**ETHICS AND PROFESSIONALISM FOR NEUROLOGY RESIDENTS**

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**INTRODUCTION**

In addition to developing excellent diagnostic skills, technical skills and preparing residents to pass the ABPN board examinations, a core task for us is to teach residents how to provide humane and professional care to their patients. Professionalism is one of the 6 core competencies mandated by the Accreditation Council for Graduate Medical Education (ACGME) in July 2001. All residency programs must integrate a system linking educational outcomes with program improvement. All programs are required to define the goals and objectives of each educational component of the residency, integrating the 6 core competencies, and determine if competency has been attained by the learner in each of these areas. Like many of you, at times I feel overwhelmed by the amount of work involved in setting up these components and assessment tools. All neurology residency programs have competing pressures making implementation challenging: decreased faculty time for teaching, increased documentation requirements of program directors, increased demands on clinical productivity by hospitals, reduced numbers of support staff, and work duty hour restrictions. None of us wants to waste time re-inventing the wheel, but would like to use tools already developed that will “fit” our programs. Local resources (faculty, funds, OSCE labs, etc...) and needs will dictate which educational components and assessment tools will work best for an individual program, although the ACGME is actively seeking tools that provide excellent reliability, validity, and are generalizable to many programs through the Outcomes Project (1).

Our institution has no department of ethics, and it is with this background that I will later discuss implementing an ethics course and educational assessment tools for ethics and professionalism. If the thought of teaching ethics is intimidating to you, I have learned that one need not be an expert in a field such as ethics in order to be effective in facilitating meaningful discussion of practical ethical issues we face as neurologists. Your experiences combined with basic knowledge of ethical conduct and case law is more interesting to your learners than discussion of ethical theory!

**PROFESSIONALISM: SKILLS, ATTRIBUTES, AND BEHAVIORS**

What is professionalism? It is an attribute or set of behaviors that most of us recognize when we see them, but is more difficult to define. A brief definition from the Medical Professionalism Project, American Board of Internal Medicine (ABIM) is, “Professionalism is the basis of medicine’s contract with society (2)”. The ACGME common language description of the professionalism competency states, “residents demonstrate professionalism as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds (3).” The specific skills, behaviors and attitudes which comprise professionalism are numerous, but are eloquently summarized by the ABIM Professionalism Project (2):

3 Fundamental Principles

1. Principle of primacy of patient welfare – dedication to serving the interest of the patient over market forces, societal pressures and administrative pressures.  
2. Principle of patient autonomy – respect patient autonomy, empower patients to make informed decisions about their treatment as long as those are in keeping with ethical practice and do not lead to demands for inappropriate care.
3. Principle of social justice – must promote the fair distribution of health care resources; eliminate discrimination whether based on race, gender, socioeconomic status, ethnicity, religion.

10 Professional Responsibilities

1. Commitment to professional competence – physicians must be committed to life long learning to provide quality care.  
2. Commitment to honesty with patients – communicate honestly so patients are informed before consent to treatment and after treatment. Inform patients when medical error has occurred as this is the basis for appropriate prevention.  
3. Commitment to patient confidentiality – appropriate safeguards be applied to the disclosure of patient information, except when there are overriding considerations in the public interest.
4. Commitment to maintaining appropriate relations with patients – never exploit patients for any sexual advantage or personal financial gain.
5. Commitment to improving quality of care – commitment to maintaining competence, working to increase patient safety, minimize overuse of health care resources, optimize outcomes of care.
6. Commitment to improving access to care – work to reduce barriers to equitable health care, promote public health and preventive medicine, and work as a public advocate.
7. Commitment to a just distribution of finite resources – while meeting individual patient needs, physicians are required to provide care based on cost effective management of limited resources. Avoid superfluous tests and procedures.
8. Commitment to scientific knowledge – promote research, create new knowledge and ensure its appropriate use.
9. Commitment to maintaining trust by managing conflicts of interest – there are opportunities to compromise professional responsibilities by pursuing private gain with for-profit industries. Physicians have an obligation to disclose these relationships to the public and deal with conflicts that arise.
10. Commitment to professional responsibilities – as members of a profession we are expected to work collaboratively, be respectful, participate in self-regulation, including remediation and discipline. We should define standards.

Other lists of professional behaviors, skills or attitudes include:

- I = Integrity
- C = Courteous
- H = Honesty
- A = Attentive
- E = Excellence
- R = Respectful
- A = Altruism
- E = Enthusiastic
- A = Accountability
- S = Safe
- R = Respect
- D = Duty.

The ABPN has developed a Neurology Core Competency Chart which summarizes the goals and objectives of the professionalism competency. This list is available on the AAN website and summarized below (4):

1. The physician will demonstrate responsibility for patient care including:
   a. Responding to patient and health professional communication in a timely manner
   b. Establishing and communicating back-up arrangements, including emergent care
   c. Appropriate documentation in medical records
   d. Providing coverage if unavailable
   e. Coordinating care with other members of the medical team
   f. Providing for continuity of care, including appropriate consultation or transfer

2. The physician will demonstrate ethical behavior, integrity, honesty, compassion, confidentiality, provide informed consent, and disclose conflict of interest.

