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Education and Training Update

Supporting the Resident Doctor When Their Personal and Professional Values and Morals Are Challenged

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Abstract

Challenges to personal and professional values and morals are commonly experienced by resident doctors during clinical practice, with an associated psychological reaction. This psychological reaction is on a continuum, ranging from transient discomfort, and in repeated cases, to moral distress and moral injury. This educational guidance article offers several practical approaches for clinical educators to support resident doctors when their values and morals have been challenged. Three complementary approaches are described: debriefing, speaking up to address systemic factors and psychological support. These approaches address the important individual and systemic factors associated with values and moral challenges, with associated benefits for wellbeing and quality of patient care.

Keywords: morals; ethical dilemmas; residency; psychological distress

1. Introduction

Resident doctors live and work in a world shaped by personal and professional values and morals, influencing how they think, behave, and interact with others [1]. These values and morals are commonly challenged in clinical practice, with an associated psychological reaction [2]. An example is when a resident doctor experiences situations where limited resources, such as Intensive Care Unit (ICU) beds or ventilators, require them to prioritise which patients receive life-saving treatment. This situation creates a challenge between their values and morals, with a duty of care for all patients equally and the healthcare organisation's need to allocate resources in a way that maximises overall benefit. Clinical educators have an important supportive role, helping resident doctors recognise, understand and respond constructively to values and moral challenges encountered during practice.

In this education guidance article we discuss how clinical educators can support resident doctors when their personal and professional values and morals have been challenged across a variety of situations during clinical practice. Our aim is to provide practical guidance for clinical educators since they usually have a designated responsibility for supporting resident doctors' clinical learning, professional development, and wellbeing within the workplace. The specific name of the role will depend on the healthcare system, including clinical supervisors, educational supervisors, attending/consultant physicians and faculty members.

We present several practical approaches alongside illustrative case scenarios that demonstrate their application. Our guidance is informed by our collective experience in training and developing clinical educators to support resident doctors when their personal and professional values and morals have been challenged. We recognise that the approaches we describe are based on our practice within the UK but the principles described, and illustrative examples, can be transferable to other global settings, and readers should consider how to adapt the approaches to their own settings.

2. Formation of Personal and Professional Values and Morals

An individual's personal and professional values, such as empathy and integrity, constantly intersect during the provision of clinical care [1]. Personal values develop from a combination of influences, including family upbringing, cultural and societal norms, personal experiences, and individual reflection. Early informal and formal education shape initial beliefs that inform values, while life experiences and exposure to different perspectives refine or challenge these beliefs and values over time. Each individual actively makes choices about which personal values they consider as being essential for living their lives, such as honesty, respect, kindness and fairness. Professional values are determined by professional responsibilities, such as ensuring patient autonomy and maintaining confidentiality. These professional responsibilities are described in codes of conduct, legal requirements, practice standards, and workplace policies and procedures [3].

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An important distinction is between values and morals [4]. Values are general beliefs about what a person considers important or worthwhile, whereas morals are firmly held beliefs about what they consider is right or wrong and, consequently, what a person ought or ought not to do when they have to act in a particular situation. For example, a doctor may value patient autonomy, considering it important for patients to be involved in decisions about their care. Their moral belief may be that it is wrong to make a treatment decision on behalf of a competent patient without first seeking and respecting their wishes. This distinction is crucial in clinical practice because it helps explain why some situations cause only temporary discomfort, while others lead to more lasting ethical dilemmas.

3. The Relationship Between Levels of Challenge and Psychological Reaction

Clinical practice presents resident doctors with situations that vary in the level of challenge to their personal and professional values and morals. These challenges arise when individuals recognise a course of action that is consistent with their values, and especially their moral beliefs, but are constrained from acting accordingly, often because of systemic organisational factors such as limited resources and health service policies and procedures [2]. The challenge to values and morals can occur along a continuum, from low to high. During and immediately after these situations, an individual can experience a psychological reaction, which can occur along a continuum from mild psychological discomfort to a more intense and longer lasting psychological reaction, with moral distress or moral injury [5]. Repeated low-level challenges to an individual's values and morals may lead to an accumulating psychological reaction with increasing levels of discomfort, which can progress to longer-lasting moral distress and, with continued exposure, potentially intensify further to moral injury [5]. See Fig. 1: Relationship between levels of challenge and psychological reaction. The figure illustrates the relationship between the level of challenge and the intensity and duration of the psychological reaction. It highlights that repeated exposure to low-level challenges may lead to moral distress and moral injury but also that a single exposure to a high-level challenge can lead to moral distress or moral injury.

