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Respecting the Autonomy of People with Mental Disabilities: An Educational Strategy to Raise Awareness among Psychiatry Residents

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Abstract
This study explores the development and implementation of an educational strategy aimed at enhancing bioethical awareness among psychiatry residents, with a specific focus on respecting the autonomy of individuals with mental disabilities. Recognizing the limitations in bioethics training within psychiatric education, particularly in resource-constrained settings of the Global South, the proposed approach integrates theoretical knowledge with practical, reflective, and contextualized learning modalities. Utilizing an action research methodology, the strategy was applied over two cycles with a sample of two residents in a university hospital in Bogotá, Colombia. This initiative contributes to filling the gap in ethics education within psychiatric training and highlights the need for contextually adapted experiential learning approaches to prepare future psychiatrists for complex ethical challenges in clinical practice.

Keywords: Autonomy, Mental Disability, Bioethics Education, Ethical Practice

Introduction

Based on my experience as an educator in psychiatry training programs, I have repeatedly observed the difficulties faced by psychiatry residents when addressing ethical issues in their clinical practice, particularly in the care of individuals with mental disabilities. This shortcoming is evident not only in a limited understanding of fundamental bioethical principles but also in the lack of practical tools to

promote and respect patient autonomy, an essential aspect of contemporary psychiatric care. This observation has motivated the present work, in which I aim to critically reflect on the teaching of ethics in psychiatry and propose a training strategy that, beyond conveying theoretical knowledge, fosters an ethical sensitivity capable of confronting the complex challenges involved in caring for vulnerable populations.

The bioethical training of psychiatry residents remains limited, particularly concerning the care of people with mental disabilities (Jain et al. 2011). This gap presents serious challenges when addressing the ethical dilemmas that arise in clinical practice. Within the hospital setting, the teaching of bioethics should focus not only on conveying concepts but also on developing skills to resolve ethical dilemmas in ever-changing, real-world contexts (McKneally and Singer 2001). Health professionals, accustomed to the dynamism of clinical practice, have reported that learning is more effective when based on ethical models presented through concrete examples or situations, rather than through abstract philosophical discussions (McKneally and Singer 2001). This reality has led to proposals for bioethics to be taught specifically within each medical specialty, enabling contextualized and directly applicable learning (Howard et al. 2010).

Evaluations conducted in psychiatry residency programs reveal a low number of well-structured educational initiatives, along with limited assessment of their outcomes (Bloch and Green 2009). This situation is even more critical in the Global South, where ethical training in psychiatry is even more deficient and where the absence of formal educational programs restricts the development of fundamental ethical competencies (Ghias and Ahmer, 2010).

In response to this scenario, various authors have suggested strategies aimed at integrating ethics into everyday clinical practice. One such proposal involves incorporating ethical dimensions into daily supervision and care, encouraging educators to serve as models of ethical behavior by openly sharing the moral conflicts that arise in patient care and promoting reflective spaces such as ethical-clinical rounds (Bloch and Green 2009). This integration of formal and informal teaching emerges as a key element to strengthening ethical training. Sheehan (1994) identifies three key elements to support this aim: the presence of role models, the cultivation of sympathy toward patients, and the need for ethics educators to show sympathy toward trainees.

The experience in hospitals affiliated with Harvard University supports this approach. Scher and Kozlowska (2020) propose that the teaching of ethics should not rely solely on structured courses but should also be conveyed implicitly through clinical practice itself. According to these authors, a humanized psychiatry requires clinicians to be capable of identifying, analyzing, and resolving ethical dilemmas arising in practice without necessarily mastering exhaustive philosophical terminology.

At the core of this reflection on ethical practice lies the principle of autonomy, widely recognized as a fundamental pillar of medical ethics (World Medical Association 2013; Kemp and Rendtorff 2008; The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1978). Respecting autonomy essentially means defending each individual's right to live according to their own values, beliefs, and life projects (Schermer 2002a). As Dworkin (1993) asserts, recognizing autonomy is to enable the very possibility of self-creation.

However, autonomy does not develop in a vacuum. It depends not only on individual capacities — such as understanding and deliberation — but also on external factors that facilitate or hinder decision-making. Traditionally, as McLeod and Sherwin (2000) observe, ethical reflection has tended to focus on external threats to autonomy, such as coercion, without sufficiently considering the structural conditions that support or undermine individual agency. From a critical perspective, Mackenzie (2018) proposes understanding autonomy as a social construct, shaped by networks of interdependent relationships and power structures that define the very possibilities of decision-making.

This view is essential when considering disability, understood, according to the Convention on the Rights of Persons with Disabilities (2006), as the result of the interaction between individual conditions and social barriers that limit full and effective participation in society. Disability, therefore, is not conceived solely as an individual deficiency but as a situated, diverse experience deeply affected by the environment.

