember one of the first covers I did, one of the nursing staff goes... 'just to let you know, so-and-so is febrile and so-and-so has gone into AF and so-and-so is also febrile.' I'm like going 'OK, what do I do?' [laughs] (Interview 2, p.13).

Responsibility was a recurring theme, particularly in participants' discussions of what worried them about internship. As one resident said, "I think everyone's just a little bit worried about the fact that all of a sudden you've got responsibility to people" (Interview 3, p.10).

Their role as subjugate learners was also discussed. One participant said "[o]n ward rounds I certainly don't mind standing at the back writing and listening while everyone's making the big decisions, because that's what you do as a junior doctor" (Interview 5, p.17). Another participant spoke of the importance of "listening to instructions, accepting, accepting that you should just do what someone more senior says" (Interview 8, p.5). For this participant, this "accepting" was crucial to success as an intern. There was also a great deal of evidence that junior doctors perceived

themselves as learners. As one participant said, when starting as interns, “we didn’t know anything more than when we were medical students last year” (Interview 8, p.5).

Some participants also recognised themselves as employees or human resources:

[a]nd then I did the relieving rotation for I think about five weeks. Which is just, oh look it’s interesting but it’s pretty, you just, you’re just filling in because, I suppose it’s just because the hospital technically has to have a doctor there. But the reality for me was that I’d done like one medical job before. And I was working in neurosurgery. I worked for three days in neurosurgery. Like I haven’t even done a surgery job yet! So I pretty much got there on the first day and it was like, you know, ‘I’ve been a doctor since January and I’ve never done any surgery before so you’re going to have to tell me exactly what to do. Assume nothing’ (Interview 10, p.1).

This intern recognises that she was not working in neurosurgery because of her skills, which she lacked due to her inexperience, but rather because the hospital had to have someone in the particular job. Another spoke of herself as “an employee of the hospital” (Interview 1, pp.30-1). One resident identified her role as an employee of the hospital, but resented what she saw as this administrative aspect of being a junior doctor:

I think it’s kind of funny that they, that they pay junior doctors to do that kind of stuff [displaying x-rays at meetings]. Because you learn nothing by sticking up x-rays...[And people] go ‘well, you know, we have all these problems with putting junior doctors into hospitals’ and this kind of stuff, and I’d say ‘we have all these problems with wasting junior doctors’ training time’ (Interview 5, pp.16-7).

Here, aspects of the hospital employee role are articulated as real but problematic elements of being a junior doctor.

As well as providing evidence for the reality of the roles in their experiences, participants’ discussions also highlighted that there were additional complexities within each of the three roles identified in chapter three. For example, with respect to

the clinician role, a junior doctor's level of clinical responsibility varied significantly during internship and residency depending on the specific rotation. As one resident described it, "some intern jobs involve more responsibility than others" (Interview 3, p.15). Working in the emergency department or covering overnight involves significantly more patient care responsibilities than working on a ward during the day. One participant claimed that:

[y]ou're not practising medicine as an intern at all. Oh, towards the end you are but then, having said that, this is your day to day stuff. So Monday to Friday I had my registrar there just reeling off things for me to do...And so that was Monday to Friday and then I will never forget the first after hours shift I did, which was fourteen hours long and you're just paged! And these are actually sick people! That you have to treat! Now I have to practise medicine do I?! (Interview 7, p.7).

Another participant similarly described the variation in responsibility levels she had experienced during her internship.

I think that a lot of the challenge is just trying to get a feel for where the boundaries lie. And, and it seems that often when you start a new job then the question you're most often asking is 'should I be doing this?' or 'should I be doing that?' or, you know, 'no, that's a nursing task' or that, you know, 'the third year resident will do that'...I suppose on some occasions you just do something that you weren't supposed to do and you get told that that wasn't your job to make that decision. But then it's difficult too because I've also worked overnight and doing in this relieving for other roles where all of a sudden you just have to assume greater responsibilities and make more decisions by yourself (Interview 10, p.16).

Although being a clinician is a consistent part of being a junior doctor, the exact nature and degree of the responsibility seems quite variable depending on the particular working situation within the hospital overall.

Participants' discussions also suggested that the subjugate learner role was in fact separable into two related but distinct roles. Being a subjugate was not always related to being a learner, and vice versa. For example, one participant highlighted that it is not only junior doctors who are learners. Rather, "medicine is ongoing learning"

(Interview 4, p.9). With the evolution of new knowledge and technologies, doctors are constantly learning throughout their careers. Thus playing a learner role need not be limited to the subjugate members of the medical team. Another participant commented on the way in which degree of knowledge on a particular topic need not directly map with increasing status in the medical team:

I think in some ways you'll always be a learner and for slightly different reasons. Like at the start obviously everything's quite new and you're not an expert in anything. But having come from medical school your education is quite broad, and you're reasonable in a lot of areas...In terms of your knowledge, I guess you go from having not that much expertise in any area but quite broad stuff, through to being as a consultant an expert in one area but no idea in other things...And sometimes I find it quite funny where there's a problem in an area other than what the consultant's specialty is or what your unit specialty is, whereas, and you think 'God, that's a really basic problem, I could tell you what' [laughs]. And they'll ask for a consult from that team. And, and you and your registrar say 'but, this is what you do!'. But the consultant is, is quite removed from that because they've not dealt with that specialty for years and want someone else's opinion on that. And some of the consultants are great and realise that, you know, for example your registrar's just done the exams and they have sort of as good a broad knowledge as you're ever going to get. And some of them are quite happy to let the registrar make the decisions about that. Some of them still want consults from other units, and you have to call up the registrar [in that unit] going 'I'm really sorry about this' [laughs] (Interview 3, p.49-51).

These comments indicate that even when a junior doctor is equipped with the necessary medical knowledge, he or she must nonetheless play the role of subjugate in the medical team. It was not because this participant had something to learn that she had to call registrars from other units, but rather because of her role as the consultant's underling. Participants' discussions indicated that seniors' demands often relate to tasks to be done for the team rather than things to be learned for the junior's benefit. Understanding junior doctors' learner role as distinct from their role as subjugate reflects this separateness.

Participants' experiences also suggested that the subjugate role related closely to the smooth functioning of the medical team. Many explicitly identified themselves as working as part of a team, making comments like "I feel like...I'm a team player with all these other people which include people quite a lot more senior than me" (Interview 1, p.30). Recognising and acting in accordance with your junior position in the team was seen as fundamental to the team functioning well. For example, one participant stated that "it's important to be aware of your place in the team, like you'd see people that would overstep the, well *I think would overstep what their role was*" (Interview 7, p.23, participant's emphasis). She then went on to describe a resident who was seen as working outside the boundaries of her junior position, and recounted that resident's registrar as saying

'I hated working with her because she'd just do whatever she wanted without, I'd rather someone who didn't know as much who wanted to ask me about everything than someone that thinks they know everything and does whatever they want' (Interview 7, p.23).

Limiting one's actions to those appropriate for the least experienced member of the team and implementing the more senior doctors' plans diligently were seen as crucial to the team functioning effectively:

some people like to talk back and question a lot. I mean, as an intern, yeah it's fine to talk back and question but really at the end of the day they're much more experienced than you are. And they've seen a lot more than you have so I just find that if you get along with your team and you work together well instead of trying to be dominant then that really helps...[S]ome people who tend not to fit in,...they're really dominant opinionated types. They tend to not fit into teams very well. Like they're really confident, they're too cocky or they just don't like being told what to do. Or too much opinion, sometimes it's not a good thing. Because then they sort of tend to clash with other people. They don't get along and then, I think it makes it difficult if people dislike each other (Interview 8, p.23).

In light of this perceived link between playing the subjugate role and the effective functioning of one's team, the role that I have been calling 'subjugate' up to this point could be better labelled 'team member'.

Being a junior team member was also more complex in participants' experience than was articulated in chapter three. Firstly, although the intern or resident is junior to both the registrar and the consultant, the nature of the relationship with each of these types of senior doctor can be importantly different. One intern said

at the other hospitals I really felt like me and my registrar were a team and we were working together and I had a great registrar and there was lots of support there. And the consultants just floated in and out. And sometimes they knew who I was, most of the time they didn't, you know, whatever (Interview 1, pp.33-4).

This participant's description makes it sound as if both she and her registrar together were juniors to the consultant in this situation. This is in contrast, for example, to other participants who saw themselves as subjugate to their registrars who "just want you to do the jobs" (Interview 7, p.7). Another participant's discussion of asking questions indicates the complexity of the junior team member role in relation to registrars and consultants:

if the consultant then comes in and I go 'oh, I don't quite understand why this is going on' and occasionally a registrar will look at me like 'I can't believe you just asked that!'. And the consultant always goes 'oh well because' because they don't mind explaining it to you (Interview 5, p.9).

Here the resident's role as the most junior team member is playing out differently with the registrar present compared to the consultant. In both cases she is playing the role but the expectations of her seniors differ. While the registrar seems to take the role as requiring straightforward deference and following instructions, the consultant's understanding seems to involve also an element of the learner role, making questioning appropriate for a junior team member.

Additional roles: teacher, competitor

The interviews highlighted two further roles that junior doctors are positioned in by their organisational context. One is the role of teacher. Because of the apprenticeship structure of medical learning, junior doctors sometimes find themselves supervising

medical students on clinical placements. Yedida and colleagues have investigated residents' role as teacher, highlighting the "intense conflicts" that residents can experience between their own needs and their teaching responsibilities (see also Bensinger et al., 2005; Yedidia et al., 1995, p.615). Participants described various aspects of their teacher role:

I have shocked myself by finding myself get[ting] frustrated with medical students that kind of ask me questions. I guess it comes in the realm of, that when you're pushed for time and you're stretched in terms of your own resources, to then be asked a question when you think someone should know this, maybe you have a short [temper] (Interview 4, p.10).

Some things that are very clear to you are often not very clear going the other way. And it was the same when I suddenly had interns [when filling in as a registrar]. Like I went from being, you know, the dregs to suddenly having a couple of interns. And you'd ask them to do something and then, you know you'd say 'this person needs an urgent ultrasound' and they'd, and you'd see them an hour later and you'd go 'how did that ultrasound go?'. And they'd go 'oh I booked it for tomorrow'. And you'd be like 'ok, normally urgent means we need it pretty soon' (Interview 5, p.7).

Junior doctors as competitors with their peers was a further role that participants implied. Because the system in which they are training involves year-long jobs and competition for limited specialty training places, junior doctors are necessarily positioned as competing with their peers. As one participant said, "there's always the stress of applying for jobs for next year" (Interview 8, p.13). Another participant explicitly described her present hospital as a "competitive environment" (Interview 7, p.10). One participant was particularly candid about the way in which her role as a competitor shapes her behaviour at work:

I as a surgical trainee and that's a, knowing that that's a very competitive field, I don't use the workplace to debrief. Which some people do and that's fine. And other people debrief to me and I'm happy to be involved in that. But I prefer to keep my professional self at work and my personal self to my personal life, so I debrief to people close to me who don't have anything to do with my career or anything like that...I certainly wouldn't risk being the trainee who had a cry or the trainee who

didn't cope by leaving my personal self at work. You know, and whether it would make any difference or not I don't know but I'm not willing to find out (Interview 5, pp.29-31).

Thus, as well as the three roles identified in chapter three (now four roles, having separated the learner role and the subjugate/team member role), the interview data indicates that junior doctors are also positioned in the roles of teacher and competitor by the environment in which they work.

Junior doctors are positioned in both of these additional roles by virtue of their organisational context. Although these additional roles are not created by formal hospital structures in the way that the roles of clinician, learner, team member, and employee arguably are, interns and residents are required to be teachers and competitors because of the nature of the wider system of medical education in which they are participating. The decisions made by hospitals and educators as a body to continue with the apprenticeship model of teaching and the system of year-long positions for junior doctors mean that junior doctors are necessarily teachers and competitors. However, as I argue in detail in chapter seven, the teacher and competitor roles are less central to internship and residency than the other roles discussed.

THE MULTIPLE-ROLE POSITION AS SHAPING AND LIMITING ACTION

Participants' discussions suggested not only that they were positioned in these multiple roles, but that this positioning affected their actions. One intern spoke about the conflicting demands that the various roles sometimes involve:

[it's a challenge to] strike that balance between doing things that you think are correct, doing the things that the consultant wants, and doing the things that the patient wants. Ideally they should all be that one thing, but sometimes it, they do sort of conflict..., conflict time-wise I think. In that you need to prioritise which ones to do first.

R: And how do you make those decisions when you feel like you're sort of pulled in different directions a bit?

Yeah, I think whoever's [laughs] going to cause you the most trouble! [Laughs] So usually it would be the consultant, the consultant's would be the first thing. And the registrar's, whatever they, they obviously would come first. And patients I guess is after that. And then your own sort of things. I regret to say, but it's sort of, your own sort of opinions and things sort of come in after all of that, that stuff's been done and prioritised (Interview 6, p.15).

For this intern, his obligations as a team member were his top priority. When there were conflicting demands on his time, the consultant's and registrar's requests "would be the first thing" he gets done. The implication in the passage is that he has been taught to prioritise in this way by his environment. It is his seniors that are "going to cause [him] the most trouble", and thus it is his obligations to them that he fulfils first. "[D]oing the things that the patient wants" and "doing things that you think are correct", that is fulfilling the responsible clinician role, come lower down the priorities. However, his relationship to his mode of prioritising seems to be a complex one. His use of the phrase "I regret to say" suggests that he has some reservations about the type of prioritising that his environment demands. The fact that "your own sort of opinions and things" come in last does not seem to be one that he accepts as necessarily appropriate. The implication is that the demands of the environment in relation to the multiple roles he is playing are pushing him to prioritise in ways that he does not entirely endorse.

This idea that playing multiple roles shapes junior doctors' action is further illustrated by the following participants' stories. In each case, the junior doctor's action was limited by being a learner and being a junior team member, creating significant conflicts with her perceived obligations as a clinician.

Susan's story

I had a patient in emergency who'd like got assaulted..., hit in the face with a bar. And I had like examined him and I was really pretty certain that he had a facial

fracture...Generally in Australia the convention is that if you think that someone has facial fracture then you would go and get a facial CT [scan]. Because that's like a high resolution scan that will demonstrate the fracture, and then would be a useful film to show the surgeons if that's what you thought needed to be done.

But in emergency the interns can't ask for a CT without talking to their reg[istrar] first. And this was like Queen's birthday weekend and that department was just incredibly busy. And the registrar on was English. And in the UK it's a lot more difficult to get a CT in general and they use things like skull film, like plain x-rays of the face and the skull a lot more than we do in Australia.

And anyway so I sort of had said to my registrar 'oh, you know, I've got this guy and this is the story and it really looks like he might have a zygomatic fracture. Do you want to come have a look? I think he might need a CT.' And he just sort of went in and had a bit of a look and was like 'oh no no, just get plain facial bone films'.

And I knew that would cause problems because the radiographers won't even do facial bones films. Like I knew that I would have to argue with the radiographers even to get them to do the plain film because they know that normally you'd do a CT.

And so in the end, and so for that reason I really pushed it with him. Like I checked, you know, 'are you sure this is what we want to do?'. And he was like, and, I think there were two problems. Like firstly he probably was used to the UK conventions. And secondly I think that I'd had a closer look at the patient than him, which is often the situation that the intern is. That they're not, they don't have much authority or as much experience but they actually probably spend more time looking at the patient because, because you feel, probably because you feel uncertain and you want to really check everything. And he was like 'well, I dunno, I think it's really low probability that this guy's broken his face so we'll just get facial bones film and we can send him home'.

And so then I had to sort of argue with the radiographer to get it done. And got it done and then it showed like in the facial sinus, it just had fluid in the sinus and we couldn't see a break. But the fact that there's fluid in the sinus implies that there's a break that you can't see. So we had achieved exactly nothing by doing this thing which I'd had to argue for anyway and the guy had like stayed around for two hours for nothing.

And anyway then, so then the registrar just sort of discharged him home with like, to come back the next day for a facial CT...And in the end he had like a really terrible fracture and I just felt like we'd done the wrong thing...

Maybe if I'd been more assertive, yeah I think that's always the feeling that like perhaps if I'd been more assertive and thought 'no I really think this guy has a fracture and that we should do a facial bone CT'. But then always in the back of my mind is well, you know, this is probably only the third or fourth of this type of fracture that I've seen. So, you know, if he [the registrar] says that it's low probability fracture then he's probably right. Like it's always that doubt...you never really trust yourself because you're always aware of your own inexperience (Interview 10, pp.7-9).

Despite being “really pretty certain” of her patient’s condition, Susan cannot follow up her diagnosis with the action she sees as appropriate. This seems in part attributable to her positioning as a learner: “in emergency the interns can’t ask for a CT without talking to their reg[istrar] first”. The sphere of influence allowed to her by the hospital is limited because of her inexperience, presumably in part to facilitate junior doctors learning when particular tests and treatments are in fact appropriate as well as to ensure a good use of resources. Her obligations as a junior team member also seem to be shaping Susan’s action. She diligently works to fulfil the registrar’s treatment plan, “argu[ing] with the radiographer to get it done” despite her own reservations. She also seems to see herself as having responsibilities qua clinician, “really push[ing] it” with the registrar when his decision conflicts with the course of action that she perceives as best for the patient and feeling concerned about the patient’s hospital experience. Her feeling of responsibility to the patient conflicts with the demands of being a learner and a junior team member, who lacks the organisational authority and self-belief to act to bring about the appropriate outcome for the patient. Her position playing multiple roles shapes her experience of this situation and limits her options for action in it.

Louise's story

The other story was this [resident] who'd...been called to see [a patient] at nine twenty. She'd had a terrible day because she was the resident of the registrar that had gone home sick. And so she's sort of been trying to mop up the pieces and, all day. And then the last patient she'd seen was at nine twenty and she'd, this was a girl that she'd been handed over that if she didn't pass urine to call the consultant and see if he wanted to put a catheter in because they'd had some problems with urinary retention.

And so it was nine twenty, she was supposed to go down for handover at nine thirty so she just called the consultant without seeing the patient properly. And he yelled at her on the phone for not seeing the patient properly which, yeah, isn't common at [my current hospital] but does, like, it, you know, happens every now and then.

And so then she felt really bad. She ended up having to explain that she'd had a terrible day. He got on the phone to the mother, got a totally different story to what was really going on because the mother was stressed and whatever else. And so she [the mother] was saying 'oh, she's [the patient] this, and she's that and rarara' and she wasn't any of those things. So then the consultant ordered to put a catheter in.

And this girl was three and adamant she didn't want a catheter, had been totally traumatised by the catheter she'd had the night before, so they were going to have to give her nitrous [oxide, a happy gas] to be able to put it in. And so [the consultant] said 'just organise the nitrous in ED [the Emergency Department]'. And so [the resident had] called emergency... Emergency said 'no, we don't offer that service anymore', so she called anaesthetics and then anaesthetics hasn't called back because they had two theatres running emergency-wise and so it wasn't going to happen.

And so she got down [to the handover meeting] and was stressed because this consultant had yelled at her and she thought that it was a bad decision anyway. This kid didn't need a catheter. And she felt like the mum had given the wrong story, but she [the resident] hadn't been able to back it up because she hadn't seen the kid properly. But clearly this kid was running around quite happily on the ward and so mum's story about 'she was so distressed' and 'she's got pain rarara' and she didn't, so she [the resident] felt like she [the child] was being misrepresented and that this consultant was making a bad decision.

So then the registrar, who had been in tears just before, calls the consultant up and the consultant yells at the registrar and tells her to calm down...And all of us are sitting there going 'I can't believe we're going to put a catheter in this girl, who's got a psychological reason why she's not passing urine, this is like the worst thing to do!'. And we were so frustrated that we thought that this kid wasn't being well managed.

And in the end it all worked because the anaesthetics people couldn't come down for a couple of hours. The consultant had gone home by the time anaesthetics had decided they couldn't help and so, and then at like three o'clock in the morning she passed urine. And it was all fine.

But these two people have gone home feeling like they hadn't done their job properly, they hadn't looked after all the parents properly, they weren't doing what the consultant said because they didn't think the consultant was saying the right thing and because they couldn't do it, and just torn, and like it had all been and nothing good had happened. Like they came out of the day going 'I haven't actually felt like anyone's been well-treated today' (Interview 1, pp.49-51).

The resident in this story is in part functioning in the role of hospital employee, trying to "mop up the pieces" of the mess created when an ill colleague was not replaced. She is also playing the role of team member, ringing the consultant for his decision on how the child's treatment should proceed, as the hierarchy dictates. These roles involve conflicting demands in this situation: in trying to cover the work of the sick registrar, she runs out of time to properly examine the child and so cannot report well to the consultant. This individual resident, as well as the handover group of residents and registrars, feel also the obligations of their clinician role. Louise describes it as "all of us are sitting there...so frustrated that we thought that this kid wasn't being well managed". The junior doctor's various roles are implicitly invoked in Louise's conclusion to the story. The resident at the centre of the story is described as "going home feeling like they hadn't done their job properly"; she has failed as an employee. She also "hadn't looked after the parents properly", failing in the clinician role. Similarly, "they weren't doing what the consultant said", failing in the team member role. Despite her best efforts, the resident's actions have been so limited by the

conflicting demands of the multiple roles that she is required to play that she leaves frustrated and demoralised: “just torn...and nothing good had happened”.

Thus, the interview data enables development of the idea of the multiple-role position in three important ways. Firstly, it confirms that participants perceived themselves in the three roles outlined in chapter three. Secondly, it suggests additional depth within the three roles posited. These include the separateness of the subjugate and learner roles, and the idea that functioning as a team member is the key requirement of the subjugate role. Thirdly, two additional roles were invoked in participants’ discussions: teacher and competitor. Participants’ descriptions of their experiences also support the claim that being positioned in multiple roles shapes junior doctors’ actions at work, at times in personally challenging ways. This can be seen further in the next chapter which discusses participants’ descriptions of the ethical challenges associated with their work. Their responses to these ethical challenges in many cases demonstrate the power of the multiple-role position in creating ethical challenges and limiting their action options.

CHAPTER 5: REFINING THE TYPOLOGY OF ETHICAL ISSUES

In this chapter, I present ways in which participants' stories of their ethical difficulties both support and challenge the typology of issues developed in chapter three. In line with my approach in the literature review, I have included in this analysis both those issues that participants explicitly framed as ethical ones and other experiences that were not framed in this way but that fulfil the broad definition put forward in chapter one. All eight of the ethical issues listed in the initial typology were discussed by junior doctors in the study, including some new specific challenges within these issue types, and I examine these briefly in the first section of this chapter. However, the stories told by participants also deviated from the existing literature in some important and interesting ways and this data is the focus of the majority of the chapter.

One way in which participants' stories deviated from previous research was that their ethical challenges were not moral problems in the standard sense of difficulties in identifying the appropriate action option. The crucial moral question in these stories is not 'what *should* I do?' but rather 'what *can* I do now about this problem?'. In many of the experiences they described, junior doctors both knew what the ethically appropriate thing to do was and attempted to do it. The problem arose when their actions failed to produce the effects at which they were aimed. It is junior doctors' specific professional position and the agency limitations associated with it that creates the ethical challenge in these situations, supporting the idea that junior doctors differ from medical students and more senior doctors in ethically important ways.

My process of selecting stories for inclusion in this chapter and the associated appendix (Appendix B) from the wealth in the transcripts centred on two criteria. The first was breadth. In order to answer most effectively the research question 'What kinds of ethical issues are associated with medical internship and residency, and how are these issues best conceptualised for ethical analysis?', the full range of ethical

issues encountered by participants needed to be represented. However, where multiple participants discussed a particular issue, I have included only one or two stories due to limitations of space. I do not claim that the stories included are typical or representative. In many cases, participants dealt with the same issue in radically different ways. This brings me to the second criteria: the degree of morally-relevant detail in the participants' stories. I argued in chapter two that philosophers need rich contextual detail in order to produce useful ethical analyses of healthcare situations. On this basis, where multiple stories were told about the same issue, I have included the one (or ones) which described most fully the context of the junior doctor's difficulty. A further selection consideration, less influential than the two criteria just described, was including data from all participants. Considering that each junior doctor in the study contributed a different perspective, I aimed to include at least one story from each. This chapter and Appendix B include stories from twelve of the fourteen participants and, including the stories presented in other chapters, all but one of the participants are quoted directly.

SUPPORTIVE STORIES AND NEW EXAMPLES

In this section, I describe the overlap between the data from the participants and the initial typology of ethical challenges associated with internship and residency that I developed in chapter three on the basis of existing research (reproduced in the left-hand two columns of table six below). Each of the eight types of ethical issue initially identified was represented in the data. Illustrative stories from the interviews are included in Appendix B. The titles of these stories are listed in the right-hand column of table six.

It is important to note that participants' experiences emphasised the artificiality of dividing the ethical challenges into separate categories. Particular experiences often involved multiple ethical issues for the junior doctor. For example, a senior discouraging disclosure of an error involved both challenges around truth-telling and the difficulty of addressing the inappropriate behaviour of others.

The interviews identified three new specific ethical challenges. These are listed in italics in table six. Of the three new challenges identified, two fell into the category of truth-telling. These challenges were deception of patients about the course of their treatment and seniors discouraging disclosure of errors. Several participants described situations in which registrars or consultants had firmly discouraged junior doctors from revealing mistakes to patients or to hospital administrators. (One of these stories is analysed in detail in chapter seven. Another, “The intern was told not to reveal”, is included in Appendix B.) One intern also told a story of a patient who was deceived about the way her treatment was proceeding, specifically the cancellation of a scheduled test to which she was being transported (“A very modified version of the truth” in Appendix B). This type of occurrence was described by the intern as common.

The other new challenge identified was unpaid overtime. It was the unrecognised nature of the hours worked, rather than the long hours themselves, that was most problematic for this group of junior doctors. Participants had stories of working three to five hours overtime every day on a particular rotation, of being discouraged by their seniors from reporting the hours they worked, of consultants amending timesheets when overtime was reported, of hospital administrators stating from the outset that no overtime would be paid, of ward rounds scheduled to begin before rostered hours, and of expectations that paperwork be completed out of rostered hours. The ethical challenge of seeking payment for overtime is the focus of chapter eight.

Each of these three new ethical challenges, as with those in other categories, emphasised that junior doctors’ multiple roles play a part in creating the ethical challenges that they face. For example, the story about deception of patients about the course of their treatment involved the junior doctor’s employee role, deciding how best to allocate a limited resource (in this case, a test booking at another hospital). The initial patient’s booking was reallocated when a sicker patient came under the team’s care. However, the intern and her colleagues also felt their obligations as

clinicians to the initial patient, creating conflict and uncertainty about the best course of action, particularly in terms of explaining their decision to the initial patient. In the instances where more senior doctors were deceiving patients (for example, about why their surgery had been cancelled), the junior doctor's team member role further complicated the issue. Similarly, the ethical challenge of unpaid overtime can be seen as arising from conflicting demands associated with the different roles. As an employee, the medical administration wants a junior doctor working to the rostered hours for budgetary and safety reasons. However, as a team member whose job is to assist the registrar and consultant, a junior doctor is not in fact free to leave at the scheduled time, creating the ethical challenge of deciding the hours to record on one's timesheet.

One of the challenges identified in the literature review was particularly prominent in the experience of this group of junior doctors. This was involvement in treatment perceived as futile. Five of the fourteen participants told detailed stories of being involved in treatment that they perceived as futile. These experiences had been particularly distressing for participants and, in some cases, continued to trouble them. For these reasons, chapter nine focuses on this ethical challenge. The participants' stories highlighted that junior doctors encounter the issue of futile treatment in a way unique to their professional stage. Unlike the standard debates around futile treatment that tend to focus on the question 'is this particular treatment futile?', the issue for junior doctors is more complex. For them, the problem is being unavoidably *involved* in treatment that they perceive as futile. Because of interns' and residents' junior team member role, they are rarely in a position to influence major decisions about the course of a patient's treatment. Thus, they find themselves in the situation of having to implement treatment that they perceive as harmful to the patient or wasteful of resources. For these junior doctors, the ethical question in this type of situation is not whether the treatment is futile but rather about the moral status of implementing a decision that the agent believes is unethical.

Overall, there was significant overlap between the data collected and the initial typology of issues formulated from existing research, with participants' stories confirming that the eight types of ethical issue identified in the literature review were all pertinent and real in the professional lives of this group of junior doctors. Three previously unarticulated challenges within this typology of issues were identified by the interviews: deception of patients about the course of their treatment, seniors discouraging disclosure of errors, and unpaid overtime.

Type of ethical issue	Specific ethical challenges	Stories from the data; see Appendix B
Telling the truth	To patients and relatives about diagnoses and prognoses To patients about lack of experience To consultants about tasks performed To colleagues when seeking tests <i>Deception of patients about the course of their treatment</i> <i>Seniors discouraging disclosure of errors</i>	“Families don’t want you to tell” “I feel bad preying on their cluelessness” “Honesty really is the best policy” “A very modified version of the truth” “The intern was told not to reveal”
Respecting patients’ autonomy	Respecting patients’ wishes about treatment, including at the end of life Maintaining confidentiality Seeking informed consent	“They were just so worried” “The fact that the patient’s there is implied consent” “I’ve had to do pregnancy tests on unwilling girls”
Preventing harm	Dealing with potential harm to patients associated with their treatment Avoiding harm to patients when involving them in education	“You’re exposing patients to your learning curve”
Managing the limits of one’s competence	Coping with feeling inadequately prepared for one’s responsibilities Negotiating lack of supervision/role modelling by superiors Making mistakes	“This ten weeks is never going to end” “I’m a doctor by name but I have no idea” “It was a misdiagnosis”
Addressing the behaviour of others that is perceived to be inappropriate	Dealing with peers’ mistakes/ incompetence Subjugating own opinions and values to superiors’ demands Involvement in treatment perceived as futile Observing the unethical behaviour of others Demeaning humour about patients Compromised superiors Superiors handing risky tasks down the hierarchy Dealing with verbal or physical abuse by patients or superiors, including sexual harassment	“His daughter was the nurse unit manager” “He was a bit lazy” “This constant pressure to treat people”
Conflicts of interest	Treating family, friends, and self Offers of gifts or hospitality from drug companies	“I prescribe for my family” “You go into denial” “Having drug companies constantly around hospitals”

Impact of working conditions	Dealing with transience Working long hours Feeling unsupported by hospital administration Working when unwell Lack of cover for absent colleagues <i>Unpaid overtime</i>	“Just a massive strain on your life” “You go to work and push people away” “You’ll forever not get paid the hours you actually work”
Setting interpersonal boundaries with patients	Dealing with sexual advances or romantic intentions Treating disliked, difficult, or dangerous patients Controlling compassion	“I really don’t like you as a person”

Table 6: Revised typology of the ethical challenges associated with internship and residency, with story titles

‘WHAT CAN I DO?’ RATHER THAN ‘WHAT SHOULD I DO?’

