# Defining and Evaluating Physician Competence in End-of-Life Patient Care

## A Matter of Awareness and Emphasis

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The issue of death and dying in the context of patient care, requisite knowledge, and clinical competence has received limited attention in America in the environment of medical education and residency training. National efforts toward reform in providing health care, coupled with public demands for more humanistic care at the end of life and for increasing physicians' accountability, reflect an atmosphere ripe for changing the attitudes of both the medical profession and society in caring for dying patients ("Report and Recommendations from the Board of Directors," American Board of Internal Medicine [ABIM] End-of-Life Patient Care Project, June 1995).

At first glance, evaluating physician competence in providing end-of-life patient care appears ponderous. The strategies for consideration are not unique, however. In fact, many of them are currently used to evaluate other aspects of clinical competence. Crucial to the process of evaluating physician performance is developing and disseminating a common definition so that all involved—both evaluators and evaluatees—understand what elements of clinical competence are being examined.

### Defining the Competencies

In October 1993, ABIM initiated a small project on end-of-life patient care, an important goal of which included defining the scope of clinical competence expected of board-certified internists in the care of dying patients. The definition that has evolved from this initiative can apply to other specialties. It begins with the identification of core competencies: medical knowledge, skills in interviewing and counseling, use of the team approach, symptom and pain control assessment and management, professionalism, humanistic qualities, and medical ethics ("Resource Document on the Identification and Promotion of Physician Competency," ABIM End-of-Life Patient Care Project, October 1995). The specific components for each competency are further defined in Table 1 and supported by the literature.[1-15]

### Evaluating Physicians

The traditional methods of evaluation described are placed in the framework of incorporating a greater emphasis on end-of-life patient care in concert with other areas of medical knowledge, content, and judgment on which physicians are tested and assessed.

*Written Examinations*

The most common approach to evaluation is the use of standardized written examinations featuring multiple-choice questions, particularly single-best answer (A-type) items such as those developed for board certification and recertification examinations. Components of competence in end-of-life patient care that are easily applied with this strategy are medical knowledge (palliative medicine, depression), symptom and pain control assessment and management (use of opioids or sedation, adjuvant analgesics, control of dyspnea), and medical ethics (advance directives, double effect, futility, nutrition and hydration). A spectrum of issues around which to develop test items includes terminating life-sustaining treatment and withdrawing or withholding life support, the right to refuse therapy, power of attorney for debilitated patients, terminal care, and implications and applications of living wills.

Many standardized written examinations also contain "core" questions. These are defined as items that test what physicians would be expected to know to provide basic patient care.[16] In that regard, end-of-life management issues should be considered valued and viable topics in the development and inclusion of core and noncore questions on certification examinations. Accordingly, the American Board of Medical Specialties should encourage its member boards to include related questions on their certification and recertification examinations.

In addition, including end-of-life patient care questions on national in-training examinations can help increase awareness in residency programs of the impor-

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TABLE 1.—*Physician Competencies and Definitive Components*

| *Components* | *Core Competencies* |
|---|---|
| Medical knowledge | Palliative care<br>Assessment and treatment of psychological distress<br>Pharmacologic and nonpharmacologic treatment of pain and other symptoms |
| Interviewing and counseling skills | Listening<br>Truth telling<br>Discussing dying as a process<br>Giving bad news<br>Dealing with families of dying patients |
| Team approach | Understanding the multidisciplinary nature of end-of-life care—physician, nursing staff, social services, palliative care or hospice team, pharmacist, chaplain, patient, patient's family, patient advocate<br>Promoting collegiality<br>Enhancing ability of team members to fulfill professional responsibilities |
| Symptom and pain control assessment and management | Communication skills<br>Comfort<br>Use of opioids, sedation, or adjuvant analgesics<br>NSAIDs<br>Control of dyspnea, anxiety<br>AHCPR and WHO guidelines |
| Professionalism | Altruism<br>Nonabandonment<br>Respect for colleagues<br>Accountability<br>Honoring patients' wishes<br>Confidentiality<br>Transference and countertransference |
| Humanistic qualities | Integrity<br>Respect<br>Compassion<br>Courtesy<br>Sensitivity to patients' needs for comfort and dignity |
| Medical ethics | Advance directives<br>Do-not-resuscitate or do-not-intubate orders<br>Nutrition and hydration<br>Conflicts of interest<br>Futility<br>Double effect<br>Surrogate decision making<br>Physician-assisted suicide |