Historically, people with disabilities have been subjected to discrimination and exclusion, often justified under discourses of paternalism, charity, or medicalization (Montoya et al. 2016). These practices, rooted in erroneous conceptions, have had direct and persistent impacts on their rights (Montoya et al. 2016). Today, the social model of disability proposes a major conceptual shift: it highlights that social barriers, rather than individual conditions, are the true sources of disability and exclusion.

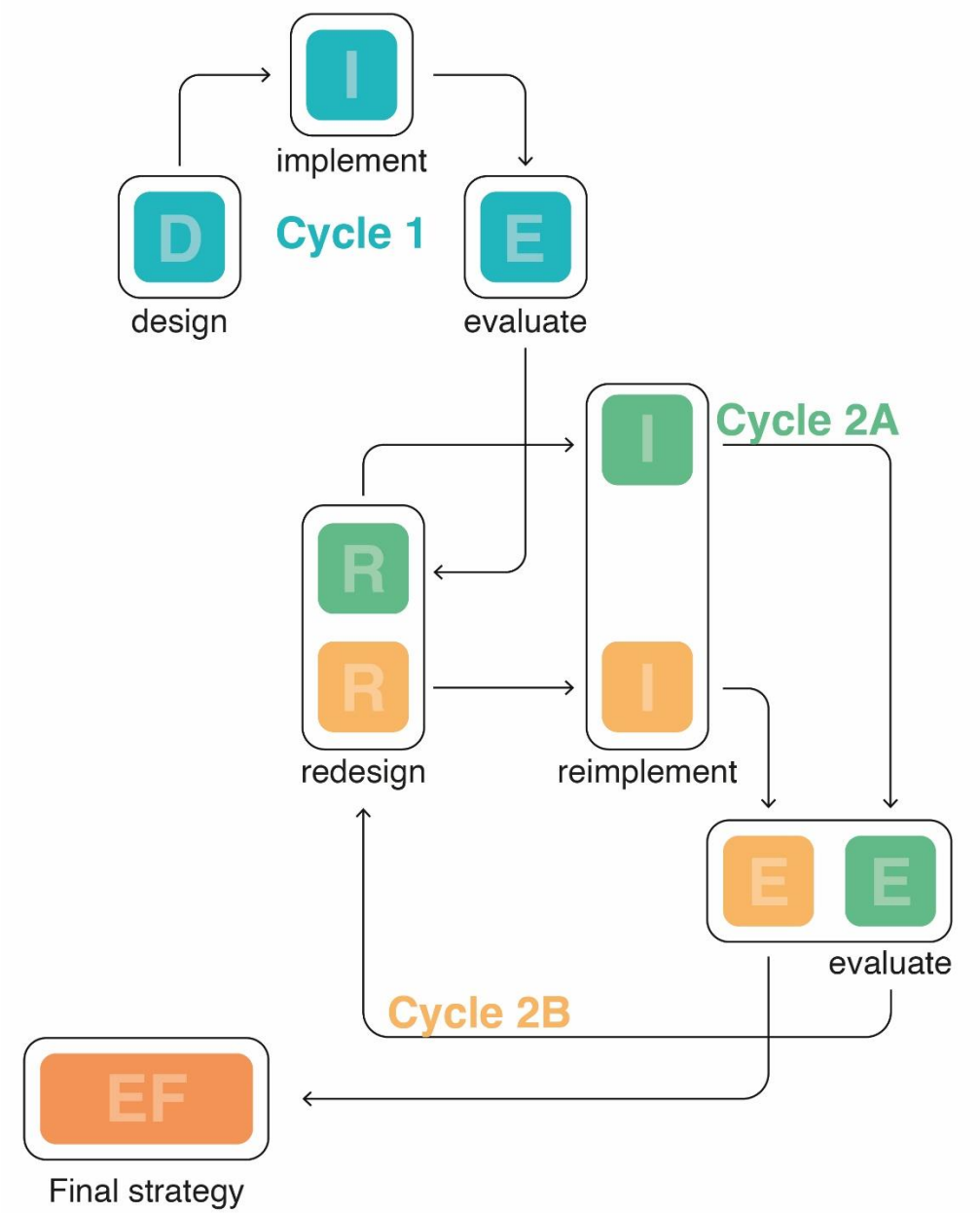
In this research, I explain the process of developing and implementing a bioethics pedagogical strategy for psychiatry residents. This strategy aimed to build knowledge about respecting the autonomy of individuals with mental disabilities through the use of multiple pedagogical tools. In this work, I offer a perspective from the Global South, with particular emphasis on academic environments characterized by limited resources. I regard this study as a significant contribution, given the limited number of publications on ethics pedagogy and, to the best of my knowledge, as the first publication of its kind within this context.

Methodology

This study is a qualitative investigation, grounded in the critical theory paradigm and employing an action research (AR) methodology. Action research is a research methodology that enables teachers, regardless of the educational level at which they work, to systematically investigate and evaluate their own practice (McNiff and Whitehead 2011). The primary purpose of AR in pedagogy is to systematically examine one's own teaching practice with the dual aim of improving it and contributing to theoretical knowledge (Norton 2009). Unlike other methodologies, in AR the researcher is not an external agent but simultaneously both a participant and an investigator.