Participants’ stories also illuminated the kinds of ethical issues associated with internship and residency in ways not captured by previous research. The limited existing work on junior doctors’ ethical issues tends implicitly to frame junior doctors’ ethical challenges as questions about what they should do. This is, of course, unsurprising in the context of philosophical ethics in which the central question is ‘what should the agent do?’. However, some of the ethical challenges recounted by participants challenged the centrality of this question. Some of their moral difficulties seem much better described by the question ‘what *can* I do now about this problem?’ than by the question ‘what *should* I do?’. The ethically appropriate end-point was often perfectly clear to the junior doctor. It was producing this outcome from his or her junior position that was problematic. The intern or resident would do his or her best to bring about the outcome that he or she saw as appropriate, but was thwarted by the agency limitations imposed by the hospital environment. The following story illustrates this idea.

Sometimes you’re unwillingly associated with senior doctors who are just behaving badly. And because you’re sort of part of their team then you can’t really create any, it’s difficult to sort of create distance...[One patient] got a biopsy because when she

initially came under our unit then there was a possibility that this was a reversible disease...She knew that this was a possibility and she was hanging all her hopes on this. And we got the biopsy results through at something like 5.15 on Friday. And the family had been asking me all day because the family always tends to interact because they see you more on the ward whereas they see the registrar less because the registrar will be off doing stuff.

And, so as soon as the biopsy results came in I sort of had a quick read through and told my registrar. And he was like, we read through them together and I mean essentially what they said was that this was an irreversible process... So the hope was gone. But, you know, I mean a biopsy report is relatively technical. And also the problem was that it was, it was not an ideal specimen. And really to explain the results to her you would have to tell her that in fact it wasn't a great biopsy. And my registrar was the person who'd done the biopsy and

R: So was it just unlucky that it was a non-ideal specimen? Or was it something that he'd done wrong?

Well [pause], probably, he'd just started and so I imagine that it was partly his inexperience. But then equally I think an experienced biopsy, like sometimes if it's a really big fat person and there's a shortish needle it can be, but that wasn't the case in this. But, you know, you could still unluckily get a bad specimen. But anyway, this was really a result that it was the registrar's job to convey to the patient...I had said to him [the registrar] 'the family's been asking all day, can you talk to them about this biopsy result?'. And he was like 'yes yes, I'll do it before I go home'.

And then I was [working] on the weekend, just with a consultant who covers over the weekend. And I got there on Saturday and the family came straight up to me and they were like 'what was the result of the biopsy?'. I was like 'oh no! He hasn't told her.' And I was like 'oh I'm going to be coming round with the consultant on the ward round shortly. Can we discuss it then?'. And they're like 'yeah, ok' and, you know, they weren't very happy but.

And so then when the consultant came on who wasn't even the [usual] consultant, so wasn't even familiar with the patient at all, I sort of made a point of saying, you know, 'this is a very anxious sixty year old lady who, you know, has unfortunately progressed to endstage renal failure over the last month as a result of like a medical therapy. And we've only just got the results of the biopsy back last night and she

doesn't know them yet and we're going, like the family's asking. We're going to have to tell her about them today, this morning'. And, I mean I think I really made an effort to try and convey to him, you know, the importance of this discussion to her and her family.

But honestly, he just went in there and it was, it was *horrible* to watch the way he talked to her...He just spoke really condescendingly and with no eye contact. He would just be looking around the room, like in the corners. And so he didn't even realise that she had started crying, you know, with her daughter there. And so he just, I can't remember what he said but he even made it sound worse than, I think he made the prognosis sound worse than it actually was. But using really vague and condescending terms to a person who'd actually sort of done a lot of research to find out about, and was probably prepared for a lot more information than he wanted to give. So all he essentially said was, you know, 'you've got endstage renal failure and you're going to need dialysis for the rest of your life. And you probably have damage to the vessels everywhere else in your body too'. That was pretty much what he said. Without looking at her at all during that whole time.

And so then he left and she pretty much just wanted to discharge herself from the hospital and never come back...I felt that I'd had quite a good relationship with them up 'til then even though they were really stressed by the whole situation. But then after that it was like they had written me off too. That they didn't want to trust me anymore either (Interview 10, pp.10-3, participant's emphasis).

At both stages in this story, the junior doctor is in no doubt about what morally ought to be done and each time plays *her* part as the intern in bringing about the appropriate outcome. From her perspective the question is not 'what should I do?'. In the first instance, she sees clearly that the registrar ought to explain the results of the biopsy to the patient as soon as possible. She plays her part in producing this outcome, telling the registrar when the results arrive and communicating to him the urgency of the results from this family's perspective. Having been assured by the registrar that he will deal with the family this afternoon, she has done the work of the intern in making the right thing happen given that, as an intern, she does not have the authority or detailed knowledge required to do it herself. At the second stage, when the registrar has failed to fulfil his commitment, this junior doctor again perceives what morally

ought to be done – the consultant needs to explain the results well to the family. As before, she works from her intern position to make this happen, explaining the situation to the consultant and communicating the importance of this discussion to this family. But again, despite doing what she ought to do, the ultimate outcome is not the morally appropriate one at which the intern was aiming. She has done what she should, but due to her constrained sphere of influence and action as a junior doctor, doing what she should has not produced the morally appropriate outcome. This crucial question ‘what *can* I do?’ could be rephrased as a question about the extent of a junior doctor’s moral obligation: ‘having failed so far in my attempts to get the right outcome to happen, how much more am I obliged to do? Is it ethically enough to have tried?’.

The following story (Donna’s) has a similar structure. Again, what the intern should do is clear to her but doing it is insufficient to produce the ethical outcome.

There was one thing that really turned me off general surgery. I don’t know if I’m allowed to tell you [laughs], explain it. But basically, this guy was dying and the surgeon wanted to operate and I said that that was pointless, he’s going to die anyway, why are you going to bother operating, putting him through an operation? And I was outvoted basically. And I said I didn’t, and basically, I basically told my direct seniors which weren’t the bosses that I didn’t want to be part of this operation because I didn’t feel comfortable doing it. And they [the registrars] said ‘you’ve got to pull the party line a bit more’. And I thought ‘that’s not what I want to do’. And I didn’t sit in on the operation. I just went, I just actually said ‘look I, I’ve got to be on the wards’, something like that, I don’t want to be there. But I got in a bit of trouble for that...

R: So was it difficult to make the decision? Like how did you decide what you wanted to do in that?

No I just, I knew as soon as I heard the story and I looked at the patient. I said ‘this guy is going to die on the operating table’. Which he didn’t, he ended up dying a day later. But I knew that he wasn’t going to make it through. In my heart I felt like I was making the right decision. And I just basically stuck by my guns and just said

'look, I don't think this is the right decision'. And got in a bit of trouble for that. But for me I'm just, always go with instinct so it just didn't seem like [inaudible].

R: So did you talk to your reg[istrar] first or who was the first person you sort of said 'hmm, I'm not happy'

My reg said. And didn't get passed on to the consultants. But I said that I didn't want to be involved in the surgery basically.

R: And how did they respond?

They said 'it's good that you feel comfortable talking to us about this type of thing but just be a bit quieter about it'. Because I was saying it in the middle of a ward. And said 'maybe next time you should consider following the team line a bit more', yeah.

R: And so then you were able to go to someone different and say that you weren't happy to do it?

Oh no, I just said, I didn't say, I just said it to them. And they said 'look, that's fine'. They said 'we'll raise that with the consultant' and nothing came out of it. And I just said to the consultant 'look, I've got to be on the wards basically, I don't want to, I can't be in the theatre at this point in time. Maybe one of the medical students can come and help you if you need an extra pair of hands'.

R: So in the end the consultant might not even have known that you had a problem.

Sure, yeah. But I didn't think it was worth kind of raise it, especially because, she'd called in another consultant who had agreed with her that they should go ahead with the operation. So two consultants against an intern, I didn't think it was worth, you know, fighting that fight so I just basically excused myself and walked off, yeah.

R: And on reflection are you happy with it?

Well I would have preferred not to have the operation. But I think I made the right decision (Interview 13, pp.3,9).

Unlike the intern in the previous story, Donna ultimately uses the institutional constraints on her action to her advantage. This participant can be seen as using the

agency limitations associated with her position to attempt to preserve her integrity once she realises that the surgery she perceives as futile will inevitably proceed.

This theme of ‘what can I do?’ rather than ‘what should I do?’ arises slightly differently in the next story. This story would fit neatly into the typology category of ‘negotiating lack of supervision’, but also demonstrates further the way in which junior doctors’ ethical challenges need not be focused on identifying the ethically appropriate action option. This junior doctor seeks help with a deteriorating patient, without success. It is clear to him that recruiting a more senior colleague is what he ought to do. The problem arises when he cannot do this successfully.

The most demanding situation I found is when patients are very ill and there’s no help around. That was, they’ve been the worst situations. And they’ve, that’s only happened twice to me. Once was in the emergency, during my emergency rotation where, in my, I thought something bad was happening with the patient and there just wasn’t anybody around. And the people that I asked had said they were too busy to deal with anything. So I’m just sort of left there not knowing what to do. And I guess I really didn’t, I don’t know what I ended up doing. I just sort of, just walked around and just looked for, kept looking for someone until I found someone to sort of talk to, talk to about. And nothing, nothing came out, I mean nothing happened to the patient. But it was a scary experience to sort of be all alone in such a busy hospital and just not have any, any help.

R: So were the people that you went to for help too busy? Or doing other things or?

Yeah no they had their own things and it was emergency and they had their patients that were probably more sick than mine to deal with at that situation, or they had handover or something, I forgot the exact situation but a lot of them were just not available at that time, yeah.

And the second time, similar sort of thing but people weren’t answering pagers and yeah, the situation was sort of difficult. They wanted me to deal with it and obviously I didn’t know what to deal with it. They were helpful enough to tell me what was wrong, no no, not what was wrong. What was wrong with my management plan of it. But not helpful enough to [laughs] tell me what was a better management plan. So they said ‘oh that’s not good, you shouldn’t do that’. I’m like ‘ok. What do

you want me to do?'. It's like 'oh I thought you guys should decide on that'. So I really just, just left it up to the, I did what I could to sort of, I called the people, let them know it was urgent. I just had to leave it at that though. I wasn't going to, there were other things that were sort of creeping up that I needed to get done as well. And there was just no point staying down there trying to fix this one thing that I couldn't fix anyway.

R: So you just sort of let the next step up know

Yeah, that's basically all I could do at that stage. It just, wasn't, yeah I couldn't, I didn't know what to do. And I think it's probably safer to do nothing than to do something. And so I, I just let the next patient [person] up know and then just sort of, a very generic sort of plan. If the patient happens to crash or something, call, call a code blue or do something so people would definitely come but until then I can't do anything. And yeah, I mean documenting that down to say that you've done that and you've tried all of this and it hasn't worked, I think.

You just, yeah you just have to learn. I think I just had to learn how to just leave it at that and deal with it, yeah. I don't particularly find it that worrying anymore. I mean if it, if you can't do anything and you've let people know and they're not doing anything about it, it really, there's nothing much you can do apart from stress and there's no point in stressing (Interview 6, pp.18-9).

An interesting aspect of this story is the effects that these experiences seem to have had on this junior doctor's outlook. From initially being extremely concerned by the lack of support, the participant becomes accepting of this type of situation. His approach changes from keeping looking for help to documenting that he has tried to seek a senior doctor's advice, presumably to protect himself if the patient deteriorates. This change in outlook points to the potential impact on junior doctors of their position-related inability to bring about the outcomes at which they aim. In this case, it seems that because this intern is prevented by the environment from achieving the good outcome he was aiming for, he learns to stop trying or at least to aim for something lesser. His perspective on this type of situation changes. These changes in perspective were of great concern to some participants and are discussed further in the next chapter which focuses on character.

This chapter has outlined the types of stories that participants told about ethical challenges involved in their work, seen in the context of the typology of ethical issues identified from previous research. The additional ethical challenges that the interviews highlighted were deception of patients about the course of their treatment, seniors discouraging disclosure of errors, and unpaid overtime. A particularly prominent challenge for this group of junior doctors was their involvement in treatment that they perceived as futile. I have argued throughout that participants' stories reflect an ethical uniqueness involved in the position of junior doctor and that many of the ethical challenges they encounter can be understood as conflicts between the demands of the various roles that they play. I have also suggested that junior doctors' ethical challenges are sometimes better described by the question 'what can I do?' than by the standard medical ethics question 'what should I do?'. Participants' stories suggest that the ethically appropriate outcome can be clear to an intern or resident. It is producing this outcome in the context of their limited agency that can be highly problematic for them. In the next chapter, I turn to a different type of ethical difficulty that was discussed in the interviews: concerns about character. The issues and stories presented in this chapter have essentially been about 'doing', raising questions about junior doctors' action. However, as suggested in relation to the final story, some participants also talked about issues of "being", raising questions about what kind of people or doctors they should be or were becoming through their internship and residency experiences. These views are the focus of the following chapter.

CHAPTER 6: CONCERNS ABOUT CHARACTER

Some participants discussed their experiences in character-related terms, illuminating a different type of ethical difficulty created by junior doctors' multiple-role position. Participants' reflections suggest that the hospital's organisational needs create pressures for junior doctors that can prevent them acting in line with their own deeply-held ethical beliefs and commitments about good medicine and moral action in general. One intern asked herself a rhetorical question that encapsulates the problem: "in the structure that we work in, is it possible to be the kind of doctor that you want to be?" (Interview 4, p.2). One result of these environmental pressures was that junior doctors responded to patients in ways that were discordant with the values that the interns and residents reflectively embraced. In this chapter, I begin by discussing participants' concerns about character and the changes in perspective that their internship experiences are precipitating. I then focus on one intern's story that describes an instance of this discordance between one's response and one's actual values. In explaining her response to the situation, this participant invokes the concept of the good intern, an idea she sets up as distinct from the good doctor or the good person. This concept suggests a way of analysing the ethical issues about action identified in previous chapters, one that engages with the reality of junior doctors' multiple-role position. I will develop this concept into a normative framework in the next chapter. Thus, participants' concerns about 'being' offer a way forward in thinking about their challenges around 'doing'.

AM I BEING THE KIND OF DOCTOR I WANT TO BE?

Many participants spoke in ways that can be conceptualised as concerns about 'being', about character and personal qualities, rather than about performing specific actions (although these are of course intertwined). My interview question about

participants' advice to new interns was often answered in terms of being – “be nice to the nurses” (Interview 3, p.67), “never ever be afraid to ask for help” (Interview 7, p.30), “be efficient” (Interview 5, p.25) – suggesting that issues about the kind of person one ought to be were central to internship for this group of junior doctors. Several participants reflected extensively on issues of character. Their insights are important because they illuminate a further ethically-challenging aspect of junior doctors playing multiple roles, namely the difficulty of reconciling one's own deeply-held values with the values required by one's team or employing hospital.

One intern, Donna, explained her change of heart about a career in surgery in the following, arguably character-based, way. The crucial situation involved the surgeons in her team deciding to operate on a dying patient (described in greater detail in the previous chapter), a decision with which Donna was very uncomfortable.

[T]his guy was dying and the surgeon wanted to operate and I said that that was pointless, he's going to die anyway, why are you going to bother operating, putting him through an operation? And I was outvoted basically. And...I basically told my direct seniors which weren't the bosses that I didn't want to be part of this operation because I didn't feel comfortable doing it. And they [the registrars] said 'you've got to pull the party line a bit more'...I kind of got that feeling that they [the consultants] didn't look at the patient overall kind of thing. And there was a few other things that weren't so stark I guess that were just kind of, you just kind of thought about it? Like just people said things that [made you go] 'mmm, that doesn't sound quite right'. I think I'll enjoy kind of, in one sort of way I think I'm a nicer person than that [laughs]...I guess like I can understand where they're coming from. Like I don't think you'd be able to operate on those people if you didn't kind of think in that way but I, I, I just don't want to *be* that. Yeah, long term (Interview 13, p.3, participant's emphasis).

In this situation, Donna's own values misaligned with those required of her as a team member. The “party line” and the pressure to conform to it conflicted with her own view about the ethical justifiability of the treatment. One of Donna's worries was about how the surgeons perceived the patient. She understands the problematic perspective as a necessary part of being a surgeon: she says “I don't think you'd be

able to operate on those people if you didn't kind of think in that way". Here perspective is intimately linked to character. The concern is about the way that surgeons "look at the patient" and "think" and about being or becoming the kind of person that she sees this outlook as reflecting. Donna understands herself as being of different character – "a nicer person than that" – and wants to remain so. Her abandonment of surgery as a career path thus seems to relate primarily to the character traits she associates with surgeons. Her reasoning is that "I just don't want to *be* that".

Another junior doctor, Kate, similarly expressed concern about perspective and the kind of person she is and wants to be. Again in her discussion, organisational constraints feature as limiting her ability to act in line with her own values. In this case, her description implies a perception that emotional engagement with patients is incompatible with the type of work that is required of her as an intern.

I'm quite an emotional person and as a medical student found like I would get emotional about situations that I would, the patients. I haven't had that [since becoming an intern].

R: What do you think has changed? Because the environment's similar when you're a medical student

It is but the pressure's different. You're not, you don't, you're not as stretched. A lot of the time I feel like I'm engaged, like the work that I'm doing, I'm so busy that I don't have time for emotional, for any of my emotional brain to even be engaged. Like everything else, all of my coping mechanisms are stretched just over getting done what I have to get done. So that happens. And it's really, it's quite amazing. And I guess I'm not comfortable with that. And that is part of the reason why I've, heading towards a career in general practice, where I hope that I can have the time and the ongoing relationships with patients so that I can be, not that I think that you need to be overly emotionally involved but I can, I can show more empathy to the patient and their situation. At the moment I'm basically, like a lot of that has changed (Interview 4, p.22).

Kate's description suggests that she has characterised the hospital environment as incompatible with being empathetic. In her intern job she is so "stretched", so "busy" that she cannot engage emotionally with patients. "The work that [she's] doing" prevents that kind of relationship. She is "not comfortable" with this "change" in herself. Her rationale for pursuing a career in general practice is a character-based one. She wants to "show more empathy to the patient and their situation" than she is as an intern in the hospital context.

Kate also discussed how normalised the medical world becomes for junior doctors, particularly in contrast with the exotic and intense nature of the same world for their patients.

I'm really surprised by how many patients I just like forget, that I will run into at a supermarket or they'll come back in outpatients clinic and walk in and go 'Kate!', and I'll be like 'nup, I have no recollection of you'. So that's a bit of a surprise, that you can forget so many people...Them coming into hospital and seeing a doctor or seeing a surgeon is far more a poignant moment for them and something that stays in their mind than it is for me. It's my everyday...It becomes a very normal world, to the point that you can find, be very humorous and sort of casual about quite severe things. Like quite, this is something I wasn't really aware of, that, the fact that you know, I can really distance myself emotionally. It's something that happens really quickly. So that the MET call I get which is an emergency, a medical emergency team call or a code blue, that I get at 9:45, while I'm capable of doing everything I need to do, I might walk away at eleven and go 'that bugger! Like why did he have to go and have a cardiac arrest fifteen minutes before I was leaving?!'. Like, you know, 'I wanted to do this tonight, I wanted to do that', and you can kind of, and then you go 'wait a sec', like really in the scheme of things, me missing out on watching a TV show or chatting to a friend is nothing compared to what they're going through. But you distance yourself from, because it's my everyday (Interview 4, pp.20-1).

Kate explicitly attributes the unexpected change in her outlook to the everyday nature of the hospital environment saying twice that "it's my everyday". She suggests that it is because the hospital "becomes a very normal world" that her responses at work sometimes no longer reflect her deeply held values. Again the concern is expressed in terms of "being": she can "be very humorous and sort of casual" about things that she,

on reflection, actually thinks are “quite severe”. She has to correct herself when she feels aggrieved by the patient whose illness prevents her leaving work. The passage suggests that as a result of her internship experiences, her responses to patients are coming apart from her own ideas about relative importance, about how things ought to be valued “in the scheme of things”.

Response-value discordance

One participant, Eva, reflected in detail on an experience of this discordance between her response and her actual values.

One day I was so busy at the start of this job. And at the start of the job everything’s such a fricking schmozzle because you don’t, you know, time management just goes out the window because everything’s new. And I was really stressed out. I was in preadmission clinic. I was already two hours overdue. I couldn’t go any faster. Everything was unfamiliar. The ward was paging me and I was just like ‘oh my God, leave me alone. Just leave me alone’.

And then I got this call, outside call, thought ‘I better answer, who knows who’s calling?’. Picked up, and it’s some patient’s family. And I was sitting on the phone going [thinking] ‘are you crazy? What makes you think you can call me?’. I was like, you know, ‘if every patient’s family was calling me I’d never get anything done’.

And I was *extremely* polite on the phone. And the lady said to me ‘oh, you know, I heard my mum’s getting this scan. When’s it happening?’. I said ‘she’s getting the scan now. But we’ve got another one [test]. We’re going to do them as inpatients so that, if we leave it as outpatients it’s going to take much longer. So we’re going to keep her in until Friday, get them both out of the way and then we’ll send her home’. And she said to me ‘can you let me know what the result is? Can you call me and let me know what the results are of those investigations, and then also just let us know what day you’re planning on sending her home?’. And I was like ‘sure, sure’.

And I got off the phone and I was thinking ‘how demanding!’. I was like ‘goodness gracious, I’m going to call her with the results and I’m going to call her to tell her what day we’re’ and I was ‘oh my God!’. Two seconds later I was like ‘Eva, fucking idiot!’. What she’s asking is the *minimum* that I should be providing. You know, the

woman's got metastatic breast cancer. They're asking the results of an investigation which says whether this thing's spread all over her body. And I'm sitting there going 'oh, such a big deal to call her and go this is the result'? They're asking what day she can come home, probably so someone can actually be there to look after this poor woman! And I was just so angry at myself that I was so stressed out timewise that something that I think is the *minimum* requirement for good patient care and decency towards the family, I was outraged that someone was calling me to request this information from me, you know?

And it just, it just made me, that's like the system things that you have no control over that are very frustrating. That I go that should be the very least I'm doing for every single one of my patients, going 'this is what we're waiting on, this is what we're doing, and this is probably when your person is going to come home so be ready'. But you don't! You don't! ...It's just that you've got other things on your mind and at the end of the day that person isn't your relative. Do you know what I mean? It's not your priority when, that probably matters more than, you know, getting the radiology list in for next week's theatre. That probably matters more on a, in an absolute sense of what's important in life, letting them know. But practically for you as the intern, the consequences, whether you call her, tough shit, you know, she doesn't find out and she gets annoyed. You don't have the films ready, you get shouted at. You know, the individual consequences are much more for your practical work than [for] not telling her. Like that annoys me as a person. Like I go 'that's a shortcoming on my behalf'. But as an *intern*, what makes me a good intern is that I get that other shit done. Not that I've called [patients' families]. I mean ideally the angel intern would do all of it but sometimes, you know, you just don't get it all done. I think, that I find frustrating sometimes (Interview 9, pp.25-7, participant's emphasis).

Eva's story is interpretable as one about character. As with Kate's discussion, it expresses a concern about the kind of person she is becoming as she experiences internship. Despite her frustration and anger with herself, Eva seems to have in fact *acted* in accordance with her reflected view of what the right thing to do is in the situation that she faced. She describes herself as "extremely polite on the phone" to the patient's daughter and responds "sure, sure" to her request. (Whether she later rang the daughter back with the information requested is not clear; if she did, the point is even stronger.) Supporting the idea that the story is interpretable as one about

character, Eva's distress seems more a response to her recognition of a change in her outlook rather than any concern about how she acted. She is cross with herself for perceiving the situation in the way that she did rather than for performing some wrong action.

Her outlook upsets her because of its discordance with the actual values that she holds. Eva's distress seems, at least in part, attributable to her experiencing a mismatch between her considered views about good doctoring and what she herself perceives as important when that actual patient care situation arises in her work as an intern. Because of the pressure she is under – the newness of the job, the stress, the workload, “the system things that you have no control over” – she responds in a way that makes her “just so angry with [her]self”. In the thick of things, she genuinely resents providing that which she reflectively believes is the minimum decent standard of care.

This issue of junior doctors developing a distance between their immediate responses to work situations and their actual values can be seen in other writing. Autobiographical writing by interns regularly contains guilty admissions of wishing inconvenient patients dead or resenting patients' reasonable demands. Foxton, for example, a UK intern who wrote a newspaper column for the *Guardian* during his internship, writes

I am gradually, regrettably, ceasing to care...Part of the problem is, of course, that I'm just so busy. ‘What was the result of that test my father had yesterday, doctor?’ people ask, quite reasonably. And the responses that spring into my head, in order of increasing shamefulness, are: ‘What test?’, ‘How the fuck should I know?’ and ‘What's it got to do with you?’ (Foxton, 2007, p.26).

Pemberton, also a UK intern, similarly writes that

[i]t was for the Mr Clarkes of the world that I became a doctor. I naively thought that after doing a medical degree I'd be qualified to help people, ease their suffering. But as I stare at Mr Clarke all I can think is why does he have to be dying during my shift? Couldn't he have waited? (Pemberton, 2008, p.15).

A key feature of these descriptions is the writers' condemnation of their responses. For Foxton, his responses are "regrettable" and "shameful" just as Eva berates herself and Kate is "not comfortable" with her lack of empathy.

This idea of response-value discordance has some links with the concept of moral distress. Moral distress, as originally defined by Jameton, "arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton, 1984, p.6). Moral distress is primarily discussed in the context of nurses' limited agency, but has recently been applied more broadly to a wider range of healthcare professionals, including doctors (see for example Kalvemark et al., 2004). However, in significant ways, response-value discordance is different to moral distress. For Eva and other junior doctors, response-value discordance seems to go deeper than moral distress because it is their very responses that are at stake. It is not just that they cannot *do* something that they think is morally required, but rather that the responses they are experiencing within themselves are not those that they reflectively believe are ethically appropriate. While moral distress relates to what an agent can and cannot do, response-value discordance seems to relate more to the person that an agent is and the doctor that an intern or resident is becoming. It is an issue of character rather than simply limited action.

In the existing body of junior doctors' narratives, response-value discordance is generally recorded without consideration of the ethical import of these experiences. The stories are framed simply as unpleasant, awkward incidents attributable to the fatigue and stress of hospital work, without further exploration of their moral import or implications. Shem's classic fictionalised account of internship provides such an example.

I was surprised to hear myself cursing under my breath as I resuscitated her, 'I wish she would die so I could just go to sleep,' and I was shocked when I realised that I'd just wished a human being dead so I could go to sleep. *Animal* (Shem, 1985, p.127).

Some writers are more reflective. Foxton, for example, praises his peers who guiltily share their similar stories, writing that

these doctors who jokingly admit to nasty feelings like these, they are the ones you would want to be your doctor. Because they're the ones honest enough not to get caught up in that elaborate fantasy doctor world where you're as noble, infallible and omnipotent as the medicine you think you practice (Foxton, 2007, p.118).

Sharing these stories of discordance is taken as evidence of being disturbed and embarrassed by one's responses. For Foxton, a doctor discussing responses discordant with his or her values is evidence that he or she is in fact a good doctor.

I suggest that moments of response-value discordance ought to be recognised as having significant ethical import, particularly by junior doctors themselves. Such experiences highlight personal ethical commitments that are under threat, and thus are worthy of thoughtful consideration by the doctors involved. If a junior doctor is concerned about the values shaping his or her behaviour, as arguably all doctors ought to be, he or she needs to pause and reflect when it seems as though those values are changing. Taking notice of response-value discordance facilitates the enacting of values that one embraces wholeheartedly and with ethical justification, rather than simply those values encouraged by the environment. Active interrogation of the experience of response-value discordance seems to have some potential to protect junior doctors against having their moral commitments shaped passively by organisational pressures and hospital priorities. Recognising and engaging with response-value discordance can thus be seen as an ethical challenge for interns and residents. It is an ethical challenge of a somewhat different nature to the action-based challenges identified in the typology, focusing as it does on overarching values and fundamental ethical commitments.

“THE GOOD INTERN”

Eva invokes the concept of “the good intern” in her discussion of her experience of response-value discordance. She suggests that is her efforts to be a good intern that have undermined her own ethical outlook. Her prioritising other work over communicating with families “annoys [her] as a person” but, in her words, “what

makes me a good intern is that I get that other shit done”. Her discussion alerts us to the possibility that being a good intern is a different matter to being a good person or a good doctor. She presents the good doctor as focused on things like “good patient care and decency towards the family” in contrast to the good intern who is concerned with their “practical work” like “getting the radiology list in for next week’s theatre”. Fulfilling the employee and team member responsibilities seems crucial to being a good intern. The “good” in her concept “good intern” thus seems to refer more to success in the hospital environment than to the professional goal of improving patients’ well-being that is standardly associated with being a good doctor (Oakley & Cocking, 2001, p.75; Pellegrino & Thomasma, 1993, p.xiii; Drane, 1988, p.32).

Eva’s use of the idea of a good intern invites philosophical reflection on what it means to be a good junior doctor. What *is* a good intern? How should we understand this concept? Up to this point, I have articulated the various roles in which junior doctors are simultaneously situated by aspects of their organisational context, using the notion of the multiple-role position to describe junior doctors’ complex situation in the hospital. However, Eva suggests a different type of concept with her notion of the good intern. “Good intern” as she uses it does not describe the junior doctor’s situation, but rather dictates what the junior doctor has to do in order to be successful in his or her organisational role. “The good intern” in Eva’s story is a normative concept, one that describes how junior doctors ought to act.

