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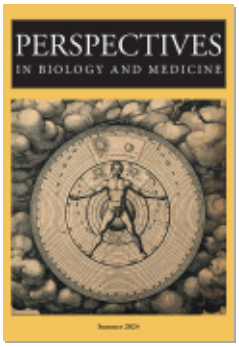

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Moral Diversity for Medical Trainees

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ABSTRACT While the proliferation of diversity, equity, and inclusion (DEI) initiatives among medical schools and residency training programs has provided important benefits of demographic and experiential diversity among medical trainees, there has not been a similar emphasis upon the importance of moral diversity in medical training. Enhanced attention to the importance of moral diversity and the centrality of conscience to medical practice might allow trainees to better interface with the morally diverse patients they serve, learn important virtues like humility, patience, and tolerance, and deepen their understanding of and appreciation for alternative moral viewpoints among their fellow practitioners.

Recent discourse within academic medicine surrounding systemic racism, gender inequity, and abuses of power have led to a moment of reckoning, both by acknowledging the academy's sordid history and by seeking to construct a more just and equitable future form of practice (Peek et al. 2021). One important response has been an enhanced emphasis on diversity, equity, and inclusion (DEI) initiatives for both undergraduate and graduate medical education (Swartz

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et al. 2019; Valencia 2022). Such initiatives champion the importance of enhanced representation of those who have been historically marginalized and provide robust dialogue about how to both identify and mitigate ongoing patterns of injustice (Boatright et al. 2023). For example, in response to the diversity gap affecting the US health-care workforce, the ACGME implemented a diversity accreditation standard in 2019 that requires residency programs to implement programs to enhance diversity of recruitment (ACGME 2019).

Encouragingly, measures like this have thus far been demonstrated to increase diversity and representation of historically marginalized communities within medicine; to provide important and practically beneficial education to students, trainees, and educators; and even to improve the mental health of students at institutions where such changes are enacted (AAMC 2019; Hardeman et al. 2016; Rosenkranz et al. 2021). This success is largely due to the intentional focus on amplifying the voices of members of traditionally marginalized communities, who advocate not only for equitable opportunity to practice but emphasize the value and benefit of diversity as such—that diverse, equitable, and inclusive environments actually allow for more growth, innovation, and empathy than traditionally homogenized environments do (Boatright et al. 2023).

While DEI efforts within medical education clearly ought to be celebrated and supported, we believe such efforts deserve to be broadened. That is to say, while these initiatives rightly focus on enhancing diversity and representation of those from a variety of demographic and experiential backgrounds, there has not been a concomitant emphasis on the recognition of another crucially important form of diversity, one that is foundational to the practice of good medicine: that of moral diversity.

Moral Diversity

The term "moral diversity" refers to the presence of a variety of viewpoints on a given moral issue or issues—viewpoints that may prove not only disparate but also sometimes incompatible. Environments that champion moral diversity recognize that while the open exchange of ideas, free from fear of judgment or coercion, is sometimes uncomfortable, this type of exchange is crucial for allowing members of such environments to learn from one another and grow in their own capacity for moral reasoning (Marino 2017).

Medical education and training, by their very nature, are endeavors in which many of the contentious issues underpinning moral diversity may arise. Dealing as medicine does with questions surrounding the beginning and end of life, suffering, and the right use of biotechnology, medical students and trainees will often encounter controversial and contested issues not only in their own education and practice, but also as representatives of the profession who interface with the public. Trainees may be expected to provide a position and account for a variety

of complex issues, ranging from abortion, physician-assisted suicide, and obligatory vaccinations, to name a few examples.

As physicians will recognize, moral diversity manifests directly in clinical care as well. Physicians in both training and practice will invariably encounter patients who hold a variety of beliefs on contested issues, many of which may pertain to their own care. In order to take care of the patient in front of them, despite firmly held ideological differences that may exist on contested issues between them, they should be aware of their own biases (Liaison Committee on Medical Education 2023). This can only happen in an educational milieu that supports such formation and in which students have learned to coexist with others who hold different positions in the education and training space.

Therefore, the presence and development of moral diversity within the profession of medicine in both training and practice is central to allowing students, trainees and attendings to develop their own moral reasoning, learn to disagree charitably, and to hone important virtues like patience, tolerance, humility, and empathy (Cherry 2015).