AHCPR = Agency for Health Care Policy and Research, NSAIDs = nonsteroidal anti-inflammatory drugs, WHO = World Health Organization

tance of physician competence in this aspect of medical care. Many specialties, including internal medicine, neurology, and surgery, provide in-training examinations at regular intervals during residency. These examinations can signal a degree of preparedness for certification and can be useful in identifying the need for more intensive self-study strategies during the rest of training.[17] Similar emphasis is needed during medical school, and related medical knowledge and problem-solving skills should be assessed on parts II and III of the United States Medical Licensing Examination administered by the National Board of Medical Examiners.

*Self-assessment*

Another useful evaluation strategy is self-assessment; it is adaptable to many formats, including questionnaires, multiple-choice questions and essay examinations, and workbooks. This approach can be modified for both training environments and practice settings and can be designed to elicit attitudes about and confirm understanding of didactic material related to physician competence in caring for dying patients. Self-assessment also has a longtime linkage to continuing medical education—the American College of Physicians' Medical Knowledge Self-assessment Programs, for example—and in that venue can be used to reaffirm knowledge and the application of practical principles of palliative medicine and drug usage, the importance of communication skills, and understanding of alternative therapies. Educational videos are tools that also can be used in conjunction with both continuing medical education and structured self-assessment programs.[18]

A self-assessment survey was developed in conjunction with the ABIM End-of-Life Patient Care Project

TABLE 2.—*Preliminary Results of Residents' Self-assessment Survey—Reaction and Feelings After a Patient Died (n = 231)*

| *Representative Survey Questions* | *Affirmative Response, %* |
|---|---|
| **Feelings when their patient died** | |
| Relieved that suffering had ended | 39 |
| Sad | 36 |
| Upset | 18 |
| Unaffected | 9 |
| Other | 18 |
| **Reaction after their patient had died** | |
| Took a break to regroup | 49 |
| Cried | 37 |
| Called or visited patient's family | 27 |
| Sent note of condolence or sympathy card | 12 |
| Attended patient's memorial service or funeral | 10 |

and piloted during the summer and fall of 1995 in 55 internal medicine training programs. The survey is designed to seek residents' perceptions of personal experiences with dying patients, to identify opportunities for learning within the educational environment, and to offer recommendations that could improve physicians' patient care skills and level of professional comfort in caring for the dying. The 20-item survey focuses on a spectrum of issues, including residents' actual experiences with dying patients and families, perceptions of adequate training, self-evaluation of competencies, importance of health care team members, experiential autopsy acquisition, exposure to palliative medicine services, and recommendations to improve physicians' training.[19-22] One of the goals of the survey is to develop an instrument that could be used in primary care and general surgery training programs to gauge changes in clinical experiences and curriculum and, ultimately, to improve patient care.

Preliminary results from 12 programs with 231 residents responding (67% of 343) show that the instrument appears to be effective as a self-assessment tool. Five items from the 20-item survey are summarized briefly. Residents were asked at what levels of training did they participate with an experienced physician in a meaningful, influential discussion about death with a dying patient. Responses show that 55% had such experiences as medical students, 80% during the first year, 45% during postgraduate year 2, 21% during year 3, and 9% during year 4. Residents were asked to describe their experiences of end-of-life care with patients and their families and their perceptions of the quality of those experiences. Of the respondents, 63% indicated that their experiences were more positive, 31% felt that there were an equal number of positive and negative experiences, and 6% reported that they had more negative experiences. As noted in Table 2, residents were also asked how they felt when their patients died and what reactions were displayed.