We present two illustrative examples of the relationship between levels of challenge and psychological reaction. Both examples also highlight the essential interrelationship between clinical situations encountered, individual personal and professional values and morals, and systemic organisational factors in contributing to the challenge and the associated psychological reaction:

(a) Low-level challenge with low-level psychological reaction producing transient mild psychological discomfort

Example of challenge: Consultations with patients presenting with a minor problem, such as an upper respiratory tract infection, when they are insisting on being prescribed medication, even though the doctor knows from the evidence that the medication is unlikely to help. This creates a challenge between the resident doctor's values and morals, with a duty of care that respects autonomy for all patients, and the duty to do no harm and allocate resources in a way that maximises overall benefit. The challenge is low-level because the challenge is mainly to the resident doctor's values and not their moral beliefs.

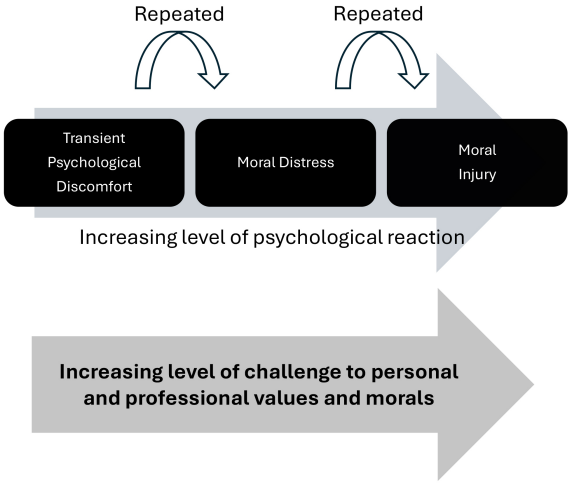


Fig. 1. Relationship between levels of challenge and psychological reaction. The figure was made from Microsoft PowerPoint (Microsoft 365 (Office), Microsoft). This diagram primarily illustrates the path of repeated exposure to challenges; the path for a single high-level challenge will be described in the main text.

Psychological reaction: The resident doctor can experience transient low-level mild psychological discomfort, such as unease, tension or anger, that lasts for only a few minutes or hours. A more intense and longer-lasting psychological reaction could be produced if this situation was repeated, especially if the doctor's moral beliefs were challenged.

(b) Higher-level challenge with a more intense and longer-lasting psychological reaction with moral distress and moral injury

Example of challenge: A resident doctor is aware that an effective treatment is available but cannot be prescribed. During discussions at a cancer multidisciplinary team meeting there is discussion that a patient may benefit from a newer, costly medication but is not eligible for funding. This creates a high-level challenge between the resident doctor's values, especially their moral beliefs about what ought to happen, with their professional responsibilities to provide the best possible care for the individual patient while also allocating resources in a way that maximises overall benefit. The challenge is increased since the resident doctor must follow mandatory local or national prescribing rules despite potential benefit to the patient.

Psychological reaction: The resident doctor can experience a high and long-lasting high-level psychological re-

action over several hours or days, which has been described as moral distress [5].

Moral distress typically intensifies when there is increasing severity and repeated challenges to a resident doctor's personal and professional values, and especially their morals [5,6]. When individuals repeatedly encounter situations over several weeks and months in which they are unable to act in accordance with their values and morals, there is increasing moral distress. The moral distress feelings of frustration, anger and helplessness become stronger and more persistent. This accumulation of moral distress may lead to moral injury, which is a more profound and enduring form of high psychological discomfort that arises when an individual fails to prevent actions that significantly challenge and violation of their personal and professional morals [5,6,7]. Moral injury can also occur when an individual experiences a single major challenge to their morals [7]. For example, a resident doctor is caring for a critically ill patient who has clearly documented wishes not to receive invasive life-sustaining treatment. During an acute deterioration, a senior clinician instructs the resident doctor to commence cardio-pulmonary resuscitation despite the documented wishes, and the resident doctor feels unable to challenge the decision because of the senior clinician's authority. The patient subsequently dies after receiving treatment that the resident doctor believes was contrary to the patient's expressed wishes, and experiences intense guilt, with a sense of having violated their personal and professional morals.

Progressively accumulating moral distress and moral injury can have a significant psychological impact on a resident doctor's wellbeing and mental health, with anxiety, depression and feelings of guilt, but there can also be a major impact on the wider organisation in which they work, with increased absenteeism, turnover and attrition [8,9]. Both of these impacts can also have a potential impact on patient safety and the quality of patient care.