3. The physician will demonstrate respect for the diversity of patients and their families

4. The physician will review his/her professional conduct and remediate when appropriate

5. The physician will participate in the review of professional conduct of colleagues.

6. The physician will acknowledge medical errors and remediate.

TEACHING METHODS
After defining the professional skills, behaviors or attitudes you wish residents to acquire, one must consider how to teach these, and method of evaluation. A survey of a large group of senior residents indicated that the 3 most common ways they learned professionalism were contact with positive role model clinical teachers, contact with patients and their families, and contact with negative role model clinical teachers (5). Role modeling has a significant effect on residents, in their perception and demonstration of professionalism. Several studies have shown that basic positive personal qualities such as social-mindedness and altruism decline during undergraduate medical education and student behavior begins to reflect self-centeredness and cynicism (6,7,8). As nearly all medical schools teach courses in professionalism, ethics, and doctor-patient communication, the problem is unlikely to be a result of failure of the formal curriculum. The “hidden curriculum,” the students’ exposure to what faculty actually do in our daily work with patients and each other, and not what we say should be done, is the strongest influence on students’ understanding of professionalism (9,10). Reviewing this important role with faculty is important, and faculty should be held accountable for their professional behavior. Anonymous resident feedback to faculty on how good a role model they are may help.
Other methods successfully employed by an internal medicine program included an extensive orientation with residents interviewing each other, drawings of their personal situations, a problem solving exercise demonstrating the superiority of group decision making processes over individual decision making, and a variety of other components which require faculty dedicated to providing mentorship and video review of resident communication skills (11). One of the education methods employed by this program was the integration of an ethics course as instruction in bioethics is a clearly stated neurology program requirement (3). There are other compelling reasons to provide education in bioethics to neurology residents. A survey of neurology residency training program directors published in 1996 found none provided a formal ethics course during residency, but 40.2% provided some form of education in ethics in the form of grand rounds, discussion groups, or clinical rounds (12). Another survey of US neurologists' knowledge and behavior in end-of-life care revealed a gap between established medical, legal, and ethical guidelines for the care of dying patients and the practices of many neurologists (13). An example of this gap was the reported belief by 37% of neurologists that treating dyspnea in a patient dying of ALS with morphine in doses that may reduce ventilatory drive was illegal, a misunderstanding of the principle of double effect which has been upheld by the courts.

ETHICS COURSE
In the spring of 2003 we gave a 10 week course in bioethics using the curriculum developed by the AAN's Ethics, Law and Humanities Committee. "Ethical Dimensions of Neurologic Practice: A Case-Based Curriculum for Neurology Residents," developed in 2000 (14). This curriculum was developed in response to the survey published by Wichman and Foa (12). This curriculum includes and introduction to ethical analysis and 14 cases. Each case is followed by an outline for ethical analysis and case comments. The cases covered a variety of topics such as truth-telling and disclosure, relationships with the pharmaceutical industry, presymptomatic genetic testing, and professional misconduct of a sexual nature. Case presentations and the ethical analysis outline were distributed to residents in advance. The 10 week course was mandatory for residents except when on off site rotations. Weekly 1-hour discussions were facilitated by faculty. Facilitators reviewed case comments prior to each session and added supplementary information when appropriate, i.e., HIPAA. After discussing one or two cases, copies of the case comments were given to residents. I developed a 27 question written examination based on the case comments provided in the publication and administered it as a pretest prior to the start of the course and at the end of the course as a post-test. Both examinations were returned to each resident after completion of the course. Giving this course as a block allowed the use of a single pretest and post-test as a summative evaluation method. Alternatively a pretest/post-test could have been developed for each session with the course administered intermittently over the duration of a residency. Formative evaluation of the course was provided by neurology residents after completion of the course through a survey (15).

Of our 15 residents in spring 2003, 12 completed the pretest, course and post-test. Three residents missed substantial portions of the course due to off site rotations and were not included in the analysis. In the summative evaluation of the effectiveness of the course, resident performance on the examination improved from a mean pretest score of 57.3 ± 11.4 to a mean post-test score of 76.5 ± 11.8 (p<0.0004, paired t-test). In the summative evaluation of individual resident learning during the course, 11 of 12 residents improved from pretest to post-test, and none declined. The range of individual resident improvement was 3-41%. There was no difference in improvement scores based on level of training. There was no difference in improvement between residents trained in US medical schools versus international medical schools (p=0.30, student t-test). The total percent correct score from the 2003 AAN RITE was available for 11 of the 12 residents studied. There was a trend between pretest score and total percent correct score from the RITE (p=0.08, correlation), but no correlation between percent improvement and total percent correct RITE score (p= -0.32, correlation).

Ten residents anonymously evaluated the course. The evaluation by residents agreed that this was a useful educational course with 86% responding they felt more confident in addressing ethical issues after completion. All residents felt the text was well prepared, interesting and pertinent to their training.

The total faculty time devoted to this project was approximately 40 hours. Full review of the text and development of the exam took 5 hours; preparation to facilitate took 1 hour each week, while facilitation lasted 1 hour. Survey development was less than 1 hour. Database management and statistical analysis took 2 hours. The education coordinator spent 4 hours transcribing the examination and grading it. The facilitators remarked the case notes were extremely helpful in leading discussions even though none had prior exposure to facilitating in ethics.

We do not know the reliability coefficient of this examination tool. As this examination is given to future resident cohorts, it will be possible to determine the reliability coefficient. It would also have been preferable to have a separate pretest and post-test with about 25% overlap in questions. It would have also been worthwhile to
analyze differences in learning based on exposure to formal ethics in medical school, but we could not do this without breaking the blind of our survey. There are certainly other ways to use this curriculum. A faculty mentor could use the curriculum to foster discussion and have each resident document their learning in a written form for inclusion in a resident portfolio. The curriculum could also be used to foster discussion of resident encountered ethical dilemmas. Documentation may be through a sign in sheet, or written document for inclusion in a resident portfolio.

OTHER ASSESSMENT TOOLS USED BY THIS PROGRAM

1. GLOBAL RATING SCALE

Monthly resident evaluation forms structured to provide assessment in each of the six competencies, including professionalism are the most common form of evaluation tool we use. Global rating scales are completed retrospectively by faculty and based on general impressions collected over the duration of a rotation. Written comments are an important component of these. These are inexpensive to develop and administer, but are highly subjective with untrained raters. Training raters is difficult as evidenced by one study which showed that even with feedback on rating patterns, seasoned clinicians do not change their rating behavior (16). There is also a tendency to rate all items equally based on an overall impression of resident performance, the so called “halo effect,” I have no outcome data on the reliability of this rating scale in our program. This is the latest version of our professionalism rating scale. Including lists of “superior” and “unsatisfactory” behaviors in the description is helpful for raters. Our education committee continues to work on definitions of satisfactory attributes.