A convenience sampling method was employed, with a sample size of two psychiatry residents working in the consultation-liaison psychiatry service of a university hospital in Bogotá, Colombia, during the 2024–2025 academic year. The pedagogical strategy was divided into two cycles. Each cycle lasted one month of observation, and subsequent fifteen days of analysis and redesign of the pedagogical strategy. Figure 1 illustrates the structure of the two research cycles.

Figure 1. Composition of the Research Cycles



Cycle 1, conducted with the first resident, consisted of designing (D), implementing (I), and evaluating (E) the initial strategy. Cycle 2, carried out with a single second resident, involved a redesign (R), reimplementation (I), and subsequent evaluation (E), which were integrated in Cycle 2B to consolidate the final strategy (EF).

During the second cycle, there was a one-month interruption due to a resident's vacation period, during which I carried out a redesign of the strategy. Therefore, the second cycle is divided into two

distinct phases.

The pedagogical strategy was composed of five core components: topic reviews, case discussions, reflective supervision, immediate feedback, and the provision of informal conversation spaces with the residents. In the topic review sessions, the residents reviewed articles on autonomy, mental disability, and decision-making capacity assessment in hospital settings. During reflective supervision, residents were encouraged to discuss their own clinical practice and to reflect on the thoughts and emotions elicited by interactions with patients and families. These supervisory spaces also incorporated immediate feedback on their clinical interviews, diagnostic approaches, and therapeutic strategies. Within these two spaces reflective supervision and immediate feedback) ethical and medical discussions were intertwined. We simultaneously addressed strictly psychiatric issues and engaged in ethical reflection. Based on prior research on ethics education, I did not require formal philosophical discussions or the application of ethical theories. Instead, I aimed to stimulate curiosity, co-construct methods for identifying ethical problems, and explore approaches to resolving them.

Finally, the informal conversation spaces with the residents proved fundamental for understanding them as individuals, beyond their roles as students. These were weekly or bi-weekly gatherings, often over a shared meal, where we discussed non-academic topics.

Data were collected through initial and final interviews with each resident and through my field journal. Interviews were transcribed and coded by myself on two separate occasions, fifteen days apart. For data analysis, I used Atlas.ti software, version 25. This study was approved by the Ethics Committee of the Universidad de los Andes (approval number 2024300728) and the Ethics Committee of Clínica Universitaria Colombia (approval number 029-24). Each participant signed a written informed consent form before the start of the study, and verbal informed consent was obtained prior to each interview. Participants were informed that the interview would be recorded and transcribed. Any data that could potentially identify participants were anonymized.

Results and Discussion

With the first resident, I perceived clear results from my efforts. We built a trusting and collaborative teacher-student relationship. Discussions went beyond purely clinical matters to address ethical and broader life questions. Through feedback, I observed that the resident developed her own approach

to interacting with patients. She also questioned her approach to diagnosis and treatment proposals during the project. I can affirm that this first resident reinforced my perception that the pedagogical strategy I was developing was useful and valuable. Regarding the understanding of the concept of mental disability, the change brought about additional reflections…

Interestingly, after the intervention, the resident no longer viewed disability as a deficit or as incapacity to decide. Throughout the process, she reframed disability as a social construct, a change fundamental to fostering a more humane and dignified approach toward individuals with mental disabilities.

During the analysis of the first cycle, a new thematic category emerged, which I termed the humanization of education. As Kumar (2014) emphasizes, humanizing medical education requires more than the addition of a few isolated courses. Marcum (2008) argues that a purely objective and scientific approach to understanding results in the decontextualization of knowledge. He asserts that humanizing medicine entails integrating intuition and the recognition of the other as a contextualized and culturally embedded individual into objective analysis. This perspective demands an openness to engage with others beyond impersonal theoretical frameworks. In this context, the resident frequently referred to the dehumanizing aspects of medical education. For example:

“In medical education, I believe one is primarily evaluated based on whether they fulfill their responsibilities and remain productive. It’s only when someone fails to meet those expectations that others begin to take notice and ask, 'What’s wrong with you?” (Resident 1)

She recognized a pattern of residents being instrumentalized as mere workers, evaluated solely on productivity, negating their needs as thinking and feeling human beings. I was particularly moved by reflections on her experience as a student, for instance:

"When we go out to eat, she says it’s her safe space, and I wonder: at what point did her training become an unsafe space?" (Teacher’s field notes)

As the research progressed, humanization of education became a central theme. In Genzaburo Yoshino's book, “*How Do You Live?”*, the protagonist’s uncle explains human relationships as:

"For people to be in an inhuman relationship is quite a shame. Even between perfect strangers, human relationships have to be human. […] What kind of relationships are they? […] There is nothing more beautiful than people nurturing goodwill toward their fellow beings. And those are the human relations that humans truly deserve." (Yoshino 2021, 89-90)

This simple yet profound definition encapsulates what we discussed with the resident: the most important aim is to seek the good of others, recognizing ourselves as reflective beings. I believe humanization in education stems from respect for our students and for ourselves. As Esquirol (2006) defines respect in “Respect or the Attentive Gaze” (El respeto o la mirada atenta): "It is an approach that maintains distance, an approximation that does not collapse proximity." (47)

Thus, approaching another respectfully allows one to appreciate their singularity. I also found that building a humanistic and ethical psychiatric practice, as Scher and Kozlowska (2020) argue, requires more than transmitting philosophical concepts; it is in the daily living practice where we can challenge, resignify, and model behavior. This demands spaces for educators themselves to reflect on their teaching practices. I found such a space with my thesis advisor, with whom I could rethink my pedagogical approaches.