There can be confusion between moral distress and injury with burnout when supporting a resident doctor with these presentations. Understanding the distinction is essential for supporting resident doctors since there are differences in their underlying causes and subsequent approach to management [10,11]. Burnout primarily arises from chronic occupational stress and is characterised by emotional exhaustion, depersonalisation, and reduced performance [12]. In contrast, moral distress and moral injury are primarily caused by repeated high level challenges to an individual's values and morals, which can lead to guilt, shame, and a sense of betrayal against their personal and professional morals [5]. This reflects damage to an individual's moral integrity and for doctors, both their personal and professional identity. The distinction has important implications for ensuring that specific interventions are implemented which can support resident doctors. Although burnout, moral distress and moral injury can coexist, they represent different problems requiring different primary intervention targets. The focus of managing burnout is increasing individual resilience and the reduction of systemic factors producing chronic occupational stress and improvement of working conditions [12]. In contrast, moral distress requires opportunities to recognise, reflect upon and develop responses to situations that challenge their personal and professional values and morals. Moral injury may require more intensive psychological support. In addition, for both moral distress and moral injury, actions that reduce associated systemic factors, such as high workload and lack of clinical autonomy, need to be addressed.

4. Understanding the Extent and Factors Associated With Moral Distress and Moral Injury

An understanding of the extent and factors associated with moral distress and moral injury in resident doctors can enhance clinical educators' awareness of its frequency and how to provide appropriately targeted support.

A recent scoping review of moral distress in resident doctors identified 36 publications, with studies limited to mainly US, UK and European settings [2]. The extent of moral distress among resident doctors was difficult to quantify due to different definitions and identification methods, small sample sizes, a variety of specialties and several clinical situations. The only identified study that had a specific focus on prevalence found that 96.3% of neurology resident doctors in Germany experienced moral distress weekly [13], whereas other studies reported moderate-to-high moral-distress scores rather than prevalence estimates.

The available evidence from the recent review highlighted that moral distress was particularly associated with end-of-life decision-making, clinical uncertainty, hierarchical relationships, inadequate communication, limited autonomy and perceived inability to advocate for patients. These experiences were compounded by resident doctors' limited experience, uncertainty about the right course of action and limited educational support to manage the situations. In addition, organisational pressures, resource constraints, and conflicts between institutional priorities and professional values were also associated with moral distress.

In the UK, there have been two large national surveys which were conducted in the COVID 19 era:

(a) The General Medical Council (GMC) Barometer Survey (2023) introduced a specific metric of "values conflict", which was defined as situations in which doctors are required to act in ways that challenge their personal or professional values [14]. In this survey, 22% of doctors across all stages of career reported experiencing such challenges at least weekly. This measure was strongly associated with structural pressures within the healthcare system, including workload intensity, resource limitations, and reduced clinical autonomy.

(b) The British Medical Association (BMA) survey (2021) more broadly conceptualised the investigation into "moral distress", which was defined as the experience of knowing the morally appropriate course of action but being unable to act accordingly due to external constraints [15]. Using this definition, approximately 78% of doctors across all stages of their career reported experiences consistent with moral distress when the concept was explicitly described to them, with a substantial subset reporting more severe and persistent impacts consistent with moral injury. The prevalence of moral distress was almost 90% of doctors from ethnic minority backgrounds and resident doctors, with approximately 50% reported also experiencing moral injury due to continuing situations producing moral distress. The main reported causes of moral distress and moral injury were staff shortages, limited resources, and inability to deliver the doctor's intended care for a patient.

Overall, the recent review and surveys have highlighted that moral distress in resident doctors appears to be an important and relatively common experience, with a need for support that includes how to address the important systemic organisational factors associated with moral distress.

5. Supporting Resident Doctors Across the Continuum of Challenge and Psychological Reaction

This section presents several practical approaches for clinical educators supporting resident doctors experiencing challenges to their personal and professional values and morals, with the associated psychological reaction ranging from transient psychological discomfort to moral distress and moral injury. These approaches are informed by our collective experience in training and developing clinical educators to support resident doctors. Our selection of approaches was pragmatic. We were influenced by the review evidence from nursing about the importance and effectiveness of debriefing for supporting challenges to values and morals [16], which aligned with our experience of using a reflective and developmental approach for supporting learners. We also recognised the importance of taking action and speaking up to address systemic factors, and identified the practical Giving Voice to Values (GVV) approach, which had been widely implemented in nursing [17]. In addition, we had received training in Mental Health First Aid (MHFA), which had been widely implemented in workplaces, including healthcare, for first responders to support individuals with a continuum of mild to more intense psychological reactions to a variety of situations [18].