Challenges to Moral Diversity in Medical Training

While a focus on moral diversity is central to cultivating an environment of growth, the structure of contemporary medical education and training poses particular challenges to the presence and cultivation of such diversity, for three main reasons.

First is the firmly hierarchical and evaluative nature of medical education and training. Medical students and trainees, who frequently find themselves in places of relative disempowerment, experience this hierarchy and power differential especially keenly. Besides the strong social desire to fit in and not deviate from the views of one's superiors, the looming sense of evaluation colors the training experience for both medical students and residents (Zaidi et al. 2020). Given the importance of being perceived favorably by one's superiors, medical students and trainees may prioritize agreeing with and complying rather than honestly conveying or advocating for their views on a given moral issue, particularly those that might be viewed with controversy. This issue has received particular attention as it pertains to the ability of trainees to conscientiously object to certain forms of care or procedures, but the moral conflicts that trainees feel likely manifest much more ubiquitously across a broad array of less overt moral decisions or dilemmas (Card 2007; Hilliard, Harrison, and Madden 2007; Lomis, Carpenter, and Miller 2009; Wiggleton et al. 2010). Indeed, the issue of moral distress as it relates to students and trainees often presents itself in the context of hierarchical relationship decision-making, rather than in stereotypical controversial medical ethics decisions (Hilliard, Harrison, and Madden 2007).

The second major issue is a lack of attention to and appreciation of moral diversity in the training that medical students and residents receive in their medical ethics curricula. The regnant bioethical framework in which students and residents are taught is that of principle-based ethics, a system that champions the importance of four dominant bioethical principles used to help negotiate ethical dilemmas (Beauchamp and Childress 2001; Gillon 2015). The four central principles of autonomy, beneficence, nonmaleficence, and justice guide students' and residents' consideration of ethical issues that arise. This system, known in biomedical ethics as "principlism," has been criticized as placing too heavy an emphasis on the mere resolution of dilemmas and for only detecting salient moral issues when they arise in conflict. Additionally, some critics view Principlism as emphasizing a universal position of ethics and neglecting tradition-specific systems that arguably provide more robust interpretations of ethical scenarios, which may represent a stark departure from the moral and ethical frameworks most patients subscribe to (Durante 2009; Walker 2009). While some attention may be paid in medical school medical ethics courses to alternative ethical frameworks—including deontology, consequentialism, casuistry, or more tradition-specific systems of thought—principlism dominates how students are taught to conceive of ethics, and it is the system recognized on board exams and in clinical consultation dialogue. Because this framework is the one that students and residents are most exposed to, students and residents may be tacitly (if not explicitly) taught that alternative systems of thought, including religious or cultural belief systems that are often invoked in discussions of moral diversity, are viewed as out-of-bounds within the public and supposedly neutral space of the hospital or clinic (Durante 2009).

The third major issue is a lack of confidence that different viewpoints will be received in good faith, or even listened to at all, particularly from those who may hold minority positions on certain moral issues (Reitz and Higgins 2020; Walker 2009). Ethical conflict in general is viewed by some as a significant potential barrier in medical education, and such conflict can potentially contribute to moral distress for those holding minority positions, insofar as it impedes their ability to practice in concert with their beliefs (Berger 2014; Paros and Tilburt 2018). Furthermore, there is increasing concern that those acting against majority positions may be deemed "unprofessional," a charge that can result in professional sanctioning (Genuis and Lipp 2013).

Conscience in Medicine and Medical Training

Given these challenges to the cultivation and exercise of moral diversity in medical training, is there a way to reframe the issue of moral diversity to emphasize its importance, and even centrality, to both medical training and practice? Ultimately, we believe that enhanced attention to the importance of moral diversity

in training is possible, through a renewed attention to the centrality of conscience to medical practice, particularly for medical trainees.

