A MODEL FOR CLINICAL ETHICS EDUCATION IN OTOLARYNGOLOGY RESIDENCY

BY

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Abstract

Contemporary surgical practice is inextricably linked to the practice of clinical medical ethics. The Accreditation Council of Graduate Medical Education (ACGME) in its development of core competencies has recently recognized this association for resident physicians. Included in these competencies is professionalism, and a key component of the professionalism competency is ethics education.

This thesis will begin with a brief historical overview of medical ethics education in medical schools and surgical residencies. I will then report and analyze the results of a nationwide survey of all US otolaryngology residency program directors designed to assess the current status of ethics education in otolaryngology training programs. The second chapter of the thesis will describe the development and presentation of a pilot program in clinical surgical ethics education for the otolaryngology residents at the Wake Forest School of Medicine in 2011-2012. The third chapter of the thesis will describe an ongoing virtue ethics journal club during the 2012-2013 academic year developed to discuss and nurture topics relevant to the character development of otolaryngology residents. The last chapter will reflect on the development of this ethics education program, assess its strengths and weakness and offer some personal reflections on the program.
Chapter 1

A Historical Review of Medical Ethics Education and a Determination of the Baseline Practices of Ethics Education in Otolaryngology Residency Training

The contemporary practice of medicine and surgery is inextricably associated with the practice of clinical medical ethics. “Surgeons live and practice an intense form of applied ethics. We deliver bad news; guide patients and their families through complicated decisions to arrive at appropriate informed consent; we live a code of truth among ourselves, our patients, and our trainees; we must deal with end-of-life issues; and we make plans for extended, palliative and hospice care. Finally, as only we surgeons know, we go to bed knowing that in the morning we will spend hours with someone’s life literally in our hands” (Kodner 2003).

The field of clinical medical ethics has emerged and developed over the past 4 decades. The advancement of technical abilities in the fields of medicine, surgery and intensive care, combined with the societal changes of the 1960’s, including increased distrust of authority and a better informed public, have led to the increasing importance of medical ethics in general and an increased emphasis on medical ethics education in the undergraduate medical curriculum (Eckles 2005). In postgraduate medicine, the American Council for Graduate Medical Education (ACGME)’s Residency Review and Institutional Review Committees announced a paradigm shift in residency education in 1999. This shift involved measuring the actual success of residency training programs at achieving well-trained, educated, ethical and compassionate physicians rather than the
programs’ potential to develop technically competent physicians who may lack ethical and professional skills. To achieve this goal, the ACGME committees have endorsed 6 general competencies: Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and System-based Practice. These competencies are now expected components in the development, implementation and evaluation of all residency curricula. (Larkin 2005).

This first chapter will take a brief historical look at the establishment of ethical standards of clinical medical and surgical practice. I will then review literature that documents efforts to establish ethics curricula in undergraduate medical education. Next I will examine the literature regarding ethics education in surgical residencies. Lastly I will present the methodology and results of a survey of medical ethics education in otolaryngology residencies I performed during my time as a student in the Masters of Arts in Bioethics program at Wake Forest University and as a Clinical Assistant Professor of Otolaryngology at the Wake Forest School of Medicine.

**Brief Historical Background of Medical Ethics**

While the recognition of the importance of medical ethics education is a relatively recent phenomenon, the significance of the ethical behavior and character of the physician/surgeon had been identified as early as the 4th century BCE in the writings of Greek physicians. The famous Hippocratic Oath has been thought of as a starting point for the western tradition of medical ethics. The Oath’s core principle that the physician
should act for the good of the patient is recognized as a continuing principle in medical ethics to this day (Tung 2000). The Oath has undergone many revisions in the intervening years in an attempt to modernize its language and remove some of its cultish and trade guild references. Despite these shortcomings, the Hippocratic Oath continues to be recited by 60% of US medical students at their graduation from medical school (Dickstein 1991).

In the late 18th century infectious epidemics treated at the Manchester Infirmary in England were the cause of a drastic increase in the number of hospital staff physicians. This increase in staff caused a bitter controversy between the long established staff members and their newly appointed colleagues. In 1791 Sir Thomas Percival was chosen by trustees of Manchester Infirmary to author a document describing proper etiquette and conduct for staff members of the infirmary. His initial work was republished in an 1803 treatise entitled Medical Ethics: A Code of Institutes and Precepts Adapted to the Professional Conduct of Physicians and Surgeons (Percival 1803). While the purpose of his work was to improve relations among the staff members of the Manchester Infirmary, his writing also provided fundamental guidelines for physician behavior toward patients (Hanlon 1998).

In 1847, the American Medical Association (AMA) was formed in Philadelphia, Pennsylvania, by a group of 246 physicians under the leadership of Dr. Nathan Davis. During the first half of the 19th century lax medical licensing laws created a situation where the public could not distinguish between highly trained physicians and those with
poor education and unsavory morals. One of the first actions of the AMA was to establish a code of medical ethics to restore confidence in American medicine. The *AMA Code of Medical Ethics* was unanimously passed at that first meeting of the AMA in 1847. Many of the themes of Percival’s treatise were included in the *AMA Code of Ethics*, and large segments of his treatise were quoted verbatim. The *AMA Code of Ethics* was the first attempt by a national medical organization to bind its members to a code of conduct. The AMA claimed rights to this document and expected its members to follow the code. The code was designed to regulate member licensing, establish requirements for minimal education standards, and clean up the prior abuses of the medical profession (Tung 2000). The *AMA Code of Ethics* emphasized the Hippocratic ideals of beneficence, nonmaleficence, and patient confidentiality, while incorporating rules of professional etiquette and of consultation defined by Percival. The *AMA Code of Ethics* underwent multiple revisions in the 20th century, but many of the underlying principles and ideals remain intact. In 1957 the AMA reduced the Code of Ethics to a preamble with 10 brief principles of medical ethics. The principles were further reduced to 7 in 1980 and increased to 9 again in 2001. The current AMA Code of Medical Ethics is a living document reviewed and written by the Council on Ethical and Judicial Affairs for the AMA. The code as currently written contains the latest version of the Principles of Medical Ethics as well as the official opinions of the American Medical Association on contemporary medical ethical issues. It evolves as the changes in medicine and the delivery of health care raise new questions about how the ethical physician functions in day–to-day practice (AMA 2013).
The conclusion of World War II revealed the atrocities of Nazi doctors who had experimented on Jews, Gypsies, political prisoners, homosexuals and prisoners of war during their concentration camp incarceration. During the Nuremberg trial of the Nazi doctors, the Hippocratic Oath was cited as a guide to ethical principles in medicine. The Nuremberg court proposed 10 principles to guide human subject experimentation, called the Nuremberg Code (Tung 2000). While the Nuremberg Code specifically addressed concerns such as voluntary and informed consent to research, societal good as the primary goal of human subject research, and the avoidance of unnecessary suffering, there existed no modern international oath or code applicable to clinical practice. To fulfill this need for a code of conduct for clinical medical practice, scholars returned to the Hippocratic Oath with multiple attempts at modernizing its language and eliminating its more anachronistic references to pagan gods, sexism, and the guild mentality (Pellegrino 1993). The Declaration of Geneva drafted by the World Medical Association in 1948 is an example of the recasting of the Hippocratic Oath into modern language (World Medical Association). The Declaration of Geneva lacks any body to enforce the principles it sets forth, and some national professional organizations do not belong to the WMA, thus limiting it influence.

The surgical profession, long separate from medicine, lagged in the development of ethical creeds. The Hippocratic Oath forbade surgery and the early AMA excluded surgeons. The American College of Surgeons (ACS) was formed in 1913, and the Fellowship Pledge of the ACS is one of the earliest surgical ethical guidelines. The pledge places the welfare and rights of the patient above all else, affirms the existence of
a social contract between surgeons and society (without providing details of that contract), and prohibits certain financial arrangements such as fee splitting (American College of Surgeons). In addition, the ACS from its inception has had a Central Judiciary Committee to deal with reports of misconduct by its members. In response to an ongoing interest in surgical ethics, the ACS has published guidelines on many ethical issues, sponsors ongoing surgical ethics continuing medical education, and has recently published *Ethical Issues in Clinical Surgery* emphasizing the teaching of medical ethics to surgical residents (McGrath 2007).

**Medical School Ethics Education**

Prior to the 1970’s, bioethics education in United States medical schools mainly occurred through “osmosis”, the informal transmission of values and practices from attending physicians to medical students in a traditional apprenticeship model. Fox et al. report that in 1972 only 4% of U.S. medical schools had formal, structured and required medical ethics curricula; this percentage rose to 100% by 1994 (Fox, 1995). Traditionally, medical ethics classes are taught during the first or second year of medical school and include large classroom lectures often complemented by small group discussion. These classes tend to emphasize cognitive goals of recognizing, articulating, clarifying, analyzing, and debating ethical issues. The content of these classes typically includes moral theory (e.g. deontology and utilitarianism), moral principles (e.g. respect for autonomy, nonmaleficence, beneficence, justice), codes of medical ethics, and various topics related to medical ethics (e.g. abortion, conflict of interest, euthanasia) (Fox 1995).
Despite the acceptance of medical ethics education in U.S. medical schools, there remains controversy regarding the goals of these ethics education programs. There have emerged two points of view in the literature regarding the goal of medical ethics education. The first camp places emphasis on using medical ethics education as a tool for creating virtuous physicians and the second camp seeks to provide future physicians with a set of skills for analyzing and resolving ethical dilemmas. This dichotomy has been called the “virtue/skills dichotomy” (Eckles 2005).

Among the champions of the virtuous physician camp are Edmund Pellegrino and David Thomasma. While they recognize both sides of the virtues/skills dichotomy, they ultimately claim that the primary goal of medical ethics education should be the creation of virtuous physicians (Eckles 2005). They argue that medicine is inherently a moral profession and can be taught “by practice, by example and even by the study of ethics” (Pellegrino 1993). They also claim that teaching medical students medical ethics results in a skill set that will help them to resolve clinical dilemmas. This skill set can inspire “self criticism and examination of one’s own values” and thus may indirectly serve to improve the student’s character (Eckles 2005). Shelton advocates for the teaching of the “good doctor” skills and traits that exemplify the goals and ideals of the profession of medicine. These characteristics include “respect, compassion and honesty”, characteristics that are fundamental to any morality and that all professional medical caregivers are expected to embrace (Shelton 1999). Hafferty argues that medical school training at its root is not just the transmission of medical facts and technical skills but is
also a process of moral enculturation. This enculturation includes the transmission of normative rules regarding the behavior of physicians toward patients, the practice of medicine and surgery itself, and the emotional response of future physicians to the trials and tribulations of medical practice. Educators generally acknowledge that the overall process of education is a form of socialization and that all socialization involves a moral dimension. Minds - young and old, teacher and student - are being shaped in a framework that transmits notions of right and wrong, of appropriate and inappropriate actions (Hafferty 1994). Thus, moral education occurs within the subculture of medical education, and the cultivation of moral virtues or vices by student and teacher alike are possible. Medical educators must recognize that, in addition to the formal curriculum that transmits medical knowledge and surgical technique, a “hidden curriculum” exists that transmits these normative values to the future medical professionals (Hafferty 1994). This enculturation into the normative rules of medical practice is the basis for the transmission of values and virtuous behavior.

A second camp, including the majority of medical ethics authors and educators, proposes that the goal of medical ethics education is to provide the student with a required skill set to resolve medical ethics dilemmas. Many of these authors claim that it is unrealistic to expect ethics education to create moral physicians, and instead the emphasis and instruction should be focused on providing future physicians with a sufficient set of skills to navigate ethical dilemmas (Eckles 2005). These authors cite evidence that an individual’s character is formed at an early age and that by the time students arrive at medical school their fundamental character is well formed. A medical student who is a
liar before an ethics course will continue to be a liar at the end of the course. He or she may develop an improved appreciation for why this behavior is unacceptable and an increased awareness of the social ramifications of lying, but he or she will remain a liar nonetheless (Levine 1997). Veatch claims there is no agreement regarding which set of virtues should be taught. He argues that the proper set of virtues to be taught is not obvious, citing differences between the classical Homeric virtues, virtues of the Christian tradition, and those virtues necessary to practice in a modern, secular and multicultural society. Veatch also claims that different virtues may be necessary for different physician roles. Certain medical or surgical specialties may value one virtue more than another. For example, trauma surgeons may value the virtue to make decisions rapidly under pressure more highly than pathologists. Different roles and situations may require a different set of virtues, and thus teaching one specific virtue set is problematic. The difficulty of measuring virtue among medical students and of assessing whether teaching increases virtuous behavior may incline many educators to favor skills based curriculum (Eckles 2005). There exists controversy as to what specific ethical skills should be emphasized. Nonetheless ethical skills that will help the medical student to recognize an ethical dilemma, clarify the ethical issue, analyze the moral conflict using moral theory, and communicate and justify a moral recommendation should be taught and evaluated.

The skills/virtue dichotomy is, in my opinion, an artificial one. Medical ethics education represents both a skills and a virtues education. Medical students and residents should be exposed to a combination of clinical ethical skills as well as virtue ethics education. The program I will describe in the following chapters of this thesis will demonstrate my
program for ethics education of otolaryngology residents, encompassing both of these areas of clinical medical ethics. Recognizing that medial educators are in a position to inform residents technically and morally is central to this program of ethics education.

Medical ethics education does not take place in a cultural vacuum. The medical student internalizes much of the culture of medicine, its values, beliefs, attitudes and behaviors, outside of the formal medical education curriculum. This “hidden curriculum” is more concerned with continuing the culture of medicine than with teaching medical knowledge and technique. Often what is taught within this “hidden curriculum” is antithetical to the ethical goals of medical practice and can result in the progressive decline of moral reasoning during undergraduate medical education (Hafferty 1994).

Sociologically, medical training is the pathway by which laypersons are transformed into physicians. Students are taught what is valued in the new culture and the methods by which these new values are to be organized and obtained. Society at large and the medical culture in particular expect physicians to think about and react to patients and situations differently than lay people would. Thus the medical education of students is more than just acquiring medical knowledge and technical skills; it is also about learning new rules about values and responding to medical mistakes. Students enter medical school with a given set of values and norms and leave medical school as physicians with those norms and values modified. Their values have been modified to those of a physician acceptable within the culture of medicine and expected by the society at large (Hafferty 1994). As a surgeon who has been through this process of medical school and
post-graduate medical training I can attest that the “hidden curriculum” exists and much, if not all, of what is learned to be a surgeon takes place within it. Bosk, in his analysis of post-graduate surgical training, acknowledges that above all else surgical training involves the transmission of a distinct surgical morality (Bosk 2003).

If ethics education is to be faithfully undertaken within medical education, this “hidden curriculum” must be acknowledged. Some of what is conveyed within the “hidden curriculum” is in direct conflict with the messages of formal medical ethics education. Medical ethics educators must recognize this broader context of ethics training and acknowledge that the powers behind it are often more forceful than formal ethics education. Unless this fact is acknowledged, formal ethics education will be doomed to be buried in the context of mixed messages residents receive in the daily activity of life on the ward, in the clinic and in the operating room.

