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How individual ethical frameworks shape physician trainees' experiences providing end-of-life care: a qualitative study

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1 **ABSTRACT**

2 **Objectives**

3 The end of life is an ethically challenging time requiring complex decision-making. This study
4 describes ethical frameworks among physician trainees, explores how these frameworks
5 manifest, and relates these frameworks to experiences delivering end-of-life care.

6

7 **Design:**

8 We conducted semi-structured in-depth exploratory qualitative interviews with physician
9 trainees about experiences of end-of-life care and moral distress. We analyzed the interviews
10 using thematic analysis.

11

12 **Setting:**

13 Academic teaching hospitals in the United States and United Kingdom.

14

15 **Participants:**

16 We interviewed 30 physician trainees. We purposefully sampled across three domains we
17 expected to be associated with individual ethics (stage of training, gender, and national
18 healthcare context) in order to elicit a diversity of ethical and experiential perspectives.

19

20 **Results**

21 Some trainees subscribed to a best interest ethical framework, characterized by offering
22 recommendations consistent with the patient's goals and values, presenting only medically
23 appropriate choices, and supporting shared decision-making between the patient/family and

medical team. Others endorsed an autonomy framework, characterized by presenting all technologically feasible choices, refraining from offering recommendations, and prioritizing the voice of patient/family as the decision-maker.

Conclusions

This study describes how physician trainees conceptualize their roles as being rooted in an autonomy or best interest framework. Physician trainees have limited clinical experience and decision-making autonomy and may have ethical frameworks that are dynamic and potentially highly influenced by experiences providing end-of-life care. A better understanding of how individual physicians' ethical frameworks influences the care they give provides opportunities to improve patient communication and advance the role of shared decision-making to ensure goal-aligned end-of-life care.

39 INTRODUCTION

40 For clinicians, the end of life is an ethically challenging time characterized by complex
41 decision-making. Modern technologies can keep individual organs functioning nearly
42 indefinitely, creating challenges in balancing the benefits and harms of medical interventions.
43 There are a variety of ethical frameworks that help clinicians make decisions in such complex
44 cases. The four principles framework (“Principlism”) proposed by Beauchamp and Childress is
45 commonly used in the clinical setting, which distills ethical factors into the principles of
46 autonomy, beneficence, non-maleficence, and justice.(1) This framework does not dictate the
47 relative prioritization of each principle but rather suggests that they all ought to be considered to
48 guide decision-making.(1) Other frameworks exist as well; for example, some clinicians may for
49 example, use a utilitarian approach or a consequentialist one.

50 Clinicians vary in the individual ethical frameworks that inform how they approach end-
51 of-life decisions: some may prioritize respecting a patient’s autonomy while others may
52 prioritize a patient’s best interest, which incorporates elements of the principles of beneficence
53 and non-maleficence. In this paper, we refer to this practice as a clinician’s *ethical framework*
54 specifically within the context of Principlism: the ethical principles an individual prioritizes in
55 their clinical practice.

56 Others have studied the way that physicians’ personal values and goals inform their
57 ethical decision-making,(2,3) but prior work has not assessed physicians’ ethical frameworks and
58 their implications for patient care. In previous work, we have found that physicians tend to
59 approach end-of-life care with ethical frameworks (best interest vs. autonomy) that derive from t
60 he healthcare context in which they practice medicine.(2,3) *Individual* ethical frameworks among
61 physician trainees have not previously been explored, however, and are of particular interest.

Trainees have limited clinical experience and decision-making autonomy. Their ethical frameworks may be particularly dynamic and potentially highly influenced by specific experiences with end-of-life care including the context in which that care provision occurs. We conducted an exploratory study to describe ethical frameworks among physician trainees and how these frameworks manifest and relate to their experiences delivering end-of-life care.

METHODS

Design

This is a qualitative study exploring physician trainees' experiences around providing end of life care. This study is part of a larger project exploring systems-level factors that contribute to potentially inappropriate high-intensity treatments near the end of life. This study was grounded in a constructivist paradigm, which recognizes that individuals derive their understanding of the world through their experiences and reflections,(4) using a mixed deductive-inductive approach. The best interest and autonomy frameworks were developed in prior research(5) and helped shape the interview guide, which we designed to further explore participant experiences and individual ethical frameworks. Through the themes that emerged and our analysis, we were able to delineate the characteristics of best interest and autonomy ethical frameworks. Interviews and data analyses were conducted concurrently. The study was approved by the IRB of the [Redacted]. Participants gave informed consent before participating.