Thanks to this, for the second cycle, my advisor and I decided to focus the pedagogical strategy more explicitly on humanization: making reasonable accommodations based on the student's needs and encouraging self-reflection on the emotions and thoughts elicited by patients.

With the second resident, I encountered a very different dynamic. My role as a teacher was challenged, as my preconceived expectations about how she would behave with patients and with me were not fulfilled. I assumed that creating spaces for reflective discussion and immediate feedback would be well received - but it was not. She seemed uncomfortable, resistant to feedback, and withdrawn.

During reflection spaces, her only answers were “fine” or “I don’t know.” When given feedback, she often cried, showing distress and anxiety. After a conversation with my advisor, I decided to suspend reflective supervision and feedback:

"I feel I am harming her, bringing her distress without contributing meaningfully to her education. I told

her we will change the plan, and she thanked me, explaining she had been feeling very pressured and needed space. I realize I was not truly seeing her." (Teacher's field notes)

Respect must be directed toward the concrete and singular, not the general and abstract (Esquirol 2006). Thus, with a month's break during her vacation, I redesigned the pedagogical strategy. Using the framework of reasonable accommodations, I decided not to conduct reflective supervision but continued discussing clinical cases at her request, assuming a purely observational role. This second part of the rotation proved constructive for both her and me. It showed me that humanization cannot be standardized; it is not a rigid formula but a way of approaching teaching.

Esquirol (2006) also critiques institutional environments in which the other is reduced to a number, a file, a diagnosis, or a function. According to him, dehumanization occurs when:

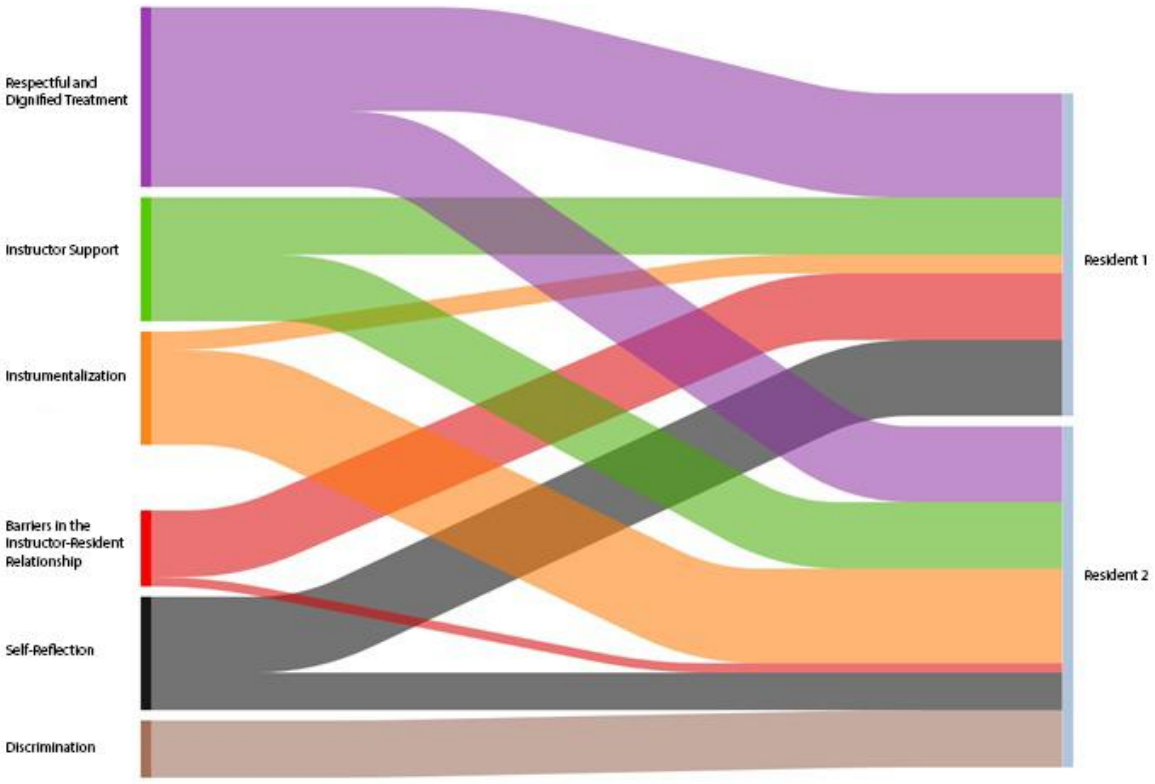
- The other is objectified (as in overly technified medicine or bureaucratic education);
- Distances are imposed without relationship, or relationships are formed without appropriate distance;
- Attention to the concrete is lost, and impersonal frameworks are absolutized.