**Ethics Education in Surgical Residencies**

Beginning in the 1980’s, the American Board of Pediatrics and the American Board of Internal Medicine began requiring ethics education during residency training and have tested for competency in their respective certifying examinations (Grossman 2010). However it was not until 1999 that the ACGME Residency Review and Institutional Review Committees endorsed 6 general competencies: Patient Care, Medical Knowledge, Practice-based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and System-based Practice. These general competencies must be taught,
measured and evaluated for each resident in accredited residency programs. By placing interpersonal communications and professionalism on the same level as medical knowledge and patient care, the ACGME is sending a message to residency training programs that the moral development of future physicians is to be valued on par with the technical knowledge related to patient care. The ACGME committees are seeking to balance the moral character needed in every physician-patient relationship to provide compassionate care with the technical expertise needed to provide competent surgical care. By emphasizing practice-based learning and interpersonal communication skills, the core competencies are requiring residents to develop effective relationships with patients and their families and to work together for the best outcomes in health care. These habits, if ingrained in residents early in their career, will serve them well. It has been shown that the lack of an effective patient-physician relationship often results in increased litigation (Hickson 1992). The elevation of non-technical competencies to such a high level of importance places technical specialties such as general surgery and the surgical sub-specialties in a very difficult situation. In addition to learning the medical knowledge and the patient care aspects of our specialty, the highly technical aspects of the surgical skills must be learned and mastered. The task of integrating the core competencies into the surgical residency educational curricula has generally been left to the programs themselves, since only they have intimate knowledge of the experiences needed for their residents to attain the required proficiencies. The professionalism requirement of the ACGME core competencies requires the resident to demonstrate a commitment to carrying out professional responsibilities and adherence to ethical principles. Among these requirements are compassion, integrity, respect for patient
autonomy and cultural awareness (ACGME 2007). Ethics education is an integral component of professionalism within the ACGME core competencies, and a robust ethics curriculum within surgical residency would certainly meet the required professionalism component (Helft 2009).

In contrast to medical specialties, there exists a paucity of literature regarding ethics education in the surgical specialties. As of 2013, there were only 16 articles published regarding ethics education in general surgery or the surgical subspecialties. The majority of these articles describe the experience of a single institution, detailing the specific teaching methodology within the ethics education implemented at each residency program (Schneidman 2009, Wenger 1998, Robb 2005, Packer 2005, Holloran 1995, Klingensmith 2008, Kodner 2003, Angelos 1999, Wenger 2000). The primary methodology used was lecture-based didactic sessions. The data from these articles can be examined and summarized to suggest that the residents who undergo ethics education gain greater confidence in addressing ethical issues (Grossman 2010). Helft’s review of the surgical ethics education literature sorted the published literature into 4 basic categories: studies concerning the need for ethics education and a framework guiding teaching practices (Newton1986, Kodner 2003, Escobar 2005), prevalence of ethics education in surgical training programs (Downing 1997, Grossman 2010), empiric studies of surgical ethics education (Holloran 1995, Wenger 1998, Angelos 1999, Klingsmith 2008) and methodological studies of the measurements of educational program outcomes (Robb 2005, Joyner 2007). The results of the literature review showed a recognized need for ethics education and an increasing prevalence of ethics education in surgical
residencies. Most empiric studies described single institution experiences, and they were done with small numbers of residents. The results were generally favorable, with an improvement of the measured ethical variables after ethics instruction. The methodological studies showed variable results from the three institutions reviewed, with no general conclusions regarding a best methodology for teaching ethics to surgical residents (Helft 2009). Washington University published data from a 5-year experience of teaching ethics using a case-based ethics curriculum that showed an improvement in resident confidence to manage ethically challenging situations (Klingensmith 2008).

In 1997, a survey was conducted by Downing et al. to evaluate the status of ethics teaching in general surgery residency training programs. Downing used an eighty-item questionnaire to elicit objective data from program directors regarding program demographics, availability of ethicists, established hospital ethics programs, and the ethics curriculum for residents. The respondents were also asked to share subjective information about their attitudes toward the importance of ethics education for surgical residents, topics that should be included if ethics were part of the curriculum, and whether ethics should be included in the standard surgical examination. The non-responders were mailed 2 subsequent reminder questionnaires. The data was then statistically analyzed and presented.

In the Downing study, a 71%(198) response rate was obtained, with 85% percent of respondents favoring a standardized curriculum in ethics, but none of the respondents indicated that they had regularly scheduled ethics sessions as part of the general
education of surgical house staff. Twenty-eight percent of respondents offered no formal ethics education, 48% offered only one ethics education event a year, and 24% offered two or more events. Thirty-five percent of the respondents indicated that they had a faculty surgeon with either interest in or advanced training in ethics. Those programs with a faculty surgeon with a special interest or expertise in ethics sponsored a greater number of ethics teaching activities. The majority of the respondents indicated that the responsibility for ethics education should be within the surgical faculty. When assessing the attitudes toward ethics education, the program directors ranked education and experiences during surgical training as being the major source from which surgeons should learn ethical practice. Despite the fact that the majority of respondents indicate that teaching and testing of ethics should occur in medical school and during surgical training, a minority indicated that ethics should be part of the Surgical In-service Training examination or the written General Surgery board examination (Downing 1997).

A study a year later in pediatric surgery questioned the graduates of pediatric surgery residencies. This study consisted of an eighty-item questionnaire gathering the respondent’s demographics data, educational experience in bioethics during pediatric surgical residency and self-assessed expertise in bioethics. This study yielded a 78% (109) response rate with only 9% reporting a formalized clinical bioethics education as part of their pediatric surgical residency. Informal bioethics education, which was defined as resident participation in the management of patient ethical dilemmas, was noted in 88% of respondents. Twenty-eight percent of responders reported additional experience in bioethics, either with advanced study in bioethics or as members of hospital
ethics committees. All respondents preferred case-based discussions with a knowledgeable individual and supervised sessions dealing with real patient dilemmas as the best teaching modalities. Ninety-seven percent of the responders agreed that clinical bioethics should be an element of the pediatric surgery residency program. Over half of the participants noted that pediatric surgical practice frequently include ethical dilemmas and that more instruction in bioethics during residency would have been helpful (Robin 1998). These findings of graduates of pediatric surgery residencies mirrored the findings of Downing’s survey of general surgery program directors a year earlier. Both of these groups (residency program directors and graduated residents) affirmed the importance of clinical bioethics education in surgical residencies.

In 2008 Grossman performed a follow-up study of general surgery residency program directors. Using a web-based questionnaire modeled after the survey developed by Downing a decade earlier, Grossman surveyed all U.S. general surgery programs directors to gather data regarding program demographics, availability of ethics consultants in residency, ethics teaching modalities, curricular activities incorporated into ethics education and any perceived impediments to ethics education. Program directors were also asked to describe their attitudes towards the importance of ethics education. This survey yielded a response rate of 44% (113) compared to Downing’s 71% response rate. Only one responder admitted that there was no formal ethics education program incorporated into the general surgery residency program. The manner in which ethics education was incorporated into the program varied, with the majority of the programs using ethics education as part of the core surgical education curriculum. The
methodology for ethics education also varied, with the most common modality being
lecture-based didactic sessions. Other methodologies included case-based learning and
an integration of both lecture and case-based learning. Faculty from multiple disciplines
was used to facilitate ethics education, and most affiliated institutions had an associated
ethics consultation service. Eighty-three percent of program directors favored mandatory
and formalized ethics education, and 94% believed their surgical residents to be satisfied
with their ethics education. There were 3 impediments to ethics education listed by
program directors: limited faculty with ethics expertise available for teaching activities,
limitations imposed by the 80 hour work week and lack of faculty interest (Grossman
2010). This follow-up survey demonstrated that in the intervening twelve years, 99% of
general surgical residencies had incorporated ethics education into the curricula, with
many more resources available to enhance ethics education. Although Grossman does
not attribute this increase in ethics education in general surgery residencies to the
implementation of ACGME core competencies, this requirement for accreditation
undoubtedly had an influence in the reporting of increased ethics education.

A Survey of Ethics Education in Otolaryngology Residencies

Along with Drs. Dan Kirse and Megan Wilson Wood of the Department of
Otolaryngology of Wake Forest University School of Medicine, I designed the present
study to evaluate the current status of ethics education in otolaryngology residency
training programs in the United States in light of the recent requirements for ethics
educations as part of the professionalism core competency recognized by the ACGME
(ACGME 2007). To improve the ethics education of Otolaryngology residents, we must first establish a baseline of ethics education in Otolaryngology residency programs. The recent studies of ethics education in general surgery residencies offer a comparison with Otolaryngology resident ethics education.

**Survey methods**

A survey of all ACMGE-accredited otolaryngology residency training program directors was undertaken after approval by the Wake Forest University Institutional Review Board (IRB 18369). The survey was a 17 question; multiple-choice, web-based questionnaire modeled after the previous Grossman survey of general surgery program directors (Grossman 2010) and is attached to this thesis as Appendix A. The questionnaire, along with an introductory e-mail message (Appendix A) describing the goals of the research, was electronically distributed to the program directors (PDs) of all ACGME-accredited otolaryngology training programs, using the web-based Survey Monkey system to reach the broadest range of potential responders. The initial e-mailing was followed by two reminder e-mails at 1 and 3 weeks after the initial e-mail to all non-responders. The follow-up e-mails contained a link to the Survey Monkey website to allow these non-responders to complete the survey. All responses were de-identified to increase potential response rate to the survey.

The survey was designed to acquire data regarding program demographics, established ethics curricula, the availability of resources for ethics education, the ethics teaching
methodologies, and any impediments to ethics education. In addition to these data, PDs were asked to comment on their opinion of resident desire for formalized ethics education, the level of importance the residents place on ethics education in their program, the desire for increased ethics education by residents, the level of resident satisfaction with their ethics education and the level of resident preparedness to deal with challenging ethics situations.

Survey results

Despite the initial e-mailing and two-reminder emails, survey participation was low, with only 23 of 103 program directors responding. Participating program directors were first asked to supply demographic information. Only twenty-one of the respondents supplied demographic data. The majority, 18 of 21, of the Otolaryngology residency training programs were university-based, with 1 program community-based and 2 programs military-based. All primary training hospitals were larger than 300 beds, and 12 training programs were based at teaching hospitals with greater than 600 beds. The programs varied in the number of residents matriculating each year, from one to four residents a year.

When questioned regarding the principal ways in which otolaryngology residents are exposed to ethics education, the majority (75%) reported ethics education to be part of the core curriculum, 55% reported exposure on a case-by-case basis as specific situations arise, 50% stated that ethics education was included in departmental grand rounds, and 1
program responded that ethics education was part of the critical care rotation. Four programs listed other methods of exposure to ethics education. These four programs used methods such as Journal Clubs, Mortality and Morbidity conferences and also Ethics and Palliative Care consultations as their principal means of ethics education exposure. Three programs failed to respond to this question. Regarding the methodology used to teach ethics, 40% percent of the PDs responded that they used a combined case-based/lecture format as their primary teaching methodology for formal ethics education currently incorporated into the core curriculum. Thirty-five percent reported lecture-based didactic learning sessions, 15% reported case-based learning, 2 programs admitted to having no ethics education currently incorporated into the residency training program and 3 respondents failed to answer this question. The majority of otolaryngology residency training programs (70%) utilized members of the facility’s ethics faculty to provide ethics education in their department. Other institutions used clinical faculty from multiple departments to facilitate ethics education. These departments included: surgical faculty 60%, medical faculty 30%, pediatric and psychiatry faculty 5%. Ninety-five percent of respondents indicated that ethics consultation service was available at their primary teaching hospital.

When asked questions about resident attitudes toward ethics education, the results were split: 50% believed that residents desire formalized ethics education, and 50% believed that residents do not desire formal ethics education. When asked what level of importance residents were believed to place on ethics education, 50% responded with a neutral response, indicating that the residents had no preference for importance of ethics
education, 25% felt residents would place a high importance on ethics education, 20% would place low importance and 5% very low. None of the program directors perceived that otolaryngology residents placed a very high importance on ethics education. Ninety-five percent of responders believed that residents at their institution do not desire more formalized ethics education than is currently being offered. Forty-five percent of the program directors believed that residents at their institution were somewhat satisfied regarding their ethics education, 25% believed them to be extremely satisfied, and 30% responded neutrally regarding their resident’s satisfaction regarding ethics education. Fifty percent of directors believed their residents to be somewhat prepared in dealing with ethically charged situations upon completion of residency, 35% believed their residents to be very prepared, 10% percent had a neutral response and 5% believed them to be somewhat unprepared.

Finally, the residency program directors expressed attitudes toward ethics education in otolaryngology residency. Fifty-five percent somewhat agree that ethics education can improve one’s ability to handle ethically challenging situations, 25% very much agree, 10% responded neutrally, 5% somewhat disagreed and 5% very much disagreed. Seventy percent believe that ethics education should be a mandatory part of the core educational curriculum in otolaryngology residency. Fifteen percent of responders believe that ethics education should be self-selective, available to residents, 10% believe ethics education should be on an “as needed” basis when challenging situations arise, and a single responder believed ethics education should not be formally required during residency but rather implemented for undergraduate or medical students. Sixty-five percent of
program directors reported multiple resources available at their home institution to facilitate ethics education. These resources included ethics departments, ethics consultation services, faculty with ethics education and training and faculty willing to participate in ethics teaching. Thirty percent reported some resources available, and 5% reported few resources available for ethics education. Thirty-five percent of respondents did not believe that the additional requirements/restrictions on residency training affect the ability to institute a formalized ethics education curriculum, while 30% found these restrictions to be somewhat challenging, 20% very challenging and 15% nearly impossible. When asked to list significant impediments to instituting a resident ethics education program, the largest contributor was lack of faculty interest (cited by 55%), followed by lack of resident interest (45%), the 80-hour work-week (40%), limited faculty with ethics expertise available for teaching (40%) and lack of university or departmental support (15%). Thirty percent of respondents reported minimal impediments to ethic educations activities.

**Discussion of Survey Results**

The field of Otolaryngology is demanding technically, intellectually and ethically. Virtually every clinical encounter includes an exchange of information as well as recognition of values; within every surgical theater is a technical dance as well as a moral symphony. The contemporary patient demands the moral awareness of her surgeon as well as his technical and intellectual expertise (Siegler 1996). The ACGME has acknowledged this fact by establishing core competencies for graduate medical education
Medical schools in the United States universally include ethics education in their curricula (Fox 1995). Downing’s survey of general surgery programs in 1997 showed that 72% of responding general surgery residency programs responding had ethics education programs in place, and Grossman’s follow up survey in 2009 showed 99% of responding programs offered ethics education programs (Downing 1997 Grossman 2010). Our survey of Otolaryngology programs showed that 90% of the respondents had some form of ethics education in place at their institutions. The major limitation of our data is the poor response rate to our electronic survey. Despite the initial e-mail and two reminder e-mails, only 23% of otolaryngology program directors responded to the survey. Previous electronic surveys of otolaryngology program directors on other subject matter have generated survey responses of 39% and 46% (Sharp 2011, Shen 2011). There was also a downward trend in response to requests for information related to ethics education in general surgical residencies from 71% in 1997 to 44% in 2009 (Downing 1997, Grossman 2010). Whether this decrease in response rates represents a fatigue to surveys in general and the resultant lack of interest to respond to surveys overall, or a lack of interest in the particular subject matter of ethics education in otolaryngology residency programs, remains difficult to determine. Another possibility for the limited response rates could be technical limitations of Internet based surveys. Technical issues such as
browser incompatibility and web blocker software could have prevented some program directors from easily responding to the web-based survey.