<table>
<thead>
<tr>
<th>Unsatisfactory</th>
<th>Satisfactory</th>
<th>Superior</th>
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</thead>
<tbody>
<tr>
<td>Professionalism</td>
<td>Performing at expected level</td>
<td>Always admits to mistakes, shows insight into errors, is always honest and fully committed to quality improvement</td>
</tr>
<tr>
<td>Denies mistakes, blames others, no insight into errors, dishonest, no commitment to quality improvement</td>
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</tr>
<tr>
<td>Apathetic, shows little interest in learning, “just getting work done”, unreliable</td>
<td>Performing at expected level</td>
<td>Always enthusiastic learner, extremely committed to patient care, always reliable</td>
</tr>
<tr>
<td>Avoids interacting with patients and their families</td>
<td>Performing at expected level</td>
<td>Always attends to the needs of patients and their families</td>
</tr>
<tr>
<td>Frequently late to rounds, clinic and lectures, unexplained absences</td>
<td>Performing at expected level</td>
<td>Always on time to rounds, clinic and lectures; absences always explained and fully justified</td>
</tr>
<tr>
<td>Insensitive to the diversity of patients and hospital staff</td>
<td>Performing at expected level</td>
<td>Sensitive to the diversity of patients and hospital staff</td>
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2. 360° EVALUATIONS

A 360 degree evaluation uses rating forms completed by multiple observers in a person’s sphere of influence. Evaluators should include peers and subordinates in addition to superiors. This tool can not be used to assess all of the core competencies, but professionalism and interpersonal/communication skills are particularly applicable to its use. When used in the business setting these tools have high reliability. Peer ratings may be the best to evaluate professionalism, as people may act differently when not under the scrutiny of faculty (17,18). Peer evaluation was well accepted by students in these studies, however reports from the business world indicate these can cause “uproars” when done either well or poorly. At least 8 anonymous peer responses should be obtained, and responses should be compiled and presented to each resident for review. For resident evaluations, at least 5 nurse responses, and more faculty or patient responses are recommended.

We introduced a 360 degree evaluation 2 years ago. Initially we obtained responses from nursing staff, clerical staff, the program coordinator and patients. Last year we introduced peer evaluations. Frankly, my short experience with these is that the written comments are extremely beneficial for identifying behaviors that need modification as reported by nursing and clerical staff. They are also an excellent source for positive statements about resident behavior, especially residents who are quiet about “going beyond the call of duty.” We have difficulty getting our goal of 20 patient responses per resident. The introduction of peer reviews caused an uproar, in part I believe because I could have implemented this better, but also because many of the statements
were “on the mark” and difficult to accept from peers. A cover letter with these evaluations emphasizes responses should not be an opportunity to vent grievances, but should be aimed to provide constructive feedback and reflect a pattern of behavior.

### 360 Degree Evaluation of Residents by Peers

<table>
<thead>
<tr>
<th>PROFESSIONALISM/INTERPERSONAL &amp; COMMUNICATION SKILLS</th>
<th>5 Always Exhibits Behavior</th>
<th>4 Usually Exhibits Behavior</th>
<th>3 Occasionally Fails to Exhibit Behavior</th>
<th>2 Consistently Fails to Exhibit Behavior</th>
<th>1 Unable to Evaluate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deals with colleagues in a friendly and respectful manner.</td>
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<td></td>
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<tr>
<td>Exhibits sensitivity to the diversity of patients &amp; staff.</td>
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<tr>
<td>Sign outs complete and provide useful information.</td>
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<tr>
<td>Is on time for rounds and conferences.</td>
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<tr>
<td>Understands how to prioritize clinical duties.</td>
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<tr>
<td>Is enthusiastic and has a good attitude towards their responsibilities.</td>
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<tr>
<td>Is responsible for completing all clinical work; does not “dump” work to peers.</td>
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<tr>
<td>Makes self available to address patient and family concerns</td>
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<tr>
<td>Is a good team player.</td>
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</table>

Comments:
### 360 Degree Evaluation of Residents by Nursing and Support Staff

<table>
<thead>
<tr>
<th>PROFESSIONALISM/INTERPERSONAL &amp; COMMUNICATIONS SKILLS</th>
<th>5 Always Exhibits Behavior</th>
<th>4 Usually Exhibits Behavior</th>
<th>3 Occasionally Fails to Exhibit Behavior</th>
<th>2 Consistently Fails to Exhibit Behavior</th>
<th>1 Unable to Evaluate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deals with colleagues &amp; staff in a friendly and respectful manner</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Exhibits sensitivity to the diversity of patients &amp; support staff</td>
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<tr>
<td>Keeps nursing/support staff aware of plans for patients</td>
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<tr>
<td>Makes support staff aware of coverage when absent.</td>
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</tr>
<tr>
<td>Understands how to prioritize clinical duties</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is enthusiastic and has a good attitude towards their responsibilities.</td>
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</tr>
<tr>
<td>Makes self available to address patient and family concerns</td>
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<tr>
<td>Returns patient phone calls in a timely manner</td>
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<tr>
<td>Is a good team member.</td>
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</table>

Comments:
### 360 Degree Evaluations of Residents by Patients

**Resident Name** ________________________________

**Date** ________________________________

**Please circle your response to each item below:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Can’t Evaluate</th>
</tr>
</thead>
<tbody>
<tr>
<td>This doctor was truthful and told everything I needed to know</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
<td>Can’t Evaluate</td>
</tr>
<tr>
<td>This doctor greeted me warmly by name; was friendly; was not crabby or rude.</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
<td>Can’t Evaluate</td>
</tr>
<tr>
<td>This doctor treated me with respect.</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
<td>Can’t Evaluate</td>
</tr>
<tr>
<td>This doctor listened carefully to me and didn’t interrupt.</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
<td>Can’t Evaluate</td>
</tr>
<tr>
<td>This doctor discussed treatment options and asked my opinion; let me help decide what to do.</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
<td>Can’t Evaluate</td>
</tr>
<tr>
<td>This doctor encouraged me to ask questions and answered them clearly.</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
<td>Can’t Evaluate</td>
</tr>
<tr>
<td>This doctor explained what I needed to know about my medical problems in a way I could understand.</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
<td>Can’t Evaluate</td>
</tr>
<tr>
<td>I would like to see this doctor come to my community to practice after their medical training is completed.</td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Neutral</td>
<td>Disagree</td>
<td>Can’t Evaluate</td>
</tr>
</tbody>
</table>

**Any additional comments:**
3. Video Trigger Tapes

One study of teaching methods found that teaching by speaking alone, showing visual material alone, and combined speaking and showing each resulted in good retention of material at 3 hours (>70%) (19). However, retention at 3 days was only 10% for speaking, 20% for showing, but 65% for combined speaking and showing. Videotape (CD or DVD) can enhance learning as a tool to foster discussion and demonstrate a variety of clinical skills. The videotape we used was developed during a faculty development course of the American Academy on Physician and Patient and is copyrighted by the American Academy on Physician and Patient, all rights reserved. The short vignettes demonstrated a variety of situations with examples of good and bad physician behavior. Vignettes included problems with disclosure, professional duty in light of work duty hour restrictions, “the late patient,” truth telling, and “who is the patient”. In our program these vignettes resulted in lively discussion, not least of all because residents were able to discuss personal experiences after seeing their program director exhibiting some unprofessional behavior. A sign in sheet was used to document participation, however if would have been worthwhile to have each resident produce a written document for inclusion in their portfolio reflecting on an aspect of their professional behavior that would benefit from improvement.