Thus, to humanize is to resist the power of anonymity, proceduralism, and empty efficiency, and to revalue the presence of the other as face, as word, and as vulnerability.

This experience taught me that respecting the autonomy of others — whether individuals with mental illness or my own students — requires humanizing myself as an educator.

In the category of Humanization of Education, Resident 1 identified forms of dehumanization such as the instrumentalization of residents and discrimination based on gender and emotional states. She recognized as strengths of the pedagogical strategy the opportunities for self-reflection on her practice, guided by the instructor, as well as the student-teacher relationship as a source of support during the clinical rotation.

Figure 2. Sankey Diagram Comparing Resident 1 and Resident 2 in the Category of Humanization of Education



Flow of thematic categories emerging from the residents' experiences. The diagram illustrates how categories such as respectful and dignified treatment, instructor support, instrumentalization, barriers in the instructor–resident relationship, self-reflection, and discrimination were expressed differently by the two participants. Resident 1 emphasized respectful treatment and instructor support but also noted barriers in the relationship, while Resident 2 highlighted instrumentalization, self-reflection, and experiences of discrimination.

It is noteworthy that, although the pedagogical strategy was not explicitly focused on humanization, it nonetheless elicited significant reflection on the topic. For both residents, the most relevant factor in humanizing education was being treated with dignity by their instructors. However, their perspectives differ meaningfully in respect of dehumanization of medical education: while Resident 2 emphasized the teacher-student relationship as a critical barrier, Resident 1 focused on the instrumentalization of the resident, highlighting a lack of recognition of the resident as a person rather than merely a

functional role. These findings prompted reflection on the notion that humanizing medical education requires an active effort to recognize learners as individuals with specific needs and desires.

Arguably, the most significant outcome of this process was the realization that bioethics education is fundamentally a process of reflection, rather than the mere transmission of content. Perales (2008) reflects on this issue, noting that medical education has focused primarily on the transmission of knowledge, while neglecting a deeper and more applied ethical formation in medicine. Quoting Sheehan (1994) once more, it becomes evident that the moral development of students should constitute a fundamental priority in their education.

Finally, it is important to emphasize that the success of this strategy would not have been possible without the direct supervision of an experienced pedagogue. Teaching has been described as a form of self-realization that extends beyond the purely professional realm, impacting free time and even social and familial contexts (Fernández 2014). Becoming a good teacher is grounded in a positive self-concept and the perception of having adequate tools to effectively transmit knowledge and experiences (Fernández 2014). Teaching by example demands careful self-observation and the support of educational mentors, as was the case for me. Thus, I also contend that humanizing education requires recognizing the needs of educators themselves.

Conclusion

In sum, I conclude that bioethics education in psychiatry must be pursued along three complementary pathways: fostering understanding of clear and concise concepts accompanied by their simultaneous clinical application, and the creation of spaces in which students can openly discuss ethical conflicts that extend beyond clinical cases. The role of the teacher as a model of ethical behavior is fundamental; one cannot teach what one does not practice oneself, with regard to both patients and students. Accordingly, fostering students' moral development is at the heart of ethical training. Finally, it is essential to establish support spaces for educators, allowing them to clarify their perspectives and develop the respectful and humanized approach that education demands.

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List of figures and tables

Abstract figure.