This survey was undertaken to determine a baseline of interest, activity, needs and resources available to otolaryngology residency PD in regards to ethics education. Since many otolaryngology residency training programs now exist outside the direct supervision of and resources available to General Surgery departments, the information gathered from previous surveys of General Surgery program directors may not accurately reflect the needs and resources of otolaryngology departments. The results of our survey of otolaryngology PD show that those programs responding have diverse curricula utilizing many formats, including the core otolaryngology curriculum, case-by-case education and the grand rounds format. The methodology used by PDs for ethics education was also diverse, with the majority using some variation of case-based learning and smaller numbers using didactic sessions. One respondent admitted no formal ethics education, and there were 3 non-responders to this question. It is likely that the results of this survey may also be skewed to those programs that already have an ethics education curriculum. Since ethics education is a required portion of Otolaryngology residency training as mandated by the ACGME, those residency training programs that do not have an ethics education program in place are in danger of being found noncompliant, and thus the directors of these programs may not have been willing to respond to the survey.
Only 70% of the responding otolaryngology program directors believe ethics education should be mandatory, despite the ACGME core competency requirements. Twenty five percent of respondents felt ethics education should be self-selective, available for interested residents, or on an “as needed” basis as challenging situations arise, and 5% believe ethics education should not be formally required in residency, rather implemented in undergraduate or medical student education. The need for ethics education has been clearly stated by the ACGME requirements and is well supported in the literature. The fact that society at large expects surgeons to have a working knowledge of clinical medical ethics in addition to technical skills and medical knowledge should drive the need for ethics education in otolaryngology residency training (Siegler 1996). We as otolaryngologists who accept the responsibility of training the next generation of our profession must accept that one of our first duties is to inform their moral development as well as their intellectual and technical knowledge.

The largest impediments to ethics education were lack of faculty interest and expertise, lack of resident interest and the 80-hour workweek requirement. Despite these limitations, I maintain that ethics education should be an integral and required part of otolaryngology resident training. It is incumbent that residency program directors recognize these limitations and find ways to continue and enhance ethics education. Otolaryngology faculty must be educated about the importance of ethics education to their residents, the future of the profession. Although individual faculty members may not have specialized training in ethics, they certainly recognize the importance of ethical behavior in their individual patient encounters as well as interpersonal relationships with
colleagues. If individual faculty cannot be convinced of the importance of ethics education to their residents, I question whether they should be involved in resident education and training. If ethics expertise is not available from within the department, individuals with ethics education expertise should be sought out from within the institution to provide the necessary expertise to provide this education. Resources for ethics education should be garnered from outside the department and institution if necessary to enhance this portion of the resident’s ethics education, possibly from an associated medical school or university. Lacking these resources, independent ethics consultants or educators should be sought out if there is no other avenue to obtain appropriate ethics education to meet the needs of the residents and adhere to the standards set forth by the ACGME. While the residents themselves may not recognize the importance of ethics education, they must be brought to understand the significance of clinical medical ethics and its importance to their future patients and society in general. The ideal people to emphasize this learning opportunity and its importance are the otolaryngology faculty. These attending physicians have real world experience that can be brought to bear to emphasize the crucial importance of ethics education. If attending physicians fail to emphasize the importance of ethics education and ethical behavior to their residents, they are doing their residents, the medical profession, future patients and society in general a disservice. The otolaryngology residency program directors must accommodate to the reality of the 80-hour workweek for residents. More education is crammed into less and less time. The reality of teaching medical knowledge and technical skills must be balanced with the need to produce ethical physicians and
surgeons. This may require sacrificing other educational opportunities to provide adequate time for the resident ethics curriculum.
Chapter 2

Year One of a Pilot Program in the Wake Forest School of Medicine Department of Otolaryngology: Clinical Ethics Education

The second chapter of this thesis will describe the pilot program in clinical ethics education I developed for the otolaryngology residents in the Section of Otolaryngology at Wake Forest School of Medicine. Additionally, it will discuss the results of the post-course survey to assess resident satisfaction with the format of the program, as well as the resident’s self-perceived ability to recognize and handle clinical ethical issues pre- and post-course completion. This course was developed, in part, to satisfy the requirements of the Accreditation Council of Graduate Medical Education (ACGME) for ethics education in otolaryngology residency. However, it was also developed to provide the otolaryngology residents with clinical ethics skills in a more formalized curriculum, in order to assist their ethical discussion with patients and to develop ethical problem solving skills. Prior to my development of this program, the section of Otolaryngology at Wake Forest met this ACGME requirement for ethics education by stating “…our residents have excellent faculty role models for professionalism and learn the qualities through ample interaction with faculty in outpatient clinics, when rounding on inpatients and also in the operating room” (Otolaryngology PIF). The residents developed clinical ethics skills by informally observing and modeling the ethical behavior of their attending physicians. Attending physicians were expected to model clinical ethical skills for their residents, usually without any formalized ethics training. There were also brief self-
administered online modules for all Wake Forest School of Medicine residents to complete prior to matriculating from residency. The content and quality of these online modules varied greatly.

Participants

The participants in this clinical ethics education pilot program included ten residents from the PGY 2 to PGY 5 level. At times, surgical interns and medical students assigned to Otolaryngology rotations attended the ethics conferences, participating in varying degrees in the discussion, but they were not surveyed at the completion of pilot program since they did not participate in the majority of the conferences. All of the participants noted that they had medical ethics courses during medical school. Initially, they expressed varying degrees of interest in clinical ethical issues and little recollection of the specific content of their medical school ethics education. These residents provide the primary contact for all inpatient clinical care of patients admitted to the Otolaryngology service at Wake Forest Baptist Medical Center, under the direction of otolaryngology attending faculty. They are the primary contact for emergency department and inpatient consultations and also are responsible for an outpatient clinic where they provide all manner of otolaryngology care to an uninsured and under-insured patient population under the supervision of attending otolaryngology physicians.
Structure of the Pilot Program

I developed a series of six case-based ethics education modules and presented ethics education conferences to the Otolaryngology residents on a bi-monthly basis during the 2011-2012 academic year. These modules consisted of 60-minute presentations on designated Wednesday mornings, the departmental academic day. These presentations were made following an Otolaryngology Grand Rounds presentation to maximize resident participation. On any given conference day approximately 8 of the 10 residents participated, with some being absent due to operating room attendance, vacation, or other scheduling conflicts. This series of conferences was developed and based upon Ethical Issues in Clinical Surgery published by the American College of Surgeons (McGrath 2007). The Committee on Ethics of the American College of Surgeons developed Ethical Issues in Clinical Surgery for the express purpose of helping surgeons examine the ethical underpinnings of clinical surgical practice in today’s complex practice environment. The topics presented included: Confidentially, Competition of Interests, Truth Telling and the Surgeon–Patient Relationship, Professional Obligations of Surgeons, End-of-Life Issues and Substitute Decision Making. The first fifteen to twenty minutes of the conferences were dedicated to the examination and discussion of the moral theory underlying the topic being discussed and the remaining time was dedicated to the application of clinical ethics skills by using example cases. The Power Point slides used during these presentations are attached as Appendix B.
Conference 1: Introduction and Confidentiality

From the beginning of the conferences, I emphasized to the participants that medicine and surgery take place in a relationship that is uneven by its very nature (The Doctor-Patient relationship). Every clinical encounter includes an exchange of clinical information as well as a moral encounter with an exchange of values between the surgeon and the patient. As surgeons, we are an authority regarding medical and surgical information; however, patients are in authority regarding decisions on their medical and surgical care. Often the moral component of the clinical encounter is not obvious to both parties, since there is a shared value of restoration of the health of the patient. It is only when the values of the surgeon and patient come into conflict that the moral dimension of the clinical encounter becomes obvious (Jonsen 2010). In addition, Siegler claims that the modern patient demands both moral awareness and technical and intellectual expertise of her surgeon (Siegler 1996).

The ACGME has echoed this sentiment by establishing six core competencies for graduate medical education in 1999 (ACGME 1999). Professionalism is one of these core competencies, and clinical medical ethics remains at the center of the competency of professionalism. The American College of Surgeons and The Royal College of Physicians and Surgeons of Canada have recently established curricula for bioethics education for residents (ACS, RCSC). I emphasized to the residents that moral deliberation does not lead to a single morally correct answer in all clinical situations, but
it will aid the surgeon in determining what options are ethically impermissible. The theories of moral philosophy grounding ethical decisions are multiple, including virtue theory, consequentialist theory, deontologic theory, social contract theory and simple rule keeping. Often combinations of these theories provide moral justification for a particular act, and the judgment of the agents involved in the specific circumstance is essential to moral deliberation. The method for moral reasoning used in these conferences was a combination of the model proposed by John Moskop, PhD and the CASES approach as developed by the Veteran Health Administration (Moskop unpublished, VHA). This method included the following steps: 1) Recognizing that a conflict of values exists, 2) Stating the moral problems as clearly as possible, 3) Collecting the relevant information, 4) Identifying the options for action, 5) Evaluating the options in the context of rights, duties, values and interests of the parties affected and 6) Assessing the consequences of actions. I stressed to the participants that although this method for moral reasoning was presented in a linear fashion, the process of moral deliberation often required the agent to move back and forth between the steps to achieve the goal of well-reasoned moral deliberation and to arrive at morally acceptable conclusions.

After the introductory moral theory background, the first session turned its attention to the issues of confidentiality in the surgeon-patient relationship. The learning objectives for the participants were to understand why confidentiality was important, understand the shift from the one-on-one surgeon-patient relationship to the team approach of medical care as it applies to confidentiality, understand the principles justifying exceptions to confidentiality and be aware of some of the legal requirements regarding confidentiality.
Confidentiality was explained as having its premise in the patient’s right to privacy and to be left alone. Once the patient’s private information is shared with the surgeon, it becomes confidential between the surgeon and patient. This confidentiality can only be broken in specific circumstances. Confidentiality serves three central purposes in the clinical setting. First, it acknowledges respect for the patient’s sense of individuality and privacy. The patient’s most personal information is kept confidential to respect the patient’s autonomy and avoid vulnerability. Second, confidentiality is important in achieving the central goal of medicine and surgery, which is to improve the health of the patient. Maintaining confidentiality assures the patient that his private information will not be shared further. The result is that patients feel free to give private information and communicate honestly with treating surgeons. This communication is critical to the diagnostic and treatment process and overall patient care. Third, in keeping information confidential the patient can be protected from possible discrimination in employment, housing and insurance practices (McGrath 2007). Lastly, confidentiality was reviewed in the face of current legal requirements, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which standardized and codified policies and procedures for the privacy of patient confidential information (HIPAA 1996).

Hypothetical cases were then discussed and analyzed to enable the participants to work through various confidentiality scenarios. The first case discussed whether it was appropriate to breach confidentiality and to report to public authorities in the case of an aggravated assault. This case highlighted the tension that exists between maintaining patient confidentiality and the statutory requirement to report certain actions in the
interest of public welfare. While statutory duties exist and deference to the law should be
honored in most cases, it was emphasized that the law does not always define moral
actions. If there is no clear relationship between demanded disclosure and the safety of
the individual or the public, then moral arguments can be made to contest demanded
disclosure of confidential information.

The second case involved the tension between the surgeon’s duty to maintain patient
confidentiality and the surgeon’s responsibility to warn a third party to prevent harm. In
this case a man was determined to have HIV and refused to warn his spouse. Options
considered were to continue to encourage the husband to inform his wife voluntarily, to
contact the wife and his other sexual partners directly, or to inform the health department
of the infection and have the health department proceed to contact his sexual partners.
The ethical analysis of this case showed that the need to protect third parties could
supersede the need to keep patient information confidential. In this case, the surgeon’s
professional obligation to maintain the confidentiality of patient information was
outweighed by the surgeon’s professional obligation as a member of society to protect
another identifiable individual from harm. It was further discussed that this obligation is
not limited to physicians, but extends to other professionals such as psychologists, clergy
or other professionals who may have access to confidential information that directly
affects the safety of innocent third parties. In this case it was decided that the health
department has the resources and policies in place to minimize harm to all concerned and
is the best option for notifying the patient’s potential contacts.
The last case in the confidentiality presentation involved an infected surgeon. The question asked was: What duty does the infected surgeon have to disclose his infection status to potential patients? This subject hit the otolaryngology residents very close to home. All the residents are exposed to infectious blood-borne diseases such as HIV and hepatitis during the course of their training. Residents were questioned: if surgeons are infected with blood-borne pathogens, should they limit their practice to non-operative procedures or should they disclose to each individual patient their infection status during the discussion of risks inherent for a given procedure? Should a blood-borne exposure occur, what is the proper method for notification of the patient? It was noted that national law is largely silent on this issue; however, the North Carolina State Medical Board does have a position statement in place for HIV/HBV infected health care workers (North Carolina Medical Board 2003). In this discussion, the residents were asked to assume patient roles. I asked them if they thought the information that their surgeon carried a blood-borne pathogen was prudent information that they would want to know prior to making an informed consent decision for their own surgery. This discussion was framed in the context of the deontological categorical imperative: “Never act except in such a way that I can also will that my act maxim should become a universal law” (Kant 2002). The answer of all the residents was that information of the surgeon’s positive HIV or HBV status would be necessary for them to form an adequate informed consent decision for invasive surgical procedures.
**Conference 2: Competition of Interests**

The second conference was on the subject of competing interests in surgical practice. Here the concept of the fiduciary duty of the surgeon to her patient was introduced. Fiduciary duty was first discussed in the legal sense as the primary duty to act for the benefit of others. Fiduciary duty is derived from a covenant of trust between the parties involved and from the principle of justice. Physicians profess their intention to serve individual patients in this fiduciary way. In the case of surgical practice, putting aside self-interest and focusing on the interest of the person for whom the surgeon is acting as a fiduciary, namely the patient, exemplifies this fiduciary duty. Competition of interests involves situations where self-interest is in tension with another obligation. Not all competing interests rise to the level of a conflict of interest. Physicians are constantly encountering competing interests for their time. They must balance the allocation of time between patient care, continuing medical education, teaching, research and family obligations, just to name a few. Many times competing interests can be balanced such that most of the interests are satisfied in the process of arriving at the correct course of action. Sometimes however, competing interests require the surgeon to make decisions that fulfill one set of interests to the detriment of another obligation. The classic conflict of interests in medicine exists when the surgeon’s financial interest motivates behavior contrary to the needs and interests of the patient. Other conflicts can involve professional, personal or family obligations. The presentation next turned to why competing interests are problematic. Potential harms included: direct harm to patients (such as unnecessary surgery), and the degradation of the integrity of medical decision making.
making resulting in distrust of the medical profession and decreased effectiveness of the health care in general. It was further discussed that even the appearance of conflict of interest may be enough to cause damage to the individual surgeon’s reputation or to the reputation of the medical profession in general.