Developing a trigger tape can be time consuming, and may be costly especially if actors are used (20). The video tape used in demonstration during this session was produced by 8 physicians. We spent approximately 8 hours defining the purpose of the tape and developing scenarios. It was largely unscripted. The filming took 5 hours. The editing was completed at the Cleveland Clinic Foundation. Alternatively we could have used clips from films with poignant demonstrations of doctor-patient interactions such as "Wit" and "The Doctor."

The Consortium of Program Directors might consider developing a trigger tape for all program directors’ use for education in professionalism or interpersonal/communication skills.

4. End-of-Life Palliative Care Course

Instruction in end-of-life palliative care (EOL) is a neurology program requirement (3). Baseline data from 24 neurology programs demonstrated faculty and residents tend to rate themselves as able to perform EOL care despite significant knowledge gaps (21). Select faculty and residents participated in the National Residency End-of-Life Physician Education Project led by David E. Weissman, MD with the goal of developing and implementing an effective EOL course (22).

Fifteen residents and 8 faculty anonymously completed a pretest and pre-course EOL confidence assessment developed by David E. Weissman, MD, “Residency Curriculum Project: Resident and Faculty Baseline Assessment.” (22). This course was held weekly for one hour over 14 weeks in the spring of 2004. The course was developed by multiple facilitators including nurse specialists in dementia, neuro-oncology and ALS, a neurologist specialized in treating ALS, a palliative care program director, and residents who had attended the EOL project. Topics included breaking bad news, EOL care in brain tumors, EOL care in dementia, Do Not Resuscitate orders, use of narcotics, EOL care in ALS, spirituality, holding a family conference, and prognostication. Sessions included lectures, role play and group problem solving formats. The post course assessment included a post-test which was developed using 20% overlap in questions from the pretest and the EOL confidence assessment tool. Fourteen residents and 5 control faculty who did not attend the course completed the post course assessment. The EOL self assessment tool asked physicians to rate their ability to perform 16 EOL tasks such as being able to determine decision making capacity and being able to administer narcotics with a Likert scale with 1=need basic instruction to perform task, to 4=able to perform task competently and independently.

The mean pretest score was 48.1 ± 16.9% for residents and 59.0 ± 8.2% for faculty. Post-test scores improved to 67.2 ± 10.6% for residents (p=0.001, t-test), but not for the faculty control group 52.4 ± 9.9 % (p=0.2). Residents significantly improved their confidence in performing EOL care from pre course (mean 3.09 ± 1.01) to post course (mean 3.40 ± 0.93, p<0.001), but again there was no change in the faculty control group from pre course (mean 3.48 ± 0.82) to post course (mean 3.41 ± 0.82, p=0.5). Residents performed significantly better than faculty on the post-test (p=0.01, t-test), but there was no difference in the confidence level between the two groups (p=0.9, t-test) (23).
OTHER SUGGESTIONS FOR TEACHING/ASSESSING ETHICS AND PROFESSIONALISM

1. Objective Structured Clinical Examination (OSCE)

An OSCE involves 12-20 separate encounter stations often using standardized patients, with stations lasting typically 10-15 minutes. Tasks evaluated may include taking a history, demonstrating interpersonal or communication skills, demonstrating professionalism, performing a focused physical exam, interpreting an x-ray, or performing a procedure. This tool provides a standardized means to assess learner skills. Experienced OSCE labs have standardized patients who portray roles accurately and convincingly with detection rates of unannounced standardized patients in a community practice of less than 10% (24). An OSCE with 14-18 stations is usually a reliable measure of performance, however a 14 station ethics OSCE developed by Peter Singer, MD and Anja Robb and administered to residents was found to have poor inter-station reliability (25). The blueprints of these stations are available on the ACGME Outcomes Project website (1), and Dr. Singer allows use of these materials for teaching or evaluation. The blueprints are not copyrighted and may be freely reproduced.

While there are issues with the reliability of these stations as a testing tool, certainly these cases could be used in other settings, such as role play. The cases cover topics such as withdrawing care, sexual misconduct, and truth telling. One may consider using a sign in sheet to document participation or inclusion of a written document in a portfolio as part of this exercise.

2. Clinical Vignettes “Willingness to Deceive”

Lying to a colleague is ethically problematic because it may harm the deceived or patients under his or her care. It may also harm the credibility of the medical profession. Investigators from several internal medicine residency programs in Pennsylvania developed a series of vignettes to evaluate the use of deception between physicians (26). A copy of these vignettes is also available on the ACGME Outcomes Project website (1). An anonymous survey with 5 vignettes was given to residents. Residents were asked how likely they were to lie:

1) if an unhelpful colleague asks to swap overnight call on a night you don’t want to work
2) if a friend and colleague and reliable physician asks you to provide a urine sample for a mandatory drug test after he has smoked marijuana
3) if you are asked by an attending a specific lab value during rounds and you don’t recall the exact value, and the attending is likely to ridicule you if you don’t know it
4) if a unit secretary is admitted to the hospital and asks that her history of genital herpes not be documented in her chart
5) if you admit a patient with anemia and forget to perform a rectal exam, overnight he develops a myocardial infarction as a result of undetected GI bleed

The more serious the deception, the less likely residents stated they would use deception, however 36% reported they would lie to avoid switching call, 15% would misrepresent a diagnosis in a medical record for a patient, 14% would fabricate a lab value to an attending, 6% would substitute their own urine for a friend’s drug test, and 5% would lie about checking stool for blood to cover up a medical mistake. Investigators found that faculty teaching style contributed to the likelihood of lying in scenarios 3 and 5.