The concept of the good intern in Eva’s story seems a *prudentially* normative idea rather than a *morally* normative one. It describes what a junior doctor needs to do in order to progress smoothly through internship and up the medical hierarchy, rather than what a junior doctor needs to do in order to act ethically. However, Eva’s use of the notion of a good intern suggested to me the possibility of a morally normative version of the concept, as well as the potential of such a morally normative version to be a framework for analysing junior doctors’ ethical challenges. I have argued throughout this thesis that ethical analysis of the issues associated with internship and residency must take into account junior doctors’ multiple-role position and the real

agency limitations that it creates. A detailed articulation of the concept of an ethically good junior doctor could encapsulate the multiple roles that junior doctors play: the ethically good junior doctor can be posited as virtuous in relation to his or her various roles. The focus of the next chapter is the development of this role-based notion of the morally good junior doctor and its usefulness as a framework for ethical analysis. Participants' concerns about character, particularly their reflections on response-value discordance have therefore suggested a potential way of thinking about their ethical challenges around action.

CHAPTER 7: CONCEPTUALISING THE GOOD JUNIOR DOCTOR

Eva’s story indicated that being a good intern is not just a matter of being a good doctor. In her words, “ideally the angel intern would do all of it”, communicating with patients’ families as well as churning through the “practical work”. In this chapter, I develop the concept of the good intern systematically from an ethical perspective, arguing that the good junior doctor can be conceptualised as being good with respect to four different roles: doctor, medical learner, team member and employee. I suggest that there are specific virtues associated with each of these four roles, but also that there is potential debate about the components and nature of each set of role virtues. The virtues associated with being a good doctor, for example, are to some degree controversial. The diagram below represents the conceptualisation of the good junior doctor that I put forward.

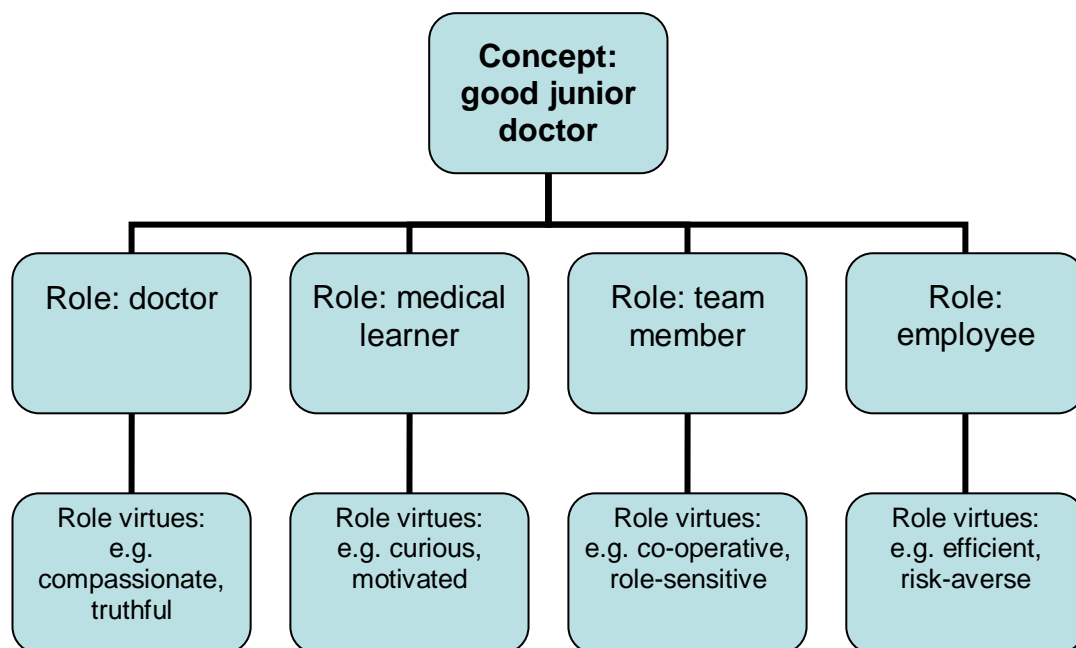


Figure 3: The concept of the good junior doctor

Having outlined a possible set of virtues for each of the four roles, I argue that many of the ethical issues associated with internship and residency are best understood as role virtue conflicts. The ethical challenges faced by junior doctors are primarily conflicts between the virtues associated with the different roles (for example, between doctor virtues and employee virtues). Some challenges involve conflict between different understandings of the components making up a set of role virtues (for example, about the virtuousness of deference in a medical learner). In the final section of the chapter, I use one participant's story firstly to demonstrate the way in which junior doctors' ethical challenges involve conflicts between sets of role virtues, and secondly to show the potential normative richness of conceptualising junior doctors' ethical issues in this way. Thinking about junior doctors' ethical challenges in this role-based framework offers a method of ethical analysis that both reflects and engages with junior doctors' particular position of agency, capturing moral considerations that are overlooked by other ethical frameworks like consequentialism and principlism.

ROLE MORALITY AND JUNIOR DOCTORS

In chapter three, in light of current literature I suggested that junior doctors' professional situation positions them in three different roles: doctor, subjugate learner, and employee. The interview data discussed in chapter four suggested firstly that the subjugate and learner roles are separable, secondly that the subjugate role was essentially about being a good team member, and thirdly that there are two additional roles played by interns and residents: teacher and competitor. In this section I look again to existing literature, this time for ideas about the virtues associated with four of these roles: doctor, medical learner, team member, and employee.

I focus on just these four because most writing on professional roles bases claims about role virtues on a posited fundamental nature or goal of the activity in question. Pellegrino and Thomasma, for example, take "the derivation of the characteristics of the good physician [to be] from the nature of the kind of activity medicine is"

(Pellegrino & Thomasma, 1993, p.xiii). In line with this, I will focus only on the roles of doctor, medical learner, team member, and employee in conceptualising the good junior doctor. This is because, to my mind, it is these four activities – serving patients’ health needs, learning medicine, membership of a medical team, and hospital employment – that together represent the telos of internship/residency. Unlike medicine per se, internship and residency lack a single straightforward goal. The telos of these early professional years instead seems to be a genuine hybrid of those associated with medical practice, medical education, and hospital employment. This hybrid goal justifies setting aside teacher and competitor in conceptualising the good junior doctor. The training of undergraduate medical students and the competition between junior doctors for career opportunities do not seem fundamental to the aim of the early postgraduate years in the way that medical practice, further learning, teamwork, and hospital employment do. Making sense of the idea of internship without competition between peers is certainly possible, suggesting that this element is not essential to being a junior doctor. The teaching role is similarly peripheral, played only sporadically in the absence of more senior doctors and outside the scope of junior doctors’ formal evaluations. Thus, in conceptualising the good junior doctor, my focus is on the four fundamental roles.

I assume that each of the four elements of the hybrid telos is itself morally good. The role virtues I put forward are dependent, in the sense that their goodness relies on the goodness of the end to which they are being employed. For example, efficiency is only a virtue if the goal being pursued is a morally worthwhile one. In the context of healing, efficiency is a virtue. In the context of burglary, it is not. The four goals of internship and residency seem plausibly to be morally worthwhile. Directly serving patients’ health needs and learning medicine are obviously ethically sound pursuits. Being part of a medical team and the hospital as a whole organisation also seem morally good, when these structures are viewed as ultimately aimed at promoting patients’ health.

It is also important to emphasise that the role virtues I suggest in this chapter are not being put forward as definitive. While I outline virtues plausibly associated with each of the four roles, my fundamental claim is that each of the roles constituting the concept of the good junior doctor involves a set of role virtues and that these sets differ substantially (but not necessarily entirely) from one another. Assuming the plausibility of the sets I outline, I use these in analysing junior doctors' ethical challenges in subsequent discussions, but I am primarily advocating the form of analysis rather than the exact contents of the role virtue sets. The success of my analysis is thus not tied to acceptance of the particular virtues I outline, but rather to acceptance of the role virtues approach as a useful one. Articulating definitively the sets of role virtues is a task for a future project. But as a starting point, what does existing literature have to say about the virtues associated with doctors, medical learners, team members, and employees?

The role virtues of a doctor

The virtues of a doctor have been discussed extensively in philosophical literature. These discussions are positioned firmly in the context of professional ethics (see, for example, Oakley & Cocking, 2001, ch.3; Pellegrino & Thomasma, 1993, ch.3; Drane, 1988, ch.1). Pellegrino and Thomasma, for example, describe medicine as “a moral enterprise that imposes collective responsibilities of great moment on its practitioners” and claim that “the most crucial dilemmas of medical ethics today...are dilemmas of professional ethics, those that go to the heart of what it is to be a physician” (Pellegrino & Thomasma, 1993, pp.35,31). In these discussions of the good doctor, a person is a good doctor to the extent that he or she displays the character traits and fulfils the obligations associated with being a member of the medical profession.

Empirical data is emerging about practitioners' own views on medical virtue in their particular speciality (eg. Braunack-Mayer, 2005; Larkin et al., 1996), however the vast majority of discussions draw on the overall goal of the profession in order to elucidate the character traits of the good doctor. For example, Oakley and Cocking

invoke the profession's goal as a basis for a conception of the good doctor. They claim that

[t]he content of the regulative ideals of a good doctor must be determined by reference to some model of what doctoring purports to be. That is, those regulative ideals will be informed by an account of the proper goals of medicine as a *practice* – a *philosophy* of medicine – and an account of what sort of doctor-patient relationships are appropriate in such a practice (Oakley & Cocking, 2001, p.75, italics in original).

Similarly Drane, in his book *Becoming a good doctor*, specifically aims to “develop a catalogue of character traits dictated by the needs of patients and the nature of medical acts” (Drane, 1988, p.32). Pellegrino and Thomasma are typical in defining “the ultimate end” of medicine as “the health of individuals and society, while the more proximate end is a right and good healing action for a specific patient” (Pellegrino & Thomasma, 1993, p.86).

The specific role virtues derived from this telos are various. In the table below, I present the lists put forward by three prominent books in this area: *Becoming a good doctor: the place of virtue and character in medical ethics* (Drane, 1988), *The virtues in medical practice* (Pellegrino & Thomasma, 1993), and *Virtue ethics and professional roles* (Oakley & Cocking, 2001). The book by Drane and that by Pellegrino and Thomasma both represent systematic attempts to articulate the role virtues of a doctor and are widely cited in discussions of medical virtue. Oakley and Cocking use medicine as an illustrative case in advocating a virtue approach to professional ethics in general. None of these philosophers presents his list as definitive or complete (Oakley & Cocking, 2001, pp.75, 93; Pellegrino & Thomasma, 1993, p.60; Drane, 1988, pp.17, 29-30), but the contents of the conceptions and particularly the points of overlap are worth noting. As the various writers understand similar virtues in differing ways, I have included brief descriptions of their understandings of each virtue. I have used the authors' exact terminology in naming the virtues, even though this produces inconsistencies across authors.

Drane	Pellegrino and Thomasma	Oakley and Cocking
Benevolence – the disposition “to treat... patients in a caring and personal way” (p.63)	Compassion – “the character trait that shapes the cognitive aspect of healing to fit the unique predicament of <i>this</i> patient” (p.79, italics in original); co-experiencing the patient’s suffering (pp.79-82)	Beneficence – “a disposition to focus on the patient’s own psychophysical needs” including “sensitivity and tactfulness” (p.93)
Justice – “fair distribution of medical goods and services”; the disposition to “giv[e] to others what is their due” (p.105)	Justice – “the strict habit of rendering what is due to others” (p.92)	Justice – ensuring that “morally irrelevant grounds” do not determine who receives treatment (p.93)
Truthfulness – the disposition “to a real communication designed to meet the patient’s needs, and to a beautiful communication in the sense of being a sensitively and artfully delivered truth” (p.53)		Truthfulness – “enables doctors to meet the constraint of respect for patient autonomy”; also improves outcomes (p.93)
	Fidelity to trust – involves “becoming familiar with who and what the patient is and how she wants to meet the serious challenges of illness, disability, and death” and providing “the proper timing, sensitivity and degree of detail appropriate in each case” (p.76)	Trustworthy – facilitates patients’ disclosure (p.93)
	Fortitude – “moral courage”; “the virtue that renders an individual capable of acting on principle in the face of potential harmful consequences without either retreating too soon from that principle or remaining steadfast to the point of absurdity” (p.111)	Courage – being “not too easily deterred from treating serious infectious diseases”, while also taking adequate precautions to protect their own health (p.93)
	Temperance – “the constant disposition of physicians toward responsible use of power for the good of their patients”, avoiding both underuse and overuse of technology (p.122) (Humility is suggested as a separate virtue but	Humility – a preparedness to concede, after reasonable effort, that treatment has failed (p.93)

	is not discussed further, p.60)	
Respect – the attitude of reverence towards patients’ capacity for autonomy and their autonomous acts (p.64)		
Friendliness – “being well disposed toward affectionate relationships with other persons and controlling hostile forces within oneself”; “understanding” (p.89)		
Religion – in the sense of grappling with deep questions about the meaning of life, rather than specifically organised religion (pp.28-9)		
	Prudence/phronesis – the guide to acting rightly with respect to all the virtues; “helps us to discern, at this moment, in this situation, what action...will most closely approximate the right and the good” (p.85)	
	Integrity – the integration of all the virtues into a whole; the predictable “judge[ment of] the relative importance in each situation of principles, rules, guidelines, precepts, and the other virtues in reaching a decision to act” (p.127)	
	Self-effacement – effacement of self-interest; altruism (p.157)	

Table 7: Existing accounts of the virtues of the good doctor

Some consistent themes emerge from these accounts. The virtuous doctor is seen as **compassionate** and **benevolent**, engaging with patients sensitively and caringly. The good doctor is also posited as **truthful**, but in a way shaped by his or her compassion; the medical virtue of truthfulness is not just brutal honesty. The virtuous doctor is **just**, allocating resources including his or her own skills on ethical grounds. Facing the combination of medical complexity, human mortality, and vast technological

possibilities, the virtuous doctor is appropriately **humble** about the possibility that treatment may fail. Altruism is presented as a further character trait of the good doctor. He or she is to some degree **self-sacrificing**, putting patients' needs first. This connects with the medical virtue of **integrity**; the virtuous doctor acts in line with his or her ethical principles even at some cost to himself or herself.

It is important to note that each of these virtues is understood as intrinsically involving an appropriate judgement about degree and target. This draws on the Aristotelian idea that

virtue of character...is about feelings and actions, and these admit of excess, deficiency and an intermediate condition...Having these feelings at the right times, about the right things, toward the right people, for the right end, and in the right way, is the intermediate and best condition, and this is proper to virtue (Aristotle, 1999, II 6, 1106b17-24).

Thus the claim is not, for example, that the virtuous doctor is completely self-sacrificing at every opportunity. Extreme, rash instances of self-sacrifice would not be instantiations of the *virtue* of self-sacrifice. The virtue involves the appropriate degree. Pellegrino and Thomasma emphasise this point, arguing in relation to compassion that

[a]s a virtue, compassion also strives for a mean. If the physician identifies too closely as cosufferer with the patient, she loses the objectivity essential to the most precise assessment of what is wrong, of what can be done, and of what should be done to meet those needs. Excessive cosuffering also impedes and may even paralyse the physician in a state of inaction. Cosuffering also has the danger of so close an identification with the patient's suffering that the physician unconsciously imposes her values on the patient (Pellegrino & Thomasma, 1993, p.81).

Such "cosuffering", while arguably compassionate in some sense, fails to qualify as an instance of the virtue of compassion. Oakley and Cocking give the example of "medical courage" involving doctors being "not too easily deterred from treating serious infectious diseases" while also "not rashly fail[ing] to take adequate precautions against becoming infected themselves" (Oakley & Cocking, 2001, p.93).

Here again the virtue intrinsically involves appropriateness with respect to degree and situation.

The role virtues of a medical learner

A different set of virtues could presumably be posited in relation to medical education. In this section I explore possible contents for such a set. There is, to my knowledge, no virtue ethics work explicitly exploring the medical learner role, although work on teaching medical students to be virtuous *doctors* does exist (see for example Barnbaum, 2001; Coulehan & Williams, 2001; Wear & Castellani, 2000; Kopelman, 1999). Philosophical literature on the virtues associated with learning in a general sense is also very limited. Work here tends to focus on teaching philosophy students to become better thinkers (see for example Battaly, 2006). However, the question of the relationship between character traits and learning in general is very much a live one in education research. An influential textbook in the area posits the question “how does learning vary as a function of personality characteristics?” as one of the key unanswered questions about learning (Hergenhahn & Olson, 2001, p.450).

It seems reasonable to assume that character traits such as being curious, motivated, questioning, and engaged are role virtues for learners in general, as such traits facilitate the acquisition of knowledge and skills. However, my focus in this section is specifically on the role of *medical* learner. This is because medical learning is to some degree unusual in that much of it takes place on other people. Although learners in many other disciplines and contexts such as teaching and the law learn using those people in their professional care, undergraduate medical students as well as qualified doctors need to engage with patients *physically* in order to learn. (Other healthcare professions such as nursing and physiotherapy also involve this type of learning.) Thus it seems likely that the medical learner’s role virtues will include a set of character traits relating to physically interacting with unwell people that may not apply to learners in general.

Despite the lack of systematic philosophical work in this area, medical educators write of the characteristics of good medical learners in ways that can be read as essentially positing role virtues. Writing on the recent move towards problem-based learning (PBL) in undergraduate medical education is particularly useful here. PBL involves the theoretical investigation of problems similar to those that students will meet in their professional lives, tackled in small tutorial groups (Parker, 1995, p.307). As Walton and Matthews write,

the principle of PBL is to put learners in a particular situation, and then to give them a task or challenges as a source for learning, and arrange it to be of a kind similar to work with which they will be confronted in their professional future (Walton & Matthews, 1989, p.543).

PBL is seen as teaching a set of professional skills that will serve the new graduate throughout his or her medical career. The focus is on developing skills of reasoning, synthesis, and critical thinking rather than the systematic memorising of disciplinary slabs of information. A key emphasis is on “self-directed learning”, posited as necessary for the “lifelong continuing education” involved in medicine (Walton & Matthews, 1989, p.544).

Existing writing on PBL is illuminating in terms of the medical learner’s role virtues. Educators implicitly present a clear conception of the good medical learner in their articulation of the advantages of PBL. For example, Walton and Matthews write of PBL as valuable in part because it encourages learners to “see ignorance as a challenge to further learning rather than as a cause for shame” (Walton & Matthews, 1989, p.544). Here the good medical learner is implicitly posited as **curious** and questioning. Various authors emphasise the way in which PBL requires collaborative learning amongst peers (Parker, 1995, p.307; Walton & Matthews, 1989, pp.544, 547). The good medical learner is thus **co-operative** and team-orientated. The good medical learner is also **committed** to his or her education and development; PBL facilitates “acceptance of the necessity and challenge of life-long learning” (Walton & Matthews, 1989, p.544). He or she is **motivated**. A key value of PBL is its

perceived ability to motivate learners through group discussion and relevance to practice (Schmidt, 1993, pp.426-7). Being **responsible** is a further role virtue posited here; educators enthuse about the self-directed nature of PBL and the importance of “putting students into the driver’s seat” (Walton & Matthews, 1989, p.549). The good medical learner is seen as taking responsibility for his or her own learning and decision-making. Being **tolerant of uncertainty** is also implicitly put forward as a medical learner role virtue:

students have to learn to become comfortable with the concept of ‘probability’ rather than of ‘certainty’, and to realize that decisions have often to be made on inadequate grounds. They have to learn to tolerate doubt (Walton & Matthews, 1989, p.547).

Good medical learners, it is suggested, are able to function in the context where definitive factual information relevant to their decision-making may be unavailable or nonexistent. Good medical learners are also disposed to listen closely to patients and are **patient-focused** in the sense of recognising patients as their most fundamental learning resource (Walton & Matthews, 1989, p.549). Further medical learner role virtues implied are being **vocal** in the learning context, and being **reflective** about their learning and behaviour. The role virtue of being vocal is implicitly posited in claims such as the following:

[i]n small group learning students have to discover that they have actively to play their share, to realize that silence will be liable to be taken as assent, and to develop the habit of intervening when they recognize that their silence is being misinterpreted (Walton & Matthews, 1989, p.550).

Here, PBL is seen as useful because it forces students to speak up. With regard to the role virtue of self-reflectiveness, it is suggested that reflection is crucial to good practice and that “in PBL, this form of learning is built into the structure [of medical schooling]” (Walton & Matthews, 1989, p.551).

In the hospital context where junior doctors are actually educated, the character traits of the good medical learner may of course differ from those theorised by educators. The setting in which learning occurs plays an important part in determining the traits

that function as role virtues for the medical learner. Assuming that the telos of medical learning is the acquisition of knowledge about and skills for the treatment of human illness, and understanding “good” in the sense of “effective” or “successful” in relation to this goal, the character traits described above may not be those of the good medical learner in the hospital context. Ward rounds, for example, as a formal educational experience for junior doctors might suggest other role virtues. Being deferential to authority, and competitive could plausibly be seen as virtues of the medical learner in the context of ward round questioning or of limited opportunities for development of a particular skill (for example where a patient with a highly unusual condition is being treated in the hospital). In such situations, being competitive rather than co-operative may be most effective for gaining learning opportunities. Deference to authority may ingratiate junior doctors to their superiors in ways that open up additional learning opportunities, such as the chance to assist in an interesting surgical procedure. Despite these potential controversies about the exact contents of the set of character traits that would be conducive to medical learning, the key point stands: there are a set of role virtues associated with being a medical learner.

The role virtues of a team member

Similarly, there are a set of role virtues associated with being a good team member that differ substantially from those of the good doctor or the good medical learner. As discussed in chapter four, contributing to the smooth functioning of the medical team was seen by participants as crucial to success as a junior doctor. In this section I will assume that the telos of team membership is the effective functioning of the team for the fulfilment of its (presumably ethically sound) objectives. Although, in the junior doctor context, there is some overlap between the team’s objective and the telos of medicine, in line with the sentiments expressed by participants I will assume that it is the effective functioning of the team per se that is the fundamental concern of the good team member.

Once again, virtue in relation to this particular role has not been a topic of interest to philosophers. However, management literature on organisational teams offers some insights into the role virtues of the good team member. In this context, Clegg and colleagues define a team as “two or more people psychologically contracted together to achieve a common organisational goal in which all individuals share at least some level of responsibility and accountability” (Clegg et al., 2005, p.211). The medical teams in which junior doctors work clearly fit this definition; the members are together invested in the hospital’s goal of caring for patients and each bears some responsibility for furthering this aim.

One role virtue of the good team member that is clearly implied by management literature is that of being **hard-working**. Good team members are posited, in part, as those who actively participate in the team’s endeavours, contributing at least their fair share to the work of the team. The fact that freeloading and its destructive effects are a consistent concern in textbook discussions of organisational teams is evidence for being hardworking as a perceived role virtue of a team member (see for example Clegg et al., 2005, p.217; Carlopio et al., 2001, p.509). A further team member role virtue implied in management literature is being **communicative** with other team members. Fried and colleagues make the compelling point that “a group cannot function effectively as a team unless members can exchange information” (Fried et al., 2000, p.172). Being **trustworthy** and appropriately **trusting** are also posited as role virtues of team members. Carlopio and colleagues identify various features of successful teams including “a high level of trust among members” (Carlopio et al., 2001, p.466).

One text defines teams in terms of “interdependence among members and differentiated member roles”. This suggests two further character traits of good team members: being **co-operative** and being **role-sensitive**. In terms of co-operation, any team’s desired outcomes are necessarily dependent on members acting co-operatively. In the hospital context, for example, the delivery of good patient care requires that each member of the team does the tasks expected of him or her by the other members;

the consultant's skilful operation is undermined if the intern fails to care appropriately for the post-operative patient on the ward. It has also been suggested that effective team functioning requires team members to be aware of their specific place in the team and the responsibilities and restrictions associated with that place. As Fried and colleagues state, "[a]s team members, it is critical to understand where we fit within the context of a particular team" (Fried et al., 2000, p.159). Thus the good team member can be seen as having the character trait of role-sensitivity. This certainly seems to be the case for internship and residency. Recall that this "team member" role was initially conceptualised as that of "subjugate". Unlike, for example, being a player in a sporting team where each member has different responsibilities but similar status, the intern or resident in the medical team has limited power compared with his or her more senior colleagues by virtue of his or her position. The team member role as played by junior doctors is quite specific to strictly hierarchical team structures. As has been discussed, sensitivity to the boundaries associated with this junior position in the team is a necessary part of functioning well as an intern or resident.

The role virtues of an employee

In this section I focus on employees generally, but also relate the role virtues under discussion to junior doctors' hospital context specifically. This is because being employed by a hospital is similar in many ways to being employed by any large organisation. I propose that the role virtues of a good employee relate to ability to achieve the goals of the organisation for which he or she works. A person is virtuous qua employee if he or she has the character traits conducive to furthering the organisation's aims (assuming that the organisation's aims are themselves morally good).

The goals of the public hospitals that employ junior doctors can be difficult to pin down. Their mission statements primarily emphasise compassionate, respectful, high quality patient care. The Victorian hospital consortium Eastern Health is typical, with its stated aims "to continuously improve the quality and safety of patient care" (Eastern Health, 2003). However, the way in which the public hospital system is

structured inherently limits public hospitals' pursuit of these goals. (The following discussion relates to the Australian state of Victoria, but significant similarities exist with other Western jurisdictions.) Public hospitals are funded by the state government through the Department of Health. (Before the establishment of the Department of Health in 2009, this function was performed by the Department of Human Services.) Each year, hospital administrators and the Minister for Health, through the department, agree on a range of objectives, projects and targets for each individual hospital network (Department of Human Services, 2007a). These agreements are presented by the department as "ensur[ing] delivery or substantial progress towards the key shared objectives of financial stability, improved access and waiting times, and quality of service provision" (Department of Human Services, 2007a). Because of their financial dependence on the department, hospitals cannot avoid having their goals constrained by those of the government. The department's complex system of funding incentives and penalties for hospitals in relation to their fulfilment of the government's priorities (see for example Department of Human Services, 2007b, p.27) ensures that a hospital's activities must mirror the government's aims for health in order for the hospital to remain viable. Thus, the role virtues of a hospital employee will be those character traits conducive to furthering the goal of compassionate patient care, within the constraints imposed by the government's potentially different emphasis.

A disposition to work speedily and effectively is useful in furthering institutional goals. In website descriptions of the good employee by employers and consultants, being **efficient**, productive and hardworking are posited as crucial attributes (see, for example, Illinois Department of Employment and Security, 2008; Anonymous, 2008a; Gates, 1998). Participants in this study mentioned various aspects of hospital organisation that suggest that the good hospital employee is efficient, such as some hospital administrators' unwillingness to pay overtime and the lack of allocated meal breaks or protected study time. The good employee gets things done, churning through his or her workload. Across management literature and website descriptions, the good employee is also posited as knowledgeable and **competent**, doing his or her

work not only efficiently but also well (see, for example, Anonymous, 2008b; Anonymous, 2007, p.31; Vecchio et al., 1996, p.95).

A further, related, role virtue of the employee is **dedication** to the job. Building employees' commitment, motivation and dedication are recurring themes in management literature (see, for example, Clegg et al., 2005, p.250; D'Aunno et al., 2000, p.65; Vecchio et al., 1996, pp.203,261). Writing on employee recruitment emphasises finding people who "fit" with the organisation's goals and culture (see, for example, Smethurst, 2006; Sirbasku, 2002, p.32; Randell, 1998, p.16). This emphasis can be understood as implying dedication as a trait of the good employee. Although dedication is arguably a requirement of professionalism in any employment context, dedication seems to be required at a particularly intense level to qualify as a good *hospital* employee. A willingness to work long hours, accepting the interference with family life and personal pursuits that this involves, seems to be a necessary part of hospital work caring for patients, given current resource constraints. (The acidity of doctors' criticisms of hospital administrative staff who work nine-to-five is revealing of the degree of sacrifice involved (see for example Foxton, 2007, pp.xi-xii)). The virtue of dedication being outlined here, I am sure these doctors would argue, relates to the hospital's *medical* employees only.) In the hospital case, it is difficult to separate dedication to the job from dedication to patients. The commitment to patients and continuity of care that motivates many doctors to work unpaid overtime, also directly benefits the organisation in achievement of its goals. The fact that several of the junior doctors I interviewed were advised by their more senior colleagues to cultivate an uncomplaining attitude to the hardships involved in their jobs is further evidence for dedication as a hospital employee role virtue.

Flexibility is another employee role virtue implied by writing in this area. Management literature emphasises the importance to the organisation of employees' flexibility. Bill Gates, for example, includes flexibility in his "Ten Attributes of a Good Employee" (Gates, 1998). Flexibility is undoubtedly important in enabling hospitals to meet their organisational goals. In order to provide good quality patient

care, hospital consortia require workers on the wards throughout every day and night and across all of the various geographic locations that they serve. Thus, hospitals need employees who are willing to work in the multiplicity of locations where they are needed and who quickly adapt to become effective in their new environments. The rotation system experienced by junior doctors and registrars is evidence of hospitals' need for flexible employees. Although rotating is to a certain degree justified by the educational rationale of increased exposure to diverse work (Medical Practitioners Board of Victoria, 2005, p.4), serving the organisation's need for human resources is clearly an underlying motivation and benefit. The shift work required of doctors indicates a further way in which its employees' flexibility is necessary to furthering the hospital's aims.

There is also reason to believe that the good employee has the character trait of **risk-aversion**. He or she is concerned to avoid exposing the organisation to financial, legal or reputational risks. (This is in contrast to the medical risks to the patient, which directly concern the junior doctor qua doctor and relate to the doctor's role virtue of benevolence). In the hospital context medical errors, misdiagnoses, hospital-acquired illnesses, and other adverse events during a patient's admission expose the organisation to these risks. It seems plausible that, qua employee, the junior doctor ought to be concerned about protecting the hospital from these risks which potentially impede the hospital's achievement of its goals.

I have argued that the good junior doctor is good qua four roles – doctor, medical learner, team member and employee – and that each of these four roles involves a differing set of role virtues related to that role's fundamental goal. It is worth noting that there are several overlaps in the sets outlined. Co-operation, for example, is put forward as a role virtue of both the medical learner and the team member. The sets are however substantially different. Although there is a degree of ambiguity about the exact contents of each set, this conceptualisation of the good junior doctor is useful in understanding the ethical issues associated with internship and residency: interns' and

residents' ethical challenges tend to be conflicts between virtues associated with their various roles, or about the components of a set of role virtues.