Specific cases of competing interests including financial, professional and personal were discussed in an attempt to outline the criteria for identifying conflict of interest. These criteria include the following: situations where patient outcome may worsen because the surgeon subordinates the interest of the patient for personal gain, situations where the surgeon may make decisions that do not directly harm the patient but are not in the patient’s best interest, situations that create the potential for secondary gain, and situations that present the appearance of conflict of interest. Conflicts of interest are addressed at multiple levels. These include the individual physician carefully monitoring her own actions, the medical community monitoring its member’s actions through codes of conduct and guidelines for the resolution of conflicts of interest, and society as a whole enacting regulations and law to resolve conflicts of interest if the individual and medical community cannot police themselves. We lastly discussed how conflict of interests should be managed. The tools for managing conflicts of interest are to minimize the environment where conflict of interest may occur, to disclose to the patient and public when a potential for conflict of interest is present, and in some instances to prohibit certain actions when the risk of conflict is severe. The ethical ideal is to accommodate competing interests as well as possible and to recognize that the patient’s interests take priority over the interests of the surgeon and third parties (McGrath 2007).
Conference 3: Truth Telling and the Surgeon-Patient Relationship

The third lecture involved taking a closer look at the surgeon-patient relationship and special conditions that exist within that relationship as they apply to communication and the informed consent process. We discussed some of the special conditions of the surgeon-patient relationship, including the following: the patient presents in need of rescue from a disease process, the surgeon often does not have a long term relationship with the patient, the decision for surgery is often made within the first clinical encounter, and the patient is often fearful of surgical risks and sequela (Little 2006). Common characteristics of the surgeon-patient relationship include: being shorter term, more intense, highly emotional and having an increased sense of loss of control. These characteristics may make it harder for the patient and surgeon to form a strong therapeutic relationship. Also to be considered in this relationship is the tension that can exist between the patient’s sense of autonomy and the surgeon’s commitment to beneficence. The surgeon is an expert in medical knowledge and the surgical discipline. It is incumbent upon the surgeon to gather the relevant patient data and combine this with his expert surgical knowledge to arrive at a recommendation for best patient care. The patient then must take this recommendation for care and develop a plan for the treatment of the surgical condition that is congruent with his or her own value system. The surgeon’s recommendation for optimal patient outcome may be in conflict with the wishes of the patient. To remedy this conflict and determine the best course of action for a specific patient is the heart of the surgeon-patient relationship.
In discussing truth telling and the informed consent process, the participants and I explored the bioethical principle of respect for the autonomy of the patient as the primary principle underlying informed consent. We discussed that informed consent is not a form to fill out and have the patient sign but is a process in which information is communicated honestly between surgeon and patient. The elements of informed consent include disclosure of risks, benefits, and treatment options to the degree that a reasonable person would find sufficient to base a clinical decision. This is the reasonable person standard of informed consent (Canterbury v. Spence). This standard allows and in fact usually necessitates that the surgeon express a recommendation for the patient’s treatment. She needs to be more than just a repository of facts but must communicate her values as to the appropriateness of surgical intervention. Furthermore, this communication affords the surgeon the opportunity to help the patient explore his or her own values regarding the proposed surgical intervention. The participants were cautioned to take a non-directive approach to the values discussion with their patients since the surgeon’s values regarding a specific set of medical circumstances may differ significantly from the patient’s values given the same circumstances. The second element of informed consent was an assessment of the patient’s rational understanding of the proposed procedure. This is a measure of the individuals’ capacity to make medical decisions. Capacity was presented to the residents as being a medical determination that was case and decision specific. Thirdly, we discussed the importance of the patient’s choice to be voluntary and without coercion from the surgeon, family members or other interested individuals who may have an interest in the outcome of the patient’s care. Lastly, the patient must be able to effectively communicate his or her decision to the
surgeon. I emphasized open and honest communication during the transfer of information to the patient and how this communication encourages the informed consent process, which helps the patient take ownership of their healthcare.

Illustrative cases were then discussed to guide the participants through various scenarios of conflict during the informed consent process. These cases included a patient who declined surgical intervention in a life-threatening situation and a patient who did not seem to appreciate the consequences and sequela of his proposed treatment. The residents engaged in significant discussion about the proper way to handle these two cases, and in the course of discussion they brought up other examples of cases where this clinical dynamic was encountered.

**Conference 4: Professional Obligations of Surgeons**

The fourth topic, professional obligations of surgeons, was discussed in the context of the social contract that exists between medicine and the public (Cruess 2008). It was pointed out that society has certain expectations of the medical profession as a whole. Among these are service to those in need, guaranteed clinical competence, altruistic service and high moral integrity. Society expects surgeons to promote the public good, to make decisions in a transparent way and to be accountable for their actions. In return, medicine and surgery are granted a significant degree of autonomy and trust in licensing and regulating their practice. This is evidenced by the presence of state medical licensing boards, professional associations and professional standards set largely by the profession.
itself, with limited interference from outside organizations. Because of recent abuses of this social contract and trust, such as fraudulent billing for medical service and the continued licensing of incompetent physicians, medicine has suffered a decline in its high esteem as a profession. As medicine moves from a professional model toward a business model of practice, this high esteem will become even more precarious. The residents observed that, as a result of these breaches of public confidence, outside influence by legislators and bureaucrats has become more intrusive in the practice and regulation of medicine. The session identified three general obligations of surgeons: our primary obligation to the health of our patients, our obligation to other medical professionals, and our obligation to society as a whole.

Two cases were discussed, each emphasizing various aspects of professional obligations to patients. The first case facilitated the discussion of professional competency and how competencies are determined. In surgery, competencies are specific to the task at hand. Residents are participants in graded responsibilities under the supervision of their attending surgeon. Once they graduate from residency they are judged to be competent by their residency director and later by members of an examination committee and certification by professional licensing boards and specialty organizations. Surgeons are presumed to be competent at the completion of their residency, and they must maintain their presumed competency through continuing medical education and in some instances through maintenance of certification by specialty boards. Continuing competency is also assessed by peers in the setting in which they practice, as, for example, by the granting and renewal of hospital privileges. Failure to maintain this competency jeopardizes the
moral foundation of the surgeon-patient relationship. Failure to maintain competency also undermines the medical profession’s obligation to society as a whole. If the society cannot rely on medical professionals to be competent in their specific practice setting, reliance on the medical profession as a whole is called into question.

The second case involved the surgeon’s responsibility in maintaining care for patients in an on-call situation. In this case it becomes the surgeon’s responsibility to continue a commitment to unpleasant patients. This was analyzed in the context of social contract where the public has expectations that the surgeon will use his knowledge and skill to render care to “unpleasant” or indigent patients as a feature of his broader obligation to society as a whole. Dr. Edmund Pellegrino describes the moral basis for this obligation as follows: “The physician’s knowledge… is not private property…Rather, the profession holds medical knowledge in trust for the good of the sick. By accepting the privilege of a medical education, those who enter medicine become parties to a covenant with society…[They] enter a community bound by [this] moral covenant” (Pellegrino 1993). This can also be seen as an obligation to other members of the medical profession. Surgeons must not be seen as “dumping” unsavory patients on another provider simply for the first surgeon’s convenience.

Other cases were used as tools for discussion of the surgeon’s obligation to the profession and society in general. It was stressed that the surgeon has responsibilities to evaluate and supervise other members of the treatment team, while always keeping the best interest of the patient as his or her primary focus. Surgeons are required to report
incompetent physicians and not to undertake procedures that they themselves are not competent to perform. For example, although a surgeon may be competent to perform a specific procedure, the remaining members of the surgical team may not be competent to perform the procedure or the facility in which he is practicing may lack the appropriate resources. In these cases it is the obligation of the operating surgeon to keep the best interest of the patient foremost. In keeping with the resident’s responsibility for their training, a case was discussed where a resident was asked perform a procedure without direct supervision. The residents discussed whether this was ever appropriate and if so, under what circumstances? Residents play an important oversight role in their own education, and added responsibility is often seen as an achievement. However, residents must not accept increased responsibility if they have doubt about their competency to proceed. The primacy of protecting the patient is paramount, and competencies of the resident must be addressed separately.

**Conference 5: Substitute Decision Making**

The substitute decision-making conference began by reviewing the issues related to patient autonomy. Autonomy was defined as being free of the controlling influence of others (liberty) and having an adequate understanding of the situation at hand to allow for self-choice (agency) (Beauchamp 2009). The underlying moral principle of surrogate decision-making is the respect for the autonomy of the individual patient. When a patient lacks the capacity to make autonomous decisions, a surrogate decision-maker is authorized to make a treatment choice on the patient’s behalf. The patient’s wishes may
be expressed in a document such as a living will or health care power of attorney. The standards for proxy decision-making were then discussed. The highest standard that proxies should use to make medical decision is the Substituted Judgment standard. The Substituted Judgment standard requires the surrogate to make, to the best of their ability, the same decision as the patient would have made based upon their knowledge of the patient’s values, beliefs and principles. The surrogate decision maker should use the expressed wishes contained within any documented living will to guide them in making surrogate health care decisions. In the absence of documented expressed wishes, the surrogate should rely upon their personal knowledge of the patient’s wishes. If the surrogate cannot meet this standard then the Best Interest Standard (a decision made to promote the patent’s overall welfare based upon good medical judgment) should be used. Factors that should be considered under the best interest standard for the patient include: weighing the risks and benefits of the procedure, pain and suffering associated with the proposed treatment, potential for benefit and possible sequela of the procedure (AMA Opinion 8.081) Questions for the surgeon to consider in cases of surrogate decision making include: Is the person making patient care decisions for an incapacitated patient a legally authorized surrogate? By what criteria is the surrogate making decisions? How can surgeons mediate conflicts between surrogates?

Cases were then discussed to illustrate the difficulties in the surrogate decision-making process. If no surrogate was identified for an incapacitated patient, then how is the correct course of action determined? We discussed the process of obtaining a guardian for an incapacitated person and the criteria that are used to determine whether the
surrogate is making appropriate decisions regarding medical treatment. The Best Interest standard was discussed as it relates to effectiveness of treatment, risks of treatment, and the benefits and burdens of treatment modalities on the incapacitated patient. Conflict between surrogates was then discussed, as well as the legal hierarchy of surrogate decision makers. Lastly, decisions regarding substituted decision making for children were discussed using a case requiring urgent decision-making. This expanded into the consideration of the religious beliefs of parents as they relate to medical decisions regarding their children. Parents are presumed to be acting in the best interest of their children. If, in the opinion of the surgeon, the child’s best interests are being ignored or subjugated to the parent’s wishes, an ethics consultation or a legal opinion should be sought. Ultimately, it is the physician’s responsibility to act to protect the child’s best interests.

**Conference 6: End-of-Life Issues**

The last of the series of clinical ethics conferences was dedicated to end-of-life issues. Once again, the primary moral principle underlying end-of-life issues was respect for the autonomous individual. We discussed the primary importance of exploration of the patient’s values regarding end-of-life care. The patient’s values often do not correspond to the surgeon’s values, and, as previously stated, long-standing surgeon-patient relationships, which would allow for increased knowledge of the patient’s values, are not the norm in modern surgery. The surgeon cannot presume to know the patient’s value system, and ultimately the patient’s wishes must be honored. Practical considerations
were discussed, including raising important questions regarding end-of-life care early in the disease process rather than later. We discussed the importance of determining the capacity for patients to make decisions regarding their end-of-life care, as well as respecting their decisions regarding medical limit setting. It is imperative to remember that issues can and do change during the disease process. I emphasized the need to have other resources, such as the patient’s primary care physician, clergy, social work and ethics consultations, to facilitate decisions regarding end of life care.

Cases discussed included the possibility of having do not attempt resuscitation orders in the OR, issues related to apparent medical futility in the ICU after surgery, and issues surrounding withdrawing and withholding treatment. Residents were anxious to bring up their personal experiences related to these issues. It was clear from the discussion that these residents have dealt with many end-of-life issues on a professional and personal level. These issues raise a great deal of moral distress among the residents. Discussing them in a personal and non-threatening conference aided in their ability to think through the issues involved in a systemic manner and helped them to deal with their own moral distress.

**Grand Rounds**

At the completion of the six resident conferences a senior resident and I led an ethics grand rounds open to all otolaryngology faculty and residents to discuss the clinical ethical issues we had covered throughout the one-year course. This review was well
attended by the faculty and residents alike. This conference highlighted many of the clinical ethical issues discussed and reviewed some of the cases previously presented to highlight ethical issues encountered by the residents. This conference was well received by the entire faculty in attendance, and it evoked lively discussion with multiple participants. It was very valuable to hear other faculty input as to how they would have handled the cases presented. They offered another faculty perspective aside from my own in clinical ethical decision-making. This conference reinforced to the residents that clinical ethical skills are used and practiced by their entire faculty, if not explicitly as in our conferences, then implicitly in daily encounters with their patients. One of the senior faculty commented that we “all should treat others as we would want to be treated” thus subliminally reinforcing the idea of Kant’s categorical imperative or the Christian Golden Rule. Several of the faculty members approached me after the ethics grand rounds to thank me for working with the residents on this skill set and giving the residents a forum to discuss clinical medical ethics in a more formal venue. There is recognition on the part of some of the attending otolaryngologists that this clinical ethics education module is a valuable tool for the residents to further their professional education in the area of clinical ethics skill and professionalism

Resident ethics education program survey

A six-question survey of the residents was completed at the end of the clinical ethics education conferences. The purpose of this survey was to assess their satisfaction with the format of the program and determine the resident’s self-perceived ability to recognize and
handle clinical ethics issues before and after completing the program. The survey questions are attached as Appendix C. Nine of the ten residents completed the survey. Sixty-seven percent of the residents attended all of the sessions. Nearly half (44%) described a moderate awareness of clinical ethical issues in surgery prior to the clinical ethics education; a similar percentage felt somewhat aware, and one resident was minimally aware. This result is not surprising given that the residents had varying degrees of clinical experience in surgery prior to taking the course. Sixty-seven percent of the residents found the clinical ethics sessions to be moderately helpful in identifying ethical issues and 33 percent found them to be very helpful. After attending the sessions all of the residents felt either moderately (89%) or much (11%) more prepared to deal with challenging ethical issues encountered in surgical practice. All residents preferred the current didactic and case-based format to a formal lecture methodology of teaching clinical ethics skills.

Overall, I would consider the clinical surgical ethics education sessions a success. At its most basic level, my initial goal was to help the residents recognize that all clinical encounters are comprised of moral as well as technical components (Jonsen 2010). Once this fact was recognized, the residents could appreciate that most clinical encounters proceed without difficulty because there are no conflicting moral values between the patient and surgeon. Both the surgeon and the patient have restoration of the patient’s health as their primary goal. It is only when the values of the patient and surgeon differ as to how to restore the patient’s health that moral tensions arise within the clinical encounter. The cases, as they were presented, demonstrated examples of potential real
world clinical encounters where the moral values of the surgeon and patient were in tension. A second goal of surgical ethics education was to give the residents the skills to recognize these areas of moral conflict, to provide them with a basic understanding of the moral theory that articulates the conflict of values and to give the residents the clinical ethical skills to maneuver through and resolve the moral conflict. At this point in the resident’s career they already recognize many of these moral conflicts, but may not know why the conflict exists, and they have few clinical ethical skills to formulate the value conflict and resolve it. By understanding the underlying moral principles discussed in this series of conferences and by utilizing the clinical ethical skills developed during discussion of case examples within these conferences, the residents will have increased opportunity to resolve clinical ethical conflicts in their future practice. A third and lesser goal of these sessions was to meet the requirements for clinical ethics education and professionalism prescribed by the ACGME (ACGME 2010). This requirement was met in a definitive and concrete way by documenting that these clinical ethics education sessions occurred and by noting resident attendance at the sessions. This was a departure from the previous method of meeting the ACGME requirements which stated that the residents acquire professionalism skills through informal role modeling of their attending physicians.