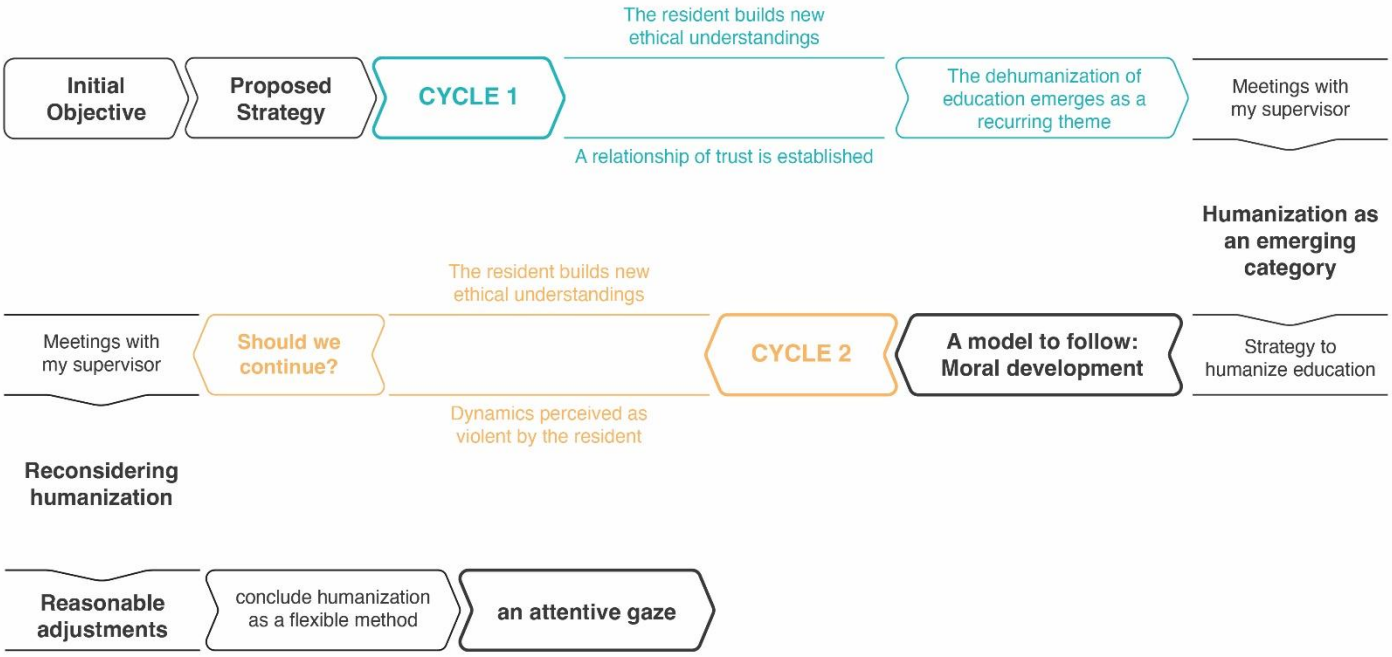


Figure 1. Composition of the Research Cycles (page 8)