Our recommended approaches for supporting resident doctors across the continuum of challenge and psychological reaction are debriefing; speaking up and psychological support. These approaches are complementary and can be combined to align with the specific support required. For example, a resident doctor who believes that continued invasive treatment is inappropriate but feels unable to challenge a senior decision may experience moral distress. Debriefing can help the resident doctor to reflect on what happened, explore the values and morals involved, and distinguish what was within and beyond their control to act. Speaking-up approaches can then be discussed and support offered to the resident doctor to appropriately communicate their concerns and develop confidence in addressing similar situations in the future. Where the experience is associated with a psychological reaction, additional psychological support can be provided, especially when this reaction is more intense.

(a) Debriefing

An important aspect of debriefing is providing resident doctors with a developmental opportunity to reflect on their experiences and learn from them, with support for implementing new approaches to decision-making and responses to future situations that challenge their personal and professional values [16,19]. This can prevent the progression of low level psychological discomfort to moral distress and moral distress to moral injury.

An important consideration is group debriefing sessions, with potential benefits compared with individual debriefing, since these sessions can reduce the feelings of isolation and helplessness that often occur with moral distress. These sessions can create a shared space where doctors can openly discuss their values and morals, and discover that colleagues share similar values and morals, and also experience similar challenges to these values and morals. However, group debriefing can be challenging for resident doctors, especially because differences in language proficiency, cultural norms, professional hierarchies, and expectations about expressing uncertainty or challenging others may inhibit open participation and disclosure of morally or emotionally difficult experiences. Skilful facilitation by an experienced educator and/or facilitator may be required if group debriefing is implemented.

A practical structured debriefing action-orientated framework has been described and widely implemented to alleviate moral distress [20]. The framework has two key components: preparation and implementing of an eight step debriefing method. Each of these components has specific tasks for the clinical educator and resident doctor.

Preparation

(1) Identify the resident doctor's needs with consideration of what they may need from the discussion in the debriefing.

(2) Establish the purpose and goals, with clarification of the focus. This can be emotional processing, understanding the ethical problem, supporting coping, identifying future actions, or a combination.

(3) Gather relevant information about the clinical situation to understand the circumstances and the challenge to values and morals.

(4) Plan the logistics, with consideration of the timing, location, confidentiality and the conditions needed for a psychologically safe discussion. An important consideration is individual or group discussion.

Implementing eight-step debriefing

(1) Describe the event. The resident doctor is invited to describe the clinical situation that created a psychological reaction (transient discomfort, moral distress and moral injury), establishing a shared understanding of what occurred and the circumstances surrounding the experience.

(2) Identify feelings. The resident doctor explores and articulates their emotions associated with the experience, such as guilt, anger, frustration, sadness, helplessness or regret.

(3) Identify the challenge. The clinical educator helps the resident doctor identify what made the situation challenging to their personal and professional values and morals, including the perceived conflict between what they believed was appropriate, based on their own personal and professional values and morals, and what they were able or required to do.

(4) Explore the underlying personal and professional values and morals. This step focuses on clarification of the resident doctor's personal and professional values and morals. The individual can be asked: "What is really important for you in how you provide care—and why is it so important?" This can help the doctor to understand why there has been a challenge and why they have experienced the psychological reaction.

(5) Consider alternative perspectives. The resident doctor is encouraged to consider how others involved in the situation may have understood the circumstances and to recognise that situations that challenge personal and professional values and morals may involve competing legitimate values or perspectives.

(6) Share experiences and responses. The opportunity to share similar experiences, reactions and ways of responding can reduce isolation and normalise the experience of moral challenge while providing opportunities for mutual learning.

(7) Identify coping strategies and possible actions. The discussion moves towards identifying constructive ways of responding, both for the management of their values and moral challenges, such as speaking up, and/or managing their psychological rection.

(8) Summarise learning and plan follow-up. The clinical educator consolidates the key insights and practical actions arising from the debriefing, identifies any ongoing support needs and considers whether further individual or organisational action is required.

An important aspect of the described debriefing framework is decision-making strategies for considering alternatives and consequences, and this can reduce reacting quickly when under challenging situations. A key aspect of values and morality-based decision-making is that it can reframe the situation. Instead of managing challenges as personalised disagreements and opposition to others or attempting to eliminate the challenge, these strategies can support a reasoned approach for understanding the underlying principles at stake, such as fairness and autonomy, which may be competing with important healthcare priorities, such as efficiency and individual care. This values and morality-based decision-making strategy enhances the balance of trade-offs, allowing individuals to make informed judgments about which of their values and morals should take precedence in specific situations. Calmly thinking through situations can begin to minimise the psychological reaction and moral distress that is evoked by a challenging situation. This approach also improves communication with others, as individuals are better equipped to justify and discuss the basis for their decisions. See Box 1: An illustrative example of 'balancing trade-offs'.