The results of the post-course survey confirm that these goals were met. The majority of our residents reported an increase in their awareness of clinical ethical issues. All residents found that they were moderately or much more prepared to deal with challenging ethical issues encountered in surgical practice. All residents preferred the
case based teaching methodology that was used and noted that this methodology was what resulted in their increase in clinical ethical skills.
Chapter 3

Year Two of a Pilot Program in the Wake Forest School of Medicine Department of Otolaryngology: Virtue Ethics Education

The third chapter of this thesis will describe the ongoing pilot program in ethics education I am developing for the otolaryngology residents at Wake Forest School of Medicine. This program was developed, in part, to satisfy the requirements of the Accreditation Council for Graduate Medical Education (ACGME) for ethics education in otolaryngology residency. I also wanted to provide the residents an opportunity to look critically at the character traits or virtues of successful surgeons.

The origin of this portion of the pilot project is a discussion I had with Daniel Brudney, PhD of the MacLean Center for Clinical Medical Ethics at the University of Chicago. During my time as a bioethics student at Wake Forest University I had the opportunity to complete a fellowship in Clinical Medical Ethics at the MacLean Center. Part of our instruction during the fellowship involved in-depth study of the moral foundations of clinical medical ethics. During our study of virtue ethics Dr. Brudney made the comment that the Aristotelian concept of the telos of man and the ways in which virtues were attained to reach the telos are similar in many ways to post-graduate medical training. He drew the parallel between the human virtues as those properties, behaviors and characteristics that enable human flourishing, and the virtues of residents as those properties, behaviors and characteristics that enable residents to become good doctors (Brudney 2010). The practice of medicine has as its telos the restoration of the patient’s
health. The process of residency training is to enable resident physicians to develop both technical expertise and professional behavior that will be used to restore patient health. The professional development of resident physicians includes developing those virtues that improve the physician-patient relationship and promote the well being of the patient.

Participants

The participants in this virtue ethics education pilot program included ten residents from the PGY 2 to PGY 5 level. At times, surgical interns and medical students assigned to Otolaryngology rotations attended the ethics conferences, participating in varying degrees in the discussions. All of the participants noted that they had medical ethics courses during medical school. They had neither prior knowledge of nor formal education regarding virtue ethics. These residents provide the primary contact for all inpatient clinical care of patients admitted to the otolaryngology service at Wake Forest Baptist Medical Center, under the direction of otolaryngology attending faculty. They are the primary contact for emergency department and inpatient consultations and also are responsible for an outpatient clinic where they provide all manner of otolaryngology care to an uninsured and under-insured patient population under the supervision of otolaryngology attending physicians.
Structure of the Pilot program

I developed a series of five conferences on virtue ethics as it pertains to residency training. I began this portion of the project by polling the otolaryngology faculty, asking them to select the five virtues they thought most appropriate to instill in their residents throughout residency training. I e-mailed a list of virtues defined by Larkin as being consistent with the ACGME general competencies (Larkin 2005). Seven of the fourteen faculty responded with their list of the 5 most desirable virtues. Three virtues were listed by a majority of the responding faculty. These virtues were integrity, judgment, and conscientiousness. In addition to these values, I selected the virtues of trustworthiness and prudence to be two other important virtues to an otolaryngology resident. These five virtues became the subject matter of this portion of the pilot program in ethics education for the otolaryngology residents. I then reviewed the medical ethics and virtue ethics literature to obtain journal articles and book chapters that explain virtue theory and its role in medicine and resident education and that specifically address the virtues of integrity, judgment, conscientiousness, trustworthiness and prudence. As of the writing of this thesis, three of the conferences have been completed.

The format for these conferences is different from the clinical ethics conferences of year one of the pilot program described in chapter 2 of this thesis. These conferences take the format of a journal club. This format is very familiar to the residents because they have monthly clinical journal clubs lead by other otolaryngology faculty on various clinical topics. I chose a journal club format for four reasons: (1) the residents would be familiar
with the format; (2) a journal club format would promote the residents’ completion of the required reading; (3) the residents would lead the sessions; and (4) this format would foster dialog. The initial 2 conferences were used to provide background in virtue ethics theory for the residents. The remaining conferences were dedicated to discuss the virtues themselves and their application to clinical situations.

Conference 1: Introduction to virtue ethics and virtue ethics in medicine

Two book chapters were selected to introduce the concept of virtue ethics and the role of virtue ethics in medicine to the residents. I used “Aristotle’s Account of the Virtues” by MacIntyre as a basis for the general discussion of virtue ethics (MacIntyre 2007). MacIntyre draws on Aristotle’s *Nicomachean Ethics* as the canonical text for Aristotle’s account of the virtues. In that work, Aristotle asserts that every human activity, enquiry and practice aims toward some good the *telos* of man (Aristotle 2004). We next examined the Aristotelian concept of the good and asked: What is the good for man? Aristotle uses the term *eudaimonia* for that good. I described this term as difficult to translate, but sometimes rendered as blessedness, happiness or the flourishing of the human life. We discussed how the virtues are those qualities that will enable the individual to achieve *eudaimonia* and the lack of which will frustrate the movement of life towards the good (MacIntyre 2007). The virtues are those deep-seated characteristics and behaviors that, when consistently practiced, allow humans to reach their desired condition of *eudaimonia*. I pointed out that the exercise of virtues is not simply a means to the end of a good human life. What constitutes the good of man is a complete human
life well lived, and the exercise of the virtues is a necessary and central part of such a life, not merely a preparatory exercise to secure such a life (MacIntyre 2007). For Aristotle, ethics is a practical discipline to be good and act well. Virtue ethics emphasizes the traits of the agent and not the particular act of the agent. Virtues are those traits that make a person good and enable her to do good works as well. Human choices demand judgment and the exercise of the virtues therefore requires a capacity to judge and to do the right thing, in the right place, at the right time and in the right way. Virtue theory encompasses identifying the correct virtues, developing the correct habits based upon these virtues and using these habits to guide one’s actions.

Having introduced the concept of the human telos and the virtues as those qualities that allow human beings to achieve that telos, I asked the residents if they believed that this concept was relevant to the human condition in modern secular society. After some intense discussion the residents were able to agree with the Aristotelian concept of a life well lived, and the virtues being those human qualities that support the march toward eudaimonia. While there was some disagreement as to the particular virtues that were necessary for man in today’s multicultural secular society as opposed to society at the time of Aristotle, the residents agreed that the system of virtue ethics had merit for further study and application to medicine.

The next article we discussed was Pellegrino’s chapter entitled “Medicine as a Moral Community” in his book The Virtues in Medicine Practice (Pellegrino 1993). In this book chapter Pellegrino argues that medicine is a moral community and supports this
argument by providing a philosophical foundation for the moral community of medicine. He states that there are three qualities about medicine as a human activity that make it a moral enterprise and impose collective responsibilities on its practitioners: (1) the nature of illness itself, (2) the nonproprietary nature of medical knowledge, and (3) the nature and circumstances of the professional oath.

The nature of illness itself, as a universal human phenomenon, makes medicine a special human activity. Sick human beings are in a uniquely dependent, anxious, vulnerable and exploitable state. They must bear their weakness, compromise their dignity and reveal intimacies to the physician. Illness forces them into a relationship with a physician in which they are relatively powerless and therefore must trust their physician. The physician often invites the patient into this trusting relationship with the question: “How can I help you?” These circumstances of medical need constitute a moral claim by the patient on those who are equipped to provide help and profess their intention to help by asking this question (Pellegrino 1993).

Pellegrino claims that the physician’s medical knowledge is not proprietary. It is acquired through the privilege of medical education that is often financially subsidized, to a significant extent, by society in public medical schools. Medical knowledge is acquired by socially sanctioned invasions of privacy, dissection of human bodies, participation in the care of sick individuals and medical experimentation. These activities are not allowed in circumstances other than medical education. Through licensing, credentialing and board certification, society grants physicians a monopoly over the practice of
medicine. Given that this knowledge is acquired by societal convention, Pellegrino claims that medical knowledge is held in trust for society as a hole and not to be used primarily for the personal gain, power and prestige of the doctor. By accepting the privilege of medical education, those who enter medicine become parties to a covenant with society that cannot be unilaterally dissolved. Society expects good stewardship of medical knowledge in return for supporting medical education (Pellegrino 1993).

Pellegrino’s last argument for the moral community of medicine is based on the promise acknowledged publically when a physician takes an oath. The oath, whichever one is taken, is a public promise to be competent and to use this competence in the interest of treating the sick. Some effacement of self-interest is thus intrinsic to every medical oath (Pellegrino 1993).

The result of membership in the medical moral community results in society’s expectation that physicians will not take advantage of their patient’s vulnerability and will not use medical knowledge or their patient’s trust for their own ends of power, prestige and profit. In short, the physician is trusted to place his or her patient’s best interest above personal self-interest. These markers of the medical profession are in counterpoint to what is expected of a business where exploitation of a competitor’s weakness, personal self-interest and market dominance may be acceptable primary goals.

After discussing Pellegrino’s argument for a moral community I asked the residents if they agreed. I pointed out to the residents that the remainder of Pellegrino’s assertions
about the characteristics of medicine rests on his argument for the moral community. There was considerable disagreement with Pellegrino’s characterization of medicine’s moral community and especially with regards to his characterization that medical knowledge is nonproprietary. Their first argument for the proprietary nature of medical knowledge came from the years of hard work and dedication each resident had endured to acquire this vast medical knowledge. All the residents had invested at least 8 years to acquire medical knowledge in undergraduate and medical school. Furthermore, they were continuing to invest an additional 5 years in post-graduate medical training to achieve otolaryngology specialization. This course of education is daunting to consider and grueling to complete. In addition to the fact that the residents work extremely hard to attain this medical knowledge, their second argument against Pellegrino is the fact that many of the residents undertake the journey to medical knowledge at great personal expense. Many new residents come out of undergraduate and medical education tens if not hundreds of thousands of dollars in debt. In 2010 medical school graduates reported an average of $145,000 of indebtedness. Graduates at the medical schools reporting the heaviest debt burden have an average medical school debt of $204,000 (US News 2012). Average debt for Wake Forest School of Medicine 2014 graduates is estimated to be $170,000 (Wakehealth 2013). First year residents have an annual income of $45,175 at Wake Forest Baptist Medical Center (Wakehealth Residency Salary 2013). At the same time the residents are faced with mountains of debt, they are employed at only two times the poverty line for a family of four in North Carolina while often working 80 hours a week and taking 24 hour call (HHS 2013). Lastly, the residents argued that in addition to the financial burden, they shoulder many personal burdens, including delay of
gratification, and marital and relationship pressures, during their acquisition of medical knowledge.

The residents also voiced concern that the medical profession and the body of medical knowledge were held to a different and higher standard than other professional and medical industries. Then pointed out that the legal profession and pharmaceutical industry are not held to the same high standards of the nonproprietary nature of specialized knowledge. The possession of specialized knowledge and patents was more financially rewarded in these professions and industries. The residents voiced some resentment regarding this apparent disparity amongst the various professions and industry. Ultimately we discussed the differences between the concepts of profession and business and recognized that a profession will necessarily require a higher standard of behavior with its accrued knowledge base.

While there was concern for the nonproprietary nature of medical knowledge, the residents were able to agree with Pellegrino’s other two arguments for the moral foundation of the medical community: the professional oath to help the patient in need and the nature of illness placing their patients in a vulnerable position. Even though they felt that they had possession of medical knowledge that they had earned, the residents also realized that they could not use this knowledge selfishly for personal gain.
Conference 2: An argument against virtue ethics and also virtue ethics and clinical competencies.

After introducing the concept of virtue ethics in medicine to the residents, I also wanted to expose the residents to some of the arguments against virtue ethics in medicine. To this end, we discussed Robert Veatch’s article “Against Virtue: a deontological critique of virtue theory in medical ethics” (Veatch 1985). Veatch argues that virtue-based ethical theory is unnecessary in medicine for four reasons: (1) the proper virtue set is not obvious, (2) the proper set of virtues for a particular role is not obvious, (3) virtues may lead to wrong acts, and (4) virtues are unnecessary in the current structure of medical practice that occurs almost exclusively between physicians and patients who are strangers to each other and often do not share common values.

Veatch argued that, since there is no agreement on a universal set of virtues applicable to medical ethics, virtue ethics theory is not sufficient as a normative medical ethic. He argues that each role in health care, such as physician, nurse and health administrator, has enormous variation in the virtues it requires. Also a particular profession, such as physician, may require different virtues depending on the situation at hand.

Veatch next argues that even for a particular professional role, such as physician, there may be many competing images and ends. The roles of physicians across time and culture are highly variable. The role of a 1950’s general practice doctor is different from
that of a contemporary public health officer; the role of an Orthodox Jewish physician is different than that of a secular neurosurgeon. He claims that each of these specific roles has its own set of virtues, and since these virtues may not be congruent, a medical ethic based upon virtue ethics is problematic.

Veatch goes onto state that the rightness or wrongness of the specific action in medicine “is characterized by certain right-making characteristics independent of the consequences” (Veatch 1985). What if any relationship is there between the virtue of the actor and right conduct? He tries to draw a connection between virtuous character and right acts and finds that matters get complex when there is not a definable set of virtues for a specific role. The most he can deduce is that virtue produces conduct that correlates with the right-making characteristics of actions. Indeed he goes so far as to conclude that the virtues may well lead to wrong acts even though the intentions of the actor may be well meaning (Veatch 1985). Consider the instance of a physician whose virtue theory leads him to will that he would always act for the benefit of the patient. He might benefit the patient by violating the patient autonomy. He may also benefit the patient by distributing resources in an unfair manner.

Veatch’s last argument against virtue ethics in medicine is that virtue theory is unnecessary in stranger medicine, the most common form of medicine practiced in contemporary western culture. Stranger medicine is medicine practiced among people who are essentially strangers. He contrasts this to communal or sectarian medicine that is practiced within a community of shared values and beliefs. Within such a community
the health care provider and her patient share some sort of common cause or allegiance. There is a personal shared belief system and a set of values within which health care decisions are made. In stranger medicine no such shared belief system or values exist. In stranger medicine Veatch contends that patients are more concerned with the physician performing the right act to restore his or her health as opposed to the physician’s motivation for that action or the physician’s underlying character. Veatch concludes his paper with the assertion that agreement on a universally acceptable set of virtues is extremely difficult due to different cultural roles, norms and traits. He states, “…it is not clear whether promoting a virtuous life will lead to right conduct”. (Veatch1985).

The residents agreed with Veatch that determining a universally acceptable set of virtues could be difficult. They further agreed that a virtuous agent could make poor decisions and actions for the seemingly correct virtue and also recognized that there are pragmatic problems encountered by virtuous agents trying to maintain a contemporary medical practice. For instance, could a virtuous surgeon be so crippled by trying to maintain a virtue as to not be able to see the required number of patients to maintain a financially viable surgical practice? Nonetheless, they were not able to completely abandon the idea that somehow the character of the surgeon matters.