ETHICAL CHALLENGES AS ROLE VIRTUE CONFLICTS

When an ethical issue in medicine is conceived in virtue terms, it is often as a conflict between two characteristics within an assumed set of doctors' virtues. Drane, for example, discusses paternalism as a conflict between benevolence and respect (Drane, 1988, pp.65-73). These discussions often posit a particular virtue as the most fundamental. Drane argues that benevolence is "the cardinal virtue in medical ethics" and thus that "doing what will most benefit the patient medically is the doctor's primary ethical responsibility" (Drane, 1988, p.71). The other way in which ethical issues are conceived in discussions framed around virtue involves an advocacy of altruism over self-advancement or consequentialist thinking. For example, the debate around allocating resources to patients responsible for their own illness is discussed in terms of the virtuous doctor's disposition to care for the non-compliant (Pellegrino & Thomasma, 1993, p.170).

The ethical issues associated with internship and residency can be understood quite differently. Some are conflicts about the components of a set of role virtues, while most are conflicts between the virtues associated with different roles. Some issues around speaking up and questioning, for example, can be seen as conflicts about whether a characteristic is actually a virtue in relation to a certain role. These can be understood as conflicts about whether or not being vocal is a role virtue of the medical learner. One participant's discussion of asking questions describes a conflict around this issue. The discussion followed her identifying "having some sort of negotiating power" in situations that were unclear to her as the main challenge of being a junior doctor.

I mean the thing is often you get instructions that are delivered from your consultant who have been filtered through your registrar who have come down to you. And often by the time the instruction gets to you your first question is 'why are we doing

that?'. And one of the classic replies from, and it tends to be from more junior registrars is 'well if you have a problem with it, you ring Mr So-and-so or Dr So-and-so'. And you're like 'oh, no, I'm just curious' I mean, you know. I feel like the whole point of being a junior doctor is not to blindly follow commands but to actually learn why you're doing things. And certainly if you don't know why things are being done to, to ask questions. Not in an aggressive or nasty manner but just in a 'when I'm eventually a consultant I'd like to be able to make these kinds of decisions and know why I'm doing it'.

And the really interesting thing is if you ask, there's a group of registrars that if you ask that to get really walled off and defensive and I think it's because they don't know why they're doing it. And there's another group of registrars who go 'oh well I think it's basically because, you know, all of this' and try to explain it to you. And some do a very good job of explaining it.

And if the consultant then comes in and I go 'oh, I don't quite understand why this is going on' and occasionally a registrar will look at me like 'I can't believe you just asked that!'. And the consultant always goes 'oh well because' because they don't mind explaining it to you. Because their thought process to them it was very, you know, it was a, or sometimes it wasn't a clear decision. But if it's a clear decision they're happy to explain it and if it wasn't a clear decision they go 'well, I know we could have done it this way or we could have done it that way but I had a chat with the patient or I had a chat with the family and we feel that this is the better way to go. But you're right, it's not a clearcut kind of thing'. And I've never had a consultant be not wanting to explain or not willing to explain.

I mean obviously I've never asked them while blood's been pouring everywhere. I've waited til a remotely calm time but there seems, there seems to be a problem in the culture that there's a group of people who are so afraid of upsetting their boss that they won't ask questions. And then there are people like me who, you know, I think sometimes they get shocked by who want to know why we're doing anything that I don't understand why we're doing it (Interview 5, pp.9-10).

Seeing this as a clash between conceptions of the role virtues of a medical learner helps us to understand the nature of the conflict in this type of situation. The registrars who are "shocked" by the questioning resident, are (at least implicitly) positing a high degree of deference as a role virtue of the medical learner. Not

“upsetting their boss” is suggested as the primary motivation of this group. This is in contrast to this participant, whose perception is that “the whole point of being a junior doctor is not to blindly follow commands but to actually learn why you’re doing things”. Associated with this conception of the telos of being a junior doctor, she posits role virtues of questioning and being vocal. Part of the point of internship and residency in her view is “certainly if you don’t know why things are being done to, to ask questions”. Interestingly, her discussion reflects the Aristotelian point about virtues involving appropriate targets and timing. To her it is “obvious” that the medical learner waits until a “calm time” and asks “not in an aggressive or nasty manner”. Her conception of the role virtue of being vocal involves asking one’s questions in a particular type of way. The tension with colleagues in these situations can therefore be seen as the result of clashing understandings of the characteristics of the good medical learner.

This idea that some of the ethical issues associated with internship and residency can be understood as conflicts about whether a character trait is a virtue in relation to a particular role applies to a number of the ethical challenges discussed in chapters three and five. For example, telling the truth to patients about lack of experience can be seen as a question about the inclusion of truthfulness in the set of medical learner role virtues. Does being truthful serve the goal of acquiring knowledge and skills for treating illness? Similarly, negotiating a lack of supervision can be understood as a conflict between an understanding of medical learner role virtues that includes confidence, independence and curiosity and one which includes diligence, caution, and being patient-focused; the superior who leaves junior doctors to fend for themselves may well perceive himself or herself as facilitating the juniors’ learning. Subjugating one’s own opinions and values to superiors’ demands can be understood as a conflict about the appropriateness of deference as a medical learner role virtue. A detailed analysis of this type of conflict about role virtues is undertaken in chapter eight which discusses junior doctors reporting their overtime.

Although some of the ethical challenges associated with internship and residency (particularly those involving conflict with colleagues) seem to be about whether a particular character trait is a role virtue, the majority are best conceptualised as conflicts between the *sets* of virtues associated with the various roles that junior doctors play. For example, conflicts between the doctor's virtue of compassion and the learner's virtue of curiosity create the ethical issues around involving patients in medical education. The action of the good junior doctor in this situation, needing to be good qua both roles, is far from clear. Similarly, challenges around seeking patients' genuine informed consent to treatment can be understood as arising through the conflicting demands of the doctor's virtue of benevolence and the employee's virtue of efficiency, or the motivated learner wanting to gain knowledge and skills through practising procedures. The question of how the junior doctor ought to act after making a mistake is subject to the compassion and truthfulness of the virtuous doctor as well as the risk-aversion of the virtuous employee.

Looking in detail at a particular situation from this role virtues perspective demonstrates both the way in which ethical challenges involve conflicts between sets of role virtues and the potential normative richness of analysing junior doctors' ethical challenges using this framework. In the remainder of this chapter, I argue that important moral considerations in the following participant's story are captured by this framework, considerations that are overlooked by consequentialist and principlist modes of analysis. I thus use Alex's story as a kind of test case, to show that the role virtues framework is both workable and useful. I have chosen to focus on this particular story at this point as the ethical challenge involved – seniors discouraging disclosure of errors – was a new one identified by this study. Also, the participant discussed the incident in depth. The level of detail offered and the variety of concerns she raises make the story an attractive one for demonstrating differences between modes of analysis, particularly the fruitfulness of taking a role virtues perspective.

Alex's story

R: Do you ever feel like you've been put in a morally difficult position? Like, had a time when you've felt sort of ethically compromised, or?

Actually there was sort of one a bit like that. And it was a bit, oh it was really strange. What happened was I was doing vascular surgery which is obviously where all the bad things happened [laughs]. And my registrar and I had been looking after this guy who'd had a bypass on his leg. And, and, but the leg wasn't getting better. It wasn't healing the way we were expecting it to and so we'd ordered an ultrasound of his leg to see if the bypass was working or not. And if it wasn't working the plan had been to cut the leg off, because this was the last ditch attempt at a bypass for, because his artery wasn't working, there wasn't going to be anything else. And he knew that he was coming in and maybe going to lose his leg. We were going to try the bypass and if the bypass didn't work we were going to cut the leg off.

And so we, we went in, so yeah. So we ordered the ultrasound. I ordered the ultrasound. It was my first day on the job. And, and I ordered it sideways, based on what leg I remembered being the dodgy leg when I was in the room. Because I was out of the room when we decided to order the ultrasound and make that decision that we were going to cut the leg off if it didn't work.

And so we got the ultrasound report back, and the ultrasound said you can't see the bypass at all. And, and so we said 'OK, we've got to cut the leg off'. So we told him, he was OK about it. We went in, cut the leg off.

And when I was doing his discharge summary, like a number of weeks later post, you know, you know, couple of weeks after to get the physio and his new stump was healing quite well, it was all looking good, I realised we'd ultrasounded the wrong side. And that we'd ultrasounded his good leg, which isn't great, like his arteries were still pretty terrible, but he'd never had a bypass which is why there was no bypass. And, and, then we'd cut off the leg that we thought wasn't healing well, and so we don't know. We don't know if the bypass was good or not, because we cut the leg off based on the wrong ultrasound findings.

And I thought 'oh, I think I have to report this. I think I have to tell somebody this because this is one of those mistakes that', because what had happened was the sonographer had made a comment at the bottom of the sonographer's notes. Like the ultrasound person had handwritten, handwrites it all out and says 'there's no scars to

even indicate this guy had a bypass on this leg'. And the guy's got some dementia so he wouldn't have said anything about it, but the radiologist's report hadn't mentioned that, had just said 'no bypass' full stop. And so they hadn't alerted us that 'we think you've ordered the wrong side'. And we hadn't realised, had just read the radiologist's report that said 'no bypass visible' and made a decision on that. And then we'd cut the wrong leg off. So we hadn't, we'd ordered the wrong one, hadn't realised we'd ordered the wrong one. And they'd realised and hadn't told us.

And so I'm like 'look, this is one of those situations where we should' and so I told my registrar, because I had to tell my registrar, because it was the two of us that had ordered it and had then made the decision based [on that]. He'd made the decision, I'd ordered the ultrasound and anyway. And he said 'oh look, it doesn't matter, you know, we've cut the leg off now'.

And so we never reported it. And I felt really bad. I'm like 'oh, I wonder if I'm supposed to report this or not' and so in the end, when I was writing the report, report, like his discharge summary, which had to be quite detailed because he was going to rehab and they needed to know, I just wrote 'ultrasound said rarara'. I didn't write the side. I'm like 'oh, I feel bad' and, but I didn't report it.

So, yeah, I found that quite difficult because I thought we should have reported it and he said no, and I didn't feel confident going behind his back and reporting it anyway, and yeah.

R: Yep, so would, how would it have worked if you had reported it? Like, what would have happened?

I don't know. I know how [my current hospital] does it, but I would have, I think I would have told somebody who is like the clinical risk person or something, that can look at 'well, how did this mistake happen and how can we reassure this?'. And probably would have taken it down to radiology and said 'OK, this is', because we already knew. We were the, you know, we'd already learnt our lesson that clearly we need to work out which side we're ordering and whatever. So we'd learnt our lesson, but I think that the department probably needed, the radiology department needed to be told that if this happens again you need to do a better job of alerting, because a guy's leg got cut off because this ultrasound report only said dadada rather than alerting us that 'we think you've ultrasounded the wrong side'. And if the patient had been more alert, he would have gone down and said 'well why are you

ultrasounding that side? That's not where I've had my thing. It's clearly supposed to be on the other side'. But he's got a bit of dementia and he isn't quite cluey and that wouldn't have helped, so.

R: But you felt like it was the registrar's decision ultimately, whether or not to report?

Yeah. And because he was more likely to get in trouble for it than me if somebody was going to get the blame, because he'd made the clinical decision to operate even though I'd been the one that had actually ordered the ultrasound report. And I suppose I didn't care if I got in trouble because I reported something, but I did care if somebody else got in trouble because I reported something behind his back. That I'd said 'hey maybe we should report this' and he'd said no, and so that felt too bad and stuff. So I just left it. And because I knew that it wasn't going to change patient outcome for this patient. But I did feel bad because it probably could improve patient outcome in the future. Like the same sonographer's going to miss the next person who orders the wrong ultrasound and then cuts off the leg. So I'm a bit bad. I mean the leg wasn't healing well. Probably, we made the right decision anyway (Interview 1, pp.43-7).

Analysing the story using consequentialism

The key ethical issue here is how Alex ought to have dealt with her mistake. Having ordered the ultrasound for the wrong leg, she then finds herself in the situation of having to decide whether or not to report the incident to the people responsible for systemic risk-minimisation in her hospital.

Consequentialism is one possible mode of ethical analysis that could be applied to this decision. If we assume that Alex ought to choose the action with the best possible consequences (defining 'best' in terms of maximising human well-being), what should she do? The potential harm caused by doctors making treatment decisions based on ultrasound findings from the wrong limb is presumably large. One type of harm would be operating unnecessarily, wasting resources as well as causing pain and inconvenience that could be avoided. A further type of harm would be any failure to treat where treatment would be beneficial. A vast number of people would be

potentially susceptible to these harms. Every current and future patient in the hospital is at risk. Thus, although the mistake may not have harmed Alex's patient, it seems reasonable to believe that this type of mistake has the potential to cause significant harm.

Avoiding these harms seems achievable in a straightforward and uncostly way. Alex identifies the problem as a communication issue that seems very easily solvable. If the radiologists' reports simply passed on sonographers' additional observations, the harms outlined could be avoided. It seems reasonable to assume that a system for doing this would be both uncomplicated to institute and effective in preventing the harms outlined above. Then, even if human error meant that occasionally a mistake like Alex's was still made, the actual negative consequences of ordering an ultrasound for the wrong limb would not eventuate.

The well-being costs associated with the action option of reporting the error seem to relate mainly to Alex and her registrar. Alex's perception is that they might "get in trouble" for the error, particularly the registrar who was responsible for the decision to operate. The exact nature of this "trouble" is unclear, but presumably will come from more senior doctors or from hospital administration. Perhaps the fear is that they will be seen as incompetent, negatively affecting their career opportunities or as making trouble for the hospital that would presumably have to disclose the error to the patient. There is also potential for their relationship with each other to be damaged in significant ways if Alex reports the incident. The animosity that Alex's report could generate, particularly considering that the registrar expressed to her his clear opinion that she should not report, is likely to make their day to day work together less pleasant and possibly less effective as well as potentially having an impact on Alex's assessment in that rotation. If Alex reports, the patient may also be upset (assuming that he is informed about the mistake and depending on the extent of his dementia).

Considering the consequences associated with the two fundamental action options available to Alex in this situation – to report the error or to refrain from reporting the error – it seems obvious that the right thing to do on a consequentialist analysis is to

report the error. (I say two “fundamental” action options because the actual number of action options available to Alex is presumably quite enormous. The variety in the method and particularly the manner in which she could report the incident is extensive.) It seems that the negative impact of reporting is limited to Alex, her registrar, and the particular patient. This is clearly outweighed by the magnitude of the potential harm that would be avoided for a large number of future patients.

Analysing the story using principlism

An alternative possible mode of analysis is principlism. This is Beauchamp and Childress’ influential framework, mentioned in chapter one. They describe four “clusters of moral principles” that “express the general values underlying rules in the common morality” (Beauchamp & Childress, 2001, p.12). These are:

respect for autonomy (a norm of respecting the decision-making capacities of autonomous persons),

nonmaleficence (a norm of avoiding the causation of harm),

beneficence (a group of norms for providing benefits and balancing benefits against risks and costs), and

justice (a group of norms for distributing benefits, risks, and costs fairly) (Beauchamp & Childress, 2001, p.12, italics in original).

In this context of comparing principlist analysis with the role virtues framework of analysis that I am advocating, it is important to note the fact that Beauchamp and Childress explicitly claim importance for virtues as well as principles. Devoting a chapter to moral character, they argue that virtues “support and enrich” their principlist framework (Beauchamp & Childress, 2001, p.51). Their list of medical virtues includes compassion, discernment, trustworthiness, integrity, conscientiousness, respectfulness, nonmalevolence, benevolence, justice, truthfulness, and faithfulness (Beauchamp & Childress, 2001, p.30). However, I will focus on the principles aspect of their framework as this is clearly posited as the primary component, with virtue playing only a supporting role.

Thinking in terms of the principlist framework, nonmaleficence is clearly a principle relevant to Alex's decision. Alex's obligation not to inflict harm on others has been breached by her mistake. Her patient was harmed, at least to some small degree, by having the wrong limb investigated by the ultrasound. The process definitely wasted his time, and any distress caused had no justifying benefits. It is also possible that his leg need not have been amputated. Despite the clinical indications to the contrary, the bypass may in fact have been successful and a different form of treatment could have been more appropriate.

However, our focus is not on the moral status of Alex's mistake itself, but on the relative merits of the two action options facing her once she discovers the error: to report the incident or to refrain from reporting it. Here the principle of nonmaleficence relates to future patients of the hospital rather than to this specific man who had the wrong leg tested. From Alex's description, it seems that her reporting the error will not affect the outcome for this particular patient, at least not his medical outcome. (Reporting the incident may change aspects of his experience other than the medical outcome, for example increasing his distress or making him feel involved and respected. These questions are further complicated by the issue of his dementia.) If his treatment has been compromised as a result of the error, this wrong cannot be undone through Alex's reporting of the incident; as the registrar says "we've cut the leg off now". There is also a significant possibility that this patient in fact received the optimal treatment for his condition, somewhat inadvertently, in spite of the error. So it is in relation to future patients that Alex's obligation not to inflict harm on others is important.

Those who advocate a moral distinction between acts and omissions would point out that, if she refrains from reporting, Alex is not *inflicting* harm on future patients, merely *failing to prevent* the harm. However, without entering the complex debates on causation and moral responsibility, it seems plausible to assume that if Alex fails to report then she bears some moral responsibility for any harm experienced by future patients who suffer as a result of the system problem she has identified, and thus that

the principle of nonmaleficence is relevant to her decision. As outlined in the consequentialist analysis, the potential harms to future patients associated with Alex refraining from reporting are significant both in terms of magnitude and of number of people that could be affected (assuming, as above, that her reporting results in the institution of an effective system for preventing similar occurrences). The principle of nonmaleficence clearly supports reporting the incident.

What about the other three principles? The principle of justice is also relevant to Alex's decision. Ultrasounds performed on irrelevant limbs are, without doubt, a waste of resources. By making the report, Alex can prevent such wastage in the future. Here again, the principlist analysis supports reporting (assuming again that Alex bears some moral responsibility for a failure to prevent resource wastage.) Further, if we construe justice as involving the notions of fairness and respecting persons' rights, reporting is necessary to achieve justice for Alex's patient. Even though reporting will not change his medical outcome, reporting is necessary to enabling appropriate redress.

Determining the issues around beneficence and respect for patient autonomy in this particular case is complicated by the fact of the patient's dementia, as highlighted earlier. Whether reporting and subsequent disclosure to this patient and his carers would do good or promote this patient's autonomous living cannot be determined without far greater detail on this man's condition and circumstances. However, thinking in terms of obligations of beneficence and respect towards future patients, again reporting seems the optimal action option. Ensuring as far as possible that medical decisions are made on the basis of the appropriate information will benefit future patients in terms of the effectiveness and timeliness of their treatment. It would also further the aim of respecting patient autonomy; patients cannot make autonomous decisions without accurate information from the hospital about their medical condition. In another much smaller way, many patients of this hospital will benefit if this kind of incident is avoided in the future. Presumably a great many people's treatment will be slightly speedier if hospital resources are not allocated to some

unnecessary operations. Even if a new communication system is instituted, the performance of the occasional unnecessary ultrasound will probably persist due to human error. Remember it is not mistakes like Alex specifying the wrong leg that would be addressed by a system to convey sonographer's observations but treatment proceeding on the basis of such mistakes. However, the actual performance of potentially unnecessary operations as occurred in this case, could be avoided to the benefit of other waiting patients.

Overall, considering the strong reasons associated with nonmaleficence and justice and the weaker reasons associated with beneficence and respect for autonomy, it seems clear that on a principlist analysis, Alex ought to report the incident.

Analysing the story using role virtues

Consequentialist and principlist forms of analysis illuminate the moral considerations in Alex's story to a significant degree. Both highlight the potential cost to future patients in her failure to report. Their inadequacy however seems to lie in their inability to recognise the moral reasons *against* Alex reporting. In both frameworks, the answer to the question of what she ought to do is straightforward. For Alex however, this decision was clearly extremely difficult. She says throughout the story that she thought at the time that she ought to report and that she felt bad for refraining from doing so. At one point her language is even stronger. The badness is not just something she's experiencing ("oh, I feel bad") but something that she *is* ("[s]o I'm a bit bad"), a reflection on her character. Her description of herself as "bad" suggests that the force of the moral considerations favouring reporting was clear to her. However, ultimately she decided to act differently. Consequentialist and principlist perspectives seem to invite us simply to assume that Alex knowingly acted wrongly, out of self-interest (perhaps laziness or self-protection or apathy). I suggest however that understanding the story in this way overlooks some of the ethical complexity of the situation. Throughout her interview, Alex struck me as a particularly caring, well-motivated, thoughtful doctor, yet in this situation she failed to choose the action-option that consequentialism and principlism seem to unequivocally recommend. Her

decision suggests that perhaps there are *moral* considerations at play in this story that these forms of analysis are failing to capture. The consequentialist and principlist analyses outlined cannot explain firstly why this situation was so ethically difficult for Alex, and secondly why a doctor who in many other situations acted in morally thoughtful and appropriate ways, in this situation decided against the supposedly clearly ethically preferable action option.

Analysis from a role virtues perspective can explain both of these features of Alex's story. If we think about Alex as aiming to be a good junior doctor and thus aiming to fulfil the constitutive roles of doctor, medical learner, team member and employee, then further moral features of the situation are illuminated that help us to understand her decision. Looking at a passage in Alex's rationale for her decision indicates that this issue of whether or not to report can be understood initially as at least a conflict between role virtues of the good doctor and role virtues of the good team member. She says:

I didn't care if I got in trouble because I reported something, but I did care if somebody else got in trouble because I reported something behind his back. That I'd said 'hey maybe we should report this' and he'd said no, and so that felt too bad and stuff. So I just left it. And because I knew that it wasn't going to change patient outcome for this patient. But I did feel bad because it probably could improve patient outcome in the future. Like the same sonographer's going to miss the next person who orders the wrong ultrasound and then cuts off the leg. So I'm a bit bad.

The demands associated with her role as a doctor can be seen in Alex's thinking about her decision. She invokes "patient outcome" as relevant to the decision she faced. The fact that reporting would not improve her specific patient's situation and the fact that future patients would benefit by her reporting are both discussed in her rationale. But she also seems very aware of her position as part of a team. The passage suggests that she is not worried about the repercussions for her as an individual that reporting might cause, but rather about her obligations to her registrar. It is betraying her colleague that "felt too bad", and that seems ultimately to have influenced her decision. This situation can thus be understood from Alex's description as a conflict

between the doctor's role virtue of benevolence and the team member's role virtues of trustworthiness and co-operation. The latter virtues can be seen as presenting moral reasons against reporting for Alex.

These moral reasons are not merely prudential considerations. Alex is not simply serving her own self-interest in her concern about betraying her registrar. Rather, she can be seen as attempting to fulfil one of the four roles constitutive of the concept of the good junior doctor, each of which itself furthers a morally worthwhile goal. Because being a good team member furthers a morally important goal – the effective functioning of the team and thus ultimately the hospital as an organisation – the reasons Alex identifies against reporting that are associated with being a good team member count as genuinely moral reasons rather than merely prudential considerations. All four of the roles aim at morally worthwhile goals, implying that the reasons the roles generate are moral reasons.

Thinking in terms of the sets of role virtues can therefore explain why this situation presents a difficult decision for a junior doctor. Unlike analyses focused on consequences, a role virtues perspective recognises the specific position that the junior doctor is acting from and the various obligations and associated conflicts that this position involves. For a junior doctor such as Alex, it is not just a matter of maximising total well-being or acting in accordance with four principles. Her position requires her to be good qua doctor, good qua medical learner, good qua team member, and good qua employee. This makes factors such as the impact of her decision on her team highly morally relevant to her decision whether or not to report. In attempting to be a good junior doctor, she must juggle conflicts between the virtues associated with her multiple roles. Unlike in a consequentialist analysis, on a role virtues framework her betrayal of her colleague is an important moral consideration alongside her promotion of future patients' well-being. The former makes her good qua team member by being trustworthy and co-operative, and the latter makes her good qua doctor by being benevolent. Thinking of the situation as a conflict between

role virtues can explain why the situation is not a straightforward case of must-report for a junior doctor.

As well as explaining why this would be a difficult decision for a well-motivated agent in Alex's position, a role virtues perspective also enables us to think further about what Alex ought to have done. Accepting both the concept of the good junior doctor and the sets of role virtues outlined in the previous section, we can think systematically about what a good junior doctor ought to do in this type of situation. How does each of the sets of role virtues outlined dispose an agent to act in these circumstances?

Firstly, what action do the doctor's role virtues recommend for an agent deciding whether or not to report in this kind of situation? I suggested earlier that medical role virtues consistently put forward by writers in this area include compassion, benevolence, truthfulness, justice, humility, self-sacrifice, and integrity. The compassionate and benevolent doctor, focused on patients' needs, would presumably report, motivated by the avoidance of harm to future patients. The truthfulness of the virtuous doctor would also dispose her to report, at least to the patient involved and probably also to the appropriate hospital authorities. (Shaped as it is by compassion, the virtuous doctor's truthfulness may not lead her to report the incident to the patient himself if his dementia would make such a revelation distressing without compensating gain.) The just character of the virtuous doctor would further support reporting; the resource wastage issues captured by the principlist framework would motivate a just doctor to report. Humility, self-sacrifice and integrity would dispose the virtuous doctor to report in Alex's situation despite the potential negative consequences that reporting might create for her.

What about the virtues of the good team member? As Alex's rationale suggests, this set of role virtues provides some reasons against reporting. The good team member is both co-operative, concerned with the effective functioning of the team, and trustworthy, loyal to his or her colleagues. In the context of her registrar's clear indication that Alex ought not to report, these role virtues support refraining from

reporting. However, the good team member is also communicative with colleagues, indicating perhaps that Alex ought to have discussed the issue with the consultant in her team who would presumably be interested both in the treatment trajectory of the specific patient under his or her care and also in the system problem that Alex has identified. The role-sensitivity of the good team member may direct a junior doctor away from reporting in Alex's situation. The good junior doctor qua team member is aware of his or her subjugate position in the team, deferring significant decision-making to his or her more senior colleagues. Whether or not this situation is a justified deferral however seems questionable. The issue of whether reporting is an action that a junior doctor qua team member can legitimately take seems an open one and, to a certain extent, the crucial one in Alex's situation. Thus role-sensitivity does not necessarily point away from reporting. Therefore, the action of the good team member faced with Alex's decision is not straightforward.

I have framed Alex's story primarily as a conflict between team member virtues and the doctor virtues of compassion and benevolence. From her own justification of her decision, these seem to have been the key factors in play for Alex from a role virtues perspective. But what about the role virtues of the medical learner and the employee? If the concept of the good junior doctor is made up of the four roles then the medical learner role virtues and the employee role virtues ought also to have an impact on the decision of an agent in Alex's situation. What about the virtuous medical learner? What is the right thing to do in this situation for the agent disposed to play that role well? Accepting the set of medical learner role virtues outlined earlier, the virtuous medical learner's decision is less clear-cut in this situation than that of the virtuous doctor. Being patient-focused seems to suggest that the virtuous medical learner would report. However, her disposition to be co-operative with her teachers and peers and also her commitment to her education seem to point the virtuous medical learner away from reporting. The registrar has directed her to refrain and it is possible that educational opportunities and career progression will be negatively affected by making a report. She may be very self-reflective about her role in this problematic situation ("we'd learnt our lesson") without actually making a report. So here there is

conflict *within* the set of role virtues about the right action to take, as well as conflict between this set and those associated with the other roles constitutive of the good junior doctor.

Thinking back to the posited character traits of the good employee, it seems that an agent aiming to be good qua this role ought to report the incident. Being efficient, the good employee would recognise the efficiency gains associated with preventing further instances of treatment proceeding on the basis of incorrect, irrelevant, or inadequate information. Her dedication to patients would similarly dispose her to report as patients clearly benefit in various ways when this type of incident is avoided. Further, being risk-averse, the good employee would report the incident. Allowing this kind of communication problem to continue involves significant risks for the hospital and thus would not be the choice of the risk-averse employee. Although it might be argued that reporting would create legal risks for the hospital in relation to this specific patient, the prevailing view is that open disclosure is ultimately the best way of protecting organisations from this type of risk. Thus it seems clear that the risk-averse employee would choose to report. Therefore, assuming the employee role virtues put forward, overall it seems that the virtuous employee would report.

Thus, the choice of the good junior doctor in Alex's situation is not clear. Assuming the role virtues posited in the previous section, being good qua doctor clearly requires reporting. But being good qua team member offers some moral reasons against reporting. Being good qua medical learner seems partly to point to reporting but again with some significant moral reasons to refrain from reporting. And being good qua employee also seems to require reporting. Considering that virtue-based ethical analysis is not simply a matter of weighing up the character traits that would dispose an agent to act in one way against those that would dispose him or her to act in each of the alternative ways, the action guidance for Alex's situation provided by this perspective is unsurprisingly non-definitive. The role virtues all highlight ethical considerations that would influence the ethical decision-making of the good junior doctor. Unlike in consequentialist analysis, the moral reasons are not

straightforwardly additive. An action's misalignment with a single virtue might be enough to exclude that action from those of the virtuous agent. An action might involve such an affront to compassion, for example, that the good junior doctor ought not to perform the action.

However, the inability of the role virtues perspective to deliver unequivocal action guidance in this situation need not be seen as a disadvantageous feature of this type of approach. The equivocation reflects the ethical reality that there will likely be more than one morally justifiable course of action and, crucially, also reflects the framework's ability to capture a fuller range of the moral considerations involved in the situation. It is because the role virtues perspective recognises the element of the situation that made it ethically difficult for Alex, namely her relationship with her registrar, that its verdict is less straightforward than that provided by consequentialist or principlist forms of analysis. A role virtues perspective better reflects Alex's experience of the situation as an ethically complex and troubling one, compared with consequentialist or principlist approaches. And, importantly, a role virtues perspective offers a method of ethical analysis that both reflects and engages with junior doctors' specific position of agency. A form of ethical analysis that is based on junior doctors' need to be good in relation to multiple different roles reflects the reality of this professional stage. The following two chapters use this role virtues perspective to analyse in detail two of the particular ethical challenges associated with internship and residency, generating ways forward for junior doctors facing these difficulties.