Box 1

An illustrative example of 'balancing trade-offs'.

The situation

A resident doctor is caring for a 68-year-old patient with advanced heart failure. The patient has repeatedly stated that they do not want aggressive life-sustaining treatment and has signed an advance directive refusing mechanical ventilation. However, during a sudden deterioration, the patient's adult children arrive and urgently plead with the medical team to "do everything possible" to keep their parent alive, even though their parent still has mental capacity.

The challenge

There are several competing responsibilities based on their personal and professional values and morals:

Respect for patient autonomy: adhering to the patient's previously expressed wishes and advance directive.

Beneficence: acting in what appears to be the patient's best interests.

In addition, it is important to consider professional and legal obligations: following professional codes of practice and healthcare regulations.

The balancing of trade-offs

Rather than finding a 'perfect' solution that satisfies both the patient and their family, the resident doctor seeks to balance their competing responsibilities to make the most justifiable decision while acknowledging and managing the competing values and morals. In this situation, the essential patient's autonomy is respected, the advance directive is followed and mechanical ventilation is not commenced. The patient receives appropriate palliative care support to ensure comfort.

(b) Speaking up

Addressing systemic factors in the healthcare organisation, such as understaffing, unrealistic targets, or conflicting policies, is important in supporting the challenges to an individual's personal and professional values and morals.

A practical structured framework is Giving Voice to Values (GVV) [21,22] that focuses not just on knowing what is morally right, but on speaking up and implementing action:

(1) Values—What is at stake

The first step is to identify which values are being challenged or supported. This involves moving beyond a general sense that "something is wrong" to articulating the specific personal and professional values and morals involved.

Key question: What values are important to me and to others in this situation?

(2) Choice—What can I do?

GVV deliberately shifts attention from "What should I do?" to "What could I do?"

The emphasis is on recognising that there may be multiple possible responses, even when the individual has limited authority or is working within significant constraints.

Key question: What are my possible ways of responding?

(3) Normalisation—Is this a normal professional challenge?

GVV seeks to normalise values and morals-based challenges. These challenges are an inherent part of working in complex healthcare organisations.

Normalisation can help resident doctors recognise that other clinicians encounter situations like this, and finding it difficult to respond does not mean that they are personally failing. This is particularly important where resident doctors may interpret difficulty speaking up due to being inexperienced, weak or insufficiently assertive. Normalisation can also create a culture in which speaking about value and moral challenges.

Key question: How can I understand this as a normal professional challenge rather than a personal failure?

(4) Purpose—What am I trying to accomplish?

The doctor clarifies the purpose of speaking up. The aim is not simply to "win an argument" or prove that another person is wrong. Instead, there should be a constructive outcome the resident doctor is trying to achieve, such as improving patient safety, ensuring a patient's wishes are respected, and preventing recurrence of a problem. This reframes values-based action as constructive problem solving.

Key question: What positive outcome am I trying to achieve?

(5) Self-knowledge—How can I act authentically?

GVV recognises that people have different personal styles, strengths, experiences and levels of confidence. There is therefore no single correct way of voicing values and morals.

The aim of support is to identify an approach that is authentic and achievable for that individual, rather than expecting them to adopt an unfamiliar communication style. This can also involve reflecting on previous experiences, such as

- When have I successfully spoken up?
- What made it possible?
- What strategies have not worked?
- What are my strengths?
- What makes speaking up particularly difficult for me?

Key question: How can I voice my values in a way that is consistent with my strengths?

(6) Voice—What will I actually say?

This is the most explicitly behavioural component of GVV. The individual can be supported to develop a practical "script" for the conversation. The resident doctor can rehearse what they might actually say. For example:

"I am concerned that the patient's deterioration may not have been fully considered. Could we review the observations again before deciding on discharge?"

Rehearsal with colleagues is an important part of developing confidence and behavioural readiness.

Key question: What exactly will I say, to whom, when and how?

(7) Reasons and rationalisations—What might get in the way?

Finally, GVV asks individuals to anticipate the arguments, barriers and rationalisations that might discourage them from acting. This can allow the development of a potentially more effective "script".

Several illustrative GVV scripts for a range of different situations, including when speaking up has been previously unsuccessful are presented in Box 2: Illustrative examples of GVV scripts.

Box 2

Illustrative examples of GVV scripts.