We next turned to Gregory Larkin’s article that addresses the concept of virtues applied to the core competencies. Larkin’s article summarizes an attempt to use the virtues of attending physicians, residents and applicants to develop a method of meeting the core competency requirements of the ACGME. He stresses that the substrate of residency
training is the inherent character of the trainee. This substrate, when developed by a strong training program, will form the basis upon which the core competencies may be built and tested over a lifetime of practice (Larkin 2005). Given the opportunity for learners to discover their own strengths and avoid weakness over the time of residency training, residents are likely to acquire the virtues that will lead to successful careers over the long term. Aristotle argued that the virtues, when practiced, become lifelong habits. These habits in turn reflect our inherent character and by extension our competence (Aristotle 2004). By creating an environment where applicants are selected with the correct virtues and the faculty model the appropriate virtues, residents can be trained in such a way to enhance these virtues and the behaviors that develop out of the exercise of these virtues. Larkin goes on to list a number of virtues and vices that correlate with the core competencies of residency education (Larkin 2005).

Carefully defining the desirable virtues and undesirable vices specific to a given residency can aid in the process of identifying good candidates for residency. Once these traits are identified, the next issue becomes how to identify applicants who embody these characteristics. This process is problematic since it is often difficult to assess these characteristics in the reference process for applicants and in the short duration of most residency interviews. While it would be optimal for the reference process to have a specific evaluation of the applicant’s virtues and to have qualified medical students rotate on the service to assess their virtues and vices first hand, this is not practical. Moreover, the selection of superior candidates does not ensure their longitudinal success in the program.
Effective education of the residents requires the nurturing of virtues and discouragement of vices. Simply matching the correct applicant does not absolve the residency program from nurturing the appropriate skills and character. Just as skills atrophy if not properly developed and practiced, so too will character traits. In addition to ensuring their duty to ensure the technical competency of the trainee, it is incumbent upon faculty to model behavior and mentor residents to aid in developing morally competent and emotionally mature future colleagues. Faculty members should be responsible for improving their own communication and mentoring skills. Faculty behaviors are an outward manifestation of underlying faculty virtues, and faculty must display these virtues in their education of residents. Identifying specific desirable behaviors provides a pragmatic roadmap to virtue for faculty and residents alike (Larkin 2005).

The resident evaluation process is the optimal forum to address resident behaviors and the underlying virtues that contribute to these behaviors. Substandard performance can be identified and if addressed effectively can lead to rapid remediation of underperforming individuals. A second and more positive goal for evaluations is to foster the growth and development of resident virtues that lead to improved patient care, the joy of surgery and life-long learning. By identifying the specific virtues and vices that are consistent with the core competencies, residents have a defined expectation for their behaviors throughout residency. Although formal evaluations provide a specific point in time to address resident performance, faculty mentors should also provide individualized and prompt feedback to their residents regarding both their technical skills
and professional development. Faculty must take seriously their responsibility to be role models for virtuous behavior. It may be necessary for faculty to address their own mentoring skills and remediate those skills if needed.

The residents voiced their concern that, although virtues may be necessary to become a good surgeon, it was hard to determine which virtues were to be emphasized and how to measure these virtues. My claim that the outward behaviors of applicants, residents and faculty were manifestations of the individual’s underlying virtues addressed this concern. The residents also voiced their concern that patient satisfaction scores are being used as one measure of virtuous behavior and that these scores may not represent a true measure of the overall performance and competency of the physician. Examples of good and poor role modeling by faculty were also discussed. I emphasized that residency is a time of education and that education includes positive and negative examples of technical skills and professional behavior.

**Conference 3: Fidelity to Trust and Integrity**

This third conference was the beginning of our discussion of particular virtues. I used two chapters of Pellegrino’s book *The Virtues in Medical Practice* as a starting point for these discussions (Pellegrino 1993).

Fidelity to trust begins with Pellegrino’s assertion that trust is ineradicable in human relationships. Without human beings being able to trust one another to tell the truth,
follow through on actions and honor commitments, the human condition and society in general would be in jeopardy. Trust is especially difficult when humans in vulnerable conditions, such as illness, are forced to trust a professional without any prior knowledge of the professional’s trustworthiness. In these situations the patient trusts that the professional, with his specialized knowledge, will use that knowledge for the benefit of the patient and not selfishly.

Pellegrino points out that there are two levels of trust. The first level is what he describes as system trust. In system trust, the professional is trusted to be competent, knowledgeable and to act for the well being of his client. This trust is inspired less by individual characteristics then by the recognition of a defined societal role. The second level of trust is an individualized trust of the particular professional. In individualized trust, the intimacy, specificity and personal nature of the relationship compel the patient to be more concerned with the personal qualities of the professional. Ultimately the patient wants to engage a physician who will treat him or her individually, non-judgmentally, and is concerned with the patient’s personal welfare. The patient is concerned not only with what will be done to them, but who will be doing it (Pellegrino 1993).

Pellegrino argues against an “Ethic of Distrust” which has been brought on by many contemporary influences, including the malpractice crisis, commercialization of medicine and professional incompetency. This ethic of distrust assumes that the surgeon and the patient are in an adversarial relationship and should not trust one another. Instead, each
party looks out for his or her own personal self-interest. In this condition wariness replaces trust. The patient and the physician are adversaries rather than allies in arriving at the goal of restoring the patient to health. Pellegrino asserts that the ethic of distrust leads to ethical minimalism by the physician. This model of the surgeon-patient relationship ignores the inherent imbalance of power and knowledge between the physician and the patient. The patient can rarely have as much medical knowledge as the physician, and ultimately the patient must realize that the physician is the agent through which medical action will be taken (Pellegrino 1993).

Pellegrino concludes that medical facts and information must be transferred to the patient in the most value-neutral way so as not to influence the patient’s values unduly. Patient values cannot change the medical facts of the case but the patient’s values are what will determine the action taken to address the facts at hand. Trusting that the physician is transmitting the medical facts, alternative treatments and proposed outcomes in an honest manner is what allows the patient to make the correct choice for his or her medical care (Pellegrino 1993).

The residents acknowledged the importance of trust in any human relationship and especially being able to trust the information shared between physician and patient. However, the residents were quick to bring up barriers to trust between patient and surgeons. The influence of medical insurance companies, massive amounts of medical information and disinformation on the Internet, decreased time for patient care, and undue influences of third parties were all mentioned. They also observed that trust
between patient and physician is a mutual requirement. Physicians must trust that patients are providing them with accurate information regarding their medical condition. Patients who lie to physicians or try to manipulate physicians were seen as a distinct barrier to the ethics of trust.

The virtue of integrity was next addressed. We considered two situations as they relate to integrity: the integrity of the person and the person of integrity. Integrity of the person considers the person’s wholeness: physically, psychologically, socially, intellectually and spiritually. When illness occurs, personal integrity is no longer intact. The physician is called upon to restore the patient’s integrity as defined by the patient’s values, not the physician’s values. Integrity of the person is also important for the surgeon. The patient cannot violate the surgeon’s integrity by forcing the surgeon to perform procedures he or she is morally opposed to, such as abortion, euthanasia and withdrawal of artificial hydration and feeding. Both the physician and the patient are entitled to integrity of their person; neither can force their will or values upon the other. In cases where the moral integrity of the patient or physician is threatened or compromised, it may be necessary to respectfully withdraw from the physician-patient relationship without abandoning the patient. A person of integrity is one who can be trusted to respect another’s claim to autonomy. People with integrity not only respect others’ claims to autonomy but will facilitate the integrity of others. Medical facts can be presented in multiple ways. It is incumbent on the physician of integrity to present the medical facts in such a way as to facilitate the restoration of the integrity of the patient and allow for unbiased medical decision making (Pellegrino 1993).
We next discussed the application of the virtues of trust and integrity in a case example. This case discussed a surgical misadventure involving the improper placement of orthopedic hardware (Capozzi 2011). The attending surgeon had not performed the proper inter-operative x-rays and the orthopedic fellow discovered the improper placement of the hardware prior to closing the patient’s surgical incision. When she asked the attending surgeon, who had now left the hospital, if she should revise the hardware placement she was told not to worry about it and he would take care of informing the patient tomorrow. The fellow had many concerns: Was there something about the case she did not understand due to her level of training? Would the attending be honest in telling the patient the outcome of the surgery? What were her responsibilities and authority in the case? We used this case as an example to look at the virtues of the actors involved. We discussed the integrity of the patient, the attending surgeon and the orthopedic fellow and how the virtue of integrity affected all parties concerned. We discussed how honest communication among all the actors could be used to re-establish the appropriate relationships. We discussed the virtue of trust and how it affected all three parties. We addressed these questions: How could the actor’s virtues of integrity and trust have prevented the surgical misadventure? How can the parties involved use these virtues to rectify the act and prevent future occurrences?
**Remaining Conferences**

At the time of this thesis, conferences four and five have not yet occurred. The topics for these conferences will be the virtues of judgment, conscientiousness and prudence. I will continue to use chapters from Pellegrino’s *The Virtues in Medical Practice* as the primary source and other medical ethics literature as necessary to consider these virtues and provide case examples for discussion. The final conference will also consider Shelton’s “Can Virtue be Taught” and Sulmasy’s editorial “Should Medical Schools Be Schools for Virtue?”
Chapter 4

A Pilot Program in the Wake Forest School of Medicine Department of Otolaryngology: Reflections

The purpose of this final chapter is to reflect on the purpose of the pilot program in ethics education in the Section of Otolaryngology at Wake Forest School of Medicine over the past 2 years, to examine the content of the program, to critique the methodologies used, and to add personal reflections regarding the program.

To my knowledge, no formal ethics education existed in any of the surgical disciplines at Wake Forest School of Medicine prior to me initiating this program. In fact, after the first year of the pilot program in ethics education for otolaryngology residents, I was asked by Diann Holland, the chairperson of the Graduate Medical Education Coordinators Committee of Wake Forest School of Medicine to describe the specifics of our program and help them to address deficiencies in ethics education in their residency and fellowship training programs. Prior to this pilot program, ethics and professionalism education in the Section of Otolaryngology at the Wake Forest School of Medicine had been taught by faculty role modeling (Otolaryngology PIF). While role modeling is certainly an important component of the resident’s educational process, role modeling nonetheless is an area where standards are elusive and repeated negative learning experiences may adversely influence the professional and ethical development of the residents (Kenny 2003).
As described in Chapter 1, there is scant literature on ethics education in surgical residencies. The survey of ethics education in Otolaryngology programs we conducted confirmed that there is little structured ethics education in the residency programs whose directors responded to our survey, and we were left wondering whether any ethics education took place in the programs whose directors failed to respond. Through the development of this pilot program in ethics education, I have sought to provide the otolaryngology residents with a structured and academically sound medical ethics education program to complement the role modeling of ethical and professional behavior they witness on a daily basis with their attending physicians.

In selecting the content of the pilot program in ethics education, I turned to personal experience during my Clinical Medical Ethics Fellowship at the MacLean Center of the University of Chicago. This was an intensive 1-year part-time fellowship designed to provide expertise and experience in clinical medical ethics. During the fellowship there was extensive structured ethics education in Topics in Clinical Ethics, Conceptual Foundations of Health Law, Introduction to Moral Philosophy and Bioethics, as well as weekly clinical medical ethics conferences where actual cases were discussed. Based on these experiences, I decided to develop a two-part ethics educational series. The first part of the curriculum, described in chapter 2 of this thesis, is dedicated to clinical medical ethics skills. The second part of the curriculum was developed to enhance the professionalism and the character development of the otolaryngology residents. The otolaryngology residency at Wake Forest School of Medicine is a 5-year program after an initial otolaryngology internship year. This made the decision to break the curriculum
into a two-year cycle easy. In this way residents will have the opportunity to cycle through the ethics education program twice during the course of their residency.

The content of the pilot program in ethics education was derived from many sources. The content for the first year was modified from *Ethical Issues in Clinical Surgery* published by the American College of Surgeons (McGrath 2007). The topics for the 6 conferences during the first year of the pilot program were derived from this book. I developed case studies to illustrate the ethical principles that feature specific otolaryngology patients and their concerns. The content for the second year of the pilot program was determined in part by the survey of otolaryngology faculty and their choice of virtues, as well as my selections from the bioethics literature on basic virtue ethics and the ability to teach virtue.

The residents had a more positive reception to the presentation and discussion of clinical ethical skills than to the virtue ethics and character development material. I attribute this primarily to the resident’s comfort level and familiarity with the subject matter. Clinical ethics is something the residents encounter on a daily basis, and they can use the skills developed during the clinical ethics portion of the program on an immediate and practical level. Surgery tends to attract individuals who like to analyze a problem, find a solution and take action. Their personalities tend to be less tolerant of indecision and the unknown. Issues of virtue ethics are by their very nature less concrete and absolute. My perception is that the residents feel that this study of virtue is not as applicable to everyday practice. One of my goals is to show how the virtues of individuals in medical
practice and being a professional surgeon are intimately associated. This is not an easy task, and I will strive to point out practical examples of professionalism and virtue to the residents as we continue to move forward with this program. When I initially discussed ethical dilemmas with the residents, I informed them that more often than not there would be more than one morally acceptable action to resolve a specific ethical dilemma. When there is a difference in values between two individuals we can often determine what actions are morally impermissible, but it is much more difficult to arrive at a single morally required action. Learning to deal with this uncertainty runs counter to the comfort level of many surgical residents and practicing surgeons.

The pilot program used a different methodology in each of its two years, with the first year being a mixture of didactic and case-based conferences and the second year being a journal club format. These formats are very familiar to the residents. Much of medical education occurs in a case-based format, and the journal club format is commonly used to discuss and study current trends in otolaryngology. Both of these formats required active participation and encouraged dialog among the participants. The survey at the end of the first year of the program unanimously selected the case-based format as the preferred format for learning clinical ethical skills. I have not yet completed the second year of the program, but I can report that, after an initial introduction of the article by an individual resident, there has been robust discussion involving most of the participants. The conferences take place in an open area of the otolaryngology academic offices. One of the otolaryngology support staff has an office adjacent to the conference room, and she has commented to me on many occasions that she is impressed by the amount of
engagement and the dialog shared by the residents during the ethics conferences. In future years, if I am asked to continue this program, I plan on maintaining these formats for the discussion of clinical skills and virtues ethics, unless the post course surveys point to dissatisfaction with the current methodology. I also plan to develop an ethics case conference in the future to discuss current or recent cases encountered on the otolaryngology service.

I have a strong personal interest in the field of surgical ethics due to the fact that I was a private practice otolaryngologist for 15 years prior to beginning the Master of Arts in Bioethics program at Wake Forest University. This experience afforded me the opportunity to view firsthand many of the clinical ethical issues encountered in the daily practice of otolaryngology. I have dealt with patient non-compliance, end-of-life decisions, disagreements with patients regarding surgical recommendations and surrogate decision-making. I have also had the unique experience of having been a surgical patient 4 times in the past 10 years. Having been on “both sides of the knife,” I can truly speak to many of the ethical issues surrounding an otolaryngology practice both from the perspective of the surgeon and that of the patient. In addition I am an active ethics consultant at the Salisbury Veterans Administration Medical Center. I have taught clinical ethics courses for the Salisbury VAMC, the Asheville VAMC and most recently at a regional Integrated Ethics Consultation conference for the VA Mid-Atlantic Health Care Network in Hampton Virginia. I wish to impart this firsthand experience and knowledge to the otolaryngology residents in a personal as well as an academically sound and structured way. I want to share with future otolaryngologists some of my personal
experiences regarding the clinical medical ethical dilemmas encountered during surgical practice. For this personal experience to be valid it must be based upon sound ethical principles and theory. To that end I developed this program of ethics education for the otolaryngology residents.