CHAPTER 8: REPORTING UNROSTERED HOURS

One ethical challenge newly identified by the empirical component of this project was whether or not a junior doctor should report the unrostered hours that he or she has worked, particularly in the context of encouragement from hospital administrators and more senior doctors not to record overtime. This is an ethical challenge that epitomises the “mundane” dimension of a broader bioethics described in chapter one. It is very much a day-to-day ethical issue in contrast to the dramatic technology-driven dilemmas that are typically the focus of philosophical analysis. Analysing one intern’s story, I claim that a role virtues perspective is useful in understanding and thinking about ways forward for the junior doctor facing this ethical challenge. Felicity’s story involves various conflicting conceptions of the set of virtues displayed by the good employee. I argue that the most plausible conception of the employee’s role virtues supports junior doctors reporting their unrostered hours, as does the set of doctor’s role virtues outlined in chapter seven. The virtues associated with the good junior doctor’s other two roles do not point clearly to a preferable action option but do offer guidance as to how agents like Felicity ought to go about implementing the reporting overtime option that is supported by the employee and doctor role virtues. Hence, a role-based analysis offers useful action guidance in relation to this issue.

FELICITY’S STORY

Thirty-eight point five hours a week is safe working hours. So that’s what we’re rostered. But it doesn’t translate into any kind of reality, which is ridiculous...It’s not uncommon for me to do a sixty, sixty-five hour week

R: And be paid for thirty-eight and a half?

Well sometimes we get paid our overtime. It’s really haphazard. You never quite know. I, when I initially began this job I wrote down all my hours that I did on my

timesheet. And then I got paid for thirty-eight and a half. So I was like ‘what’s the deal? Do we just not get paid for any of our overtime?’

So I went and spoke to medical admin, and they said to me ‘you need to, well the problem is that something is wrong within your unit so if you’re not leaving at four during the day then that’s something that you need to take up with your registrar and your consultants’. Now I’m never going to take that up with my consultant. I’m never going to, when I’m scrubbed into theatre, holding back something or suturing something say ‘oh, it’s four o’clock, off with the gloves, I’m out of here!’. Like, that’s never going to happen.

But I did talk to my registrar about it and say ‘look, medical admin have thrown this back in our face as being that we are doing too many hours and that’s got to change.’ And he’s like, ‘oh look, get used to it. You’ll forever not get paid, you know, the hours you actually work’. And I said ‘well, when we write down our hours they crack it, like that we’re’, and he’s like ‘well don’t tell them that you’re working when you are’.

Which never, has never sat well with me at all because, it’s not even the money, but it’s the fact that then it’s, then I’m working a sixty hour week but I’m getting, I’m being recognised as working a thirty-eight and a half hour week which is safe working hours. Now if I make a mistake in my sixty-fifth hour on, you know, it’s not recognised that I’ve been working those hours, which have been shown to be unsafe.

So I’ve continued to, you know, complain and say that I want to be paid for my overtime and I write down all my hours. And I started to get paid for some of it at least. And it’s almost like if they can get away with it, they will. And there’s a lot of people that never check their payslip and will never ever say anything, but once you kind of show that you’ll, because they can’t do this, I mean it’s illegal. But it happens in every hospital system, every hospital network. It’s not something specific to the system that I work in (Interview 4, pp.7-8).

ARTICULATING THE ETHICAL ISSUE

Felicity’s ethical challenge is about *recording* the hours that she has worked. The *length* of the hours that junior doctors work has itself been a subject of debate and academic discussion, including a limited amount of work from an ethical perspective

(Wiesing, 2007; Rosenbaum, 2004; Kuflik, 2001; Green, 1995). Most of that discussion, both within and outside bioethics, frames the issue of junior doctors' long working hours as an institution-level question about the most appropriate system to adopt rather than as an individual doctor's dilemma about how to act. Distinguishing between these types of question is of course artificial to some degree. As Chambliss highlights, institutional structures create individual dilemmas: "ethical problems in healthcare are inseparable from the organisational and social settings in which they arise...they are in fact often fundamental, if unintended products of that system" (Chambliss, 1996, p.182). The individual doctor deciding whether to stay on at work on a particular day beyond his or her rostered finishing time has been placed in that situation by various structural features of hospital work. However, the issue in Felicity's story is not about setting a policy of how long junior doctors' shifts should be, nor about an individual doctor deciding whether to continue working after the end of a rostered shift. Felicity's ethical challenge is whether or not to fill in her timesheet in a way that accurately reflects the hours that she has already worked. This issue has not, to my knowledge, previously been the subject of academic attention.

Amongst the group of junior doctors interviewed however, recording hours was a significant issue. Data from the interviews supports Felicity's contention that her experience of being discouraged from reporting the hours she has worked is not unique. Several other participants discussed this issue in detail. Some reported interns and residents being explicitly discouraged from recording their hours accurately by more senior doctors:

at the hospital that I'm at now your consultant needs to sign your timesheet. And there are some consultants that if you wrote anything in the overtime box they'd cross it off (Interview 12, p.14).

Implicit discouragement from reporting overtime was also described:

at some hospitals there's a bit of a more institutional thing that you don't really put down your overtime because, you know, it's not really what people do... When your

registrar won't do it you feel as though 'well if they're not doing it I shouldn't be doing it' (Interview 12, pp.13-4).

As well as registrars and consultants discouraging reporting, participants described similar pressure coming from the administration in some hospitals. A minority of hospitals were described as having a straightforward policy of no pay for unrostered hours:

[s]ome other hospitals they don't pay [overtime]. But they're upfront 'we don't pay'. Everyone knows they don't pay. If you want to go to that hospital you don't get paid (Interview 8, p.15).

And then the memo comes round 'do not claim any overtime, you will not be paid, but do this, this, this, this, this as well within hours'. I mean it just puts you right off. (Interview 7, p.18).

Other hospitals were seen as having guidelines that greatly limited the overtime that would be recognised with payment.

You don't get paid for unrostered overtime unless it's an emergency and you can like document, you know, what you were doing at the time that required you to stay after. So in reality it means that all the discharge summaries in particular are just done after hours for free (Interview 10, p.17).

One particularly striking example of junior doctors being discouraged from accurately reporting their hours involved rostering that did not align with the schedule of ward rounds. This phenomenon, which seemed to involve pressure from both administrators and consultants for junior doctors to work overtime without payment, was described by two participants.

People would be expected to be there at 6:30 to do a ward round with their consultant. But if they wrote down 6:30 as their starting time their timesheet would be sent back to them, even though their consultant expected them to be there. And their consultants wouldn't back them up on it (Interview 12, p.14).

There's jobs where you're rostered, you might be rostered to start at 8am but the ward round starts at 7am. And you would, like there's simply no way that, you'd

basically be seen as not doing your job at all if you came at 8am...In reality you would not be doing your job. Because you wouldn't know what was happening with any of the patients and you wouldn't know any of the tasks that you needed to do (Interview 10, p.18).

In the context of these experiences, it is worth emphasising that participants also had stories of being encouraged to record their working hours comprehensively. Both hospital administration and senior doctors were sometimes described positively in relation to this issue. For example, one junior doctor described a registrar who explicitly encouraged her to report her overtime:

in the first job that I had that year my registrar said, you know, 'you'll do lots of extra hours in this job and write them all down because the bosses want you to do that because then there's an accurate record of how many hours you're spending here and they can see whether or not they need a second resident and it means that you're getting paid for what you're doing and you're not going to start resenting it' (Interview 12, p.14).

The same participant described one hospital as having "a pretty relaxed attitude to it; if you did the time and you wrote it down then they would pay you" (Interview 12, p.13). Thus, overall, participants' comments suggest that Felicity's experience is neither isolated nor universal.

It might be suggested that Felicity's decision in relation to her timesheet, while challenging, does not constitute an *ethical* challenge. This objection would posit recognition of overtime as an issue of industrial relations, for example, rather than ethics. However, in my view, the question of whether to report hours accurately does constitute an ethical challenge for a junior doctor. Recall the broad definition of ethical issues put forward in chapter one: an issue is an ethical one if it involves persons' rights, duties, and obligations and/or consequences that are beneficial or harmful to people and/or the development and exercise of virtues. Felicity clearly identifies potential harmful consequences for her that could result from failing to report her hours accurately: any mistake that she makes will not be seen in the context of the long hours that she is actually working, presumably resulting in a more

negative appraisal of her practice than is in fact justified. There also seems to be possible harmful consequences if a junior doctor in Felicity's situation chooses to report her hours comprehensively. Considering the discouraging attitudes of her registrar and the administrator, Felicity's decision to continue to record her overtime has the potential to have her labelled a troublemaker and disrupt her working relationships. The fact that it is junior doctors who will directly experience these harmful consequences, rather than patients, does not exclude the issue from the realm of the ethical. There is also the potential for harm to patients if a junior doctor does not report the overtime hours that he or she is working. It could be argued that failure to report accurately one's hours props up a system that creates risks for patients.

The issue can also be defined as an ethical one on the basis of the first part of the definition that refers to rights, duties and obligations. Employers have an ethical obligation to remunerate their workers fairly. Discouraging employees from reporting their overtime involves the potential breach of that obligation, opening employers to the accusation of exploitation. In addition, hospitals have an ethical obligation to patients to provide sufficient staff to enable their healthcare to be delivered appropriately. Where doctors are encouraged to systematically under-report the hours that they are working, meeting this obligation becomes more difficult. Without knowing the pattern of work that is delivering the patient outcomes that the hospital is recording, ways of improving these outcomes through staffing changes remain opaque to decision-makers in the organisation. Therefore, while the issue of reporting overtime may also be fruitfully explored from perspectives other than ethics, it nonetheless constitutes an ethical issue.

What were Felicity's options for action in the face of this ethical challenge? From her description, it seems that avoiding the problem by working only her rostered hours is not a genuine option. Because she works as part of a team, she herself cannot dictate when she will leave. She is absolutely definite that such an option is closed:

I'm never going to, when I'm scrubbed into theatre, holding back something or suturing something say 'oh, it's four o'clock, off with the gloves, I'm out of here!'. Like, that's never going to happen.

This view that the junior doctor as a team member cannot work strictly to the roster is supported by another participant's comments.

You would *never* as a, you would *never* just walk out of the hospital because it's the end of your shift if, if you actually, if there was something to do...It's that you kind of work within this hierarchy and there's a very strongly understood kind of set of rungs on the medical ladder. You understand 'I'm an intern now, I'll be a resident next year, I'd like the year after to be in whatever training program, I'll do my exam, I'll be an advanced trainee, I'll be a consultant'...And so you don't want to, you know, there's an understanding that, you know, you've got a job to do and you do the job...That extra half hour I think is very common. And it's basically born of an understanding that to, that handing over to the night staff a task that you can do in half the time that they can do because they don't know the patient is just, isn't great (Interview 14, pp.9-10, participant's emphasis).

A further participant confirmed that working to the roster is not a real option, but for different reasons. She invoked the ethical obligations of her doctor role, rather than the institution's organisation into teams, as precluding this course of action.

I think you have such a moral conscience as a doctor, you never, I mean I think that's a huge gap I've noticed between nursing staff and doctors is that nursing staff will leave at the end of their shift, and there is someone to pick up at the end of it. And doctors won't. I routinely stay one or two hours late because there's a sick patient and I know I'm not going to get paid but you can't, you don't leave (Interview 7, p.18).

Like Felicity, this participant is definite about the non-viability of this option; the junior doctor simply "can't leave". Thus, for Felicity, there seem to be two basic options from which to choose in this situation: report on her timesheet the actual hours she has worked or refrain from recording her hours accurately. As with Alex deciding whether to report the ultrasound error, within each of her two fundamental options Felicity has a vast range of possibilities. For example, even if she chooses to

refrain from recording her hours accurately, she may choose to report *some* of her overtime. She also has various choices in terms of the extent to which she alerts other team members and administrators to her concerns and to the way that she is approaching her timesheet. Presumably she also has further options for action in relation to this issue on a more institutional level, such as campaigning through the junior doctors' association within the hospital or through professional associations for policy change in relation to recognition of overtime. Thus, there are numerous possibilities for *how* Felicity carries out each of the two basic options. However, I will focus primarily on the fundamental choice that Felicity faces when filling in her timesheet between the two basic options of accurate reporting or refraining from recording all the hours she has worked.

A CONFLICT ABOUT THE ROLE VIRTUES OF THE EMPLOYEE

Thinking in terms of the roles that constitute the concept of the good junior doctor is a useful way for ethical analysis of this choice to proceed. The participants' comments above suggest that the doctor and team member role virtues seem to require junior doctors to *do* the extra hours; whether these role virtue sets also require junior doctors to *report* the overtime is discussed further later in the chapter. However, at its core, Felicity's ethical challenge can be understood as involving conflicting conceptions of the employee's role virtues. From Felicity's description, it seems that the various players in the situation hold differing understandings of the role virtues of the good employee, creating a difficult situation for the junior doctor who must decide how to act in the context of these various conceptions.

Felicity's description of the medical administrator's attitude suggests that the latter has an understanding of the good employee that privileges a particular kind of efficiency. The fact that Felicity is working unrostered hours is taken by the administrator as evidence that her unit is not functioning well. The perception communicated is that the problem is not that the work cannot be done by the team in

the time available but rather that “something is wrong within your unit” that ought to be addressed by the more senior doctors. Good employees, on this conception, are so efficient that overtime is unnecessary.

Felicity’s registrar invokes a different conception, one that involves the role virtue of being uncomplaining. Good employees on this conception work overtime, but are not disposed to report it nor to demand payment. He implicitly suggests that the good employee buffers the hospital administration from staffing problems. His advice to Felicity – “don’t tell them that you’re working when you are” – implies that the good employee is uncomplaining about working unrostered hours, avoiding conflict with the administrators. The registrar’s comment that Felicity should “get used to it, you’ll forever not get paid the hours you actually work” suggests that there is perhaps a certain resignation motivating this attitude. His understanding of the good employee may be a purely pragmatic one, informed by the opinion that protesting is pointless. Nonetheless, it seems to constitute an understanding of the employee’s role virtues that is importantly divergent from the administrator’s.

Further different understandings of the employee’s role virtues also seem possible. Recall the participant quoted earlier in the context of senior doctors who, in contrast to Felicity’s situation, encourage their juniors to fill in timesheets accurately. The rationale articulated was that

then there’s an accurate record of how many hours you’re spending here and they can see whether or not they need a second resident and it means that you’re getting paid for what you’re doing and you’re not going to start resenting it.

This suggests a possible conception of the employee’s role virtues in which the good employee is upfront with his or her employer about staffing requirements, in contrast to the attitude suggested by Felicity’s registrar. The idea is that the good employee provides information that enables the decision-makers to make well-informed judgements about appropriate staffing for the unit. The passage also implies that recognising overtime with payment works to preclude negative attitudes amongst employees that are ultimately problematic from the organisation’s perspective.

How plausible is each of these competing conceptions of the employee's role virtues? Does Felicity's role as an employee require her to be uncomplaining as the registrar suggests? Or is she in fact a better employee if she cultivates an upfront attitude to reporting her overtime? In the following section, I suggest that the competing conceptions can be assessed in terms of the telos of employment articulated in chapter seven, and that the most plausible conception of the employee's role virtues points to reporting one's hours accurately as the right thing to do qua employee.

WHAT TO DO?

Assessing the conceptions of the employee's role virtues

In chapter seven, I claimed that the employee's role virtues are those character traits conducive to furthering the organisation's aims (assuming that these aims are themselves morally good). I also argued that the aims of the public hospitals that employ junior doctors are not necessarily straightforward to articulate. The hospitals themselves focus on the delivery of excellent patient care in their mission statements, but their dependence on government funding means that the aspects of this outcome that they can pursue are limited by the government's own aims for healthcare which may differ in their specific emphasis. For example, the hospital's interest in treating current inpatients with compassion and respect may come into conflict with the government's priority for reducing waiting times for hospital beds. However, it seems reasonable to take high quality patient care as the public hospital's organisational aim, as long as high quality patient care is understood in a way sufficiently broad to capture the complex mix of inter-related internal and government-imposed priorities.

What is the relationship between this organisational aim of high quality patient care and junior doctors accurately reporting the hours they are working? What employee character traits are conducive to furthering this organisational aim in situations like Felicity's? The administrator's notion that efficiency is an employee role virtue has

some plausibility in the context of this aim. Caring well for the whole group of patients for whom they are responsible is presumably facilitated by Felicity's team working efficiently. However, in the context of the organisational aim of high quality patient care, it seems clear that efficiency is not the *primary* focus of the good employee in the way that the administrator implies. Efficiency ought not to be cultivated to such a degree that the quality of patient care delivered in fact begins to decrease. Focusing only on getting the work completed in the allocated time will presumably not optimise patient care. The risk is that corners will be cut and patients' medical outcomes will suffer. Efficiency as an employee role *virtue* is bounded by the goal the organisation is pursuing, and relatedly, by other virtues conducive to the achievement of that goal such as competence and risk-aversion. The administrator's notion of efficiency, where the good employee is so efficient that no overtime is necessary, seems misguided as an understanding of the role virtue of efficiency. If the vast majority of doctors in a hospital are working longer hours than they are rostered, it seems reasonable to assume that high quality patient care cannot be delivered by this number of doctors within the allocated hours. Such a group of doctors could well be displaying appropriate efficiency, making the administrator's notion that Felicity's challenge will not arise for good employees an unattractive one. Thus, while efficiency is plausibly a role virtue for hospital employees, the kind of single-minded ruthless efficiency that the administrator is suggesting does not qualify as an employee role virtue because it does not promote the organisational aim of high quality patient care.

What about the registrar's idea that the good employee is uncomplaining? Is being uncomplaining a role virtue conducive to high quality patient care? The comments from the encouraging senior doctor quoted by one participant suggest not. Being uncomplaining was posited as generating resentment and preventing decision-makers getting an accurate picture of the number of doctors required to staff the unit. Both of these claims seem plausible. Felicity's comment that "if they [administration] can get away with it, they will" certainly suggests a degree of resentment about the way she is being treated by her employer, as does the quote in which another participant's

hospital's unwillingness to pay overtime "just puts [her] right off". A further participant described a fellow intern's resentment at his unpaid overtime, while he was doing what she called "a two persons job":

what he's currently angry and bitter about is the fact that he's not getting paid for work that he's genuinely doing. And that really upsets him because he's 'fine I have to stay until 9, it's bad enough that I have to stay til 9 or 8 or 7, but then not, knowing that you're not getting paid is even worse' (Interview 8, p.14).

Whether this resentment spills over into the way that these junior doctors deal with patients is however an open question. It is obviously possible, though not inevitable, that the resentment generated by unpaid overtime will compromise the hospital's aim of high quality patient care.

More straightforwardly compelling than the impact of resentment is the claim that being uncomplaining precludes good decision-making about staffing and that this has a negative impact on patient care. Doctors systematically under-reporting their hours means that the people deciding how the hospital will be staffed lack accurate information about the amount of work associated with particular units. If Felicity writes that she has worked thirty-eight and a half hours this week when in fact she has worked sixty, those making staffing decisions are not aware of the need for additional staff in that unit. Felicity highlights that the thirty-eight and a half hour maximum has been set as "safe working hours" partly in light of evidence that longer hours contribute to greater risks for patients. Therefore, when a doctor under-reports the hours that he or she is working, particularly beyond this limit, decision-makers are deprived of information relevant to the quality of patient care. Employees drawing attention to their inability to complete the necessary tasks within the length of time deemed safe to work seem to better serve the organisation's aim of delivering good healthcare. The hospital's goal of high quality patient care is more likely to be achieved if employees are honest about the hours that they are working as this gives administrators the opportunity to staff the hospital more safely for patients.

Felicity's registrar's idea that the good employee is uncomplaining is therefore not a robust one. Rather, in light of the organisation's aim, it seems more plausible that the good hospital employee has the traits that dispose him or her to report overtime accurately. The good hospital employee is neither uncomplaining nor ruthlessly efficient as the discouraging influences in Felicity's situation respectively imply. Rather, the most plausible understanding of the hospital employee's role virtues discussed includes being upfront with those making staffing decisions and communicative about the total hours one is working.

Action guidance from the other roles

The other sets of role virtues associated with being a good junior doctor (assuming those articulated in chapter seven), also offer some support for reporting hours accurately. The suggested role virtues of a doctor included compassion, benevolence, truthfulness, humility, and self-sacrifice. These are derived from medicine's telos of improving patients' health and therefore are to be understood primarily in the context of doctors' relationships with patients. For example, a doctor having the medical role virtue of truthfulness does not necessarily imply that he or she would fill in a timesheet truthfully; the role virtue relates to interactions with patients. Self-sacrifice might initially be interpreted as supporting a junior doctor refraining from reporting his or her hours accurately, instead accepting that he or she must work without payment in order to complete the tasks necessary to good patient care. However, in the context of medicine's telos the role virtue of self-sacrifice described the disposition to put patients' needs first, rather than a blanket reluctance to ask recognition for one's work. In Felicity's situation, the role virtue of self-sacrifice seems more conducive to reporting her overtime comprehensively. Prioritising patients' needs over the avoidance of conflict with colleagues, the doctor with this role virtue reports his or her overtime to provide information necessary to improving patient care. The good doctor's sacrifice in this situation involves, not giving up pay, but accepting the potential consequences of rocking the boat.

The medical learner's role virtues offer little specific guidance in choosing between the two basic options in Felicity's situation. With the good medical learner aiming to acquire knowledge and skills for the treatment of illness, various traits were discussed in chapter seven as role virtues of the medical learner. These were, in relation to one's education, being curious, co-operative, committed, motivated, responsible, tolerant of uncertainty, patient-focused, vocal in the learning context, and reflective. Being a good learner is seen as highly relevant to the question of how long junior doctors' shifts should be. The need to see an illness throughout its course is regularly invoked as an argument for junior doctors' long working hours (see for example Cousins, 1986, p.94). But the learner role virtues seem less useful when it comes to seeking action guidance for Felicity. Because her learning does not seem to be at issue in this situation, these learning-focused virtues offer little in terms of an answer to the question of what she ought to do when deciding how to fill in her timesheet.

The team member role virtues, while offering some guidance in contrast, do not generate a clearly preferable action in the way that the doctor and employee virtues arguably do. Stipulating that the telos of team membership is the effective functioning of the team for the fulfilment of its various objectives, the good team member was posited as hard-working, communicative, co-operative, role-sensitive, trustworthy, and trusting. Understanding what these virtues imply about appropriate action in Felicity's situation seems to require more information about her team's objectives. Presumably Felicity's team aims to care well for all the patients treated in their unit, but they could also have other objectives including budgetary ones. How important to the team is minimising spending on overtime? One participant's explanation for consultants crossing off overtime on timesheets – "maybe they're just trying to save departmental money, I don't know" (Interview 12, p.15) – suggests that running a tight budget could be a team objective for some units. If this is a key aim for Felicity's team, the role virtue of co-operation points her towards refraining from recording her overtime. Being co-operative may point to refraining from reporting in Felicity's situation even if saving money is not a team objective. Considering the registrar's clearly communicated view that she ought not to report, the effective

functioning of the team may be best served by Felicity's compliance with his view about the appropriate way for her to act. The role virtue of being communicative however seems to point towards reporting overtime as the choice of the good team member. If the junior doctor's timesheet is the only way that more senior doctors will learn exactly how many hours he or she is working, filling it in accurately is important to enabling their understanding of the unit's workings. The role virtues of the team member, while clearly supporting junior doctors working beyond rostered hours when these are insufficient to complete their tasks, do not provide a clear direction in terms of whether or not to report those hours.

However, this set of role virtues does seem to suggest specific ways in which Felicity ought to act once she has made the decision to record her hours comprehensively. With the doctor role virtues and the most plausible conception of the employee role virtues both pointing to accurate reporting of overtime as the appropriate option, and the other sets offering no particular definitive direction, the right thing to do on this framework seems to be to report one's hours accurately. Assuming this, the team member virtues do seem to offer some guidance on *how* Felicity ought to go about reporting her overtime. Being communicative, she will discuss what she is doing and her justification for it with other team members rather than simply handing in her potentially controversial timesheets. Being hard-working and role-sensitive, she will make it clear through her work on the unit that her decision to accurately record her overtime is not as a protest against the hours she is being required to contribute to the team nor indicative of any unwillingness to do the junior doctor's tasks in the team context nor intended as an affront to the authority of the more senior doctors who have discouraged her from acting in this way.

I have argued that junior doctors facing situations like Felicity's ought morally to report accurately the hours that they have worked. Both the doctor's role virtues and the most plausible conception of the employee's role virtues support this course of action while neither the medical learner's role virtues nor the team member's role virtues point to refraining from reporting as the right thing to do (assuming that

meeting a budgetary target is not the key objective of the team). I suggested that neither of the understandings of the good employee invoked by the discouraging influences in Felicity's story stands up well to scrutiny in light of the hospital's aim. The organisation's goal of delivering high quality patient care implies that the employee's role virtues include efficiency (but understood in a particular limited way differing from the administrator's notion) and exclude being uncomplaining. However, it is important to acknowledge that, despite the problematic nature of the administrator's and registrar's understandings of the good employee, these understandings nonetheless constitute part of the environment in which Felicity is working. Although the most plausible conception of the employee's role virtues justifies junior doctors filling in their timesheets accurately, in practice agents like Felicity must also deal with the misguided conceptions held by others in their organisation. Despite junior doctors' theoretical justification for reporting their overtime as articulated in this chapter, acting rightly is made more difficult in the real-life context where these misguided conceptions endure. The role virtues of the team member point to some ways in which a junior doctor like Felicity ought to minimise the negative impact of her decision on her team's functioning in this complex context. Analysing the issue of junior doctors reporting their unrostered hours has demonstrated again the capacity of a role virtues framework to explain interns' and residents' ethical challenges and to capture and engage with the ethical considerations generated by their particular position of agency. For this ethical challenge, it has also produced clear action-guidance.

CHAPTER 9: INVOLVEMENT IN TREATMENT PERCEIVED AS FUTILE

Having considered junior doctors reporting their unrostered hours, I now turn to another ethical challenge that similarly involves relationships other than those between doctors and patients, in line with the broad conception of bioethics advocated in chapter one. In this chapter I use the role virtues framework to analyse the issue of junior doctors' involvement in treatment that they perceive to be futile. Unlike the hours challenge, which may to some seem particularly mundane, futile treatment is an issue that is of obvious ethical importance. In the first two sections of this chapter I outline the type of dilemma that junior doctors often face in relation to futility and argue that this ethical challenge can be interpreted as a clash between the junior doctors' various roles – particularly doctor and team member. Then, in the third section, I draw on the role virtue sets to generate action guidance for the junior doctor facing this issue.

I understand the word 'involvement' broadly in this context. I take a junior doctor who merely observes the administration of treatment by other team members as being involved in that treatment, as is a junior doctor who participates in the care of a patient directly (for example by inserting catheters or prescribing medication). This understanding is justified by the team-delivered nature of medical care in hospitals. Each patient is treated by a team of doctors and therefore all team members contribute to and potentially influence to some degree the overall care that the patient receives.

The term 'futile treatment' also requires definition as it has the potential to include a wide variety of types of medical care. For example, over-servicing such as performing unnecessary tests could be defined as futile treatment, as could any procedure on a patient whose death is imminent. In line with the majority of philosophical literature in this area, my focus is on treatment that is both futile and burdensome to the specific patient. In this context, burden is generally understood to

include not only physical suffering but also the assault of other values held by the patient. From here on, my use of futile entails the additional notion of burden. My analysis of this ethical challenge draws on the specific definition of futility put forward by Schneiderman and colleagues which I discuss in detail in the course of the chapter.

Throughout the chapter, I focus on one intern's story in particular, because of the rich contextual detail provided by this participant. I argue that Nicole's story highlights an aspect of the issue of futile treatment that is overlooked in standard philosophical discussions. Typically, futile treatment is discussed as a conflict between doctors and a patient or family. Nicole's story however describes a conflict between her views and those of the more senior doctors with whom she was working. This intra-team version of the futility issue was vividly present in several other participants' interviews and was framed by these junior doctors as particularly distressing. Using Nicole's story and the role virtue sets articulated in chapter seven, I claim that junior doctors facing this type of situation ought always to investigate the rationale underlying decisions to proceed with apparently futile treatment and to discuss their concerns with their seniors, even if such discussion will be personally difficult. I also suggest that a junior doctor facing this ethical challenge ought always to be willing to initiate and engage in ethical dialogue, and that in some situations further action (such as taking concerns outside the team or refusing to participate in treatment) may be morally appropriate.

NICOLE'S STORY

One of the hardest things to deal with overnight is patients who are on a general medical ward and who are old and dying but who aren't allowed to die yet, because their treating team are still trying to save them. As the night team, all you're trying to do is to maintain status quo and pretty much follow the treating team's plans, and then get your patients safely through to morning at which time the treating team can make some more decisions during the day. And the general medical units are all very busy and they do have a lot of really old people, frequently who are just sitting

around waiting to go to a nursing home because they're not safe to go home by themselves.

And I had this old Polish guy, he was ninety-six. And he spoke some English but not a great deal of English. And he'd come with just like an old person infection. I think he'd had a UTI [urinary tract infection] or a pneumonia or something, that really potentially might have been treatable and then maybe he might have needed some nursing home care or something. But during, I think on about the fourth day of his admission while he was getting some antibiotics and fluids, he got confused in the middle of the night, you know, as ninety-six year olds who have an infection do. Especially when they're in hospital and it's the middle of the night and stuff. And he'd got up and wandered into a utility room, like a pan room, thinking it was the bathroom and peed. And then slipped in it and broken his hip. So it was just a big disaster, you know? And I wasn't on nights, or it was another intern who was taking care of the unit at that time. So I sort of was aware of this guy, that he'd fallen over and stuff and broken his hip. And he'd got a, you know, a hip replacement for the hip.

And, so then by the time I was on nights he was sort of post-op. And he was about a week post-op and still doing very badly. By this stage really not eating anything, still just delirious. Constantly delirious, you know, and I think, the impression that I got every night was that the treating team had pretty much given up on him. Because I'd be called to him every night because he hadn't had enough fluid that day. And, you know, so I'd try and put a drip in and he'd rip it out. And I know that after I think the first or second time I just didn't want to put drips in him anymore because he'd really hurt himself. Like his skin was so thin that he'd given himself, he'd ripped off a whole big flap of skin on his hand when he'd got confused and pulled the drip out. And he was still confused so it was a fair bet that exactly the same thing would happen again. And he wasn't eating anything so he was severely malnourished. Someone had also put a urinary catheter in him, which he'd also pulled out and so like tore his urethra and so then every night I would get calls about him because he hadn't had enough fluid or he, you know, he was bleeding from his penis again because some bright spark had put a catheter in which he'd ripped out. And I just was getting so frustrated because, you know, it was just, we were just harming this man as far as I was concerned. Like he needed palliative care! He didn't need to be lying around on a medical ward and for me to go and, you know, try and think of some slipshod solution in the middle of the night.