Sample

Two researchers interviewed 30 physician trainees. We purposefully sampled to ensure a respondent pool that was diverse with respect to training context (16 physician trainees at one

US academic medical center and 14 physician trainees at a number of UK academic medical centers), stage of training, and gender. The US-based residents were interviewed in September-October 2019. 10 UK junior doctors were interviewed in July-August 2019, while the other 4 UK physician trainees were interviewed in May 2016. One researcher [Redacted] conducted the four May 2016 interviews, while another [Redacted] conducted the remaining twenty-six interviews. We interviewed participants from both countries to provide a broader basis of understanding of the development of individual ethical frameworks. Inclusion criteria included being a physician trainee in internal medicine or a medical subspecialty and experience treating patients near the end of life.

Interviews and Analysis

We created an interview guide based on a review of the literature and the research team's prior research in this area; the guide was further refined throughout the interview process (See Supplementary File 1). The interview guide explored physician trainees' experiences of moral distress and their perspectives around the ethics of end-of-life care. Researchers conducted semi-structured interviews that lasted between 40-70 minutes in length. Interviews were audio-recorded, anonymized, and transcribed. We conducted data collection and thematic analysis simultaneously so we could explore concepts discovered in in early interviews during subsequent interviews.(6) We followed the steps of thematic analysis outlined by Braun and Clarke (2006): familiarization with the data; generation of initial codes; searching for themes; reviewing themes; defining and naming themes in a codebook; producing the report. We used the identified hemes to refine our autonomy and best interest frameworks.

Identified themes were compiled into a codebook, which was refined throughout data analysis.. Interview recruitment continued until theoretical saturation was reached, a point where no new themes occurred.(7) Two researchers [Redacted] double-coded 20% of the interviews, with the remainder coded by [Redacted] using ATLAS.ti. There was broad concordance in the double-coded interviews, with disagreement resolved in discussion. The specific characteristics of the best interest and autonomy frameworks emerged from the themes we identified in the process of inductive coding and analysis, and each interview was subsequently re-read in order to determine the framework(s) to which an individual physician trainee subscribed.

RESULTS

Table 1 provides demographic information on the 30 study participants. Trainees almost exclusively described experiences of end-of-life care in the hospital, rather than an outpatient or home care setting.

Table 1: Participant demographics

US / UK	16 / 14
M/F	10 / 20
Age: mean (range)	30 (26-39)
Years of experience: mean (range)	2.9 (1-6)

US residency training typically lasts 3-7 years, with fellowships typically lasting 1-3 years. UK junior doctor training typically lasts 5-8 years, with two years of foundation training followed by work as a specialty registrar in a hospital specialty or in general practice.

Best interest and autonomy framework used in end-of-life care

We can understand manner in which physician trainees discussed end-of-life care with their patients through their conceptualization of the role of a clinician in shared decision-making at the end of life. Participants commonly discussed three decision points: 1) whether or not to make recommendations to patients around end-of-life options that are consistent with the patient's goals and values, 2) whether or not to use their clinical judgment to offer *only* medically appropriate options or to offer all conceivable treatment options, and 3) whether decision-making should ultimately rest in the hands of patient and family, in the hands of the physician, or should be shared between the patient or family and the clinical team (See Table 2).

Table 2: Practices of trainee physicians who either prioritize best interest or autonomy for end-of-life decision-making

Decision-Making Practice	Best-Interest	Autonomy
<i>Are recommendations provided?</i>	Yes	No
<i>What treatment options are offered?</i>	Only medically appropriate options	All conceivable options
<i>With whom does decision-making rest?</i>	Shared between physicians and patient or surrogate	Defers almost completely to patient or surrogate

20 trainees endorsed a best interest framework, 7 endorsed an autonomy one, and 3 described elements of both frameworks (see figure 1). Although not a quantitative study, the breakdown of respondents by country and gender can still be illustrative.