Conscience is understood as the capacity of the human mind to make decisions consistent with a good and honorable life for oneself and others (Berger 2014). More specifically, this involves harnessing the cognitive and moral faculty of practical reason and applying it to a specific situation (Eberly and Frush 2019; Sulmasy 2008). Unfortunately, many in medicine have come to understand physician conscience merely as something private and idiosyncratic, and only operative when it involves tension or refusal to engage in controversial practice (in the form of conscientious objection) (Eberly and Frush 2019). A more fitting understanding of conscience, however, is its function to allow one to identify the key factors informing a given moral decision, weigh those factors appropriately, and to act in keeping with the most appropriate course of action, taking into account both past information and the potential future ramifications of a decision (Genuis and Lipp 2013; Sulmasy 2008). Despite its understanding as something private, deeply held, and perhaps even less than rational, a correct understanding of conscience recognizes that conscientious decision-making entails a distinctly rational component and ought actually to be understood, articulated, and justified by the individual exercising it (Birchley 2012; Genuis and Lipp 2013).

Importantly, given the fact that medicine deals fundamentally with questions of moral, and not merely technical import, conscientious decision-making is central to clinical decision-making and even inseparable from it (Kinghorn 2013). Thus, medical practitioners are always and everywhere exercising conscience, either well or poorly, whether they are aware of it or not. This is why the AMA Code of Ethics (2023) recognizes that the exercise of conscience is central to preserving the integrity of medical practice.

It is ultimately through exercising one's conscience that medical practitioners and trainees are able to correctly understand medicine as a moral practice, and it is through articulation and communication of one's conscientious decision-making that moral diversity is allowed to take root. Crucially, this means that conscience is decidedly not merely private and idiosyncratic, but rather something that can be conveyed through words and actions to others. Thus, rational and conscientious medicine means that those who believe a given course of action is right or wrong ought to be able to offer some explanation for why they feel this way, rather than merely invoking conscience as a conversation-stopper.

It is this invitation to further discussion that allows moral diversity to take root and ultimately to flourish. Disagreement over important matters in medicine requires more—not less—clarification and discussion so that practitioners can better understand their own positions, while at the same time learning from those with whom they may disagree. This intellectual habit of listening to others with whom we disagree and being open to their position requires intellectual humility—the virtue of recognizing that there are gaps in one's knowledge and that

one's current beliefs might be incorrect—which has been shown to increase social cohesion and improve tolerance among individuals (Porter et al. 2022). Such humility leads to the practice of tolerance—of building and cultivating a view of respect and understanding for a diverse group of people, which is one part of the ACGME's core competency of professionalism (NEJM Knowledge+ 2023).

As noted above, it is important that a newfound emphasis upon conscientious practice for trainees not be taken as license for trainees to merely turn inward and buttress themselves against alternative moral or ethical frameworks. Rather, conscientious practice should be a communal habit that entails critical reflection of the multitude of moral viewpoints and traditions held by one's coworkers and interlocutors. The conscientious discerning and sharpening of one's beliefs should not be viewed as mutually exclusive with the continued moral and intellectual curiosity so central to good physicians—and this is a point that should be emphasized to trainees.

Teaching students and trainees about the centrality of conscience to clinical decision-making and medical practice and encouraging them to engage in, rather than shy away from, conversations involving conscientious decision-making has the potential to enhance the moral saliency of their medical practice and to increase moral diversity.

Case Study: Conscientious Medicine and Medical Aid-in-Dying

How might conscientious practice look for a medical trainee in 2024? Let us consider the case of Jonathan, an internal medicine resident who is completing his training in Portland, Oregon. In his continuity clinic, Jonathan sees Mr. Smith, a 50-year-old man with recently diagnosed metastatic pulmonary adenocarcinoma. During this initial visit, Mr. Smith states that his main goal in light of his current diagnosis is minimizing pain and ensuring a "good death." By this, he means more specifically that he would want to pursue medical aid-in-dying as a way to "maintain his dignity and autonomy" before his disease progresses, and he asks Jonathan about the prospect of providing medication necessary for this.

Jonathan has thought about the issue of medical aid-in-dying previously, and through the course of reading, discussion, and discernment, he has come to believe that physicians actively abetting the death of patients contradicts their primary call to work toward the health of those they serve. His conscientious belief is that participating in medical aid-in-dying subverts the virtue of fidelity central to the patient-physician relationship and fundamentally contradicts his understanding of good medicine.

Jonathan conveys to Mr. Smith that he desires to learn more about his current symptoms and the circumstances surrounding his illness that might cause him to feel like he is losing his dignity. He emphasizes that he desires to partner with Mr.