These vignettes could be adjusted with “neurology” scenarios, administered anonymously to residents, results tabulated, and discussed as a group, stressing the importance of collegiality.

3. Continuum 2003 Ethical Issues for Neurologists

This outstanding volume of Continuum contains 7 well written chapters dealing with issues such as, “Risk genes, stem cells, and other ethical dilemmas at the beginning of life,” “Life ending acts in the dying patient,” and “Irreversible cognitive dysfunction: the legal context (27).” There are several practice parameters and position statements from the AAN’s Ethics, Law and Humanities Subcommittee included. Chapters could be assigned with subsequent group discussion, or chapters assigned for personal review. A 40 question post-test included in the volume could be used by program directors to document learning, by documenting “passing” grades. Alternatively this could be used as both a pretest and post-test. The volume includes test answers and explanations. A portfolio document with reflection on resident encounters of an ethical nature would be another means of documenting learning. A completed exam documenting a passing grade could also be incorporated into a portfolio. The patient management problem included in the volume is based on the experiences of Christopher Reeve shortly after his injury.

4. Use AAN Practice Parameters and Position Statements to Foster Discussion

The AAN website contains all practice parameters including those pertinent to ethics and professionalism including (28):

   Ethical issues in clinical research in neurology
Assisted suicide, euthanasia, and the neurologist
Palliative care in neurology
Assessment and management of the persistent vegetative state patient.
A copy of an appendix listing AAN Ethical Guidelines is reproduced with permission at the end of this syllabus and includes topics such as (29):
Policy on conflicts of interest
Consent issues in the management of cerebrovascular disease
Managed care and neurologists: ethical considerations
Ethical consideration for neurologists in the management of chronic pain.
Discussion of individual practice parameters or ethical guidelines would not be an ideal learning situation, however, discussing cases with subsequent review of pertinent guidelines would foster greater learning. Again, written material for inclusion in a portfolio could document reflection on the cases.

5. Discuss "Hot" Topics
Current ethical issues in the news include:

1. Terri Schiavo - "Seven legal barriers to end-of-life care; myths, realities and grains of truth," is an excellent article discussing the most common misperceptions about the law as it pertains to the care of the dying, and could be paired with a discussion of cases such as Terri Schiavo’s (30).

2. Embryonic stem cell research - The editors of the New England Journal of Medicine invited two members of the President’s Council on Bioethics with conflicting opinions to discuss whether the federal government should fund human embryonic stem cell research (31,32). A more comprehensive discussion of the issue is presented in the updated report of the President’s Council on Bioethics (33). The Continuum volume listed earlier also has a chapter devoted to stem cell research (27).

3. Humanism in medicine – Two physicians write in a deeply moving fashion about the death of their father and his medical care which was provided devoid of human caring (34). This article could provide the basis for a discussion of resident humanism and resident encounters with the families of those with bad outcomes.

6. Cultural Competence/Health Literacy
We have several faculty who are excellent lecturers and facilitators of discussions on Cultural Competence. If you do not have such support Anita Misra-Herbert wrote a helpful introduction to this topic that you may find useful (35). The article discusses raising self-awareness of culture gaps between physicians and their patients, how to build the doctor-patient relationship across cultural barriers, differences in verbal and nonverbal communication in other cultures, eliciting the patient’s explanatory model of illness, and racial concordance. “The Spirit Catches You and You Fall Down: a Hmong child, her American doctors, and the collision of two cultures” by Anne Fadiman explores some of the difficulties faced by families and medical care providers when there are problems with building doctor-patient relationships across cultural barriers. The book could be assigned for personal reading with a reflective exercise for inclusion in a portfolio, or for group discussion.

The term health literacy refers to a patient’s ability to understand common health care communications, such as treatment instructions and test results. The AMA Foundation offers a Health Literacy Toolkit with 20 minute information and instructional videos with case studies. One video features physicians and office staff interacting with patients challenged by low health literacy. Another video details techniques and specific steps for health care workers to help patients with limited health literacy. These toolkits are offered freely to some groups and also for purchase (36).

FINAL WORDS
No one can do it all. Find tools that fit you program and resources.

REFERENCES
RESOURCES


2. The American Academy on Physician and Patient has some trigger tape products available for purchase including the trigger tape displayed today. Their website is currently undergoing an update. Please contact Chris Pallozola, Executive Director, at chris@physicianpatient.org if you are interested in reviewing the products offered. I am not a member of the AAPP and do not receive any financial or other benefits by mentioning their site.

<table>
<thead>
<tr>
<th>Month</th>
<th>Year</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>1990</td>
<td>Resolution on legislation regarding durable power of attorney for health care in neurology (Section 42 U.S.C. 1395aa) (1990)</td>
</tr>
<tr>
<td>April</td>
<td>1993</td>
<td>Occupational guidelines for the practice of neurology in the United States (1993)</td>
</tr>
<tr>
<td>April</td>
<td>1994</td>
<td>Ethical issues in the management of the earned, informed patient (1994)</td>
</tr>
<tr>
<td>April</td>
<td>1995</td>
<td>Ethical considerations for neurologists in the management of chronic pain (1995)</td>
</tr>
</tbody>
</table>

Website:

Reproduced with permission from AAN Publications.
Ethics and Professionalism for Neurology Residents

Lori Schuh, MD
Residency Program Director, Henry Ford Hospital

Associate Professor, Department of Neurology
Wayne State University

Disclosure

- Received honorarium from GlaxoSmithKline for speaking
- Received grants from Henry Ford Health System Graduate Medical Education
Introduction

- I am a neophyte
- I am not an ethicist
- Pragmatic
  - “Professionalism as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds”
  - “Residents must receive instruction in the principles of bioethics…”


Outline

- Henry Ford Hospital Experience
- Other practical approaches to ethics instruction and learning assessment
- Assessing other aspects of professionalism
- YOUR INPUT
Is this really necessary?

- **1999 AAN Ethics, Law and Humanities**
  - Subcommittee survey of neurologists
    - Sizable gap between established legal, medical, and ethical guidelines and the beliefs and practices of many neurologists surveyed
    - Example: 37% erroneously thought it was illegal to give analgesics in doses that risk respiratory depression in order to relieve terminal suffering


Is this really necessary?