All things considered, I would judge the pilot program in ethics education in the section of otolaryngology a success. The survey completed by the otolaryngology residents at the end of the first year of the program showed an improved awareness of clinical ethical dilemmas and a self perceived improvement in their ability to deal with ethically challenging situations. The virtues ethics portion of the pilot program has been met with active participation and dialog. I plan to survey the residents at the completion of the virtue ethics portion of the program to see if there has been an increased awareness of personal virtue and it relationship to professionalism. Once this survey is completed, I will adjust the virtue ethics portion of the program as necessary to improve their awareness of the importance of virtue ethics and its role in professionalism. I hope to expand this ethics curriculum to other surgical departments at Wake Forest School of Medicine and possibly other otolaryngology programs across the country. I view the training of future members of my profession to be not only technically competent but to be compassionate, morally responsible and professional surgeons as a tremendous responsibility and a sacred honor.
Resources

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Wakehealth Residency Salary 2013 available at:


Appendix A

Letter sent to Program Directors

Dear Program Director,

The Otolaryngology Department at Wake Forest Baptist Medical Center is conducting a survey study to assess the methods that are currently being used in the approach to ethics training and education in Otolaryngology residency training programs. Little information exists regarding whether or not implemented ethics education is a priority. Similarly, specific teaching modalities and faculty availability for ethics teaching are unknown. Interest and importance of ethics in the training and education of residents is likely viewed as beneficial, however scant literature and documentation exists on the subject.

We will be collecting survey data from all ACGME (American Council for Graduate Medical Education) Otolaryngology Program Directors in the United States in order to assess the methods that are currently being used in the approach to ethics training and education of residents. This survey will be completed using a SurveyMonkey.com platform. The data will be individually gathered and then will be built by each survey-taker while using Survey Monkey to provide the online survey. The Survey Monkey functions will allow for a register of survey-takers to be compiled for confirmation of survey completion. However there will be no information linking surveys to specific survey-takers. This study does not involve any direct personal information. Data is kept secured with access only available to selected study team members; data translation is through an electronic file. Please access the survey using the following: Insert URL here

If you have any questions regarding this study, please contact:

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Survey Tool used for Program Directors

These questions are aimed at quantifying the type and size of the institution at which you work.

1. The main hospital in your Otolaryngology residency program is best described as?
   - University based
   - Community based
   - Military Based

2. What is the size of the main hospital in your surgical residency program?
   - Less than 300 beds
   - 300-600 beds
   - Greater than 600 Beds

3. How many Otolaryngology residents are in each matriculating class?
   - 1
   - 2
   - 3
   - 4 or more
   - Other __________
These questions are aimed at quantifying the established ethics curricula existing at your institution.

1. Currently, the principle way Otolaryngology residents at your institution are exposed to ethics education is through which one of the following methods?

   As part of the core curriculum
   As part of grand rounds
   As part of a critical care rotation
   On a case-by-case basis as specific situations arise
   Other _______________________
   Not at all

2. If formal ethics education is already incorporated into the curriculum at your institution, which one of the following best describes the primary teaching methodology?

   Lecture based didactic sessions
   Case-based learning
   Standardized patients or simulation center programs
   Integrated case based/lecture instruction
   Other ______________________________
   Not currently incorporated

3. Currently, faculty members from which department or departments facilitate ethics education at your institution? (choose all that apply)

   Surgical Faculty
   Medical Faculty
   Ethics Faculty
   Pediatric Faculty
   Psychiatry Faculty
   Other
4. Does the main hospital in your residency program have an ethics consult service?
   Yes
   No

These questions are aimed at quantifying your opinion of resident attitudes toward ethics education.

1. Do you believe the residents at your institution desire formalized ethics education?
   Yes
   No

2. What level of importance do you believe residents at your institution place on ethics education?
   Very High
   High
   Neutral
   Low
   Very Low

3. Do you believe residents at your institution desire a more formalized ethics educational program than what is currently offered?
   Yes
   No
4. How satisfied do you believe residents at your institution are regarding their ethics education?
   Extremely Satisfied
   Somewhat Satisfied
   Neutral
   Somewhat Dissatisfied
   Extremely Dissatisfied

5. Upon completing residency, how prepared do you believe residents at your institution are in dealing with ethically challenging situations?
   Very Prepared
   Somewhat Prepared
   Neutral
   Somewhat Unprepared
   Very Unprepared

These questions are aimed at quantifying the existing obstacles impeding ethics education in Otolaryngology residency.

1. How well do you agree with the assertion that ethics education can improve one's ability to handle ethically challenging situations?
   Very much agree
   Somewhat agree
   Neutral
   Somewhat disagree
   Very much disagree
2. Which of the following best describes your own attitude toward ethics education in Otolaryngology residency?

- Ethics education should be mandatory. (All residents should receive mandatory ethics education as part of the core curriculum)
- Ethics education should be self-selective. (Ethics educational activities should be available to interested residents)
- Ethics education should be on an “as needed” basis. (When ethically challenging situations arise residents should research the salient issues and are encouraged to discuss these with faculty members and mentors)
- Ethics education should not be formally required in residency. (Ethics education is a topic that should be adequately explored as an undergraduate and medical student)

3. Which of the following best describes the level of resources available at your institution regarding establishing a formal ethics curriculum?

- Multiple resources
- Some Resources
- Few Resources
- None

(Possible Resources: Ethics Department affiliated with the University, Ethics Consult Service, Surgical faculty with ethics education expertise, Surgical faculty willing to participate in ethics teaching activities)
4. How do the new restrictions on residency training, such as the 80-hour workweek, effect your ability to institute a formalized ethics education curriculum into your residency program?

   It is nearly impossible
   It is very challenging
   It is somewhat challenging
   The additional requirements do not affect the implementation of additional resident activities

5. Which of the following do you believe to be significant impediments to instituting a resident ethics education program at your institution? (choose all that apply)

   80-hour workweek
   Limited faculty with ethics expertise available for teaching activities
   Lack of resident interest
   Lack of faculty interest
   Lack of University of Departmental support
   Other _______________________

   There are minimal impediments to educational activities
Dear Program Director,

The Otolaryngology Department at Wake Forest Baptist Medical Center is continuing to collect data for a survey study to assess the methods that are currently being used in the approach to ethics training and education in Otolaryngology residency training programs. You may recall receiving a request to complete a survey regarding this study. If you have not yet completed this survey, please do so at your earliest convenience at: URL inserted here

We truly appreciate your participation in this survey, as it will help us to gain insight into the current methods being used. If you have any questions or concerns, please do not hesitate to contact:

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Appendix B

Slides for Clinical Ethics Education

Ethical Issues in Surgery
Introduction and Confidentiality

Roger D. Cox, MD PACS
W.V. (Bill) Hefner VA Medical Center
Clinical Assistant Professor Otolaryngology
Wake Forest University School of Medicine

Outline
- Who am I
- What do I want to accomplish this year
- Doctor-Patient relationship
- Confidentiality

- 2008 Started MA Bioethics at WFU
- 2010 selected for Fellowship in Clinical Medical Ethics at MacLean Center
  University of Chicago
- One of 3 people selected nation wide from the VAMC to complete the fully funded fellowship

What is the purpose of these sessions?
- Most importantly, my goal is not to make you bioethicists.
- I will give as little or as much explanation of moral philosophy as needed.
- Medicine/Surgery takes place in a relationship that is uneven by nature (Doctor-Patient Relationship)
- Physicians are N/A authority regarding medical/surgical knowledge

What is the purpose of these sessions?
- Patients are N/A authority regarding their medical/surgical care
- One of the biggest complaints about ethics is there is never any absolutely right answer.
- At the end of these sessions you will hopefully discover that while there may not be an absolutely right answer but there is often a claim that is absolutely wrong
Moral Authority

- What is the foundation of physicians moral responsibility?
- Social Contract
- Consequences
- Virtues of a good Physician
- Rule Keeping
- Often a combination of the above
- Judgement of the agent is essential

A Method for Moral Reasoning

- Recognize that a conflict in value exists
- Clearly state the ethics question
- Collect the relevant information
- Identify the options for actions
- Evaluation of the options
- rights, duties, values, interest the of parties effected
- Assessment of consequences

Confidentiality

- Learning Objectives
- Know why confidentiality is important
- Understand the shift from 1on1 physician patient relationship to team approach in regards to confidentiality
- understand the principles justifying exceptions to confidentiality
- Be aware of some of the legal requirements regarding confidentiality.

Confidentiality

- Identify situations in which confidentiality has been inappropriately breached
- Identify situations in which the surgeon has a duty to breach confidentiality
- Apply a systemic approach in determining the arguments for and against breaching confidentiality by weighing the benefits and potential benefits of disclosure against the harms and potential harms of nondisclosure.

Cases

- Privacy - "The right to be left alone". Freedom from intrusion from others. This is the basis from some of our more controversial Supreme Court Cases (Contraception, Abortion, End of life). Closely linked to the principle of respect for autonomy.

Cases

- Confidentiality- Closely linked to the informational privacy. In health care interactions personal information is communicated to the provider that is sensitive in nature so the caregiver can better understand the nature of the patients condition. By calling such information confidential we understand those receiving the information have a duty to protect the information from disclosure to others. This duty can be breached inadvertently or directly, appropriately or inappropriately.
Cases
- Privacy and confidentiality are necessary conditions for self determination
- Privacy and confidentiality are necessary for the physician-patient relationship
- Patients are more likely to share honest information if their confidence is kept
- Accurate diagnosis and treatment is more effective with honest communication

Duty to report
- Your on the on call resident and called to suture a neck laceration of a 45 year old female that has superficially penetrated the platysma of the left neck and no deep structures were harmed. During the course of suturing in the wound in the ER, the woman confides in you that she and her boyfriend had been drinking that evening and after discussing finances he became enraged and lunged at her with a knife resulting in the injury. She pleads with you “Please don’t turn us in because it will only make things worse, he just drank too much and got carried away.”

Duty to report
- Should you report the incident to public authorities?
- What if the patients husband was a police officer?

Concern for the safety of Identifiable others
- A 32 year old married man presents to his primary care physician with dysuria. He tests positive for GC. On encouragement from you his is also tested for Syphilis and HIV and is positive for HIV. He states he cannot contact some of sexual partners that he has picked up in bars and refuses to tell his wife for fear that she will “bolt with the kids”

Concern for the safety of Identifiable others
- Should the physician break confidentially and try to directly contact the wife and sexual partners?
- Would the situation change if the wife were your patient also?
- Should the physician report to the public health authorities?

Infected physicians
- Dr Knife had routine colonoscopy and polypectomy that resulted in massive GI hemorrhage 10 days post procedure. He required blood transfusion and subsequently developed hepatitis B as a result of the transfusion. Ten years later while operating on a patient he is lacerated during the course of a procedure and bleed freely into the abdomen of a patient.
Infected physicians

- Should surgeons who are known to be carriers of blood born pathogens continue to operate on patients?
- If they continue to operate should they inform their patients and members of he operating room staff as to their status?
- Is the surgeon obligated to inform the patient that he has exposed her to a blood born illness?
Fiduciary Duty

- The concept of the surgeon as the moral fiduciary of the patient is central to all of surgical ethics
- Legally fiduciary means to act primarily for another’s benefit in matters
- The fiduciary should put aside self interest and focus in the interest of the person for whom he is acting as a fiduciary (the patient)

What is a conflict of interest?

- Simply defined a conflict of interest involves a situation where the self-interest of an individual is in tension with an obligation.
- In medicine the classic conflict of interest exists when a physician’s financial self interest motivates behavior contrary to the needs and interests of the patient.
- The physician must choose between the good of the patient and the physician’s own good.

Case

- Financial Conflicts of interest

Why are Conflict of Interest Problematic?

- Patients and public may be directly harmed
- The integrity of the medical decision making is called into question
- Trust in medical profession is undermined
- Effectiveness of health care is decreased
- Appearance of a conflict of interest is often enough to cause damage (free lunch)

Competing interests

- More often the concerns are not as contradictory as self versus patient
- Surgeons need to appropriately balance the limited time and resources between two competing interests
- Surgeons must place primary interest (patient care) above secondary interest (other benefits)
Case
Personal Conflicts of Interest

Criteria for defining Conflict of Interest

- Patient outcome may be worse because the surgeon is put in a position where it is to his advantage to subordinate the interest of the patient for his gain
- The situation provides reasonable concern that the surgeon may make decisions not in the patient’s best interest
- The situation creates a potential for secondary gain
- The appearance of Conflict of Interest

Who decides about Conflict of Interest?

- Individual physicians should keep patient’s interest paramount
- Medical community through codes of conduct, guidelines and disciplinary actions
- Society as a whole if individuals and medical community cannot police themselves

How to manage Conflicts of Interest?

- Minimize
- Disclose
- Prohibit
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<th>Ethical Issues in Surgery</th>
<th>Surgeon-Patient Relationship</th>
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<tr>
<td>The Surgeon-Patient Relationship</td>
<td>Patient presents in need of rescue form disease</td>
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<tr>
<td>Truth Telling and Informed Consent</td>
<td>Time is limited usually not longterm relationship</td>
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<td>Decision for surgery usually made within first visit</td>
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<td>Proximity and intensity of interactions</td>
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<td>What are some of the results of these conditions?</td>
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<th>Surgeon-Patient Relationship</th>
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<td>Less time to establish the relationship</td>
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<td>More intense relationship</td>
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<td>More emotional relationship</td>
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<td>Patient has less of a role in participation of the relationship</td>
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<td>Harder to form a therapeutic alliance with the patient</td>
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<th>Ethical Basis of Informed Consent</th>
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<td>Ethical Principle of Respect for Autonomy underlies informed consent</td>
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<tr>
<td>Respect for patient autonomy is in tension with physician’s beneficence.</td>
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<tr>
<td>Idea that “signing the form” is informed consent is incorrect. Contrary to what the lawyers want us to think this is the least important part of the process.</td>
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<th>Elements of Informed Consent</th>
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<td>Disclosure</td>
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<th>Elements of Informed Consent</th>
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<tr>
<td>Professional Practice</td>
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<tr>
<td>Guard against being coercive</td>
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<tr>
<td>Active duty to inform patient of the surgeon’s clinical judgement and make recommendations, not just raw data and facts more than just a technician.</td>
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Elements of Informed Consent

**Patient's Understanding**
- Patient's understanding. Surgeon must be attentive to the patient's understanding of the information. Let them ask questions, repeat back what they understand the procedure to be and the risk/benefits of the procedure. This is a measure of patient capacity.
- Make sure the patient understands they are authorizing the surgical management and possible complications and functional sequelae.

**Patient's Decision Making**
- Patient's also need to consider values that are important to them as well as facts when considering risk/benefits and alternatives. (evaluative understanding)
- Surgeon's role in important here since we can help the patient explore the values that are important to them and how surgery will effect that value. (ie voice)

**Elements of Informed Consent**
- The patient should be able to reason from present circumstances to future consequences of actions and have developed a sence of the probability of the consequences. (cognitive understanding)
- Surgeon's role is to access the adequacy of the patient's development of this process.