In addition to self-rating their level of competence for each of the core components in end-of-life patient care, residents were asked whether they thought their training was adequate in 12 specific areas (Table 3). These early results show several areas where residents reported their training had not been adequate.

Finally, when asked about the importance of selective educational activities in conjunction with end-of-life care, residents identified experiences with role model clinicians as by far the most important educational component, followed by small group discussions, interdisciplinary conferences, grand rounds, and journal clubs.

### *Peer Evaluation*

Assessment of physicians by professional colleagues can offer important and unique insights into clinical performance and the relationship between patients and physicians. The use of professional associate ratings provides both a practical method to assess humanistic qualities, communication skills, and professionalism and valid, reliable evaluation by peers—senior physicians, physicians-in-training, and nurses—of physicians' performance. Ten raters per physician-subject are needed to achieve validity and reliability of measurement.[23] Research shows that the ratings are not biased in a substantial manner by the relationship between the person being evaluated and the peer completing the evaluation.[24] The professional associate rating forms incorporate specific items on respect, integrity, and compassion—qualities that apply directly to the care provided by physicians to dying patients.

Other applicable descriptors to be rated on a professional associate rating form are a physician's "personal commitment to honoring choices and rights of others" and "appreciation of patients and their families' special needs for comfort and health."[23(p1659)]

### *Standardized Patients and Clinical Examinations*

The use of standardized patients and objective structured clinical examinations provides other methods

TABLE 3.—*Preliminary Results of Residents' Self-assessment Survey—Adequacy of Training (n = 231)*

| *Thought Training Was Adequate* | *Yes, %* | *No, %* |
|---|---|---|
| Controlling pain and related symptoms | 82 | 18 |
| Learning how to obtain DNR order | 78 | 22 |
| Telling patients they are dying | 63 | 37 |
| Telling patients what dying might be like | 38 | 62 |
| Informing patient's family of death | | |
| Resident knew patient | 78 | 22 |
| Resident did not know patient | 70 | 30 |
| Talking to patient who requests assistance in dying or a hastened death | 38 | 62 |
| Declaring a patient dead | 86 | 14 |
| Talking to the family after patient has died | 71 | 29 |
| Requesting permission to do an autopsy | 71 | 29 |
| Requesting organ donation | 60 | 40 |
| Filling out death certificate properly | 55 | 45 |

DNR = do not resuscitate

to assess communication skills, humanistic qualities, and professionalism within the context of end-of-life patient care. Standardized patients are nonphysicians trained to portray patients in a uniform and consistent manner. They can be asymptomatic; can have stable, abnormal findings on physical examination; or can simulate physical findings. Examinees interact with them as though they were interviewing, examining, and counseling real patients.[25]

Objective structured clinical examinations use a circuit of stations at which examinees are required to perform various clinical skills. These may include taking a brief history from a patient, doing part of a physical examination, undertaking a procedure, ordering or interpreting diagnostic studies, and counseling a patient. Objective structured clinical examinations provide a flexible approach to test administration in which various methods coalesce to obtain an assessment of clinical skills.[26]

Developed primarily to evaluate physical examination skills, standardized patients and objective structured clinical examinations can be used to measure skills in patient interviewing and counseling and rapport between physicians and patients.[25] To achieve reliability and validity in evaluating these particular skills, a range of 18 to 30 encounters with different patients is needed for each physician evaluated.[26,27] These methods are both time- and faculty-intensive in case development, administration, assessment, and feedback and are best conducted in structured and established settings within medical schools.

## Evaluating Residency Programs and Health Care Delivery Systems

To ensure consistent educational opportunities in residency training and in the delivery of quality care to patients and their families facing the final chapter of life, evaluation is essential.