GVV can be reduced to a simple sequence:

(1) Name the value: "What matters to me here is patient safety/respect/fairness."

(2) Name the concern: "I'm concerned that…"

(3) Choose an appropriate strategy: "Could we…?" / "Would it be possible to…?"

(4) Rehearse the words: "Let's practise."

Examples:

Speaking up when workload compromises patient care

Situation

A resident doctor is expected to continue working despite being excessively fatigued and recognises that their clinical performance is becoming impaired.

GVV script

"I understand that the team is under significant pressure, and I want to support the service. At the same time, I'm concerned that continuing in this state could affect my judgement and patient safety. Could we discuss what alternatives we have?"

The key GVV move is to connect the concern to a shared value about patient safety, instead of presenting it simply as a personal problem.

Challenging a dismissive attitude towards a patient

Situation

A colleague describes a patient as "difficult" and suggests that their concerns should not be taken seriously.

GVV script

"I appreciate that this patient has been challenging to manage. I'm wondering whether we might be missing something if we focus mainly on their behaviour. Could we step back and consider what might be contributing to their concerns?"

This allows the resident doctor to reframe the situation around professional values without directly attacking the colleague.

Challenging a hierarchy

Situation

A resident doctor disagrees with a senior clinician's decision but feels uncomfortable challenging them.

GVV script

"I know you have considerably more experience than I do, but I'm concerned about one aspect of the plan. Would it be okay if I explained my concern?"

This is a useful GVV strategy because it acknowledges hierarchy while still creating space for the resident doctor to act on their values.

Responding to "this is just how things are done"

Situation

A resident doctor identifies a practice that appears inconsistent with professional standards but is told by a colleague that it is routine.

GVV script

"I understand that this is how we have traditionally done it. I'm wondering whether we should reconsider it because it seems inconsistent with the standard we expect for our patients. Could we look at whether there is another way of doing this?"

This moves the conversation from "challenging the system" to "examining whether current practice reflects our shared values."

Responding when speaking up has previously been unsuccessful

Situation

A resident doctor has raised a concern previously but nothing changed.

GVV script

"I raised this concern previously, but I don't think the underlying issue has been resolved. I remain concerned because it affects patient care. Could we identify who needs to be involved so that we can address this more systematically?"

This illustrates an important GVV principle: effective voice may require persistence and choosing a different strategy or audience, rather than simply speaking up once.

An important feature of GVV is that it focuses on moving from moral awareness to moral action. It therefore complements, rather than replaces, debriefing that is mainly concerned with analysing an ethical dilemma. Speaking up is required for the effective management of challenge to personal and professional values and morals, with increasing importance for when there are repeated low level challenges and also when there are high challenge situations.

Within healthcare organisations there are often policies and processes for 'whistleblowing', which is a specific type of speaking up, especially for repeated low level challenges and high challenge situations. For example, the (National Health Service) NHS whistleblowing process in the UK is designed to allow all staff to safely raise concerns about wrongdoing, unsafe care, or risks to patients, staff, or the organisation. The process emphasises confidentiality, impartial investigation, and protection from victimisation. Staff are encouraged to first raise concerns internally with their line manager if this is appropriate. If discussing with their line manager is not appropriate, they can contact a Freedom to Speak Up Guardian, who is an independent officer within each NHS organisation responsible for supporting staff to speak up confidentially and without fear of reprisal. If internal routes are ineffective or inappropriate, concerns can be escalated externally, such as with the Care Quality Commission (CQC) or professional regulators, such as the GMC. Further advice is available from the GMC [23] and BMA [24]. There may be similar mechanisms and advice in other global settings and clinical educators can consider what is appropriate and available in their own setting.

Clinical educators also have an important role in supporting and modelling speaking up when resident doctors encounter situations that challenge personal and professional values and morals. Through their position within clinical and organisational hierarchies, educators can take the lead to actively speak up themselves following discussion and agreement with the resident doctor. This is especially important where there are repeated challenges within a specific clinical setting where the clinical educator may have a working relationship with senior colleagues who can initiate change. Clinical educators can model speaking up

themselves, demonstrating that respectful challenge is a legitimate component of professional practice rather than an act of confrontation or disloyalty.

(c) Psychological support

Clinical educators are often the first person to be approached by a resident doctor after they have experienced a situation in which their personal and professional values and morals have been challenged. An essential skill for all clinical educators is in managing the psychological reaction of doctors in these situations, but they should not be expected to provide specialist psychological care. Instead, they can facilitate access to appropriate professional support when needed.