Smith to help provide excellent care throughout the coming weeks and months, but he shares with Mr. Smith that he does not believe medical aid-in-dying is consistent with his role as a physician. In light of this, he shares that he will not initiate the process of evaluation necessary for medical aid-in-dying, but will still remain committed to Mr. Smith's care in the way he has described.

When staffing this patient with his attending in clinic, Jonathan relays his encounter with Mr. Smith. When his attending asks why Jonathan did not proceed with Mr. Smith's request to facilitate the process of medical aid-in-dying, Jonathan explains that, to the best of his understanding, this practice contradicts his obligations to his patients as a physician. He states that his conscientious belief is that to fulfill this request would be in direct contradiction to what it means to pursue his patient's health. He states that he does not believe the legality of the practice means that the practice is consistent with good medicine, and that to actively participate in medical aid-in-dying would be to do Mr. Smith a disservice and compromise his own integrity. His attending states that he disagrees with Jonathan's viewpoint and believes that the legality of medical aid-in-dying as a practice means that physicians should provide it at patients' request, but that he appreciates Jonathan's frankness on the matter.

Analysis

The above case illustrates how a medical trainee might seek to practice conscientiously in the face of challenging ethical scenarios that arise in the course of such practice. By drawing on a conscientious, reasonable understanding of medicine (a practice working toward the health of the patient) and the nature of the patient-physician relationship (one predicated on the virtue of fidelity and the physician's overriding commitment to the patient's good), Jonathan describes his position with clarity and honesty, both to Mr. Smith and to his attending physician.

It is true that either interaction might entail disagreement, and it is not enough for trainees or practitioners to simply invoke conscience as a conversation-stopper. Rather, they should engage in such interaction with charity and humility. While trainees inhabit a precarious state in the medical hierarchy and may lack the courage to voice dissent from their superiors and their patients, this is all the more reason for an attention to conscience when such controversial issues arise, particularly if the trainee inhabits a minority ethical position, as Jonathan may here.

Ideally, Jonathan's honesty and integrity in this case might engender respect rather than resentment in his relationship with Mr. Smith, even if Mr. Smith still maintains his desire to pursue medical aid-in-dying and seeks out another physician. Additionally, Jonathan's exchange with his attending physician might prove an opportunity for the two to learn from one another about the thought processes and convictions underlying their opposing positions, ultimately to allow for a

deeper respect and tolerance in this difficult and contentious ethical space. This kind of opportunity could not take root in the absence of moral diversity and conscientious practice.

It is, moreover, important to note that conscience in medicine does not merely manifest in stereotypically contentious and controversial cases, such as those involving medical aid-in-dying. Conscience is ideally invoked and drawn upon in much more quotidian instances, such as how a physician chooses to respond in the case of a patient requesting antibiotics for what seems to be a clear viral upper respiratory infection, or how a physician chooses to comport herself in response to a so-called "difficult patient." Trainees who learn to understand their clinical (and moral) decision-making as reliant upon a robust understanding of conscience are able not only to act with integrity in such instances, but also to recognize the importance of being able to articulate and justify their decision-making. Such discourse allows for heightened attention to the moral considerations underlying these everyday scenarios.

Benefits of Conscientious Practice and Moral Diversity

What are the potential benefits of seeking to increase the presence of moral diversity among medical trainees? While there have not been any empirical studies to date evaluating the presence and benefit of moral diversity initiatives in medical training programs, we can nonetheless anticipate that enhanced attention to the importance of moral diversity (and conscientious practice that underpins it) might have the following beneficial effects for medical students and trainees.

Enhance Trainee Agency and Experience

The moral faculty of conscience is directly related to the virtue of integrity—the ability to act and behave in a consistent and morally coherent fashion through time and across settings (Atkins 2019). Moral fragmentation can occur when people are not allowed to practice with integrity, which can complicate effective medical decision making and in some cases lead to experiences of moral distress (Genuis and Lipp 2013; Rushton, Kaszniak, and Halifax 2013).

In contrast, allowing for latitude in conscientious practice and the resultant moral diversity this can create allows trainees to practice in a way that is authentic to their core values, to maintain integrity in the course of their practice, and to increase self-efficacy amidst the challenges of training.