- **1996 AAN Ethics, Law and Humanities**
  - Subcommittee survey of neurology residencies
    - 59.7% no formal ethics instruction
    - 40.2% offered some education in ethics
      - 0% course
      - 79% Grand Rounds
      - 36% seminars or discussion groups
      - 26% clinical rounds with an ethicist

Is this really necessary?
Survey-continued

- Suggestions from program directors:
  - Flexible, optional curriculum to be used by local program needs
  - Educate faculty and let them educate residents
  - Keep things informal

- Ethical Dimensions of Neurologic Practice: a case-based curriculum for neurology residents, AAN 2000


Methods

- Logistics
  - Block time schedule fit this program

- Summative evaluation methods
  - Individual resident pretest and post-test scores
  - Group performance

- Formative evaluation
  - Resident survey of course
Methods

- **Curriculum**
  - Introduction to ethical analysis
  - 14 cases
  - Case comments
  - Examples: truth-telling and disclosure, relationships with pharmaceutical industry, presymptomatic genetic testing, professional misconduct of a sexual nature

Methods

- Schedule distributed; 1-2 cases per week
- Weekly hour long sessions
- 10 week course mandatory
- Residents were expected to review cases and complete analysis before each session
Methods

- Facilitators reviewed case comments prior to each session and added supplemental information when appropriate
- After discussion, copies of the case comments were given to the residents
- Discussion of resident encounters was encouraged

Methods

- 27 question written examination based on curriculum case notes was developed
  - Used as both pretest and post-test
- Anonymous survey was developed for residents
  - Usefulness of course
  - Confidence in addressing ethical issues
  - Satisfaction with text
  - Medical school exposure to ethics
Methods

- Analysis
  - Difference in pretest to post-test score for each resident
  - Group difference in pretest to post-test
  - Statistical analysis
    - Correlation
    - Student t-test

Results

- Spring 2003
- 15 residents (6,3,6)
- 3 residents missed substantial portions due to off site rotations
- 11 or 12 residents improved from pretest to post-test
- None declined
Results

Mean pretest 57.3±11.4 and Mean post-test 76.5±11.8, p<0.0004 paired t-test

Results

- Mean resident improvement 19%
- No difference in improvement based on level of training
- No difference in improvement between residents trained in US versus international medical schools (p=0.3, student t-test)
Results

- RITE scores were available for 11 of 12 residents
- There was a trend between pretest score and total percent correct on RITE (0.08, correlation)
- No correlation between percent improvement from pretest to post-test and RITE (-0.32, correlation)

<table>
<thead>
<tr>
<th>Statement</th>
<th>Mean Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>The ethics course was useful for my education.</td>
<td>3.9 (n=10)</td>
</tr>
<tr>
<td>The course, pretest and post-test were reasonable with respect to time</td>
<td>4.0 (n=10)</td>
</tr>
<tr>
<td>commitment.</td>
<td></td>
</tr>
<tr>
<td>Following the course I felt more confident in my understanding of and</td>
<td>4.1 (n=6)</td>
</tr>
<tr>
<td>approach to ethic issues.</td>
<td></td>
</tr>
<tr>
<td>The test used was well prepared and interesting to a neurology resident.</td>
<td>4.1 (n=6)</td>
</tr>
<tr>
<td>I agree with the ACGME requirement for ethics training in residency.</td>
<td>4.3 (n=6)</td>
</tr>
</tbody>
</table>

1=strongly disagree; 2=disagree; 3=neutral; 4=agree; 5=strongly agree
Results

- Faculty time commitment
  - Full review of text and exam development: 5 hours
  - Preparation to facilitate: 30-60 minutes each week
  - Facilitation: 60 minutes each week
  - Survey development: 30 minutes
  - Database management and statistical analysis: 2 hours
  - Education coordinator time: 4-6 hours
  - Time to prepare this lecture: 2 weeks

Summary

- This project demonstrated measurable learning in ethics among a cohort of neurology residents.
- Residents welcomed formal instruction in ethical issues pertinent to neurology.
- The ethics casebook developed by the AAN’s Ethics, Law and Humanities Committee is an effective curriculum that can be readily incorporated into other programs curricula
**Discussion**

- It would have been worthwhile to analyze differences in learning based on exposure to ethics in medical school.
- It would be preferable to have separate pretest and post-test questions with about 25% overlap.
- Limitations to evaluation by knowledge based exam.
- Reliability coefficient unknown until others take exam.

Other ways to use this curriculum:

- Group review of cases with discussion. Residents reflect on lessons from case. Written document for portfolio.
- Group review of cases with discussion. Residents discuss/write about ethical issues encountered with patients, faculty and peers during training and address what insights gained and possible changes to behavior in the future.
  - Written document for portfolio
  - Documentation of participation by sign in sheet.
Demonstration

- “Pretest” – 3 minutes
- Review case – 5 minutes
- Discussion – 10 minutes
- Review test answers – 1 minute

Professionalism
Medical Professionalism Project-ABIM

- Professionalism is the basis of medicine’s contract with society
- 3 Fundamental Principles
  - Principle of primacy of patient welfare
  - Principle of patient autonomy
  - Principle of social justice

**Professionalism**

Medical Professionalism Project-ABIM

- Commitment to professional competence
- Commitment to honesty with patients
- Commitment to patient confidentiality
- Commitment to maintaining appropriate relations with patients
- Commitment to improving quality of care
- Commitment to improving access to care
- Commitment to a just distribution of finite resources
- Commitment to scientific knowledge
- Commitment to maintaining trust by managing conflicts of interest
- Commitment to professional responsibilities


---

**Professionalism**

I  Integrity  C  Courteous
H  Honesty  A  Attentive
E  Excellence  R  Respectful
A  Altruism  E  Enthusiastic
A  Accountability  S  Safe
R  Respect
D  Duty
Neurology Core Competency Chart

Professionalism

- Summary of the goals and objectives of the professionalism competency
- Demonstrable behaviors (i.e., respond to patient phone calls, provide coverage)
- Respect for diversity
- Self review of conduct and remediation
- Review of the conduct of colleagues
- Acknowledge medical errors and remediate

Available at www.aan.com/students/program/psychiatry_and_neurology.pdf

Teaching Professionalism

- Survey of large group of senior residents indicated the 3 most common ways they learned professionalism
  - Positive role model clinical teachers
  - Contact with patients and their families
  - Negative role model clinical teachers
- The “hidden curriculum” - what we do, not what we say to do
- Accountability of faculty behavior