Mental Health First Aid (MHFA) is primarily a first-response approach that equips individuals to recognise signs of mental health difficulties, respond appropriately and facilitate access to further support [25]. Importantly, it provides a structured approach for recognising psychological reactions to a situation, offering initial support and facilitating access to appropriate further help. A clinical educator can follow its five-step ALGEE framework:

(1) Approach, assess and assist with any crisis

The first step involves approaching the resident doctor sensitively and establishing whether there is an immediate concern requiring urgent intervention. This includes noticing changes in behaviour or functioning, asking directly about the person's wellbeing, and assessing whether there is a risk of harm to themselves or others. In the context of moral distress or moral injury, this step is particularly important because their intensity may not be apparent from the clinical event itself. The clinical educator should distinguish between an opportunity for supportive conversation and a situation requiring immediate professional or emergency assistance.

(2) Listen and communicate non-judgementally

The clinical educator should provide an opportunity for the resident to describe what happened, why it was troubling and how they have responded to it. Active, empathetic and non-judgemental listening can help the resident feel heard and reduce the isolation that may accompany morally challenging experiences. Importantly, the clinical educator should avoid prematurely offering solutions, minimising the experience or implying that the doctor's response represents personal weakness. Questions such as "What was particularly difficult about that situation for you?" can help the doctor articulate the values, expectations or responsibilities that were challenged.

(3) Give support and information

This involves acknowledging the resident doctor's experience and providing appropriate reassurance and information about available sources of support. In relation to moral distress, the educator can help the resident doctor recognise that their psychological reaction may be an understandable response to situations in which they perceive a challenge between what they believe should happen and what they are able to do. However, validation should not imply that every response is necessarily proportionate or that the situation cannot be addressed, especially by speaking up. Where appropriate, the clinical educator can also provide information about organisational processes, supervision, peer support and professional services.

(4) Encourage appropriate professional help

The framework emphasises the importance of facilitating access to professional help when this is indicated. Clinical educators should recognise the limits of their role and avoid attempting to diagnose or treat psychological problems. Referral may be appropriate when the psychological reaction is persistent or severe, affects clinical functioning, interferes with everyday life, or raises concerns about safety. Possible sources of support may include occupational health or mental health professionals. Importantly, seeking professional help should be presented as an appropriate response to a significant psychological reaction rather than as a personal failure. Within healthcare cultures that often reward stoicism, self-sacrifice, and emotional suppression, these principles help to legitimise emotional awareness and create space for professionals to acknowledge the psychological reaction without perceiving it as weakness or professional inadequacy.

(5) Encourage self-help and other supports

The final component involves helping the resident doctor identify resources that can support ongoing coping and recovery. These may include trusted colleagues, supervisors, peers, friends and family, as well as activities that support psychological wellbeing. For moral distress, however, self-help should not be regarded as a substitute for addressing the underlying organisational problems. Where possible, clinical educators should also help the resident doctor identify opportunities to discuss their challenge to personal and professional values and morals, with the development of decision-making strategies. This can be provided through the complementary approach of debriefing.

6. Illustrative Scenarios of Managing Varying Levels of Challenges and the Associated Psychological Reactions

6.1 Low Level Challenge and Transient Psychological Discomfort

A resident doctor working an evening shift on a busy medical ward is asked to review several patients before the end of the shift. One patient, an older adult with multiple long-term conditions, wants to discuss concerns about their discharge and feels that they have not fully understood the proposed medication changes. The resident doctor recognises the importance of listening to the patient and ensuring that they understand the plan, but is under considerable time pressure from several other clinical tasks and is encouraged by a senior colleague to "keep the review brief" because the ward is busy. The resident doctor feels a ten-

sion between providing person-centred care and respecting the patient's need for information, and meeting service demands and completing the workload efficiently. The resident doctor may experience frustration because they feel unable to provide the standard of care they believe the patient deserves. The resident doctor decides to discuss their experience at the next routine meeting with their clinical educator.

Management:

Recognising the tension, the resident doctor can prioritise the patient's immediate concerns, clarify what information is essential for safe discharge, and arrange additional time or appropriate support from another member of the multidisciplinary team if required. Where workload pressures repeatedly constrain opportunities for meaningful patient communication, the doctor can speak up and raise the issue with the senior clinician or team and explore practical solutions, such as allocating protected time for discharge discussions.

The situation also provides an opportunity for a brief Supervised Learning Event (SLE), which can offer a developmental opportunity for learning, with a focus on communication, prioritisation and personal and professional values and morals. The SLE can be structured using a debriefing framework and during reflection, the resident doctor can consider how they balanced competing responsibilities, whether their actions were proportionate to the circumstances, and how they might respond differently in the future. Although the SLE is UK specific, the educational principles are widely used internationally in case based discussions for work-place based learning.