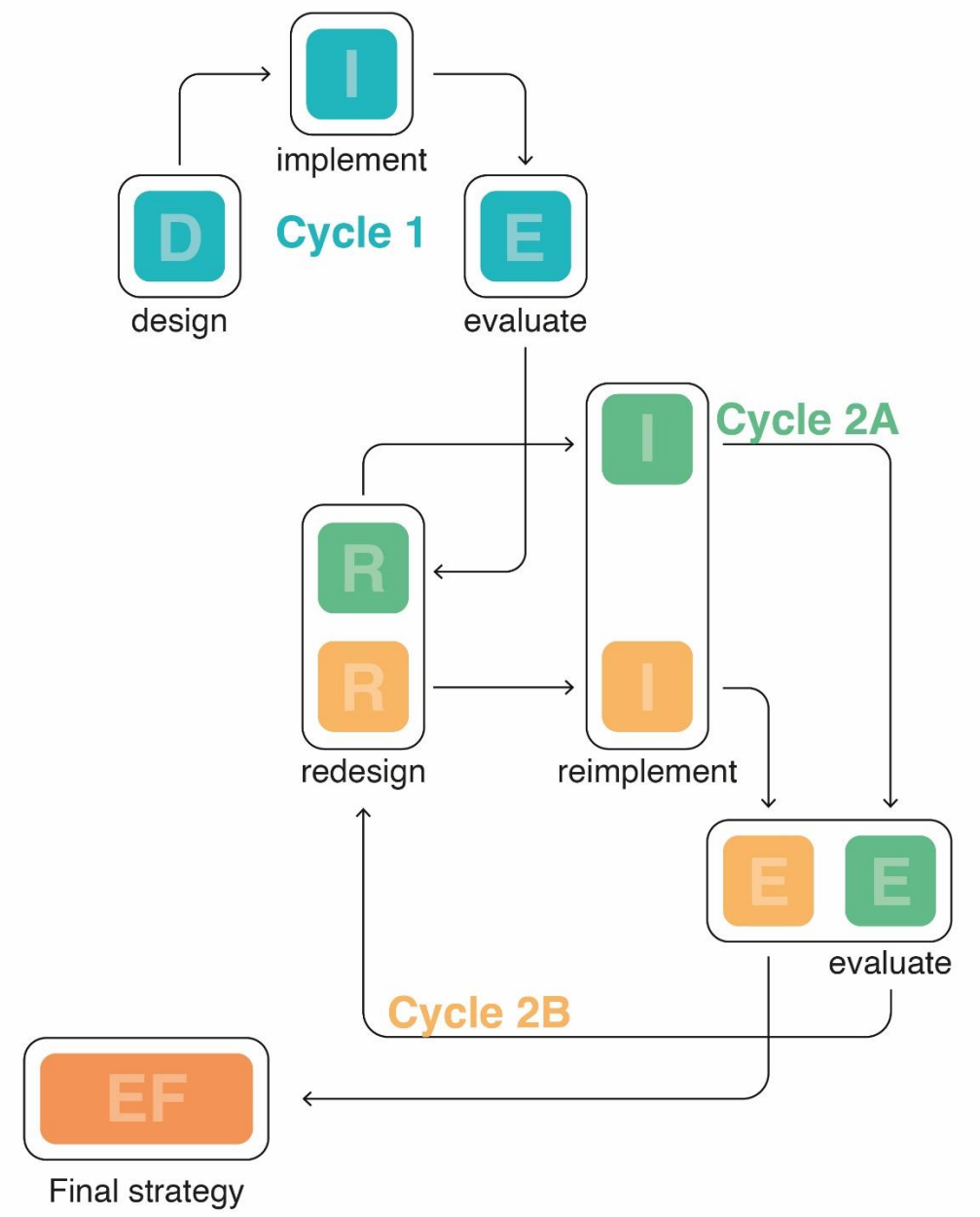
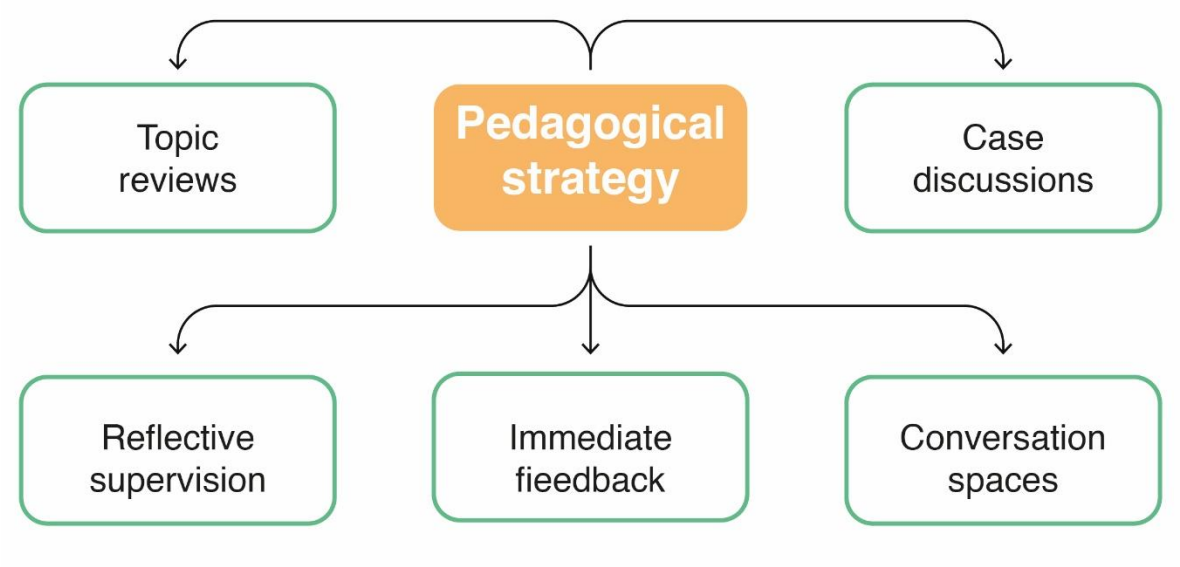