Brownness AKW, Cote L. Senior residents' views on the meaning of professionalism and how they learn about it. Acad Med 2001;76:734-737.
Professionalism
Assessment tools

- Global Performance Rating Scale
- Separated into the 6 Core Competencies
- Completed after each rotation
- Inter-rater reliability
  - “halo effect”
  - Requires training of faculty evaluators, but even with feedback hard to change rating behavior


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Professionalism-Tools
Global Performance Rating Scale

<table>
<thead>
<tr>
<th>Unsatisfactory</th>
<th>Satisfactory</th>
<th>Superior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionalism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1   2   3</td>
<td>4  5  6</td>
<td>7  8  9</td>
</tr>
</tbody>
</table>

- Denies mistakes, blames others, no insight into errors, dishonest, no commitment to quality improvement
  - Performing at expected level
  - Always admits to mistakes, shows insight into errors, is always honest and fully committed to quality improvement

- Apathetic, shows little interest in learning, “just getting work done”, unreliable
  - Performing at expected level
  - Always enthusiastic learner, extremely committed to patient care, always reliable

- Avoids interacting with patients and their families
  - Performing at expected level
  - Always attends to the needs of patients and their families

- Frequently late to rounds, clinic and lectures, unexplained absences
  - Performing at expected level
  - Always on time to rounds, clinic and lectures, absences always explained and fully justified

- Insensitive to the diversity of patients and hospital staff
  - Performing at expected level
  - Sensitive to the diversity of patients and hospital staff
Professionalism-Tools

■ 360° Evaluations
  ■ Rating forms completed by multiple people in the resident’s sphere of influence
  ■ Peer ratings may be the best way to evaluate professionalism as people often act differently when not under direct scrutiny
  ■ At least 8 anonymous peer evaluations should be obtained for reliable results
  ■ “well accepted by learners”


Professionalism-Tools

■ At least 5 responses from nurses
■ More responses needed from faculty or patients
■ My brief experience
  ■ Written comments are extremely beneficial
    ■ Identifying behaviors that need modification
    ■ Excellent source for positive statements
    ■ First peer reviews caused an uproar
      ■ Implementation could have been improved
      ■ “on the mark”
INTEROFFICE MEMORANDUM

TO: LORI SCHUH, MD
FROM: LORI SCHUH, MD
SUBJECT: 360 DEGREE EVALUATIONS
DATE: 
CC: 

As we try to better assess our residents, we are seeking to give them feedback from a more comprehensive sampling of people with whom they come in contact. That is, we would like evaluations not just from staff physicians, but also from support staff who work closely with them. As such, please take a few minutes to evaluate our residents. Please restrict comments to constructive criticisms and praise keeping in mind that the evaluation should reflect a pattern of behavior and not an isolated incident. This is an opportunity to encourage and nurture our residents and should not be viewed as an opportunity to vent personal matters or problems. All evaluations are confidential. The resident will be given the content of the comments but will not personally review the evaluation forms.

Thank you for your help.
## 360 Degree Evaluations of Residents by Peers

### Department of Neurology

**Resident:** ____________________________________  **Date:** _________________________________

<table>
<thead>
<tr>
<th>Professionalism/Interpersonal &amp; Communications Skills</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deals with colleagues in a friendly and respectful manner.</td>
<td></td>
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<tr>
<td>Exhibits sensitivity to the diversity of patients &amp; staff</td>
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<tr>
<td>Seeks out complex cases to provide meaningful learning opportunities</td>
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<td></td>
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<tr>
<td>Is on-time for rounds and conferences</td>
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<tr>
<td>Understands how to prioritize clinical duties</td>
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<tr>
<td>Is enthusiastic and has a good attitude towards their responsibilities</td>
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<tr>
<td>Is responsible for completing all clinical work; does not “dump” work to peers</td>
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<tr>
<td>Makes self available to address patient and family concerns</td>
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<tr>
<td>Is a good team player</td>
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</tbody>
</table>

**Unable to Evaluate**

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## 360 Degree Evaluations of Residents by Nursing and Support Staff

### Department of Neurology

**Resident:** ____________________________________  **Date:** _________________________________

<table>
<thead>
<tr>
<th>Professionalism/Interpersonal &amp; Communications Skills</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deals with colleagues &amp; staff in a friendly and respectful manner</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exhibits sensitivity to the diversity of patients &amp; support staff</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Keeps support staff aware of plans for patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes support staff aware of coverage when absent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understands how to prioritize clinical duties</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Is enthusiastic and has a good attitude towards their responsibilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes self available to address patient and family concerns</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Maintains patient phone calls in a timely manner</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Is a good team member</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Unable to Evaluate**

---
### 360 Degree Evaluations of Residents by Patients

**Resident Name:** ____________________________________________  
**Date:** _________________________________  

**PLEASE CIRCLE YOUR RESPONSE TO EACH ITEM BELOW:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Can't Evaluate</th>
</tr>
</thead>
<tbody>
<tr>
<td>This doctor was truthful and told me everything I needed to know</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This doctor greeted me warmly by name; was friendly; was not crabby or rude.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>This doctor treated me with respect</td>
<td></td>
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</tr>
<tr>
<td>This doctor listened carefully to me and didn't interrupt.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This doctor discussed treatment options and asked my opinion; let me help decide what to do.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This doctor encouraged me to ask questions and answered them clearly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This doctor explained what I needed to know about my medical problems in a way I could understand.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>I would like to see this doctor come to my community to practice after their medical training is completed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ANY ADDITIONAL COMMENTS:**

Based on the Patient Satisfaction Survey; developed, used and adapted with permission from the American Board of Internal Medicine.