And I so clearly remember too that like towards the end, there were two nights in a row when he just kept asking for Polish vodka. I was just thinking ‘can we get this man some vodka?! [laughs] Because there’s nothing else that we’re doing that’s going to help him right now! [laughing] Why don’t we just give him some vodka and he can die in peace?’. Instead of with us sticking needles into him.

Oh it made me so, and then, and then I got called to him on a weekend, on a Saturday night like 3 or 4a.m. because he’d had the staples of his hip surgery removed that day. And the wound had broken down, had not healed at all. So it was just like two edges with a big hole in between the two edges. And the nurses were like ‘oh, you know, what are we going to do?’ and so we sort of just patched it up for the night and I’d speak to the surgeons in the morning. Because I knew that they were not going to do anything about, you know, this ninety-six year old really unwell guy. He’d already had one operation overnight. And so I spoke to them the next morning and it was the orthopaedic registrar on. And, and I sort of, and I told them that, you know, this was a ninety-six year old man who’d come in, broken his hip in hospital and the wound from the initial operation had not healed at all and, but there were no signs of infection and that I thought this was just because he was so malnourished. Because wounds just don’t heal if you’re not eating and you don’t have any protein or anything like that. And so overnight I’d just stuck it up with steri-strips and given him some prophylactic antibiotics. And anyway he had, I don’t know how this happened but he was like ‘oh ok, well we’ll need to take him to theatre and replace his hip joint’. [laughs] And I was like

R: Who was saying that?

The orthopaedic registrar and I was like ‘this man is ninety-six years old! He hasn’t eaten anything for two weeks, you know. He’s chronically confused and’ and he was like ‘no no no, it’s never going to heal if we don’t put another hip in’. I was like [laughing] ‘it’s never going to heal if we *do* put another hip in!’.

And then I went back that night and they’d taken him to theatre and put another hip in. The thing was that they hadn’t even written in the notes, it really looked like they’d just like, I don’t think he’d even gone and looked at the guy. It was like ‘oh I just need to put a new hip in’. And then, so that was a Sunday he would have got his hip joint. And then he died on like the Tuesday or the Wednesday.

And I really thought that if, you know, I dunno. I think that he should have got to palliative care about ten days before he died. And maybe his last ten days would have been a lot nicer. And he didn't need all these painful interventions that were futile. But, I mean, that's another position, because when you're on the night team it's really difficult to get stuff done. And to have influence on what the actual treatment plan is. And the patients often seem, are often worse overnight. Especially because they're more confused and things like that. So yeah. I just thought that was a really bad outcome. You know, I think that, yep. I don't know what the orthopaedic registrar was thinking. But I mean it's easy to say that but then equally, you know, maybe someone else, maybe me or maybe the medical team should have said a week earlier 'we need to stop all interventions for this person'. But then I think partly it's because his English wasn't great and he didn't have a lot of family. So it would have been very much a case of us making that decision rather than, than like the medical team negotiating with his family what the boundaries would be (Interview 10, pp.22-5, participant's emphasis).

A DIFFERENT VERSION OF A FAMILIAR ISSUE

Nicole's story relates to a classic medical ethics issue, that of futile treatment. She describes this patient as receiving "all these painful interventions that were futile". Futile treatment has been a preoccupation of medical ethicists, particularly philosophers, for many decades. Ancient thinkers including Plato and Hippocrates highlighted the limits of medicine's power and the "madness" of doctors treating any "man [who] suffers from an ill which is too strong for the means at the disposal of medicine" (Hippocrates quoted in Schneiderman et al., 1990, p.951). (See also Galanakis, 2000, p.1576.) Some recent writing attributes the problem of futile treatment to the rise of the concept of patient autonomy in the medical context. Schneiderman and colleagues, for example, write

[s]o powerful has this notion of autonomy become that its glare often blinds physicians (and ethicists) to the validity of earlier maxims that had long defined the range of physicians' moral obligations toward patients. Among these was the maxim, respected in ethics and law, that futile treatments are not obligatory (Schneiderman et al., 1990, pp.949-50).

Developments in medical technology have also played a role in creating ethical issues around futile treatment, leading one writer to label it “a fairly new problem” (Capron, 2001, p.261). The range of treatments that could be understood as futile has increased significantly with the greater sophistication of medical technology and its associated ability to extend the lives of dying patients or those in a permanent vegetative state.

Schneiderman and colleagues’ definition of futility

Definitions of futility vary. Attempts to define the concept constitute a substantial proportion of the literature in this area (for reviews see Lofmark & Nilstun, 2002; Helft et al., 2000). In discussing this ethical challenge and Nicole’s story specifically, I draw on one influential definition, put forward by Schneiderman and colleagues. Originally published in a medical journal, their definition addresses a number of useful elements of the controversies around futility and offers a compelling notion of qualitative futility.

They frame their definition as involving both “quantitative and qualitative” components (Schneiderman et al., 1990, p.949). The quantitative component states that where doctors conclude, from their own or colleagues’ experience or from published data, that a medical treatment has failed consistently in the last one hundred cases then they ought to consider that treatment futile. (A later paper clarifies that general professional standards informed by community-endorsed values ought also to play a role in futility decision-making; this is in response to the criticism that their definition advocates individual doctors acting on their subjective impressions (Schneiderman et al., 1996, p.670)). They also state that treatments are futile if they “merely preserve...permanent unconsciousness or cannot end dependence on intensive medical care” (Schneiderman et al., 1990, p.949).

This quantitative component of their definition is ethically problematic. The hundred case cutoff point is too black-and-white. To claim that a treatment’s ethical status neatly changes from appropriate to inappropriate on the hundredth attempt is highly implausible. Where the treatment imposes any burden on the patient in terms of

physical suffering or other deprivations (such as a significant financial cost or an inability to participate in valued activities), employing it after it has consistently failed eighty or ninety times seems ethically questionable. Further, the notion of failure employed in the quantitative element of the definition seems to be a purely biological one. The implicit understanding is that a medical treatment fails if it does not restore functionality to the part of the body at which it was aimed. This biological notion of medical success and failure is incompatible with the holistic subjective understanding involved in the (far more plausible) qualitative element of their definition.

The qualitative component of Schneiderman's definition is considerably more robust than the quantitative component, and is useful in relation to Nicole's story. Schneiderman and colleagues claim that

[i]n judging futility, physicians must distinguish between an effect, which is limited to some part of the patient's body, and a benefit, which appreciably improves the person as a whole. Treatment that fails to provide the latter, whether or not it achieves the former, is futile (Schneiderman et al., 1990, p.949).

The idea is that treatment could be successful in the sense of improving the function of a particular part of a patient's body but should nonetheless be considered futile if it will not improve the patient's quality of life. Interestingly, Schneiderman and colleagues make no direct mention of terminal illness in their definition of futility. The fact that a patient is dying is relevant to a treatment's futility, on their definition, only to the extent that it affects the patient's chance of improvement in quality of life. On their definition, it is not the fact that Nicole's patient was dying that makes the interventions futile, but the fact that the interventions would not appreciably improve his overall well-being. Considering the fact that many interventions could improve the quality of life of a dying patient, this aspect of the definition seems plausible. The qualitative component of their definition thus captures the idea that any burdens of a treatment must be justifiable in terms of the benefits the treatment can be expected to deliver to the individual's well-being understood holistically. If there are no gains in

well-being the treatment is futile. And, assuming that there are also burdens involved for the patient, administering the treatment is morally wrong.

Intra-team disagreement

In typical medical ethics discussions of futility including that of Schneiderman and colleagues, those pursuing futile treatment are patients or their families. Capron, for example, in a widely-used companion to bioethics, writes about the issue of futility in terms of “the insistence of a patient – or more commonly, family members speaking on behalf of an incapacitated patient – on receiving medical intervention that physicians do not want to provide” (Capron, 2001, p.261). (Further examples include Brock, 2001, p.234; Helft et al., 2000.)

This type of conflict about futility was reported by participants in this study, with some junior doctors struggling with families’ demands for treatment:

[one thing] I find really difficult is that we’re under this constant pressure to treat people. And the patients expect it, and the patients’ families expect it, and our society expects it. And you, you’re treating some of these people thinking ‘God, why are we treating these people? It’s horrible’. And I find that really hard, particularly because I’ve been doing aged care now for six months and the average age of my patients is ninety at least. They’re *really* old. And, I mean when you, like I’ve treated one man who’s had a stroke, so completely paralysed..., had a laryngectomy, had his larynx removed for cancer so he’s got a permanent tracheostomy [tube inserted into the windpipe to assist breathing]. He can’t talk, he recurrently aspirates [fluids in the airway], you know, breathes in and has chest infections. He’s got pseudomonas colonisation which is a bug you never get rid of and basically just causes, and he’s got MRSA [methicillin-resistant Staphylococcus aureus] colonisation so he’s constantly got a chest infection. And he’s in hospital every couple of months, having thousands of dollars of antibiotics given to him. He’s abusive towards the staff. He spits through his trachy at you. He’s got no IV [intravenous] access so for me to put a cannula in him, he was going ‘no, no, no’ pulling away. But he’s got dementia so his wife’s there going ‘no, treat him, treat him, treat him’. I had to sedate him to put a drip in him. And fight him with three people holding his arm down. I was sitting there going ‘what am I doing? I am

assaulting this man.’ But because he’s got cognitive impairment he doesn’t have capacity to say whether he wants to be treated, so it’s his wife’s decision. And she unrealistically is saying ‘do everything’. And this man has *no* quality of life. I mean the things we *can* do are so much now and I think that issue of, you know, stopping and asking ‘should we be doing that?’ isn’t [addressed]. And I think people are aware of it but they still, it’s ballsy to say no. And that’s a big call, when you can. So that’s sort of been, and I’ve had multiple cases where you, you’re treating and treating and treating going ‘why are we doing this? It’s horrible’ (Interview 7, p.26, participant’s emphasis).

While some participants, like this doctor, framed the futile treatment issue in terms of an individual ethical struggle about the conflict between her views and the requirements of her job, others described more overt disagreements at a unit level. One resident, for example, spoke of “a huge disparity between the parents’ wishes and expectations and the unit’s expectations” for a child with Duchenne’s muscular dystrophy and a very severe brain injury (Interview 3, p.55).

In Nicole’s story however, the disagreement about futility was not between doctors and patients or families at an individual or at a unit level but rather *within* the treating team. Beauchamp and Childress are a notable exception to the pattern of ethicists writing about futile treatment only in terms of disagreements between doctors and patients or families. They recognise (although do not discuss in detail) that, as was the case in Nicole’s situation, “[d]isagreement often exists among health professionals” (Beauchamp & Childress, 2001, p.134). Existing empirical studies suggest that it is not uncommon for both nurses and junior doctors to experience this intra-team version of the futility issue, perceiving as futile the treatment that senior medical staff members have chosen to pursue (Moblely et al., 2007, p.261; Ferrell, 2006, p.926; Rosenbaum et al., 2004, p.404; Shreves & Moss, 1996, p.1103; Muller, 1992, pp.892-3). In one American study of a hundred and eight nurses, when asked to describe “a distressing clinical experience you have had as a nurse when you witnessed care that you would describe as futile” twelve percent responded with a narrative about a conflict between a nurse and a doctor, rather than between health professionals and patients or family members (Ferrell, 2006, pp.925-6). In the junior

doctor context, Shreves and Moss discuss futile treatment as an example of junior doctors disagreeing with consultants on ethical matters. They report that twenty-seven of their thirty-six participants (doctors in their first, second or third postgraduate year, at a single hospital) identified their most troubling ethical disagreement with their senior colleagues as one relating to “treatment ordered by the attending physician [that the junior doctor considered] to be futile” (Shreves & Moss, 1996, p.1103).

The experiences of participants in my study provide support for the notion that this intra-team version of the futility issue is a significant ethical challenge for junior doctors. In their responses to my interview question about times when they had been in an ethically difficult position, two other doctors in addition to Nicole told detailed stories about being involved in implementing futile treatment ordered by seniors. Donna’s story in chapter five of surgery on a dying patient is one example. This was the junior doctor who expressed her concerns to her registrars but ended up lying to the surgeon in order to avoid participating in an operation on a patient whom she reasonably perceived as likely to die within days. The following story, told by a different junior doctor, provides another example.

I was doing radiation oncology. And we had a patient that was sent from the country who had a fracture of their spine because they had a tumour there. They were sent from the country so that they could have radiotherapy and go home because it was a sign that they had metastatic cancer and that they weren’t going to have a very long period in which to live, so it’s to give them radiotherapy, get them out of there and get them home again.

But when they got to our hospital the consultant decided that it might be better for them to have an operation. Which then took time because he made the referral [on] a Saturday...and then the patient got sent down a few days later. And then when they went there it was said ‘we can do the surgery but we can’t do it today’ and he got sent back again. And then it turned out that the patient spent about four weeks at our hospital during which time he never had any radiotherapy and had like a lot of pain and was perpetually confused. And the consultant was always pushing for him to have this operation and encouraging the family for that as well.

And in the end he, it was, like the day before he died it was found out that he had brain metastases and that was the cause of his confusion. Which would mean that he couldn't have an operation in the first place and so all this time he'd been in constant pain. The nurses were very uncomfortable with the plan that had been made for him and didn't want to do things like put in a nasogastric tube to feed him because they thought that that was wrong because he was going to die. And palliative care consultants were saying 'this man is dying, why are we doing these things to him?'. And I, I felt, I agreed with them and I felt for the patient because he was just confused and was like 'why am I here? I want to go home'. And I just felt that he had a really terrible death and that

R: Because of that doctor's decision to?

Yeah, that was, you know, and maybe there are, like maybe there's really logical reasons for that and he's much more experienced but I just felt at the time, I just felt terrible and I used to go home and cry about it all the time.

R: And did he, the doctor who'd made that decision talk about, like did he recognise that other people were uncomfortable with it do you think?

I don't think, he didn't necessarily recognise their discomfort but he had his reasons and he thought that if you give him radiotherapy he'll always have to wear a neck brace, like a neck collar. But if he'd had an operation that would stabilise it so that he wouldn't have to wear a neck collar. That was his rationale.

R: Was there discussion

We had a family meeting where it was led by the consultant and I think that his family wanted to do what they thought was best for him so they strongly pushed for him to have the operation and to have a nasogastric tube to feed him and things like that.

R: But it upset you quite personally by the sound of it

It did, yeah. It was hard because I was the intern for two units. I was the intern for radiation oncology and palliative care. So I was seeing the patient from two different points of view. And I, I was more strongly aligned with the palliative care team because I thought their approach was better, to actually give him pain relief. And the thing that upset me on the day before he died is that the consultant told us that we

needed to sort of halve his pain relief medication in order to see whether that helped to reduce his confusion. So that upset me as well, that it seemed very much not oriented as to whether or not, his comfort and what was best for him and more about, all about getting this operation (Interview 12, pp.6-8).

This last story highlights that the dichotomy I have been drawing between the doctor-family and intra-team versions of the futility issue is to some extent a false one. The views of doctors, particularly the senior doctors directing a patient's treatment can influence patients' and families' views about what constitutes the most appropriate treatment. However, Nicole's story can be seen as encapsulating an aspect of the ethical challenge of futile treatment that is not addressed in the standard philosophical debates on this topic. Past studies as well as the interviews I conducted indicate that conflict within the healthcare team about futile treatment is an issue that can be present in medical graduates' early years of hospital practice and, as the final example compellingly indicates, can be highly distressing for junior doctors. The crucial ethical challenge for Nicole around futile treatment was not a disagreement between medical staff and a patient's family or even simply disagreeing with a decision made by her seniors. Rather, her ethical challenge was that as a result of her senior colleagues' decisions, she had to play a part in implementing treatment that she perceived as futile. Focusing on Nicole's story specifically as a detailed example of this type of ethical challenge, in the next section I argue that the problem can again be fruitfully understood in terms of junior doctors' multiple roles and the role virtue sets.

A CLASH BETWEEN THE DOCTOR AND TEAM MEMBER ROLES

On the definition of futility outlined in the previous section, the second hip replacement received by Nicole's patient was clearly futile. This operation could not improve this patient's quality of life when his overall condition meant that he would not heal. The burdens of the operation could not be justified in terms of benefits to

his well-being as a whole individual. The other interventions that he was receiving, such as the drips for fluids and the urinary catheters, also seem futile on the qualitative component of Scheidman's definition. Like the second hip replacement, each had the potential to improve the functioning of a part of the patient's body, but in the context of his overall condition would not improve his quality of life. Nicole's perception that this man was receiving "painful interventions that were futile" seems justified on the Scheidman definition.

Given this, what should Nicole have done? In arguing that doctors are morally required to decline families' requests for futile interventions, Jecker and Schneiderman claim that

requiring the use of futile interventions wrongly signals that physicians are merely tools for enacting others' (patients') goals and do not possess, as individuals and as members of a profession, independent ethical standards and ends (Jecker & Schneiderman, 1993, pp.153-4). (Brody, 1997, pp.6-8 makes a similar argument.)

The problem for junior doctors involved in treatment that they perceive as futile is that, in their work context, they *are* in fact "merely tools for enacting others' goals". In the context of the hierarchically structured medical team, the job of the intern or resident is to enact the senior doctors' treatment plans. As one participant put it, "basically our job is to do what they [consultants and registrars] tell us to do" (Interview 4, p.14). Although the *patients'* goals need not be dictating their actions in the way that the quote suggests, serving the *consultants'* professional goals for the patient is an expected part of junior doctors' responsibilities (assuming, of course, that the consultants' goals are medically appropriate). In practice, and certainly in the perception of the group of junior doctors involved in this study, junior doctors are required to act largely as the tools of their seniors. Thus the situation of the junior doctor faced with a consultant's orders for futile treatment is importantly different to that of the more senior doctor faced with a family's request for futile treatment. The possession of "independent ethical standards and ends" is not so clearly an acceptable

feature of the junior doctor's position. Nicole's subjugate position in the team significantly limits the extent to which she has professional autonomy.

The ethical justifiability of limiting the professional autonomy of a class of doctors in this way is of course questionable. While junior doctors may be treated as tools in current practice, this does not imply that such treatment is justified. As a theoretical question of professional ethics, interns and residents could perhaps be argued to have the same ethical entitlements and obligations as their more senior colleagues or, at least, an entitlement to a greater degree of professional autonomy than they are currently allowed. Through the course of this chapter, I argue that junior doctors faced with involvement in futile treatment ought indeed to act more independently than is currently standard.

Nurses are in a similar situation to junior doctors when they encounter futile treatment. They too are expected, as a result of their institutional position, to implement the decisions made by doctors. Nurses' involvement in treatment that they perceive as futile has been more substantially studied than junior doctors', and this discussion has the potential to provide insights into Nicole's situation. Mappes attributes nurses' disagreements with doctors about what is best for patients in part to the fact that nurses can have more detailed knowledge of patients due to the greater time that they spend with them (Mappes, 1999, p.557). The same argument seems to apply to junior doctors. Although this is perhaps not the case in Nicole's situation with her being on night duty, in general the time interns and residents spend with patients can be significantly greater than the time spent with the same patients by the more senior doctors caring for them.

The position of the nurse faced with involvement in treatment that he or she perceives as futile seems directly translatable into the junior doctor's position: both experience a conflict between their role in caring for the patient and their role as implementers of others' decisions. In the nursing context, Mappes writes that '[t]he dilemma arises because the nurse's apparent obligation to follow the physician's order conflicts with his or her obligation to act in the interest of the patient' (Mappes, 1999, p.555).

Nicole's description suggests that she is experiencing a similar conflict between the role virtues of the team member and the role virtues of the doctor. The pull of her obligations as a team member who co-operates with her seniors and is sensitive to the boundaries of her particular role is clear in her statement that "[a]s the night team, all you're trying to do is to maintain status quo". She is clear that it is the treating team who do the medical decision-making in these situations. But her perception of her role as this patient's doctor is also evident in her story. She is "frustrated" by the way his hospital stay is progressing and wants palliative care for him, seeing the current situation as just a series of "slipshod solution[s]". As with nurses for whom a key concern is that futile treatment denies patients palliative care (Ferrell, 2006, p.926), Nicole's compassion is affronted by this patient's treatment: "we were just harming this man as far as I was concerned".

It might be argued that there is an important disanalogy between the nurse and the junior doctor faced with involvement in treatment that they perceive to be futile. Nurses are permanent subordinates in the hospital institution. Junior doctors, in contrast, will later become senior doctors with more decision-making power. This could perhaps be taken as suggesting that there is greater reason for nurses to act when confronted with involvement in futile treatment whereas junior doctors are justified in remaining silent, biding their time until they are more influential and acting *then* in line with their professional judgement. The problem with this line of argument is that choosing to remain silent during internship and residency has implications for junior doctors' moral development. Each decision to remain silent when one's ethical convictions point to speaking up potentially erodes those convictions. As Drane argues, "[l]ike everyone else, doctors shape the ethical narrative of their lives by the ways they do ordinary things over and over again" (Drane, 1988, p.xi). As a result of delaying, the junior doctor's ethical values are less likely to be those that he or she in fact holds as a senior decision-maker. Such a delaying approach to involvement in futile treatment also fails to help the present patient to whom the junior doctor, qua doctor, has obligations. Thus, the position of the nurse and the junior doctor are usefully analogous in relation to involvement in

treatment perceived as futile: both are subordinates faced with a clash between the ethical requirements of their multiple roles and a significant decision about how to act in the face of this challenge.

Mappes advocates nurses fulfilling their obligations to patients over their obligations to physician decision-makers where these conflict. She argues that

[g]iven the fact that the *basic* obligation of both the physician and the nurse is to act in the medical interest of the patient, it is rather striking that anyone should suppose that the nurse's obligation to follow the physician's orders should ever take precedence...Presumably, the nurse's obligation to follow the physician's orders is grounded on the nurse's obligation to act in the medical interest of the patient...it would seem to follow that the patient's interests should always take precedence (Mappes, 1999, p.557, italics in original).

From a role virtues perspective, Mappes' analysis here seems overly straightforward. Certainly the nurse has a fundamental obligation to act in the medical interest of this particular patient. However, the nurse's obligation to follow the physician's orders may be based in the nurse's membership of a healthcare team. Qua nurse, her focus is rightly on the interests of this specific patient. But qua team member, she is concerned with the smooth functioning of the team. Similarly, Nicole's objective qua doctor is focused on the well-being of her individual patients, but her aim qua team member is to ensure the effective functioning of the team to meet all its potentially differing goals. Arguing that ethically she ought only to focus on the specific patient denies her role as a team member and its moral importance (outlined in chapter seven).

Nicole's situation is further complicated by her role as a medical learner. Towards the end of her story, she seems to express some doubt about her perception of the situation. Having described how difficult it is to influence a patient's treatment when working nights, she then comments that "the patients often seem, are often worse overnight [e]specially because they're more confused and things like that", seemingly justifying the registrar's dismissal of her concerns. Earlier in her interview, Nicole

stated that “you never really trust yourself because you’re always aware of your own inexperience” (Interview 10, p.9), and this sentiment seems to be reflected in her hesitation about her assessment of this patient’s situation. Nicole gives the impression that she is aware of her limited experience when she judges a senior doctor to be making a poor decision. The participant who described the situation in radiation oncology made a similar comment, hedging her criticism of the consultant’s judgement with the comment that “maybe there’s really logical reasons for that and he’s much more experienced”. In the context of her story, this participant also stated that

I think the other things [challenges] are just having to sometimes do things that you don’t want to do or you don’t think that are right. Or that if you had a choice that you wouldn’t necessarily do. But also knowing that there are times when you wouldn’t know what to do and that you would rely on the people that are making those choices. So it’s very hard (Interview 12, p.5).

These comments suggest that, when an intern or resident is confronted with a senior’s decision to pursue treatment that the junior doctor perceives as futile, his or her own role as a medical learner can be at the forefront of his or her mind. These junior doctors were aware of their seniors’ greater experience and thus were, to a certain degree, wary of their own contrasting assessment of the futility of an intervention, although the perceptions of participants in this study seem reasonable. They saw themselves as lacking the extensive knowledge possessed by the decision-makers. Junior doctors’ position as medical learners thus colours the way in which they engage with this ethical challenge.

WHAT TO DO?

What kinds of action does a role-based analysis suggest as ethically appropriate? Having understood this ethical challenge as arising from conflict between junior doctors’ various roles, what ought Nicole and other junior doctors in this type of situation to do? In this section I claim, on the basis of the role virtue sets put forward

in chapter seven, that junior doctors faced with this issue ought always to question respectfully their seniors and to discuss within their team their own concerns in an open-minded way. They ought always to be willing to initiate and engage in ethical dialogue with other team members. In some cases, further action such as refusal to participate in a particular intervention or registering an objection outside the team may also be morally required. Although this action-guidance may seem to be asking little of junior doctors, it is in fact quite demanding when we take into consideration junior doctors' lowly position and their current practice. I focus on three of the four role virtue sets, as the employee role virtues offer little direction for agents in this particular type of situation.

Action guidance from three of the roles

Virtues of a doctor

From the set of doctors' role virtues outlined in chapter seven, three seem particularly relevant to situations like Nicole's. Two of these are compassion and benevolence. The good doctor was posited as acting for the benefit of the patient, recognising and addressing his or her individual suffering. The second is humility. It was suggested that the good doctor uses medical technology and his or her power only in ways that benefit patients. Associatedly, he or she is willing to concede that treatment has failed. It seems clear that proceeding with futile treatment is contrary to these three virtues, at least in the intra-team version of the issue. A doctor acting with compassion, benevolence, and humility would not choose the second hip replacement undergone by Nicole's patient nor the other continued interventions. In a situation where the patient or family members were *requesting* treatment that the doctor believed would not benefit the patient, compassion may perhaps direct the doctor to act differently. But in Nicole's story, because no relatives are asking for the treatment and the patient is resisting the interventions, the role virtues point away from proceeding with treatment. Because of the lack of benefit to the patient, the compassionate, benevolent, and humble doctor would not simply participate

unquestioningly in a futile operation initiated by colleagues nor continue to implement burdensome interventions.

These virtues of the good doctor require the junior doctor (or indeed any doctor) to advocate against a treatment plan that is not beneficial to the patient. However, it is crucial that a doctor faced with an apparently futile intervention investigates the decision-maker's reasons for choosing such a treatment. The questioning doctor could be wrong in his or her assessment of the potential benefit offered by the treatment, due to inexperience or lack of information. This is particularly the case for junior doctors, with their limited clinical experience. The questioning doctor needs to understand the rationale behind the decision-making doctor's (or doctors') choice, in order to judge that the proposed treatment really is not beneficial for the patient and is therefore genuinely incompatible with the role virtues of benevolence and compassion.

If the questioning doctor continues to believe that the treatment is futile having sought this additional information, the characteristics of the good doctor require him or her to advocate against the treatment. For the junior doctor in this position, he or she must speak with the registrars and consultants. In order to have any chance of altering the course of the patient's treatment, the junior doctor needs to express his or her concerns to the senior doctors, particularly those with decision-making power. In Nicole's case, the doctor role virtues point to speaking up, with the aim of preventing the operation and ceasing the other burdensome interventions. But what about the other roles' virtues? How do they direct her to act?

Virtues of a team member

Superficially, the role virtues of the team member seem to point to simply complying with the seniors' decision as the appropriate action in a situation like Nicole's. Being co-operative, role-sensitive, and trusting of fellow team members, it appears initially that the good team member would acquiesce to the seniors' decision and implement the treatment plan without delay or question. However, on closer analysis, two

aspects of the team member role virtues indicate that they in fact support junior doctors speaking up in this type of situation.

Firstly, it was suggested in chapter seven that the good team member is communicative. As highlighted earlier, junior doctors often spend more time with patients than their senior colleagues do and thus can have additional information and insights to contribute to decision-making about patients' care. A junior doctor communicating his or her own perspective could thus be important to the effective functioning of the team for the fulfilment of its objectives. Communicating his or her concerns on the type of value-based question involved in the futile treatment scenario could further be seen as an attribute of the good team member, be they junior or senior. Such questioning serves a warning light function for the team, prompting reflection on the appropriateness of the team's direction. If the good team member is communicative, then he or she does not remain silent when faced with apparently futile treatment being delivered by his or her team.

Secondly, the team member role virtues are in fact compatible with the action option suggested by the doctor role virtues, namely investigating the decision-maker's rationale and discussing concerns with senior doctors. Questioning the treatment plan can be done in a way that is compatible with being a good team member, thus satisfying the virtue sets of both the doctor and team member roles. Evidence for this compatibility is provided by the following participant's description of her reaction when confronted with seniors' troubling decisions to treat:

I take the approach of always asking why we're doing things if I don't quite understand it, because I'm pretty anti doing procedures that aren't for pain relief on people who are going to die. I think that's pretty wrong and, and I, I, and I really don't like people suffering for no good reason. Like I mean, you know, young fit healthy people, if something horrible happens to them then yes you'll put them through the suffering and agony and try to fix everything and all that kind of stuff. But I mean I think if, you know, if people's best expectations of coming out are that they're going to be in pain or unable to move for, you know, what is probably only going to be a few more months of their life I'd have, the caring person inside me just

feels really uncomfortable about that. And there are, and that's exactly the time when I go to the person doing it and I go 'oh I was just curious you know, why are we doing this procedure?' or 'what are we hoping to achieve by this kind of thing?'. And often they'll say things like 'look I know that normally we wouldn't do this kind of thing but the patient specifically asked me that they wanted to have every chance at living, be it, you know, in a nursing home or wherever else. You know, at this point and I sort of had a good discussion with the patient, you know, because I've been seeing them for three years' or however long they've been seeing them. And 'at the moment, that's the direction they want to head in'. And that's, and that's absolutely fine. But, and I actually haven't had a situation yet where other people have done something morally objectionable that I've, after asking I've still been really uncomfortable with. I mean even if it's not necessarily what I think that I would have done when I'm a consultant, I can sort of understand what their choices were. And that, you know, that their intentions and their heart's in the right place. Which has always been the way so far...And I mean, you know, I haven't walked up to people and gone 'what the bloody hell do you think you're doing?!' but I go, and you know, if they're someone I don't know I say 'hello, my name's Michelle, I'm on the whatever unit I'm on at the moment. We're involved in So-and-so's care. I was just wondering what your plans were in respect to this that you're about to do to them' or that kind of stuff. And they'll go 'oh yeah', you know blahblahblah and they, hasn't been a problem. So far (Interview 5, pp.23-4).