### *Residency Programs*

One approach to evaluating residency programs recognizes the importance of establishing a baseline regarding the current emphasis placed on end-of-life patient care and then measuring the effect of curricular and experiential intervention. Recent studies show that within medical school and residency training, limited emphasis is placed on the teaching and training of physicians caring for dying patients, and few have formal curricula.[21,28,29] In fact, a review of current program requirements for accredited residency training (sponsored by the Accreditation Council for Graduate Medical Education) published annually in the graduate medical education directory shows no or only limited reference to formal training in end-of-life patient care. Relevant language from three specialties (family practice, internal medicine, general surgery) is described below[30]:

*Family practice.* Death and dying and the role of the family in illness management are defined as one of the principles of family practice.

*Internal medicine.* Issues of informed consent, living wills, patient advocacy, and related state laws concerning patients' rights are listed in the clinical ethics section of "Special Education Requirements."

*Surgery.* Educational conferences must include weekly review of all cases of current complications and deaths, including radiologic and pathologic correlation of surgical specimens and autopsies.

Greater emphasis could be placed on training residents in the care of dying patients by providing opportunities for learning during specific rotations in hospices and palliative care units and in other settings such as ambulatory clinics, support groups, and home visits.[31,32] Annual or biennial electronic literature searches, coupled with efforts by organizations committed to medical education to compile resource materials, could serve to validate innovation, change, and activity within educational and research environments.

### *Health Care Delivery Systems*

As changes in health care delivery systems continue to be driven by market and managed care forces, coupled with pervasive budgetary constraints and government regulations, patient satisfaction should play an even greater role in shaping efforts and emphasis on quality of care, particularly at the end of life. Physician assessment in the 21st century will probably focus on the system of health care delivery and the performance of physicians within that system. Physician report cards may be used increasingly to measure performance.[33] Criteria for measurement often include severity of illness, comorbidity and case mix, and patient preferences. The customers and vendors of these report cards are hospitals and health care facilities, managed care organizations (nonprofit and for-profit health maintenance organizations), industry, and agencies such as the National Committee on Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations.

Within health care delivery systems, efforts are being made to determine patients' satisfaction with all aspects of health care plans. In that regard, patient satisfaction questionnaires have been refined over the past decade and are credible tools in helping assess the communication skills and humanistic qualities of physicians.[34] Increasingly, however, patient satisfaction questionnaires are intended to determine consumer satisfaction with health care plans and health care delivery systems and may reflect less emphasis on interactions with physicians and other health care professionals. These questionnaires can help identify the need for improvement in selective skills. Because assessments of physicians' skills can vary extensively from patient to patient, ratings from 20 to 40 patients are required to obtain a reproducible, meaningful assessment.[35] Given the large systematic relationships between patient characteristics, clinic sites, and ratings, caution must be exercised when comparing physicians who provide care in different settings, particularly if the age and health status of the patient population are dissimilar.[36]

## Opportunities for Awareness and Action

Greater awareness is needed by the medical profession of the intrinsic role physicians can and should play in caring for and comforting dying patients and in consoling grieving families. Palliative medicine and hospice and home care are gaining recognition as separate, distinguished disciplines through increasing research, specialty organizations, federal legislation, quest for certification, and public demand. As a result, emphasis on end-of-life patient care will be enhanced in training and practice. These goals can be facilitated through the following targeted actions:

- Broaden the understanding of the core competencies necessary to provide end-of-life patient care;
- Profile the importance of educating physicians in end-of-life patient care as part of the agenda for national medical organizations;
- Include end-of-life patient care questions on national licensing and specialty in-training examinations and on certification and recertification examinations of member boards of the American Board of Medical Specialties;
- Assure that standards for accreditation of training programs offer opportunities for improving educational experiences in caring for patients in this final stage of life; and
- Promote a deeper understanding of the need for quality end-of-life patient care that will serve both the public and the profession well.

In conclusion, physicians' competence in end-of-life patient care can be assessed with a finite degree of validity and reliability. A definition, acceptance and understanding of specific competencies, and the application of traditional measures—the use of standardized written and oral examinations, standardized patients, peer evaluation, and patient satisfaction questionnaires—are required. Nonetheless, the judgment of physicians' competence may ultimately rest with the patients themselves and their families. Awareness by the medical profession and renewed emphasis within the educational and practice environments can make that much-needed difference.

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