Figure 2. Composition of the Pedagogical Strategy (page 9)



Concept	Initial	Final	Total	Change
Reasonable accommodations	2	2	4	0%
Deficit	5	0	5	-100%
Incapacity to decide	6	1	7	-71%
Irreversibility	5	0	5	-100%
Society as a barrier	0	2	2	100%

Table 1. Comparison of initial and final interviews with Resident 1 on the concept of disability. (page 11)

Concept	Initial	Final	Total Change
Reasonable accommodations	1	6	7	+71%
Deficit	12	2	14	-71%
Incapacity to decide	4	1	5	-60%
Irreversibility	3	0	3	-100%
Society as a barrier	2	2	4	0%

Table 2. Comparison of initial and final interviews with Resident 2 on the concept of disability. (page 16)

Figure 3. Sankey Diagram Comparing Resident 1 and Resident 2 in the Category of Respect for Autonomy (page 17)

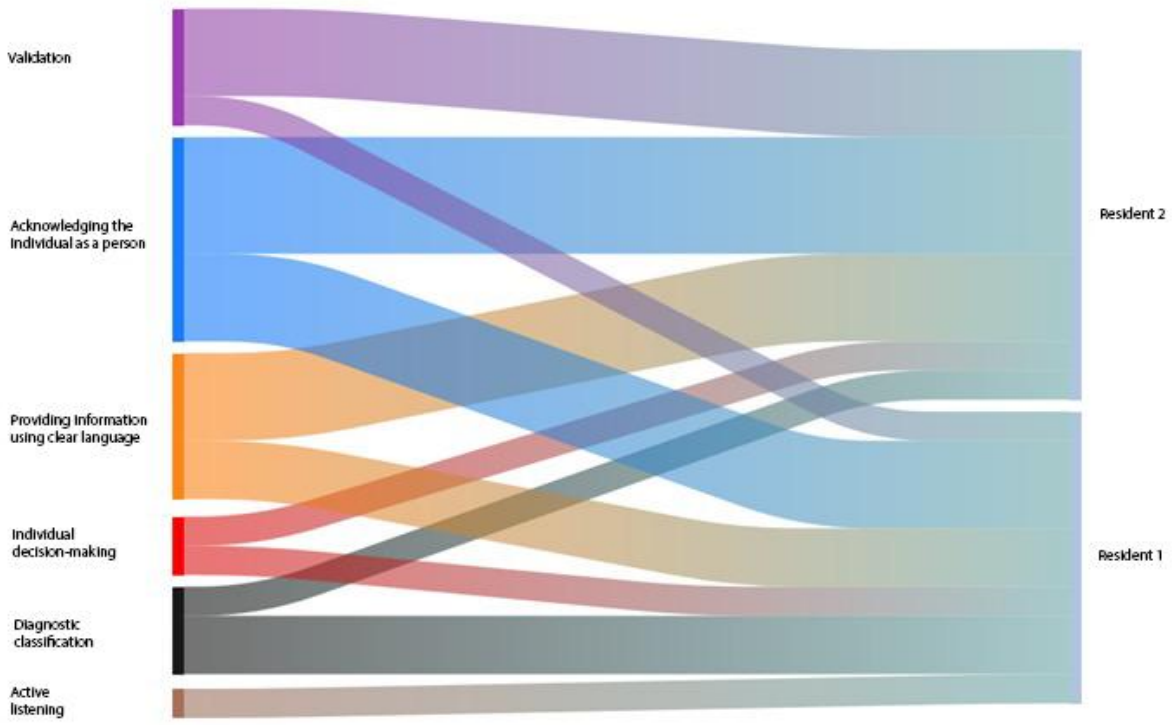
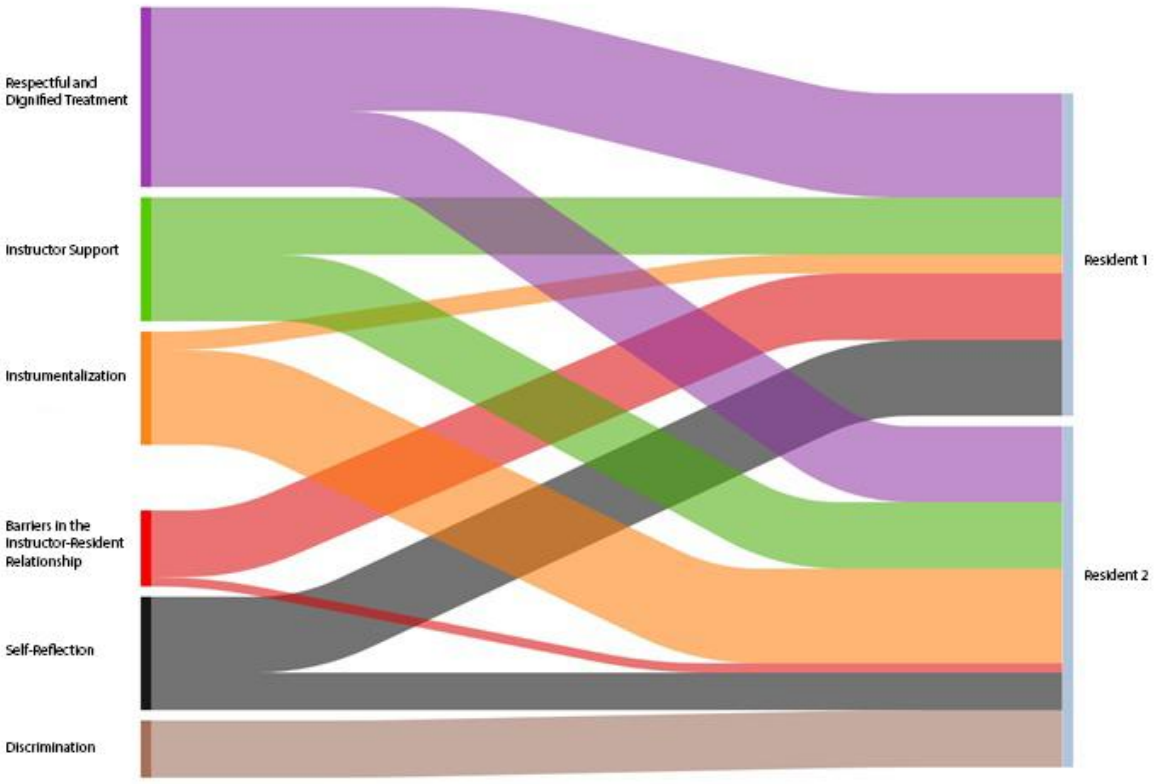


Figure 4. Sankey Diagram Comparing Resident 1 and Resident 2 in the Category of Humanization of Education (page 18)



Author Contributions:

- Juan Daniel Molina: Conceptualization; Investigation; Data curation; Methodology; Formal analysis; Writing – original draft; Writing – review & editing.
- Juny Montoya: Conceptualization; Methodology; Supervision; Writing – review & editing.

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