The success of this junior doctor's approach indicates that it is possible to seek seniors' reasons and discuss concerns without causing offence or disrupting team functioning. Acting in accordance with the doctor's role virtues does not necessarily preclude also being good qua team member. It is also worth noting that, in this participant's experience, appropriate respectful questioning has each time led her to reassess the ethical status of the course of action that she initially perceived as futile, reinforcing the point made earlier about the importance of junior doctors investigating the rationale underlying the decision that troubles them. Objecting in such cases would have in fact compromised the value of patient well-being that the good doctor aims to advance, assuming that the objection succeeded in changing the treatment plan or disrupted the team to the extent that their delivery of patient care was compromised.

Virtues of a medical learner

The role virtue set of the medical learner also points to investigating rationale and discussing concerns as the appropriate action option for an agent in a situation such as Nicole's. The outlined set of role virtues associated with being a good medical learner included being curious, vocal, reflective, and motivated in relation to the acquisition of medical knowledge and skills. These virtues all point to a junior doctor seeking further information to understand better the decision-making of a senior colleague who is pursuing an apparently futile treatment. Senior doctors' understanding of the fallibility of prognostication has been well-documented (Christakis, 1999). Junior doctors, with their more limited clinical experience, may have an unwarranted level of conviction about a patient's imminent death. They are yet to have the sobering experience, reported by more senior doctors, of patients recovering after a hasty death appeared inevitable. Seeking further information about why a more experienced colleague sees pursuing treatment as appropriate would therefore be the choice of the good medical learner. Being curious, reflective about his or her own learning, and motivated to improve his or her clinical skills, the good medical learner would want to understand the reasons behind the senior doctor's decision in order to improve his or her own decision-making. The medical learner role virtue of being vocal similarly points to asking questions about that decision and discussing one's concerns.

Three steps

1. Always investigate rationale.

Thus, a role-based analysis suggests that Nicole and other junior doctors faced with involvement in treatment that they perceive to be futile ought always to pursue their concerns rather than implement without question the treatment decisions made by their senior colleagues. The various role virtues associated with being a doctor, a team member, and a medical learner all direct the junior doctor firstly to find out more about the rationale behind a decision to proceed with treatment that appears to be futile.

2. If concern remains, engage seniors in discussion sensitively and with an open mind.

Having sought this additional information, if the junior doctor still believes that the treatment chosen by colleagues is of no benefit to the patient then he or she ought to discuss these concerns with senior colleagues. Such discussion is required by the doctor's role virtues of compassion and benevolence, and the learner's role virtue of curiosity particularly. Sensitive and respectful questioning of decisions about apparently futile treatment can be achieved by junior doctors in a way that is also compatible with their role as a team member.

It is worth noting that Nicole *did* express her view about the futility of the second hip replacement as did Donna, the intern who avoided involvement in the surgery that she perceived as futile. (It is not clear whether the participant involved in the radiation oncology situation communicated her views to her colleagues.) Both spoke with registrars, clearly expressing their opinion that the treatment was futile. However, in neither case did this change the trajectory of the patient's treatment or resolve the junior doctor's feeling of discomfort. These participants' experiences suggest that consultants need to be involved when junior doctors are expressing concerns about futile treatment. Shreves and Moss' findings around junior doctors' ethical disagreements with consultants indicate that consultants are "largely unaware" of junior doctors' concerns despite believing that it is important to involve junior doctors in treatment decision-making (Shreves & Moss, 1996, pp.1103-4). These researchers suggest that "residency directors need to encourage housestaff to discuss their ethical conflicts [directly] with attending physicians" (Shreves & Moss, 1996, p.1103). Considering consultants' position as the key medical decision-makers, in many cases junior doctors will need to discuss their concerns about futility with colleagues at this level.

The role virtue sets direct junior doctors to initiate and engage in this type of discussion in a genuinely open-minded way. Particularly as medical learners, junior doctors ought to discuss their concerns with their seniors with a view to developing

their own understanding. The aim of the discussion, at least initially, ought to be increasing their understanding rather than necessarily persuading the consultant. This openness ought to apply to ethical values as well as medical knowledge. Junior doctors ought to enter such a discussion willing, for example, to alter their own view of that which constitutes futile treatment.

From an outsider's perspective, these first two steps may seem a radically minimal conclusion in terms of obligatory action for junior doctors faced with involvement in futile treatment. However, evidence about junior doctors' behaviour in relation to speaking up about issues in their workplace suggests that it is in fact quite a demanding position from their perspective, asking significantly more than many junior doctors currently feel comfortable doing. In the context of poor working conditions, one participant in my study stated that

probably lots of people anyway feel that they can't really speak out about their situation...because they're scared of that they won't get a job or that they'll, that it will be frowned upon or they'll be seen as being a troublemaker...You always think 'I can't really complain about this' because every year you have to reapply for your job...[and] particularly when it gets to you know, doing specialty training and stuff like that it can be very competitive. And then like with the college of surgeons and stuff like that they don't, you know, they don't have to give any reasons. Like if they don't like you, you can apply and reapply and for ten years and...people will all know it's just because they don't like you. You did something somewhere along the line that they didn't like (Interview 12, pp.24-5).

This reticence about speaking up aligns with Shreves and Moss' finding that most junior doctors do not express their ethical concerns to their senior colleagues (Shreves & Moss, 1996, p.1103). Further evidence for junior doctors' unwillingness to discuss concerns with seniors comes from several studies suggesting that medical students are strongly disinclined to speak up, even when they believe that they should, for various reasons (Goldie et al., 2003; Rennie & Crosby, 2002; Dwyer, 1994). These reasons include camaraderie amongst the group, fear of retaliation by peers or teachers, disrupting working relationships, seeing some forms of misconduct as accepted norms

in that milieu, fear that they themselves may one day be subject to the same criticism, and feeling that reporting was not their responsibility (Rennie & Crosby, 2002, p.176). Discussion of concerns with seniors is thus a substantial and, for many junior doctors, quite demanding action to posit as morally obligatory.

3. Decide whether further action is required.

Further, a junior doctor may be morally required to go beyond these first two steps of investigating rationale and discussing his or her concerns with seniors. Depending on the particular circumstances, further action such as approaching senior hospital staff outside the team or refusing to participate in a futile intervention may be appropriate. In some cases, the junior doctor may legitimately decide not to take further action despite his or her concerns. Motivated by the effective functioning of the team (rather than by, for example, self-preservation), the junior doctor may judge that ethically he or she ought to concede. Such yielding is an appropriate part of membership of most kinds of teams; if all team members pursued all of their own views doggedly, a team could not function. While it is always appropriate for team members to *express* their views and thus contribute their perspective to the team's deliberations, refusal to consider any form of compromise would quickly cripple most teams. The difficulty is, of course, judging which views are appropriate targets of compromise and which are sufficiently important to justify steadfast insistence.

Compassion for patients is not a value that should readily be compromised by junior doctors. Particularly when the burden of the treatment for the patient is substantial and where further action could be taken without causing massive disruption to the team's work, doing more will be morally required. The role virtues framework provides a resource for the junior doctor in making this judgement. Although the framework may not be able to tell the junior doctor exactly and definitively what to do, it provides a way for him or her to understand the difficulty and to articulate the various competing concerns. If a junior doctor, having engaged open-mindedly in dialogue with his or her seniors, still considers a proposed treatment futile then further action is likely to be morally appropriate in a high proportion of cases.

One form that further action could take is refusal to participate in the futile treatment. Refusal to participate differs from avoidance, which could be criticised as cowardly. Where a junior doctor decides to refuse to participate in a procedure for ethical reasons, his or her refusal should be overt and public within the treating team (in contrast, for example, to avoiding involvement through deception), and limited to the problematic treatment. When attempts to advocate for the patient through discussion have failed, making other team members aware of his or her belief that the treatment compromises patient well-being is a way that the junior doctor can continue to advocate for the patient's interests. Merely avoiding involvement does not achieve this. A junior doctor refusing to be involved in a procedure will, in many cases, burden other staff. The objecting junior doctor should act so as to minimise this burden, for example by swapping tasks with other junior doctors on the ward rather than simply avoiding the problematic procedure. Again, openness about objection is important in facilitating this minimisation. The junior doctor who decides to refuse to participate also needs to consider carefully which aspects of the proposed treatment are in conflict with the core ethical value at stake, and limit his or her refusal to these aspects. Nicole, for example, could refuse to book the operating theatre for the second hip replacement or to assist in the operation, but ought not to refuse to care for the patient post-operatively. It is the operation itself that is contrary to the patient's well-being. Too wide a scope of refusal runs the risk of compromising the value that the junior doctor is trying to promote.

Even when a junior doctor decides to take further action, he or she may in some cases fail to prevent the futile intervention proceeding. From a role virtues perspective however, there is still some value in the junior doctor having made his or her position clear. He or she has acted in line with the characteristics that make him or her good in respect to the various roles constitutive of the good junior doctor. In a role virtues framework, it is not only the outcome that matters morally but also what the junior doctor *does*. Thus, this type of framework both directs junior doctors to try to influence a patient's treatment even when the odds of success are low and attributes moral value to their efforts regardless of the outcome.

In situations where a junior doctor decides that it is not ethically appropriate to take further action to prevent the futile treatment proceeding, this decision ought to be accompanied by substantial moral residue. Moral residue or remainder is the result of ethical challenges that are such that even having responded in a morally appropriate way, the “agent cannot emerge with her life unmarred” (Hursthouse, 1999, p.77). In Stocker’s words, these are situations where “one is morally compromised in doing what is morally justified” (Stocker, 1990, p.14). Because the patient suffers if no further action is taken by the junior doctor against the futile treatment, such an option will never be unequivocally attractive to the good junior doctor. Despite the ethical justifiability of the decision not to take further action in a particular case, compromising a value as important as compassion for the patient will appropriately engender feelings of regret. When futile treatment does proceed, it is particularly important that the junior doctor takes other opportunities to treat that patient with compassion as his or her care continues, for example post-operatively. The junior doctor can still act compassionately in other aspects of his or her work with that patient even if futile treatment occurs.

In this chapter, I have argued that junior doctors are sometimes directed to implement treatment that they believe is futile and that the ethical challenge for them in these situations can be understood in terms of potentially conflicting demands associated with their different roles. I suggested, based on the sets of role virtues put forward in chapter seven, that junior doctors faced with this type of situation ought first to ask about the rationale underlying the problematic treatment decision. Where this additional information does not assuage their concern, junior doctors ought to discuss their worries about the treatment with their team members, including the consultants making the fundamental decisions about how to proceed, in an open-minded way. Ideally, this process would result in a change either to the proposed treatment plan or to the junior doctor’s view that the treatment is not beneficial for the patient. Of course in some cases, incommensurable views will endure within the team. In such cases, the roles framework provides a resource for junior doctors in judging whether further action is morally required in the particular circumstances that have arisen.

This action guidance is not as undemanding as it may sound; raising one's concerns with a consultant is a substantial step for a junior doctor.

This analysis points to a need for junior doctors to be trained in effective communication with colleagues, including appropriate questioning of seniors. Many medical schools currently emphasise the importance of doctors' communication with *patients* and spend considerable time and resources equipping students with this skill. The difficulties of communicating effectively with intimidating or agitated patients are often directly addressed and useful strategies taught. Although less widespread in medical curricula, communication with colleagues is a similarly essential element of medical education. It too is necessary to effective patient care and facilitates doctors' ongoing clinical learning. Just as communicating with patients can be challenging and requires the development of a particular set of attitudes and strategies, communication with colleagues can be similarly demanding and thus requires a specific learnable set of skills. Senior doctors involved in training juniors may also need encouragement to see juniors' questioning as appropriate alongside skills in responding in ways that address juniors' needs. Further implications for medical ethics education arising from this project are discussed in the following concluding chapter.

CONCLUSION

Interns and residents need to play various roles concurrently. In the previous three chapters, I have shown the value of understanding junior doctors' ethical challenges as tensions between the requirements of these different roles. Conceptualising the good junior doctor as simultaneously good qua doctor, qua medical learner, qua team member, and qua employee provides a framework for understanding the ethical challenges faced by junior doctors, as well as a way of generating action guidance for interns and residents facing these difficulties. This framework will not always provide definitive action guidance in the sense of a single clear cut right course of action for the junior doctor. This reflects the ethical reality that there will often be many morally justifiable courses of action, and that even a morally justifiable course of action may involve moral residue. However, thinking in terms of junior doctors' multiple roles and the virtues associated with them invariably offers insight into *why* a situation is difficult and this itself is valuable to interns and residents. The ethical difficulties that they encounter need not be experienced as personal character deficiencies, in the way that some of the participants described. Rather, these ethical challenges can be understood as the result of the conflicting demands associated with the multiple roles involved in a junior doctor's work. Importantly, the framework I have put forward is a mode of ethical analysis that recognises the particular institutional position occupied by junior doctors and the constraints on their action that this position implies. This project thus provides philosophers, educators, and junior doctors themselves with a new and useful way of thinking about the ethical issues associated with medical internship and residency.

IMPLICATIONS FOR MEDICAL ETHICS EDUCATION

Having identified the kinds of ethical issues encountered by junior doctors and formulated a framework for analysing these challenges, this research has direct

implications for medical ethics education, at both an undergraduate and postgraduate level. In the following section, I make two specific suggestions for medical ethics education on the basis of this project's findings. I assume throughout that medical ethics education aims to produce ethical practitioners (Campbell et al., 2007; Goldie et al., 2004, p.713; Hafferty & Franks, 1994) rather than, for example, simply equipping students with ethical concepts (Miles et al., 1989). I also assume that published national medical ethics core curricula reflect the ethics programs currently being taught to medical students. Given the limited literature on what ethics educators are doing in practice, it is of course possible that educators in some settings are already taking the approach that I advocate.

Although I refer primarily to the Australasian undergraduate medical ethics core curriculum in this section, the suggestions I make also apply to ethics sessions offered to junior doctors during their early postgraduate years. Ethics education for junior doctors, at least in the Australian context, tends currently to be ad hoc, dependent on the particular hospital and varying with the interest level of senior staff. Although "ethical practice" is mentioned as a "learning topic" in the Australian Junior Doctors' Curriculum Framework (Confederation of Postgraduate Medical Education Councils, 2007), there is not to my knowledge any existing direction about how the topic is to be taught. This lack underpins my focus in this discussion predominantly on ethics education at the undergraduate level which has been articulated in a suggested core curriculum (Braunack-Mayer et al., 2001). The suggestions I make in this section also apply to teaching in all other national contexts that, like Australia, involve an internship/residency phase in their system of medical education.

Framing issues in terms of junior doctors' specific position of agency

This project suggests that the ethical considerations in play in a situation can vary in important ways depending on the doctor's level of seniority. In many participants' stories, the ethical difficulties arose in part as a result of their status as *junior* doctors specifically. Thus, one way in which ethics teaching could potentially be altered for

greater effectiveness would be to focus on the junior doctor's specific position of agency. For example, imagine a standard session on informed consent. Such a session might introduce the concepts of patient autonomy, competence, and paternalism, perhaps illustrated by the classic case of a Jehovah's Witness refusing a blood transfusion or the situation of a doctor deciding what information to include when explaining an operation to a patient. The discussion generated in such a class would presumably be very different if the case presented was an intern's story about doing a pregnancy test without the patient's consent while on night duty. (See "I've had to do pregnancy tests on unwilling girls" in Appendix B.) This intern was under pressure from her registrar to do the test so that the patient could be discharged and was confident that the patient was not in danger of ectopic pregnancy because she had a female partner. By positing the junior doctor as the key agent, a different set of considerations are able to emerge in discussion with students. Considerations around hierarchy and organisational pressures, that will be crucial when students attempt actually to implement their ethical principles as junior doctors, can be addressed.

Involving junior doctors themselves in ethics education for medical students would also enable this more tailored ethics teaching. Real junior doctors' experiences would provide a rich source of examples of good and bad practice by junior and senior clinicians for students' consideration that would tend to focus on junior doctors as agents. Interns' and residents' input would facilitate discussion of cases involving the ethical complexity and ambiguity that can be absent from artificial scenarios designed to make a philosophical point.

As well as using cases that focus on junior doctors, a further way of discussing junior doctors' specific position of agency with students would be to present the idea of interns and residents as playing multiple roles. Perceiving their multiple roles and the potentially conflicting demands of these roles would give junior doctors a framework for thinking about some of the inherent difficulties that their job involves and, relatedly, an understanding of a source of their response-value discordance. Recall Eva from chapter six who was "just so angry" with herself for being frustrated with

the telephone questions from the daughter of a patient with breast cancer. An ability to recognise this experience as one of conflicting demands on her qua employee and qua doctor would help render her frustration understandable. Viewed from the multiple roles perspective, her frustration is no longer reflective of a personal failing but rather becomes the inevitable product of her attempts to do her complex job well. The gap between her response and her values is explicable in terms of the conflicting demands of her multiple roles, rather than representing some straightforward blameworthy failure to live up to her ethical commitments. Teaching medical students and junior doctors to see difficulties in terms of the multiple roles that internship and residency involve could provide them with a starting point for understanding their distress and for considering how they ought to act. Such an approach to ethics teaching will align well with the increasingly influential CanMEDS framework for medical education (both undergraduate and postgraduate), which conceptualises the competent physician in terms of seven overlapping roles (Frank, 2005).

Focusing on topics based in junior doctors' practice

A further implication for ethics education from this research is the importance of focusing ethics teaching on the issues that interns and residents will themselves face in their early years of practice. One participant spoke of there being a “gulf” between “most medical ethics literature and kind of battlefield medical ethics” (Interview 14, p.17). He commented that:

I think there are lots of things that you really need to know. But I think that...you almost need a, you know, a tute that's run not by the ethicist but like, you know, some interns. Because, because, I mean those are the real things that interns face. Interns aren't present in ethics committee meetings where, you know, where in human research ethics committees where these big research projects are discussed. Interns aren't present...when people are talking about transplant surgery and planning transplant protocols. But interns are present when decisions are being made about end of life issues or, you know, or whatever else (Interview 14, p.26).

Rhodes and Cohen argue that

rather than focusing on highly unusual issues or subjects that will be decided by the legislature, courts, or voters, medical-student ethics education should address issues that are common and relevant to situations that they are likely to encounter with some frequency (Rhodes & Cohen, 2003, p.42).

I suggest the even stronger criterion that the issues addressed should be those that students are likely to encounter with some frequency *in their early years of practice*. Given that ethics teaching tends to be allocated a very limited time in an inevitably busy teaching program, educators' aim of facilitating ethical practice seems better served by making junior doctors' own ethical issues the focus of the curriculum.

This focus is important to enabling junior doctors to recognise ethically significant moments in their early postgraduate years. Several participants in this study were unable to think of a situation in response to my interview question "have there been times when you've felt like you were in an ethically difficult position?". Often, this was despite having described situations earlier in the interview that, to my mind, clearly involved ethical considerations. These responses suggest that some junior doctors' perceptions of medical ethics are limited in ways that exclude their own day-to-day decision-making. This may in part be as a result of the types of ethics topics and concepts that are presented to them as students. Discussing junior doctors' own issues is more likely to facilitate later recognition of ethically important moments in their practice as interns and residents, compared with discussion of ethical issues that they will not encounter until they are more senior.

Although Goldie, in his review of medical ethics education, suggests that curricula have recently been "broadened" to include everyday practical dilemmas alongside the classic issues (Goldie, 2000, p.111), a number of the topics suggested by national core curricula including the Australasian document still lie outside the scope of junior doctors' practice. These include issues relating to genetic and reproductive technologies, research ethics, and resource allocation. Looking to the eight broad ethical issues identified in this project, five are not currently included in the

Australasian core curriculum and would need to be introduced for it to better reflect junior doctors' own ethical challenges. These issues are

- managing the limits of one's competence ("responding to clinical error" is currently included as a topic but this issue is broader than that for junior doctors, including elements such as coping with feeling inadequately prepared for their responsibilities and negotiating lack of supervision by their superiors)
- addressing the behaviour of others that is perceived to be inappropriate,
- conflicts of interest,
- setting interpersonal boundaries with patients (again this is presumably partly covered in the existing document under "codes of ethics"), and
- impact of working conditions.

The other three ethical issues are represented in the existing list of topics, but in line with the suggestion about framing issues in terms of junior doctors' specific position of agency, teaching of these topics ought to focus on intern- or resident-specific examples of these issues such as those identified in this project. Less pertinent existing topics such as reproductive issues, public health ethics, ethical issues in complementary medicine, human research ethics, and issues in genetics and biotechnology could be set aside to be covered where time allows or students show particular interest. Specialist training would perhaps be an appropriate time to introduce students to these types of issues. Other existing topics that discuss pervasive structural issues in the health system – such as the commercialisation of medicine, resource allocation, and models of healthcare delivery – constitute important elements of a medical ethics curriculum, but again these topics ought to be delivered in a way that focuses on junior doctors' perspectives, experiences, and agency.

Thus, two key suggestions for medical ethics education emerge from this project. Firstly, teaching ought to revolve around junior doctors' specific position of agency, particularly the demands of their multiple roles. Secondly, junior doctors' ethical practice would be better-served by an ethics curriculum that focuses on issues directly encountered by interns and residents.

ANSWERING THE RESEARCH QUESTION

This project aimed to answer the question: what kinds of ethical issues are associated with medical internship and residency, and how are these issues best conceptualised for ethical analysis? As outlined in the introduction, the word 'kinds' in this question can be understood in two senses.

The first sense is the content of the issues individually. Were they, for example, challenges around informed consent, around end of life issues, around learning on patients? The table (on pages 123-4) developed from the literature review and interview data answers the research question in this first sense of 'kinds'. Eight broad types of ethical issue were identified:

- telling the truth,
- respecting patients' autonomy,
- preventing harm,
- managing the limits of one's competence,
- addressing the behaviour of others that is perceived to be inappropriate,
- conflicts of interest,
- impact of working conditions, and
- setting interpersonal boundaries with patients.

Various specific ethical challenges were identified within each of these eight types. New examples that emerged from the interview component of this study were

- deception of patients about the course of their treatment,
- seniors discouraging disclosure of errors, and
- unpaid overtime.

Involvement in treatment perceived as futile was a particularly prominent issue for the group of junior doctors interviewed. These were the kinds of ethical issues associated with internship and residency, understanding ‘kinds’ in the first sense.

‘Kinds’ could also be understood in the sense of common features of the issues identified. Can something be said about the issues as a whole group? Is there some sort of common structure or shared features about them? Taking this perspective on the research question, I have suggested two key concepts in relation to junior doctors’ ethical challenges overall: multiple roles and agency limitations. Drawing on participants’ stories and descriptions of their work, I argued that junior doctors’ organisational setting requires them to play multiple roles including doctor, medical learner, team member, and employee. Each of these roles can involve different demands and thus this multiple-role position has the potential to create ethical conflicts for interns and residents. Further, as a result of this multiple-role position particularly their junior position in the hierarchical medical team, junior doctors’ options for action are significantly limited and this can create ethical difficulties for them. In many situations, participants in this study knew what an ethically appropriate outcome would be in a particular situation but, because of the agency limitations associated with the institutional status of intern or resident, were unable to bring about that outcome. Often, the ethical question that interns and residents face is not the standard ethics question ‘what *should* I do?’ but rather ‘what *can* I do now about this problem?’.

The main original contribution made by this research – a framework for analysing junior doctors’ ethical challenges – encapsulates these two features of the ethical issues associated with medical internship and residency. It also directly addresses the second part of the research question, namely ‘how are these issues best conceptualised for ethical analysis?’. I argued that the good junior doctor ought to be understood as simultaneously good qua doctor, medical learner, team member and employee. I suggested that each of these roles has its own particular set of role virtues. This framework of four roles and their associated sets of virtues can be used as a tool for explaining the ethical difficulties that arise for junior doctors and for generating ways forward for interns and residents in such situations. The framework offers a way of understanding and analysing junior doctors’ ethical issues that recognises their particular position of agency and thus captures a fuller range of the ethical considerations involved for junior doctors in ethically difficult situations, compared with other frameworks such as principlism. The framework constitutes a useful way for philosophers, educators, and junior doctors themselves to analyse the complex and challenging ethical issues faced by doctors in their early years of medical practice.

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APPENDIX A: INTERVIEW QUESTIONS

The initial schedule of interview questions was as follows. Nearly all of the left-aligned questions were asked in each interview. The indented questions were used as additional prompts where necessary or relevant, and additional questions relating to that participant's specific recounted experiences were also asked.

Can you tell me a bit about **how you ended up here** – where you went to uni, your internship, why you chose hospital X?

And what rotations have you done this year?

Can you tell me about today, a typical day in your current rotation?

Anything you'll worry about tonight?

Can you tell me about the start of your **internship**? Do you remember your first day, your first week?

Had you heard any horror stories?

How were you feeling at this stage?

What kinds of expectations did you have?

Were there things that scared you when you started off as an intern, or in your residency?

From those past experiences, everything that's happened in your internship and residency up to now, what would you say were the **challenges** of being a junior doctor?

What have been the hard bits, for you or for your friends?

Is it how you expected it would be, being a junior doctor?

How do you find working with the hospital **administration**?

Do you feel supported by the admin?

Have you been happy with your rosters?

How have you found that 'employee' role?

Do you think others' experiences have been similar?

There's quite a bit in the literature about junior doctors' long **hours** – what's your perspective on that?

Has it impacted you professionally? Personally?

Do you think it impacts your relationships with your colleagues? Patients?

Researchers also talk about junior doctors' **transience** - has it bothered you, the moving around? Why?

What's it been like being the **most junior** doctor in the team, working with the registrars and consultants?

Have there been any times when you found those relationships difficult?

Have you felt supported? Exploited? Encouraged? Belittled?

Do you ever feel like you have to keep your own views quiet?

Do you still feel like a **learner**? Do you think that creates problems, being a learner and a doctor? What kind of problems?

Have you ever felt that there's been a conflict between you (or another junior doctor) needing to learn, and a patient's interests?

Do you think patients know when a junior doctor's doing something that they haven't done much before? Do you tell them?

Have you had any situations that have troubled you with **patients**?

Do you find it easy to switch off when you leave the hospital?

Can you think of an example?

Can you tell me about a memorable patient, one that's really stuck with you?

In the literature, there's discussion about junior doctors making **mistakes** and how hard that can be to deal with – can you tell me about your perspective on that?

Have there been any times when you've felt that you've been put in a **morally difficult** position?

What would you want to say to someone just beginning their internship?

Are there things you wish you'd been told before you started?

Is there anything else you'd like to talk about for the study? Other challenges, difficulties we haven't covered?

Are there any other stories, examples that have come to mind while we've been talking?

APPENDIX B: PARTICIPANTS' STORIES

TELLING THE TRUTH

“Families don’t want you to tell”: communication with patients and relatives about diagnoses and prognoses

You...get situations where families don't want you to tell members of their family about a diagnosis. So that's a pretty common one. I think sometimes in that situation the attitude of some people is to, you know, [think] that they [the patient] *have* to know, they always *have* to know. And I think again, sometimes that's again a defensive way of doing things. There are some situations where, where you might not read in a medical ethics textbook or something, but there are some situations where that isn't an entirely inappropriate thing. Usually the person involved knows they're ill, knows they're dying. And, you know, and usually on some level has made a decision that they're not that interested. If they were, they'd ask. They're seeing, you know, the way that everyone around them is reacting. And that's for adults and children. Children pick it up as well. They know that something's wrong. And they usually know that if they're in hospital that the something wrong has to do with them. So, I think that often people, you know, convey that, you know, that desire that they don't want to know. And I don't think that you have to tell them in that situation (Interview 14, pp.17-8, participant's emphasis).

“I feel bad preying on their cluelessness”: disclosing inexperience

Like when you're learning how to do a procedure for the first time on someone, and, you know, the registrar phrases it in a very nice way going 'I've done this lots of times and I'm going to be doing this with Belinda'. And I just go 'does this person really know that I've never done this before?'. You know? And it's like it's always this clueless person.

R: And do you think they do [know]?

Nah. Um, some people do and some people are very, you know, you get these very stoic old people who are like 'yeah, you've gotta learn love, you've gotta do it!'. You know, you go 'great! I love you. Good patient', you know. Some other people are just, they're a bit clueless, you know, and it's just like, and you go 'yes! They're clueless, yeah I can have a go. Good, I can learn'. And it's like, and you feel, I feel bad preying on their cluelessness (Interview 9, p.21).

“Honesty really is the best policy”: lying to colleagues when seeking tests

It's really important to treat radiology like human beings as well. Even if they live in a cave! But they will test you out at the beginning and they want to know that you're competent and you're able to triage your patients appropriately and request things appropriately. And they will work out if you're lying to them in order to get tests and these sorts of things. Or, and the worst thing to say to a radiologist is 'my boss said so'. Which some people do. And some people do it because their registrar goes 'oh just tell them the consultant said to do it' and they're the registrars who have no idea why they're doing things. [These doctors do] things like, you know, someone with renal failure 'oh we need a bilateral renal tract ultrasound' but they've had a CT [scan] which didn't show dilatation or anything else. And so you sort of, you know, fail to mention that they've had a CT or fail to mention that there's another, you know, probable cause of their renal failure and that kind of stuff. And, because, I mean they, everybody does need a renal tract ultrasound at some point for that problem but making them do it today by telling fibs is really the wrong way to go... Sometimes particularly the radiology, you get stuck in this situation where your boss has said to you 'you must have this done today' but the reason for making them do it today just isn't quite there. And it's a real problem after hours but, like honesty really is the best policy. If you walk in and say 'this is the story, my boss has asked that this be done today and I know that this isn't normally something you'd do today, is it possible that we can do it today?'. And if you have a good relationship with radiology they will do that kind of thing for you. Or at the very least they will call your boss and say, you know, 'we don't really see why this has to be done today'. And they'll make it more their problem. But by saying, you know, 'well my boss told, said you had to do it today' is really putting them off side (Interview 5, pp.26-7).

“A very modified version of the truth”: deception of patients about the course of their treatment

Patients are often fed a very modified version of the truth...For instance, this week we had a patient who needed a specific test that wasn't conducted at our hospital so she had to, we had to book this test for the following day. It was quite hard to get this test...She was told that it was the next morning. Ambulance was booked to take her to that test. But overnight we got a much sicker patient come in that needed that same test. And we couldn't get him in until the next day, so it would be sort of a day after. So we kind of looked at each other and thought he needs this test more than she does. But we've told her that she's booked. So the way the registrar sort of framed it to her was like that her, something happened with her test and it's fallen through. Her booking, you know, it's been delayed. And she was like 'but no, you told me, it's at eleven o'clock'. 'Oh no, look something's happened, it's not under our control, it's because it's in a separate hospital'. So the way it was framed to her was something that was out of our control but really we had made the decision that her place should be forfeited for this other person. Which you could argue ethically that you know, that he was in more of a need so the resources should go to those that have the greater need. But at the same time she wasn't told the truth.