Improve Patient Care

As mentioned previously, one default assumption held by many about conscience is that it is only operative when the patient and clinician are in disagreement about some course of action and the clinician refuses to participate in such

care—so-called "conscientious objection." This attenuated understanding of conscience is not only incorrect, it is also problematic, because it tends to imply an antagonism between the medical practitioner and the patient, that the two are pitted as rivals. Instead, the exercise of conscience by trainees (which may involve disagreement with certain actions or care plans) might be met with creative ways to still envision caring for the patient, even if the trainee might not participate in all aspects of that care.

Ultimately, by allowing trainees to be open with their superiors, peers, and patients—that is, by making space for them to practice with integrity and exercising "conscientiousness and candor"—all might be better informed about the options available to a patient and how to best align patient needs and preferences with conscientious care on the part of the care team (Curlin and Burck 2005).

Enhance Programmatic Learning

Third, and finally, programs that encourage conscientious practice and make space for moral diversity will likely create cultures of both trainee- and faculty-directed learning.

The educational experience that moral diversity might allow for has deep resonance with the increasingly popular psychological concept of the "growth mindset," which originated with Carolyn Dweck (2008) and has found its way into medical parlance (Richardson et al. 2021; Theard, Marr, and Harrison 2021). We grow and develop most when we are pushed outside of our zone of familiarity to consider ideas, beliefs, or experiences that we might initially meet with discomfort or fear. The key point is that such a mindset approaches difference as opportunity, rather than a source of fear to be avoided.

Programs that allow for moral diversity of practice, and even allow for spaces of appropriate and charitable disagreement, might witness moral, intellectual, and clinical growth to a degree not possible in ethically homogenous cultures.

Effective Response

What might it look like for a residency program to take seriously a commitment to moral diversity for its trainees?

First, it is very difficult for students or trainees to advocate on their own behalf in these areas. Structural and programmatic support that is proactive and anticipatory in nature will be required. One means to this end might be to solicit input from incoming trainees in an open-ended fashion to determine whether they may hold particular beliefs surrounding certain aspects of practice, and then to work with them to understand how their views may impact their practice and the workflow of their clinical responsibilities. Taking this proactive approach would lessen the likelihood that such beliefs might impair workflow during busy times. Many institutions have policies that support exercise of physician conscience.

Making housestaff aware of these policies and having a programmatic response for residents who have commitments that may lead them to needing support around their exercise of conscience will create a culture of inclusion and support for a diverse group of trainees. Doing so could also cultivate cultural humility, which could help trainees achieve an integrated personal-professional identity that may improve trainee wellness (Collier et al. 2021).

Second, programs might consider the integration of discussion on contested issues into the didactics and programming of the training program. Having an intentional discussion when a contested topic arises in the context of morning report or other didactic conference would help learners prepare to discuss such topics thoughtfully and serve to make those who hold a variety of commitments feel included in the discussion. Additionally, hosting dedicated discussion sessions with scholars who hold a variety of perspectives on contested topics could help model intellectual humility and an ability to converse with others who hold views ideologically different from one's own.

Third, as a clear sign of a program's commitment to creating a diverse residency class and to overcoming bias, applicants who may hold minority views on contested issues should be reviewed without negative bias, in a spirit of holistic review. Research has shown that applicants who hold certain views on abortion, for example, may be at risk for discrimination in the application to residency (Kalinowsk, Buskmiller, and Ward 2021).

Conclusion

Creating a culture of moral diversity in medical training would require not merely programmatic changes, but also effective role modeling and building and supporting a culture of intellectual humility. This requires the virtue of epistemic humility—the assumption of the good faith of those with whom one disagrees, and the sense that one might have something to learn from someone else. The true enactment of, and engagement with, moral diversity and conscientious practice might prove uncomfortable to the degree that it pushes those who participate outside of their comfort zones. It thus warrants what bioethicist H. Trist Englehardt (2015) calls "moral courage."

Yet we believe this courage is sorely needed in our increasingly polarized and fragmented world, where virtues such as humility, tolerance, and compassion are in short supply. Amidst this contentious backdrop, the vocation of medicine should be robust enough to include those of differing viewpoints. It should be a profession in which we can train and practice with and among those who hold a variety of views across ideological differences, in which we can learn from those with whom we disagree, ultimately to better serve the diverse population of patients entrusted to our care.

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