**Elements of Informed Consent**
- Surgeon should take a non-directive approach when discussing value laden issues since values and beliefs may differ sharply between surgeon and patient.
- Once the patient has formed and clarified his/her values the recommendations of the surgeon are very valuable.

---

**Summary**
- Surgeon is not a disinterested book of facts but a wealth of knowledge to assist the patient with the decision making process
- Better informed consent process may improve the surgeon-patient relationship and improve the patient's sense of ownership in their healthcare
- Open and honest communication should increase trust in the surgeon.

---

**Case**

**Refusal of Indicated Surgery**
- 21 year old male WFU student presents to the ED with 10 day history of sore throat, fever, seen at campus health days ago given z pack no better. ED obtained CT of neck showing Retropharyngeal abscess and marginal airway. You have evaluated patient and recommend urgent awake trach and I&D of neck abscess. Patient has refused wants another z pack so he go back to dorm and study for finals.
Refusal of Indicated Surgery

- If decisional capacity cannot be restored surrogate decision maker will be selected and that family member will determine what to do based upon "substituted judgement" or if this cannot be determined "best interest" standard of surrogate decision making.

Case

Case "Just go Ahead and Do It Doc"

- 54 year old male presents to your office with an large oro-pharyngeal mass and neck nodes. This has been biopsied by the referring Otolaryngologist and a CT scan has been performed. You have interviewed and examined the patient reviewed the scans, pathology. You have preliminary staged him as T4N3M0 and begin to discuss his treatment options.

Case "Just go Ahead and Do It Doc"

- Patient volunteers the name of his neighbor and you find out it was a benign branchial cleft cyst that you removed last year. What do you do?
- You begin to further discuss the case and its ramifications and the patient becomes agitated, how do you handle the situation?
Ethical Issues in Clinical Surgery
Professional Obligations

Surgery as a Profession

- Implicit social contract exists between medicine and the public
- Societal Expectations of Medicine
  - Service of the Healer
  - Guaranteed Competence
  - Altruistic Service
  - Morality and Integrity

Surgery as a Profession

- Society's Expectations
  - Promotion of the Public Good
  - Trust

Surgery as a Profession

- Medicine’s Expectations
  - Monopoly
  - Status and Rewards
  - Self-regulation
  - Functional Health Care System

Surgery as a Profession

- Certain level of professional and regulatory autonomy
  - States medical licensing boards
  - Professional associations
  - Professional standards

- Privileges of self-regulation require medical profession to have high standards of competence and moral responsibility to enter and maintain practice.

- Because of abuses in the recent past the high esteem enjoyed by medicine has declined.

- As the medicine moves from a profession to a business model this esteem becomes even more precarious.

- Once medicine loses the ability to self-regulate we open the doors for other to regulate us—legislators, bureaucrats, and attorneys.
Obligations

- Surgeons and surgical residents have obligations to three groups in general:
  - primary obligation is to our patients
  - other medical professionals
  - society/public as a whole

Obligations to Patients

- Dr. Innovator is performing a new trans-cervical robotic thyroidectomy. He has just returned from his training course in Korea and is struggling with the technical aspects of the surgery. We are now approaching the 5-hour mark of the surgery and the members of the OR team are becoming increasingly tense. Dr. Innovator is known to be a fine surgeon for a limited number of procedures but is known to stretch his technical limits at times.

Obligations to Patients

- If we are standards of competency determined?
- What factors determine competency?
- As the resident what are your obligations to the patient to resolve the moral quandary when Dr. Innovator does not appear competent?

Obligations to Patients

- Mr. Carter is admitted to your service over the weekend with an odontogenic submandibular abscess. You were able to successfully I&D the abscess and he hospitalized with IV antibiotics. During round the following morning he is upset that you had to shave a small area of his beard to drain his abscess and is making abusive and sexual remarks to insult and annoy you.

Obligations to Professionals

- You are on call the weekend when you receive a call from the ED for a 13-month-old child that has probably aspirated a foreign body and is currently stable. The on-call anesthesiologist has little to no experience with children, poor technical skills and has a reputation for poor outcomes. The nearest children's hospital is across town and routinely does airway foreign bodies.
Obligations to Professionals

- What is your responsibility for the competence of the members of the team?
- How is the competence of the members of the team determined?
- How would you handle this situation?

Obligation to Society

- Dr. Chief is in her next-to-final month of residency. Dr. Advice has groomed her through all her training and is confident of her skills and judgment. As Dr. Advice completes a difficult portion of a procedure the second room becomes available for Dr. Chief to begin another case. The second patient has signed the consent in full knowledge that a "resident surgeon may perform some or all of the operation as deemed appropriate by the supervising surgeon."

Obligation to Society

- When is appropriate for Residents to operate independently?
- What is the responsibility of the attending Surgeon?
- Does the resident bear legal and moral responsibility?
Substitute Decision Making

Autonomy
- Nature of Autonomy
  - Derived from Greek auto (self) nomos (rule)
  - Free of controlling influence of others
  - Adequate understanding to allow for self choice
  - Autonomous individuals can act freely in accordance with a self-chosen plan

Autonomy
- Required conditions for autonomy
  - Liberty: independence from controlling influences
  - Agency: capacity for intentional actions

Respect for Autonomy
- One of the basic principles of Biomedical Ethics
- Founded on the theories of JS Mills and I Kant that all individuals have unconditional worth and each have the capacity to determine his/her own moral destiny.
- Physicians must respect the moral worth of the individual and facilitate the exercise of autonomy

Surrogate Decision Makers
- When a patient's capacity is found to be lacking his/her autonomy is maintained by transferring to the patient's designated surrogate decision maker.
- This can take the form of a person (next of kin) or document (living will, HCPDA)

Standards of Proxy Decision Making
- Substituted Judgement: Requires the surrogate to make, to the best of their ability, the same decision as patient based upon their knowledge of the patient's values, beliefs and principles.
- Best Interests: Decision made in the best interest of the patient based upon good medical practice.
Criteria to consider

- Is the person a valid surrogate?
- By what criteria is the surrogate making decisions?
- How can conflicts between surrogates be mitigated?

What to Do?

- 72 year old male nursing home resident with moderate dementia found to have lung and breast cancer. He is currently able to talk and walk, and is the primary contact of the family. Talking with his nursing home buddies, he is in little pain. A lung resection will cure his cancer and leave him with a permanent drain and increased supine care. Chemotherapy and radiation therapy will have a less likely side of cure but may prolong his life and make his death more difficult and worsen his dementia.
- His dementia is to the point he does not know what year it is and is unable to understand what is happening to him. He has no surviving family or designated surrogate.

What to Do?

- How should you proceed?
- What are your viable options?
- If you found a living will how would that effect your decisions?

Who Decides?

- 80 yo man has had and emergent trach after airway obstruction during panendoscopy for his supraglottic tumor. He has suffered anoxic brain injury and has been in a coma for the past 5 days but does not meet the criteria for brain death. Steve the patient's nephew and caregiver who has lived with him for the past 10 years believes the ventilator should be turned off.

Who Decides?

- Mark the patient's son who lives across the country was not aware of his father's cancer and when notified of his current condition is rushing across the country and demands that all measures be done to keep his father alive. There is no living will, no other close relative, and no HCP.
Who Decides?

- How should you proceed given that the two surrogates disagree?
- If the two surrogates eventually agree to do everything how should the surgeon respond?

Who Decides?

- Who is the valid surrogate decision maker?
- What clinical criteria would you use to establish best interest of the patient?

Substitute Decisions for Children

- Kimberly is a 10 year old brought into your office by her mother with left ear pain and swelling below the mastoid process consistent with acute mastoiditis. You have recommended surgical intervention and are in the process of completing pre-op paperwork when Kimberly's father a devout follower of the Christian Science Fellowship arrives and states that she will not be undergoing any surgery.

Substitute Decisions for Children

- You soon learn that the mother and father are in the middle of a bitter divorce primarily related to the father's religious beliefs. It is 5 pm and Friday Evening.

Substitute Decisions for Children

- What is the role of religious beliefs in medical decisions?
- What role should the religious beliefs of parents play in the medical decisions for their children?
- What should the surgeon do if the child's decision capacity is in question and both parents adamantly oppose surgery but the surgeon feels the child will be harmed without it?

Substitute Decisions for Children

- Best interest standard
- Usually parents act in the best interest of their children
- When there is a question if the parents are acting in the best interest of their child the physician is obligated under law to protect the child's interest
End of Life issues

General Considerations

- Raise important questions with patient and family early in disease process rather than later.
- Important to discuss issues of competency with patient and family
- Discuss limit setting earlier rather than later
- Remember that issues can and do change

General Considerations

- Exploration of values - Values of the patient, family and the surgeon may all be different. Ultimately the patient's value system must be honored.
- Long standing physician-patient relationships are the exception rather than the norm. Physician cannot presume to know the patient's wishes.

General Considerations

- It may be of help to draw on other resources: clergy, social work, ethics committee to help discern the values of the patient if doubt exists.

DNR in the OR

- Your patient is a 64 year old Down's Syndrome male. He presents with an right hip fracture in need of hemi-arthroplasty. He has moderate heart failure and pulmonary hypertension related to congenital heart disease. His cognitive age is 4. His HCPQA has made him a DNAR and is reluctant to reverse this for the procedure saying she cannot live with the potential lingering death after poor outcome of "successful" resuscitation after cardiac death.

DNR in the OR

- How does DNAR cover this case?
- How can you respond to the care giver in this case?
- What is the relevant policy related to this situation?
DNR in the OR

- A 78 year old male has been scheduled for an extensive resection of head and neck cancer involving total glossectomy, bilateral radical neck dissections, total laryngopharyngectomy with free flap reconstructions. During the course of the pre-op H&P, the patient makes it known to the resident that he wishes to be made DNAR during and after the procedure and off handedly remarks that the hopes the operations will kill him.

Futility

- 64 year old male is admitted to the MICU. You are consulted for evaluation of possible necrotizing fasciitis of the neck. He had been admitted to the MICU 3 weeks earlier for renal failure, subsequently developed gangrene of the R leg requiring amputation. He has developed sepsis after the amputation requiring massive fluid resuscitation and pressor support.

Futility

- Is it an exercise in futility to operate?
- Must we operate if the family members demand it?
- Should we use the concept of futility when talking with family members?

Futility

- The patient has developed ARDS and has been intubated for the past 14 days. He has survived 1 courses of CPR and is showing evidence of anoxic brain injury after the second Code Blue. Over the last two days in addition to his dialysis his liver functions studies have begun to elevate. Your review of the CTA is consistent with necrotizing fasciitis with mediastinal extension.

DNR in the OR

- What is the resident's proper response?
- Should the patient be made DNAR?
- Should the operation proceed?

Withdrawing vs Withholding Treatments

- A 70 year old male suffered a hemorrhagic CVA after right maxillectomy, orbital exenteration, anterior cranial floor resection and free flap reconstruction of his SCCA. He remains responsive to noxious stimuli and has developed pneumonia requiring ventilatory support.
Withdrawning vs Withholding Treatments

- The surgical team has suggested to the family that the likelihood of the patient's survival is extremely low and has suggested the family consider removing life support and placing the patient in a DNR status. The family adamantly refuse stating they are "waiting for a miracle".

Withdrawning vs Withholding Treatments

- Are the physicians justified in make the recommendations they have made?
- How should the surgeons respond to the family's wishes?
- Is there a difference between withdrawing and withholding treatments?
Appendix C

Survey Tool used for Otolaryngology Residents at completion of Clinical Ethics Sessions

1. How many ethics education sessions have you attended?
   0
   1
   2
   3
   4
   5
   6

2. How would you describe your awareness of ethical issues in surgery before attending the sessions?
   Not at all aware
   Minimally aware
   Somewhat aware
   Moderately aware
   Very aware

3. So far how helpful have you found the sessions for identifying ethical issues in surgery?
   Not at all helpful
   Minimally helpful
   Somewhat helpful
   Moderately helpful
   Very helpful

4. After attending the sessions, which answer below best describes how you feel in dealing with challenging ethical issues encountered in surgical practice?
   No more prepared
   Slightly more prepared
   Somewhat more prepared
   Moderately more prepared
   Much more prepared
5. Do you prefer the current case-based didactic format as opposed to a more formal lecture mode of teaching?

   Yes
   No

6. Please provide any suggestions for improvement of the ethics curriculum.
Curriculum Vitae

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PERSONAL INFORMATION:

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EDUCATION:

Aug 2009-present  Wake Forest University Graduate School
Enrolled: Masters of Arts in Bioethics

2010-2011  MacLean Center for Clinical Medical Ethics
University of Chicago
Fellowship in Clinical Medical Ethics

1991-1995  North Carolina Baptist Hospital
Winston-Salem North Carolina
Otolaryngology Residency

1988-1989  National Naval Medical Center
Bethesda Maryland
General Surgical Internship

1984-1988  Bowman Gray School of Medicine
Wake Forest University
Winston-Salem North Carolina
Doctor of Medicine

1980-1984  Northern Michigan University
Marquette Michigan
Bachelors of Science – Biochemistry
Summa cum Laude
LICENSE: North Carolina Medical License 94-00755  
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North Carolina Medical Society
American Society for Bioethics and Humanities

EMPLOYMENT:
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February 2006- June 2009
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Graystone Ear, Nose and Throat Associates, P.A.
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Otolaryngology/Head and Neck Surgery
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North Carolina Baptist Hospital
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General Medical Officer
July 1989-June 1991
United States Navy
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Fort George G. Meade, Maryland
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June 1988-July 1989
National Naval Medical Center
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ACADEMIC APPOINTMENT:

Clinical Assistant Professor Division of Surgical Services
Department of Otolaryngology
November 2009-present
Wake Forest University School of Medicine
Winston-Salem, North Carolina

RESEARCH EXPERIENCE:

Wake Forest University School of Medicine
Ethics Education in Otolaryngology
IRB00018369
Ongoing

Wake Forest University Medical Center
1992
Department of Otolaryngology
Research Involving Serous Otitis Media

Northern Michigan University
1983-1984
Research involving charge transfer complexes

HONORS AND ACTIVITIES:

Resource Management Committee
W.G. (Bill) Hefner VAMC
Salisbury, North Carolina
2011-present

Ethics Consultation Committee
W.G. (Bill) Hefner VAMC
Salisbury, North Carolina
2010-present
Preventive Ethics Committee
W.G. (Bill) Hefner VAMC
Salisbury, North Carolina
2009-present

Credentials Committee
Frye Regional Medical Center
1998-2009
Chairman: 2002-2009

Physician Development Committee
Catawba Valley Medical Center
2001-2009

Medical Director Voice and Swallowing Center
Carolina Ear Nose and Throat/
Head and Neck Surgery Center
2006-2009

North Carolina Representative to Board of Governors
American Academy of Otolaryngology, Head and Neck
Surgery 2005-2011

Physician Member: The North Carolina Board of
Examiners for Speech Language Pathologist and
Audiologists 2002-2005

Joint Service Commendation Medal
National Service Defense Medal
Alpha Omega Alpha
Medical Student Scholars Program
Phi Kappa Phi Honor Society

PUBLICATIONS:
Salisbury, P.L., Caloss, R., Cruz, J.M., Powell, B.L., Cole,
R., Kohut, R.I., Mucormycosis of the Mandible After
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