144 These frameworks are necessarily imprecise; they are generalized descriptions of the patterns of
145 practice of physician trainees in this study that reflect the predominant ethical principle to which
146 the physician ascribes. Frameworks by definition are not designed to fully capture the nuance of
147 every individual physician's views.

148

149 **The best interest framework**

150 Many physicians characterized the role of a clinician as one who makes recommendations to
151 patients, who uses their clinical judgment to offer only medically appropriate options at the end
152 of life, and who shares in the decision-making with the patient and family. Here, trainees defined
153 'medically appropriate' as only those options that are medically appropriate for a patient and
154 consistent with a patient's goals and values. This collection of practice modes is summarized in
155 this paper under the term 'best interest framework,' as these are all methods which prioritize a
156 patient's best interest in end-of-life decision-making. This best interest framework was relatively
157 common among interview respondents. These trainees spoke explicitly about the physician's role
158 in providing guidance around end-of-life conversations:

159 *What I've seen is the patients and their families often look to doctors for guidance*
160 *around this. And I feel at least towards end-of-life issues, maybe personally more of a*
161 *paternalistic approach, because I think we have so much more experience seeing this and*
162 *being able to offer that guidance more. And one thing that I've personally found helpful*
163 *... is to make those recommendations, ... to actually say, "We, you know, people do this*
164 *and that, but I would recommend based off the situation to not continue other*
165 *interventions." (US PGY3)*

166 Many trainees with a best interest framework spoke about how they described CPR in different
167 ways to different patients, depending on the patient's underlying health. These trainees thought
168 carefully about the likelihood that various interventions (including CPR) might result in benefit
169 for the patient, and while still offering the option of resuscitation to all patients, adjusted their
170 framing of CPR in accordance with their medical understanding of whether or not the option was
171 likely to help the patient:

172 *[My description of CPR] very much differs depending on kind of like what I think the*
173 *patient's life expectancy is and what I think the likelihood is that they may code in the*
174 *hospital. So when I'm admitting a young patient for like cellulitis ... I describe it pretty*
175 *quickly, and I say something about, what CPR is....If it's someone who's elderly, or*
176 *someone who has a bad prognosis ... I say something like, "When your heart stops*
177 *beating, we do have medical interventions to try to bring you back to life. And that*
178 *involves chest compressions, pressing on your chest, and that involves shocking you with*
179 *electricity."* (US PGY3)

180 In describing the roles of patients, families, and clinicians in end-of-life discussions, one
181 participant spoke about the role of shared decision-making:

182 *Obviously, patients' wishes and family wishes are taken into account, but also the*
183 *responsible clinician makes a sensible judgment on how to best go about things... I*
184 *would say that the vast majority of the time, it's the clinician who directs where the*
185 *decision would be going, as opposed to the patient demanding a certain decision be*
186 *made.* (UK PGY2)

187 Many physicians with a best interest framework described how that approach helped relieve the
188 family of the burden of responsibility for deciding to stop aggressive treatments:

189 *I use what some people might call paternalism if I want to relieve some pressure from a*
190 *patient or family member and give them permission to consider a certain option. I will*
191 *make recommendations. But, again, even that it's sort of not paternalistic. It is patient-*
192 *centered in the way that I want to relieve their suffering in having to make a decision.*
193 *(US PGY2)*

194

195 **The autonomy framework**

196 Some physicians characterized the appropriate role of a clinician as one who offers all
197 conceivable options neutrally to patients without making their own recommendations. These
198 trainees offered every option available within the arsenal of medical practice (i.e., all treatments
199 that might sustain a particular organ system or fix a lab value without regards to whether or not
200 that may result in a reasonable hope of benefit to the overall patient.) These trainees did not tailor
201 the options they provided based on those that were most in line with a patient's values or beliefs.
202 Many physicians who prioritized autonomy stated that they felt uncomfortable inserting their
203 own "bias" into a patient or family's decision-making process by making a recommendation.
204 These physicians also thought that the decision about a patient's care at the end of life should
205 rest solely with the patient and family, rather than a shared decision made with the clinical team.
206 We designate this set of practices as an 'autonomy framework,' as they are all practices that
207 explicitly prioritize the patient or family's autonomy in end-of-life decision-making:

208 *I am of the belief that if a patient can communicate his or her or their goals to me and*
209 *what they want at the end of life, that so long as they accept what that truly means for*
210 *them, that it's my responsibility to carry that out and give them the death that they*
211 *[want], even if that's not the death that I would choose for myself. And I think sometimes*
212 *I get frustrated when people talk about certain treatments as “inappropriate” or*
213 *“incorrect” because while I think we make a lot of overall assumptions about people,*
214 *what people want at the end of their life. At the end of the day, they're the person that*
215 *guides and if they can communicate to me that that's what they want and I feel as a*
216 *physician it's my role to carry that out for them. (US PGY2)*

217 For some trainees who prioritized autonomy, this framework manifested in describing
218 interventions like CPR in the same way for all patients. This is in contrast to the more varied
219 approach based on patient characteristics describe by trainees who prioritized best interest.
220 Speaking about CPR, one said:

221 *I don't think how likely they are to code changes how I describe that...I don't think I think*
222 *about like how sick they are when I describe it to them. (US PGY2)*

223 This trainee spoke specifically about how she did not feel comfortable issuing recommendations
224 about treatment options at the end of life:

225 *I do have experiences where I've seen that patients are more satisfied and their families*
226 *feel more satisfied when they end up on hospice or comfort care, but I don't want to be*
227 *like, "And this is what my medical recommendation is," in the same way that I would give*
228 *you antibiotics for pneumonia. It feels different. (US PGY2)*

229 Many physicians with an autonomy framework justified it by describing how following the
230 family's wishes made the patient's hospital experience more tolerable for the family members.
231 Trainees described cases in which they felt they were treating the family members as much – or
232 more – than they were treating the patient:

233 *Especially for people who are very decompensated or who don't appear to be in touch*
234 *with reality anymore because of their level of illness, there is a responsibility to care for*
235 *their family members too....so I tend to let the autonomy carry a little more weight (US*
236 *PGY3)*

237

238 **Frameworks in flux**

239 Some trainees also acknowledged that their frameworks were in flux and were susceptible to
240 change as they continued their training.

241 *Yeah, I think it almost feels like there's this relationship where your level of training*
242 *corresponds so strongly with patient autonomy versus what we feel is best for the patient.*
243 *So like I'm a young intern right now, I have three months of experience, and I'm like,*
244 *patient should be able to make their own choices... And then it seems like, senior residents,*
245 *they kind of have hit the sweet spot of like, patients should be able to make their own*
246 *decisions. (US PGY1)*

247

248 **DISCUSSION**

249 This study characterizes how physicians conceptualize their roles as being rooted in an
250 autonomy or best interest framework and explores how these frameworks affect end-of-life
251 decision-making and communication. Participants had striking commonalities in the way they

characterized the components of their respective ethical frameworks, a finding which is notable given the differences within our respondent pool in healthcare systems, gender, and stage of training. However, these frameworks are generalized ones, and not all physician trainees endorse their various components in the same way.

Ethical frameworks have previously been examined in aggregate, including at the institutional(5) or national health systems level. Though this manuscript does not explicitly compare US and UK physician trainees, it is notable that UK respondents primarily held a best-interest framework, whereas the respondents in the US endorsed both frameworks. This is consistent with other studies that compare the healthcare systems of the US and the UK. The primacy of patient autonomy is apparent in the US, while the UK generally prioritizes best interest decision-making.(8,9)

In the US, there has been a historical trend away from physician paternalism, where doctors make decisions on behalf of the patient, towards patient autonomy.(10–12) Recently, there has been growing concern that the American healthcare system has now shifted too far towards prioritizing autonomy,(13,14) deferring to a patient's wishes and prompting overtreatment at the end of life that is not in a patient's best interest. This has resulted in a growing emphasis on shared decision-making where the decision is shared between the patient who brings goals and values to the conversation, and the physician who provides their clinical expertise.(15)

In the UK, patients do not have a legal right to receive treatment that is against the physician's clinical judgment, including non-beneficial resuscitation.(16) The UK's Mental Capacity Act of 2005 explicitly requires physicians to make decisions based on a best interest framework when caring for patients who are unable to make their own decisions.(17) Recent