6.2 Medium Level Challenge and Moral Distress

A resident doctor on a medical ward reviews a patient with advanced heart failure who is struggling with severe breathlessness. The resident doctor believes that the patient would benefit from a palliative care approach focused on comfort, rather than repeated aggressive interventions that are unlikely to improve outcomes. However, the senior specialist doctor responsible for the patient insists on continuing full active treatment. The resident doctor feels unable to challenge this decision due to hierarchy and fear of repercussions, even though they believe it is not in the patient's best interest. This creates moral distress: the resident doctor knows the morally appropriate action but is constrained from acting on it, leading to frustration and guilt.

Management:

The resident doctor is experiencing moral distress after being unable to successfully advocate for a palliative, comfort-focused approach for a patient with advanced heart failure, despite believing it aligns better with the patient's needs. The resident doctor's distress persists at the end of their shift and seeks urgent support from their clinical educator. The educator can offer structured debriefing and also psychological support using MHFA [25]. These strategies can help the resident doctor process both the values and moral challenges and psychological reaction. The GVV framework can also be discussed to prepare the resident doctor for how to speak up and express concerns more effectively in hierarchical settings [21,22].

6.3 High Level Challenge and Moral Injury

A resident doctor in a high-volume emergency department repeatedly manages the care of patients placed on corridor trolleys because of limited treatment space within the department. The resident doctor increasingly regards "corridor management" as inappropriate, believing it compromises patient dignity and clinical care, and they develop persistent guilt, emotional numbness, and reduced trust in the system. This creates moral injury: a deeper and lasting psychological impact arising from repeated experiences of acting against core values and morals or feeling forced to violate them. The resident doctor considers that 'something must be done' and urgently contacts a clinical educator.

Management:

The clinical educator can offer structured debriefing and also psychological support using MHFA [25], especially to identify significant associated psychological reactions with mental health difficulties. Referral to occupational health or sources of psychological support, such as mental health teams and counselling, should be considered. Speaking up is a priority and the clinical educator can present the GVV framework [21,22]. This framework can support the resident doctor in articulating their concerns related to their core values and morals more effectively within a hierarchical team and organisational structures. Initial speaking up to the emergency department's senior clinician and manager to seek a resolution would be advised, with potential for further escalation through clinical governance processes and Freedom to Speak Up routes. Advice is available from the GMC [23] and BMA [24] in the UK about the Freedom to Speak Up process and similar advice may be available in other contexts.

7. Future Directions

Effective support of resident doctors when their personal and professional values and morals are challenged requires clinical educators to have a robust evidence-base to inform their actions. However, the current evidence base about resident doctors is limited. Future research has been recommended that has a specific focus on resident doctors, with a move beyond simply documenting that moral distress exists towards understanding what moral challenges occur, how resident doctors make sense and respond to the challenges across a variety of cultural settings and clinical situations, and what educational approaches are feasible and effective in particular contexts [2].

8. Conclusion

Challenges to personal and professional values and morals are an inherent and unavoidable aspect of healthcare practice and being a resident doctor, with a continuum from low to high level. The associated psychological impact also spans a continuum, from transient discomfort to moral distress and moral injury, with significant implications for both clinician wellbeing and healthcare delivery. Effective support can be provided by clinical educators with three main complementary approaches: debriefing, speaking up to address systemic factors and psychological support. Clinical educators have an important developmental role by facilitating the doctor's management of challenges to their values and morals, both at the current time and future. This can be achieved by increasing clarity of the doctor's values and morals, strengthening their decision-making strategies to enhance coping when there are challenges and reducing reactive responses.

Key Points

• Resident doctors frequently encounter situations in which their personal or professional values and morals are challenged in practice.

• The psychological reactions to values and moral challenges occur along a continuum, ranging from transient discomfort and, when repeated or when there is a high-level values or morals challenge, to moral distress and moral injury.

• Clinical educators have an important supportive role, helping resident doctors recognise, understand and respond constructively to values and moral challenges encountered during practice.

• Three complementary approaches can provide support that addresses both individual experiences and the organisational factors contributing to values and moral challenges: debriefing, speaking up to address systemic factors, and psychological support.

• Supporting resident doctors with values and moral challenges can benefit both wellbeing and quality of patient care.

Availability of Data and Materials

Not applicable.

Author Contributions

JS conceived the article. JS, RP, JJ and MJ contributed to the development of the ideas presented. JS prepared the first draft. All authors equally contributed to the critical review and editing. All authors approved the final version and accept responsibility for the work.

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