R: Was there discussion around how you were going to tell her, or

Well we kind of did when, just casually, like as walking through the hallways going 'oh, that was a bit sticky' and the way it kind of happened was she was actually already in the back of the ambulance and was pulled out of the back of the ambulance [laughs], told to come back and had to go back into the hospital. So it was kind of this shaky scenario, and one of the interns ended up going back to her and saying 'an emergency case came up and that's why'. And we sort of had a walk, once we were walking through the corridor and went 'well that's kind of true, yeah, it was an emergency, well he was definitely more urgent than her' and so we justified it and that was it (Interview 4, pp.16-7).

“The intern was told not to reveal”: seniors discouraging disclosure of errors

This didn't happen to me personally but...one of the other interns, during a gall bladder operation, when they were removing the gall bladder they dropped a quite large stone and they couldn't find it again. And [it's] something that can happen, it's

really not of any grave concern although it can cause some pain and get inflammation afterwards. And the intern was told to not reveal that to the patient...I mean open disclosure is something that we're taught about in university but the surgeon just said 'don't mention it, they don't need to know' (Interview 4, p.19).

RESPECTING PATIENTS' AUTONOMY

“They were just so worried”: respecting patients' wishes about treatment

I did a palliative care job last year and we had a guy who was, this really jovial old Italian guy who was lovely. And he and his wife, his wife was this really doting woman, and he had a lung cancer that was blocking off part of his airway. So he came in short of breath and they wanted to give him some radiotherapy to sort of, I guess just to break down a bit, just to open up the airway. It was going to be a palliative treatment. It wasn't going to cure it, but it would help relieve his symptoms.

And they were incredibly worried about what radiotherapy meant and all the prognosis and things like that...They were really worried about side effects of it. They'd heard some horror stories about radiation. And then they, I guess they, they were also, I think underlying it all they were just so worried that he was going to die. And, and he was. He's probably not alive anymore. I, I don't know, but, but yeah, I mean I guess they were worried about the overall type thing but their specific worry at this stage was the side effects of radiation. They, we just sort of talked through risk/benefit type thing, and the fact that he was barely able to get out of bed because he was so short of breath at that stage... And that took, I guess, sort of hours of discussion over a few different times I had to go back before they actually agreed to the treatment.

But eventually they did, and you just sort of, I think people really appreciate you going back and taking the time. You sort of build up a lot of rapport and then, you know, after you have done that, I guess there's a bit of trust developed and they do, you know, if you want to bring other things to the table and say 'well what do you think about this?' then there's sort of, you know. If you take the time to sit down and do that, they're, they're a bit less worried. They sort of realise that you're trying to help them out...That kind of stuff is really rewarding I find...I dunno, it's about

reading people, it's about understanding that maybe they're completely frightened that they might not have their husband next Christmas... I dunno how you develop that, but, but it's something that's there in nearly every conversation you have with patients or their families. It's, I dunno, I guess it's something you've got to recognise and I think it's something that, that people are quite happy when you do recognise that, and you make it clear to them that you're aware that they're freaked out (Interview 3, pp.15-8).

“The fact that the patient's there is implied consent”: seeking informed consent

Certainly, you know, there's consent for procedures or whatever else but I think that the way that hospitals work is very much that...there are a set of investigations in particular that are performed and there's just, the fact that the patient is in the hospital is taken as implied consent. That, you know, that the patient has blood tests when they're in hospital. That the patient has x-rays when they're in hospital. It's I think, you know, a team will often say 'I think it's important you have a chest x-ray today' and they'll [the patient] nod 'ok'. And you know, that's not informed consent but, you know, but the patient, but most patients are happy with that situation. It's very different from, you know, kind of classical teaching about informed consent: 'this is an x-ray, you know, it's got radiation, you know, radiation can do this' and all these other things. You know, there's an assumption that the doctor's doing an x-ray for a good reason. They're not having fun torturing me. They're doing an x-ray for a good reason and ok. And so, I mean there's no consent procedure for an x-ray or for taking blood every second morning. There's no consent for, you know, changing their IV[intravenous] cannula every three days. That's not really something that anyone consents to. It's 'hi, I'm the cover doctor, I've been asked [aside], you know, thirteen and a half hours into my shift to change your IV cannula. I'll just pull the old one out first. Ok, it'll hurt a little bit, you know, and it's in'. And at no point there have you really said, you know, have you really asked them 'would you like your IV cannula?'. That's not the decision, that's not something that happens. It's, there are like I said a range of interventions and investigations that are, that the hospital and the staff seem to understand as, you know, the fact that the patient's there is implied consent for those, for that range of procedures to be performed (Interview 14, pp.20-1).

“I’ve had to do pregnancy tests on unwilling girls”: seeking informed consent

Twice in the last week I’ve had to do pregnancy tests on unwilling girls with abdo[men] pain...So they’re both young girls who came in with belly pain. And in the first case, and so you always sort of ask about their menstrual history and their sexual history and whether they think there’s any chance that they could be pregnant. But then you don’t trust a word of what they say anyway! [laughs] Like that’s just generally what happens because, you know, like the worst possible thing would be that they’re pregnant unbeknownst to them and they have an ectopic pregnancy which ruptures and then which is potentially life-threatening. Really very serious. And it’s certainly something that you would just not want to miss. Like it would be fatal for the patient and fatal for your career to have missed that.

And so I know in the first case I pretty much just went back and said ‘oh look, you know, for all women who are of your age who come in with belly pain we have to do a pregnancy test’. Like I pretty much just told her ‘you have to do this’. And then the second time, that was harder the second time because she came in with her girlfriend. And so at the time when I’d asked her, you know, she was like ‘well, you know, this is my partner’. And I said ‘oh well’, you know, I think, I said something like ‘oh well you’d be busted if you were pregnant!’ or something. They had, like they laughed, they sort of, we had a good rapport. But then ultimately I was sort of still left with this problem of like, and in the end my registrar was like ‘nup, just do the pregnancy test then discharge her once you know that she’s not pregnant’. Which is what I did but, which was just not the right thing to do. And I don’t know

R: Why was it not the right thing to do?

Well, I think that I, what I should have done is gone back and told her that she, that we had to do a pregnancy test.

R: So you did it and she didn’t know that you’d done it?

And she didn’t know that she’d done it, I’d done it. Yeah, so pretty much, because we’d taken the blood already for the other tests and that because we thought she had an infection and stuff. And she knew that she was getting those tests. And then when I like I explained to my reg[istrar] ‘oh, you know, she’s got a female partner and she says that there’s no chance she could be pregnant’ and she’s [the registrar] like ‘nah, nup, just do it anyway’. And ‘once you know she’s not pregnant you can

send her home'. And I think, I should have gone back and said 'oh look, we have to do this pregnancy test' and if she wanted to sort of vehemently disagree and, I dunno, document that she would not, that she had refused the pregnancy test then that would have been alright. But in the end we did it and it was negative and so she went home. But if it had been positive then I mean that would have been terrible. Yeah. Well I, obviously it was terrible either way but yeah...And I think that probably I only did it the way I did because I was pretty confident that she wouldn't be pregnant. So I wouldn't be caught! [laughing] So that's, which is, but I dunno, that's 4a.m. logic for you (Interview 10, pp.21-2).

PREVENTING HARM

“You’re exposing patients to your learning curve”: avoiding harm to patients when involving them in education

The big ethical issue is the fact that you're exposing patients to your learning curve...For an intern it's absolutely the fact you, you know, you're constantly asking yourself 'is this patient suffering because I'm an intern compared to', you know. Usually they're not. Usually they're not. But you're constantly asking, you know, thinking, thinking about that. Usually they're actually getting unusually thorough treatment because you're the intern, because you're anxious and you, you know, you do a full job. Whereas the consultant who's working on a kind of pattern recognition basis often, will just, will see them and 'oh that's a patient with whatever, do this'. Yeah. So I think, but I think there's an issue there. And that's not something we really talk to patients about. We don't talk to patients about exposing them to our learning curves. Patient with nausea, you know, gets medicine A, B, C or D or whatever because I think they should. I don't talk to the patient about the fact that 'you're only the third patient really I've ever seen who I've had to make a decision like this' and that's not something that happens...I think that kind of honesty is something that doesn't really help the patient (Interview 14, pp.24-5).

MANAGING THE LIMITS OF ONE'S COMPETENCE

“This ten weeks is never going to end”: coping with feeling inadequately prepared

I just came back from...my country rotation so that was a mixed rotation. So I did ED [Emergency Department], some anaesthetics, and nights. And that was an entire issue on its own.

R: Nights?

Yeah. I went berserk when I got there because, I had nights last so it was not the first one but...In [country town] at nights you're the only doctor on site and that was, if I'd known that, I didn't know that when I chose, I would never have put this hospital first. Like that scares me enough that, there were hospitals that I knew did that that I didn't rank because of that very reason. So when I got here and everyone told me that I was like 'you've got to be joking'. And it didn't end up being that bad but the anxiety for me leading up and then the first couple of weeks was ridiculous. I've been keeping actually a videodiary of this year, just to laugh at myself at the end of the year...and I watch like the clips from the first two weeks and I look like I need to go to like a psychiatric facility. It's me crying every night 'aah, I'm not going to survive, I might kill someone'.

R: What were you scared of?

[pause] At the end of the day that I'm going to kill someone, or that someone is going to be worse off for having encountered me opposed to someone else. And that, you know, and I guess also maybe bothering other people for help. That's a part of it. But more so just bad patient outcomes at the end. And also going, you know, 'why can everyone else cope with this?' and 'why have I' and actually it was, I did not think I'd get to the end of the ten weeks. If I even make it to the end of this year I think I'm going to be amazed. I was like, I thought '*never*, this ten weeks is never going to end. I'm going to quit medicine before the ten weeks is over, it's going to be so horrendous'. And it didn't, you know. But if I had had a shoddy run of nights without a supportive registrar it could have well turned out that way. My threshold for being like 'this is ridiculous, I shouldn't be here on my own' was fairly high...

One of my friends, she was a couple of years above me and she gave me some good advice. She said 'you cannot torture yourself thinking about what might come

through the door'. You just have to drop it. And that was, once she told me that, anytime I engaged in this fantasy where I was thinking of every last thing someone was going to come in with, once I stopped doing that it was, it was a psychological, you know, 'oh thank God'. Otherwise I was driving myself mad thinking about, you know, what people are going to.

And also I guess people most of the time weren't that sick that came in. They weren't that sick and when they were I just, there was lots of protocols there. Like lots of things where if this happens, whether you like it or not your registrar has to come in. So I liked those backups where 'tough shit, you have to come in. I don't care, I don't even have to make the call on whether you come in. You have to come in.' And those are really nice safeguards...And also the nursing staff were fantastic and they were like 'do you want to maybe call', you know, and they prompted you. And that was, I'm more than happy to listen so that was, yeah it wasn't so bad. But you know, had I had a terrible run or my first night had been horrendous then who knows? (Interview 9, pp.4-5, participant's emphasis).

“I’m a doctor by name but I have no idea”: negotiating lack of supervision

I had an ICU [intensive care unit] patient that was really sick and the nurses kept bugging me about the patient because she was getting worse. And they were like 'what's the plan?'. And it's an ICU patient and I don't know anything about ICU patients and my reg[istrar] was in theatre. He was actually a surgical reg operating in theatre. And I called him and he's in theatre so he can't come. And it was a medical patient. He didn't know the patient anyway. And so I called up the physician. And the physician actually said 'don't talk to me, talk to the registrar. He's not going to be in theatre forever so just talk to him'. And he didn't answer any of my questions. And so I didn't know what to do with the patient. And so luckily the patient didn't die or anything because otherwise, I didn't know what to do with the patient. I'm just going 'I'm sorry, I'm as useless as you. I don't how to do the, I'm completely, I'm a doctor by name but I have no idea what to do with the patient' (Interview 8, pp.16-7).

“It was a misdiagnosis”: making mistakes

I've made mistakes. Like when I was in ED [Emergency Department] in [country town] there was a patient who came in and I thought he had a peptic ulcer. And then

he also had a UTI [urinary tract infection] so we sent him home with antibiotics and gave him all the treatment for peptic ulcer and said review with GP [general practitioner] in a couple of days. And he actually re-presented with a necrotic gangrenous gall bladder. So he was taken to the, immediately, straight away. And then, so it was a misdiagnosis but we did liver function tests at the time. They were all completely normal. The white cells were high but the liver tests were all normal. He was, and at the time he wasn't tender on the right side. He was tender in the middle and he had a history of having taken anti-inflammatories for a long period of time. And he wondered whether he had dark bowel action so at the time, and he was really old and he was male. So at the time I didn't really think it was a gall bladder. And so that was a mis-, and then he had to go for emergency surgery. And the surgeon got really grumpy about this patient [that] actually came in two days ago but we sent him home.

R: Got grumpy with you or?

Well I actually got into a lot of trouble because the surgeon then complained to the Director of Medical Services who went and yelled at my registrar. Who was then very grumpy because he was my patient. But I actually have spoken about the patient to my registrar, gone through the history, examination, and everything. And that was the plan that the registrar told me to do. He told me to send the patient home. Initially I was really concerned about the patient, didn't think he could go home. But the reg[istrar] told me to send the patient home so I sent the patient home and, so that's a mistake. Luckily the patient's ok, alive, well, and went home, eventually was ok. But that's what I mean by we're inexperienced. And we have discussed it with the reg...but that still was completely wrong.

R: How did you feel about it?

I felt terrible. After that I was terrified of seeing patients. I was actually patient-phobic [laughs] a little bit. Like I wanted to see the little lacerations on the hand, I didn't want to see the big complicated patients because I thought 'I'm just going to misdiagnose and they're better off seeing someone more senior'. So there for a week after that I just really didn't want to take on the big patients, like the big cases, because I really didn't feel confident. I just sort of lost my confidence, yeah.

R: And how did it come back?

It just comes back eventually because you just can't, you can't just not see, you have to see, you have to go to work and see patients. And it just eventually came back. And it's more like, and the reg debriefed me and said, you know, 'with what we had at the time we couldn't have predicted this was going to happen' (Interview 8, pp.18-9).

ADDRESSING THE BEHAVIOUR OF OTHERS THAT IS PERCEIVED TO BE INAPPROPRIATE

“His daughter was the nurse unit manager”: observing the unethical behaviour of others

When I was in the country this year I had a situation where a man was transferred over for palliative care. And his daughter was the nurse unit manager of the ward. And he got admitted on to her ward. And she was administering him his morphine...That was really like the stupidest place that they could have put him. Because there were three wards in the hospital and one was a palliative care ward and that, that was just a really bad situation. And like he was having a morphine infusion so it runs over twenty-four hours. And usually what you do is you give separate amounts of pain relief, you give it separately and you mark it on the chart so that you can work out how much they're having in addition to their twenty-four hour infusion and then you can add that. But instead she'd been giving it just from the infusion machine, so it finished

R: So it wasn't recorded

Yeah, it wasn't recorded separately but it finished like eight hours before the twenty-four hours was up. And I'm like 'this isn't very good because it doesn't really allow us to see how much pain relief medication' and she's like 'well can you increase the amount?'. And the consultant that was there who was a locum consultant, not from the hospital, he just took the form and he wrote up the infusion and said 'you shouldn't have to be in this situation'. It was just a really terrible situation, like it was just really, like in the end it probably was what the patient wanted, to be kept as comfortable as possible and to have his lifespan not prolonged any more than it need be but it was just, it just wasn't, it was just really wrong...But it was, it's really tough when you're not from there, you really rely on the nurses there to, and you don't want to get them offside (Interview 12, pp.8-9).

“He was a bit lazy”: compromised superiors

Last year I had one registrar who was very, he was a bit lazy. And I thought that he was actually quite unsafe in the sense that he would like, we'd be doing ward round [and] he won't make any decisions for his patients. And it would be like me and the other intern going 'oh, how about we do this for them?'. And he goes 'oh yeah, let's do that'. And then, but because he would do that for everything that we suggested, it's like 'oh, hang on'. Sometimes we'd do a ward round and he didn't actually listen to someone's chest and [would still] go 'oh yeah, their chest is clear'. And I would be like 'oh, um, OK'...And I thought 'oh, that's not very good'. And so because I had such concerns about him, I actually approached someone and talked to them about, 'maybe it's just me, but this is what I think. I don't know who to clarify it with.' And then they actually spoke to the consultants and the consultants had a certain idea of how he was performing also and weren't too pleased.

R: So was it someone in the sort of HMO [house medical officers'], like who can you turn to in those kinds of

It was a, I did actually speak to a HMO person afterwards, but I actually spoke to the person who was looking after the interns first. And I don't know if she was the most appropriate person to talk to. Because I hadn't actually talked to anyone for a while, until one of my girlfriends called me up and said 'oh, how are you going?' and I ended up crying to her for the whole hour afterwards. And she's like 'you can't continue like this, you need to talk to someone'. That's how it happened (Interview 2, pp.19-21).

“This constant pressure to treat people”: involvement in treatment perceived as futile

[One thing] I find really difficult is that we're under this constant pressure to treat people. And the patients expect it, and the patients' families expect it, and our society expects it. And you, you're treating some of these people thinking 'God, why are we treating these people? It's horrible'. And I find that really hard, particularly because I've been doing aged care now for six months and the average age of my patients is ninety at least. They're *really* old. And, I mean when you, like I've treated one man who's had a stroke, so completely paralysed, had a laryngectomy, had his larynx removed for cancer so he's got a permanent tracheostomy [tube inserted into the windpipe to assist breathing]. He can't talk, he recurrently aspirates

[fluids in the airway], you know, breathes in and has chest infections. He's got pseudomonas colonisation which is a bug you never get rid of and basically just causes, and he's got MRSA [methicillin-resistant Staphylococcus aureus] colonisation so he's constantly got a chest infection. And he's in hospital every couple of months, having thousands of dollars of antibiotics given to him. He's abusive towards the staff. He spits through his trachy at you. He's got no IV [intravenous] access so for me to put a cannula in him, he was going 'no, no, no' pulling away. But he's got dementia so his wife's there going 'no, treat him, treat him, treat him'. I had to sedate him to put a drip in him. And fight him with three people holding his arm down. I was sitting there going 'what am I doing? I am assaulting this man.' But because he's got cognitive impairment he doesn't have capacity to say whether he wants to be treated, so it's his wife's decision. And she unrealistically is saying 'do everything'. And this man has *no* quality of life. I mean the things we *can* do are so much now and I think that issue of, you know, stopping and asking 'should we be doing that?' isn't [addressed]. And I think people are aware of it but they still, it's ballsy to say no. And that's a big call, when you can. So that's sort of been, and I've had multiple cases where you, you're treating and treating and treating going 'why are we doing this? It's horrible.' (Interview 7, p.26, participant's emphasis).

CONFLICTS OF INTEREST

“I prescribe for my family”: treating family and friends

I prescribe for my family. Simple things like ventolin for my brother, just giving him a prescription for his ventolin. Myself, pill prescriptions. I won't do it for friends, non-medical friends. I'll do it for medical friends.

R: Why is that?

I just, for liability basically. Not that I would ever think that anyone would sue me, but I would hate for them to be, I mean I'd hate for them to have had the appendix for example. I mean if you don't do it properly and document it, no way. I do it for my family, like my dad just went overseas and I gave him a prescription for some antibiotics to take in case he got unwell and that sort of thing.

R: And medical friends

Medical, I mean medical friends are usually, just say ‘Abby, can you write me a prescription for’, I mean I’d never do, the only things I do it for are contraceptives. There’s a whole routine going in the hospital, ‘I need a pill [pre]scrip[tion], can you write one?’. And antibiotics for tonsillitis or bronchitis and that’s really about all I’ve ever done it for. So apart from that, no. I mean I *never* do it for anything like opiates or [inaudible]. Never. You wouldn’t dream of it. So, yeah. But it is, it’s a power thing, ‘I can write anything I want!’. It’s kind of bad! But then the first time I wrote, no I did, I wrote one for my stepmother for nexium. She gets reflux and it was just a repeat scrip. She said ‘Abby, can you write me a scrip because I can’t get to the doctor and my scrip’s run out.’ And I kept waiting for the phone call from a pharmacy going ‘who *are* you?’, waiting. That was the first private scrip that I wrote (Interview 7, p.22, participant’s emphasis).

“You go into denial”: self-treatment

The day before I went into hospital I was psyching myself up to go back to work, with my ruptured appendix! Which I’d kind of left for five days because I thought ‘I’m not sick’. Doctors look after themselves terribly medically, and I mean that’s quite a well known thing. And there’s this push, you know, to get doctors to have their own GPs [general practitioners]. And I always thought ‘that will never be me’, you know ‘I’ll always look after myself’...

R: So with your appendix, you were in denial for a few days before?

Five days. Self-medicating. Very bad practice.

R: Five days, then got really really sick?

Then I got really sick and was off work for nearly [inaudible]. And then they had to put someone in. But yeah, it was a very typical doctor thing and I’m very embarrassed now that it happened...Even after my partner had, because I was up in Brisbane [where partner lives] and he’s an emergency intensivist, and I said ‘feel my tummy, it doesn’t feel right, I think it’s more on the right’ and he was like ‘it’s fine’. ‘Thank you’.

R: So do you reckon if you’d had, if you’d looked at it earlier, it wouldn’t have perforated?

It might not, I don't know retrospectively. No I don't think so, because it was quite an atypical presentation... So I don't think it was entirely my fault, but you do, you go into denial. I mean, I was having high temperatures for five days and taking my antibiotics that I'd self-administered (Interview 7, 20-1).

“Having drug companies constantly around hospitals”: offers of gifts or hospitality from drug companies

There's the ethical issue of having drug companies constantly around hospitals...

R: Do you encounter that as a junior doctor?

Yeah. I mean not in a way that I can actually think really obviously affects the way you practise. Except that you've constantly, you know, got one pen or another for some drug company. I can't even, I can't even name the last, the ones I'm carrying at the moment. It's just I've got two pens on me. Do I think it's ethical? Probably not. Do I do it? Yeah. And I know that, you know, the lunches at like our stroke unit meetings are paid for by drug companies. I don't really like it when I think about it but I probably [laughs] just don't think about it very much. Yeah, that's probably kind of not good enough but I just think it's the way that, the way that things happen... You're certainly, you know, part of a culture in a hospital and, and I think it's, it's difficult to work in any real, useful way outside of that culture in your hospital (Interview 14, p.28).

IMPACT OF WORKING CONDITIONS

“Just a massive strain on your life”: dealing with transience

And it's another thing that's just taken for granted, the legacy that we will just do this [move around] and it will be, and it's acceptable and there's no recourse. I mean there are very few jobs where you just sign up for whatever, wherever they throw you... So every ten weeks we move on, which kind of does feel like just as you're getting good at something you just move on again. And the first few weeks are terrible, so you've just got to prepare yourself for that.

R: So terrible in terms of adjusting?

Adjusting, and you feel that same sense of any new job. Like that you don't know where the paperwork is and you don't even know the code to get into the residents' room or anything or any of the doctors. They don't know you so they are kind of a bit standoffish. All the nurses assume that you're going to be nightmare until proven otherwise. So there's all of these boundaries. You break them down eventually and then you go. So that's hard...And the other thing is, is that you, like at the moment I'm travelling, at the hospital I've just been at, was travelling between half an hour and forty minutes. The next hospital I'm at where I start on Monday is about an hour's drive. And then I'm in...on my rural rotation after that so, and that's important, this is sort of six months into my internship and I haven't been at my actual hospital that's employed me at all. I've done all the periphery things. Which is tricky. So and you kind of, you miss out on certain other things when you go to all these periphery hospitals. Some of them, the intern teaching which should be like a weekly occurrence isn't as well-orchestrated so you may not get sessions in the rural hospitals and things like that so you miss out a little bit. It's also just a massive strain on your life. Like the rural rotation for me, it will be tricky. It's ten weeks away from my partner, I'm planning a wedding..., basically those sort of ten weeks I can't really do any of the things that go into the rest of my life. I just have to just treat it as a nothing time for all of that except for work. Yeah, it's tricky (Interview 4, pp.15-6).

“You go to work and push people away”: working when unwell

I caught some revolting virus from someone and was in hospital for a couple of days with that. And off work for five days. And again there was no-one to cover me so all my colleagues took turns each day covering the entire respiratory unit. Which is, I mean, that's, in no other job would that happen, where you rely on their goodwill to do your job. And they don't get paid extra, they don't get anything else, and I mean, being unwell is hard enough but being unwell with that burden of 'everyone else is doing my job'.

R: And you feel like you have to go back sooner?

Absolutely...And even just when you've got the flu, when you just feel shit and think 'I really do not want to go to work, I have to'. And you go to work and push people away and are sick (Interview 7, p.20).

“You’ll forever not get paid the hours you actually work”: unpaid overtime

Thirty-eight point five hours a week is safe working hours. So that’s what we’re rostered. But it doesn’t translate into any kind of reality, which is ridiculous...It’s not uncommon for me to do a sixty, sixty-five hour week

R: And be paid for thirty-eight and a half?

Well sometimes we get paid our overtime. It’s really haphazard. You never quite know. I, when I initially began this job I wrote down all my hours that I did on my timesheet. And then I got paid for thirty-eight and a half. So I was like ‘what’s the deal? Do we just not get paid for any of our overtime?’

So I went and spoke to medical admin, and they said to me ‘you need to, well the problem is that something is wrong within your unit so if you’re not leaving at four during the day then that’s something that you need to take up with your registrar and your consultants’. Now I’m never going to take that up with my consultant. I’m never going to, when I’m scrubbed into theatre, holding back something or suturing something say ‘oh, it’s four o’clock, off with the gloves, I’m out of here!’. Like, that’s never going to happen.

But I did talk to my registrar about it and say ‘look, medical admin have thrown this back in our face as being that we are doing too many hours and that’s got to change.’ And he’s like, ‘oh look, get used to it. You’ll forever not get paid, you know, the hours you actually work’. And I said ‘well, when we write down our hours they crack it, like that we’re’, and he’s like ‘well don’t tell them that you’re working when you are’.

Which never, has never sat well with me at all because, it’s not even the money, but it’s the fact that then it’s, then I’m working a sixty hour week but I’m getting, I’m being recognised as working a thirty-eight and a half hour week which is safe working hours. Now if I make a mistake in my sixty-fifth hour on, you know, it’s not recognised that I’ve been working those hours, which have been shown to be unsafe.

So I’ve continued to, you know, complain and say that I want to be paid for my overtime and I write down all my hours. And I started to get paid for some of it at least. And it’s almost like if they can get away with it, they will. And there’s a lot of people that never check their payslip and will never ever say anything, but once you

kind of show that you'll, because they can't do this, I mean it's illegal. But it happens in every hospital system, every hospital network. It's not something specific to the system that I work in (Interview 4, pp.7-8).

SETTING INTERPERSONAL BOUNDARIES WITH PATIENTS

“I really don't like you as a person”: treating disliked patients

Patients, sometimes I don't like them. That's I guess [an] ethical decision. I go, I'm just very civil. Like I just go 'I don't really like you as a person and if it wasn't my job I'd have nothing to do with you'...but I know I have to provide a basic standard of care...I can't handle patients that are sexist. I can't handle patients that are racist, homophobic, anything.

They can say one thing and that's enough for me...I have a terrible habit of, you know, they, someone can say one thing and that's enough for me to write them off. You know, that's it...Once I was in clinic and I met this guy. And I was like 'oh this guy's nice'. And then he told me he was a hunter and that was it. And it's terrible to, because that's just one part of a person but for me it was such a like,...I was just like 'yep, ok, I'll do what I have to do but I'm not giving you anything more of myself', you know?...

We have this patient who's so nasty to the nurses and calls them bitch and stuff. And I go 'well, you know what? You may be sick but fuck you. [laughs] You know what? You need to start treating people a bit more nicely'. And you do, you go, you know what, it must be so shit to be him. He's so sick. He can't get out of bed. He has to put his hand up for *every* last thing he needs to do, eat, drink, piss, poo. And that must drive a person mad. And it must make you a horrible person. And you know, when people don't answer your buzzer when you need to pee and you piss the bed, no wonder you're going to go mental. And I'm sure I'd be as nasty as him if I was in his situation. But even though I know all this I just go 'you know what? You're horrible! And I'm glad the nurses aren't answering your calls because when they do you treat them like shit'. And they shouldn't have to put up with that at work. You know? No-one else goes to work and it's ok to be called a bitch and screamed at and yelled at. And I dunno, it's that thing of, I guess there's always this thing of you can't not like your patients too. Like there's this expectation that you're

supposed to be, you know, lovely and caring and loving of everyone, yeah. Where I go 'if you were Joe Blow on the street and I knew you, I wouldn't come within a hundred metres. But because you're my patient I have to have something to do with you' (Interview 9, pp.33-4, participant's emphasis).

APPENDIX C: PUBLICATIONS FROM THIS RESEARCH

McDougall, R. (2009). Being “one cog in a bigger machine”: a qualitative study investigating ethical challenges perceived by junior doctors. *Clinical Ethics*, 4, 85-90.

McDougall, R. (2009). Combating junior doctors’ “4am logic”: a challenge for medical ethics education. *Journal of Medical Ethics*, 35, 203-206.

McDougall, R. (2008). The junior doctor as ethically unique. *Journal of Medical Ethics*, 34, 268-270.

McDougall, R., & Sokol, D. (2008). The ethical junior: a typology of ethical problems faced by house officers. *Journal of the Royal Society of Medicine*, 101, 67-70.

APPENDIX D: RECRUITMENT INFORMATION

INTERNS AND RESIDENTS

We would like to hear from interns and residents (who have been working 3 or fewer years) about their experiences since graduating, as part of a PhD research project investigating the challenges associated with internship and residency. We are interested in both good and bad experiences, and in a broad range including experiences with patients, colleagues, and hospital administration.

Participation would involve an individual interview lasting about an hour. All information gathered will be kept confidential. The project is based at the University of Melbourne, and is independent of any particular hospital.

If you are interested in participating or would like more detailed information about the study, please contact

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