275 guidance by the UK General Medical Council, prompted in part by confusion after the Janet
276 Tracey(18) and Carl Winspear(19) judgments, confirms that although physicians are required to
277 consult families about placing a DNA CPR (Do Not Attempt CPR) order, physicians are not
278 expected to default to providing CPR if there is no DNA CPR in place and providing CPR is
279 against their clinical judgment.(20)

280 Autonomy and best interest are helpful but imprecise frameworks to characterize the
281 ways physician trainees make end-of-life decisions. Within the Principlism approach, some of
282 the UK junior doctors who held a best-interest framework also prioritized the principle of justice
283 when discussing with patients the importance of fair resource allocation. For example, one UK
284 respondent described discussing the need to have criteria for the just distribution of finite
285 resources, explaining to patients that resources were finite. For others, a utilitarian or
286 deontological framework may best describe their approach. Describing an individual's ethical
287 frameworks is an inherently blunt tool that cannot fully capture the nuances and richness of one's
288 moral compass. For example, the respondent above (US PGY3) who spoke about describing
289 CPR stated that they used different communications strategies depending on the patient's
290 characteristics. They described glossing over the details for younger patients with an excellent
291 prognosis, in contrast to highlighting the process of resuscitation (i.e., "shocking you with
292 electricity") for patients with a poorer prognosis. The best-interest approach modeled here also
293 retains respect for a patient's autonomy by presenting all resuscitation options.

294 Understanding the ethical frameworks trainees use to inform their decision-making is
295 particularly important, as trainees may have ethical frameworks that are in flux and particularly
296 susceptible to their individual experiences, to the approaches of their supervising physicians, and
297 to the institutional culture in which they work. One member of our team (ED) previously found

that while experienced attending physicians felt comfortable making recommendations in a patient's best interest, trainees were more influenced by their institution's culture. Trainees at autonomy-focused institutions were more likely to adopt a reductionist interpretation of patient autonomy to mean limitless choice and thus felt less comfortable offering recommendations and guiding patient care.(5) However, a reluctance to provide recommendations to patients and families can increase the burden and guilt that patients and families experience in making their end-of-life decisions.(21) It is important to note that while ethical and clinical best practices understand that to truly honor patient autonomy, that patients must be provided with appropriate clinical recommendations and engage in shared decision-making, in actual practice, this is not always how autonomy is interpreted. In both this study and in prior studies(5), respondents have commonly equated autonomy to mean limitless choice and felt uncomfortable making clinical recommendations for fear of "biasing" the patient.

A simplistic notion of autonomy that does not allow for clinical recommendations can contribute to potentially inappropriate treatments at the end of life.(22) There are significant implications of this research in medical education. Physicians receive the majority of their ethics education while they are trainees (i.e., as medical students and residents or junior doctors). The incorporation of these research findings into formal and informal ethics curricula can have significant downstream effects on the clinical practices of physicians throughout their practice. There may be, for example, value in explicitly discussing the benefits and drawbacks of various ethical frameworks when discussing and modeling best practices for having end-of-life care conversations with trainees. Specific descriptions of experiences that capture different ethical frameworks could be developed as teaching modules to explore end-of-life decision-making with learners.

321 This study has some limitations, including the fact that US participants worked at one
322 hospital while UK respondents worked at a variety of hospitals. However, the intention of this
323 manuscript was not to compare US and UK national cultures or institutional cultures, but rather
324 to investigate ethical frameworks at the level of individual physicians. In the larger study of
325 institutional ethical frameworks, of which this study forms a part, data suggests that the US study
326 site selected for this manuscript has a best interest focused culture. As such, it is possible that US
327 respondents in this study may be more likely to possess a best interest framework than the
328 general trainee population in the US. In addition, these frameworks cannot adequately capture
329 the nuance of different physician trainees' practices and instead represent a way to understand
330 overall patterns of practice and behavior.

331 Future research could further clarify the nature of and impact of these ethical
332 frameworks, including how an individual's framework influences and is influenced by
333 institutional culture. Future research could explore a wide range of institutions with a range of
334 cultures, as well as an exploration of the role of national context in shaping individual ethical
335 frameworks. A better understanding how individual physicians' ethical frameworks influence
336 their work provides opportunities to improve patient communication and advance the role of
337 shared decision-making to ensure goal-aligned end-of-life care.

338

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