---

### Professionalism-Tools

- **Trigger Tape to foster discussion**
- **Good and bad examples of physician behavior**
- **Truth telling**
- **Residents opened up about personal experiences after seeing good and poor behavior in their program director**

- **Available through the American Academy of Physician and Patient**
- **Portfolio document from discussion and reflection**
- **Sign in sheet to document participation**
End-of-Life Palliative Care Course

- Instruction in end-of-life (EOL) care is a neurology program requirement
- Baseline data from 24 neurology programs demonstrated faculty and residents rate themselves as competent in EOL care despite significant knowledge gaps
- Participated in National Residency End-of-Life Physician Education Project led by David E. Weissman


End-of-Life Palliative Care Course

- 15 residents and 8 faculty
- Pretest and EOL Confidence Assessment Tool developed by David E. Weissman
- Weekly 1 hour course for 14 weeks
- Multiple facilitators
  - Nurse specialists in neuro-oncology, dementia, ALS
  - Neurologist – ALS specialist
  - Palliative care program director
  - Residents

End-of-Life Palliative Care Course

- Topics included
  - Breaking Bad News
  - Use of Narcotics
  - EOL care in Dementia
  - EOL care in ALS
  - Holding a Family Conference
- 14 residents and 5 control faculty completed the post-test and EOL Confidence Tool after the course
  - Post-test with 20% overlay in questions
  - EOL Likert Scale: 1=need basic instruction to perform task to 4=able to perform task competently and independently

<table>
<thead>
<tr>
<th></th>
<th>Before Course</th>
<th>Following Course</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Resident Exam Scores</td>
<td>48.1 ± 16.9%</td>
<td>67.2 ± 10.6%</td>
<td>p=0.001</td>
</tr>
<tr>
<td>Mean Faculty Exam Scores</td>
<td>59.0 ± 8.2%</td>
<td>52.4 ± 9.9%</td>
<td>p=0.2</td>
</tr>
<tr>
<td>Mean Resident Confidence in EOL</td>
<td>3.09 ± 1.01</td>
<td>3.40 ± 0.93</td>
<td>p=&lt;0.001</td>
</tr>
<tr>
<td>Mean Faculty Confidence in EOL</td>
<td>3.48 ± 0.82</td>
<td>3.41 ± 0.82</td>
<td>p=0.5</td>
</tr>
</tbody>
</table>
Objective Structured Clinical Exam (OSCE)
- 12-20 encounter stations lasting 10-15 minutes each evaluating a variety of clinical tasks
- Reliable measurement of clinical skills
- Very expensive and time consuming
- Cross sectional view

OSCE
- Peter A. Singer and Anja Robb, Ethics OSCE Project funded by Educating Future Physicians for Ontario
- Blueprints of 14 stations available through the ACGME Outcome Project website
  - Confidentiality, truth telling, sexual misconduct
  - Consistency of scores across stations was inadequate

Station Name: Sexual Impropriety

- Instructions to resident
  - Resident is seeing Carol Abbott, a new patient
  - Nurse reports Carol is depressed and wants a referral to a psychiatrist because “things didn’t work out with the last psychiatrist”

- Standardized patient instructions
  - Began seeing psychiatrist for depression 2.5 years ago
  - Mutual attraction developed - began with hugs and progressed eventually to intercourse all of which occurred in the office
  - Doctor began to act cold. Would take phone calls or open mail during sessions. You stopped going to appointments
  - You want to talk about it but are reluctant to get the doctor in trouble


OSCE-Sexual Impropriety

- Evaluation

- Checklist of 11 items (examples):
  - Resident inquired further about “didn’t work out” and established relationship was sexual
  - Informs patient that sexual contact in context of doctor/patient relationship is unethical
  - Asks how patient is feeling
  - Assures patient this is not her fault
  - Asks for name of psychiatrist
  - Resident mentions their obligation to report psychiatrist
  - Offers counseling to patient, or referral to female psychiatrist
OSCE

- Adapt to use in Role Play using residents as standardized patients and other residents as “raters”
  - Inexpensive
  - Time consuming
  - Eye Rolling and “I can’t believe we are doing this” factor
- Written portfolio document
- Sign in sheet

Professionalism-Tools

- Clinical Vignettes to Assess Willingness to Deceive
- Administered 5 vignettes to residents
  - 36% likely to use deception to avoid exchanging call
  - 14% likely to fabricate lab results to avoid criticism
    - Most likely when staff known to ridicule residents publicly
  - 5% would lie in the setting of a medical mistake
- Complete anonymously followed by group discussion and reflection on collegiality
- Portfolio

Vignettes also available www.ACGME.org/outcome/assess/profIndex.asp
Professionalism - Tools

- Continuum “Ethical Issues for Neurologists”, August 2003
  - 7 Chapters including “Risk genes, stem cells, and other ethical dilemmas at the beginning of life,” “Life ending acts in the dying patient”
- Includes Case Studies, Post-test and a Patient Management Case
- Self study with inclusion of post-test in portfolio
- Group discussion of chapters and cases

Professionalism - Tools

- Use AAN Practice Parameters/Position Statements to foster discussion
  - Resident case presentations
  - Review pertinent Practice Parameter and Position Statements (examples)
    - Determining Brain Death in Adults
    - Assessment and Management of Patients in the Persistent Vegetative State
    - Genetic Testing Alert
    - AAN Code of Professional Conduct
    - Assisted Suicide, Euthanasia, and the Neurologist

Professionalism - Tools

- Discuss “Hot” Topics
  - Terri Schiavo
  - Human Embryonic Stem Cell Research
  - Humanism
- Use AAN Practice Parameters and Position Statements to help guide discussion
- Access www.bioethics.gov
- Use Continuum “Ethical Issues for Neurologists”

Professionalism - Tools

- Cultural Competence/Health Literacy
  - “The Spirit Catches You and You Fall Down: a Hmong child, her American doctors, and the collision of two cultures” by Anne Fadiman
  - Reading assignment with personal journal for portfolio
  - Group discussions
  - Review article by Anita Misra-Hebert, MD

Professionalism-Tools

- Health Literacy - patient’s ability to understand common health care communications
- AMA Foundation offers Health Literacy Toolkit
  - Video
    - One features physician and office staff interacting with patients challenged by low health literacy
    - One details techniques and specific steps for health care workers to help patients with limited health literacy
  - Case Studies

www.ana-assn.org/ama/pub/category/8115.html

Implementation

- Local Resources
  - Medical School
  - Ethics faculty/committee
  - $
  - Time
  - Skills and interests of faculty
- Personal Style
- Faculty Acceptance
- Ability to bring about change within your department
“I’m always ready to learn, although I do not always like being taught.”
-Winston Churchill

**Last Words**

- No one can do it all
Group Discussion

- What have you implemented that has worked well?