


# Evaluation of medical ethics competencies in rheumatology: local experience during national accreditation process

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## ABSTRACT

**Introduction** Rheumatologists are the primary healthcare professionals responsible for patients with rheumatic diseases and should acquire medical ethical competencies, such as the informed consent process (ICP). The objective clinical structured examination is a valuable tool for assessing clinical competencies. We report the performance of 90 rheumatologist trainees participating in a station designed to evaluate the ICP during the 2018 and 2019 national accreditations.

**Methods** The station was validated and represented a medical encounter in which the rheumatologist informed a patient with systemic lupus erythematosus with clinically active nephritis about renal biopsy. A trained patient-actor and an evaluator were instructed to assess ICP skills (with a focus on kidney biopsy benefits, how the biopsy is done and potential complications) in obtaining formal informed consent, delivering bad news and overall communication with patients. The evaluator used a tailored checklist and form.

**Results** Candidate performance varied with ICP content and was superior for potential benefit information (achieved by 98.9% of the candidates) but significantly reduced for potential complications (37.8%) and biopsy description (42.2%). Only 17.8% of the candidates mentioned the legal perspective of ICP. Death (as a potential complication) was omitted by the majority of the candidates (93.3%); after the patient-actor challenged candidates, only 57.1% of them gave a clear and positive answer. Evaluators frequently rated candidate communications skills as superior ( $\geq 80\%$ ), but  $\geq 1$  negative aspect was identified in 69% of the candidates.

**Conclusions** Ethical competencies are mandatory for professional rheumatologists. It seems necessary to include an ethics competency framework in the curriculum throughout the rheumatology residency.

## INTRODUCTION

In terms of health, autonomy means self-governance to make free and responsible decisions that affect one's health.<sup>1</sup> Respect for patient autonomy promotes adequate communication between the

physician and the patient and is essential to the informed consent process (ICP), which has a legal aspect, represented by a mandatory document for human research protocols and for specific healthcare interventions.<sup>2</sup>

Rheumatologists are considered the primary care physicians of patients with rheumatic diseases,<sup>3</sup> and there are many clinical contexts described, where they participate in the ICP with their patients.<sup>4,5</sup>

The Mexican Accreditation Council for Rheumatology develops and applies, on an annual basis, the accreditation process for postgraduate trainees in rheumatology (TRs).<sup>6</sup> In 2018 and 2019, objective structured clinical examination (OSCE) circuits aimed at evaluating clinical competencies included two ethics stations. We herein report the results of candidate performance in a station designed to evaluate the ICP during a medical encounter, where the rheumatologist informs a patient with systemic lupus erythematosus and clinical active nephritis about renal biopsy utility and its potential complications (patient capacity was assumed).

## METHOD

### Ethical considerations

In our country, accreditation is mandatory to work as a specialist, and information from certified specialists must be public.<sup>7</sup> In the manuscript, all data from candidates were deidentified and no personal information was available at any point.

### Study design

#### TR description

The 2018 and 2019 OSCE circuits were applied to 44 and 46 candidates, respectively, from 16 different national referral centres approved for training in rheumatology.

#### Station design and evaluation

The station core skills (table 1) were selected according to the literature review.<sup>7-9</sup> The designed station material included instructions to candidates, a brief case presentation, a tailored checklist,

**Table 1** Core skills explored, corresponding items in the tailored station checklist and scoring system

Core skills evaluated	Items assigned (n)	Scoring system
Informed consent process	7	One point per item, final score translated to a decimal scale
Potential benefits of renal biopsy	1	
Knowledge transmission to the patient about the procedure	3	
Potential complications of renal biopsy	3	
Formal informed consent (legal document)	1	Mentioned to the patient (one point), not mentioned (0 points)
Delivering bad news	2	One point per item
Communication skills	6*	Likert scale (1–9); three categories: unsatisfactory (1–3), satisfactory (4–6), superior (7–9); final score translated to a decimal scale

\*Formats included two additional items but did not apply to the station. Total possible station score (0–23), translated to a decimal scale (0–10).

instructions to the evaluator, a patient–actor libretto and formats for communication skills (CS) evaluation. The station was validated by six experienced rheumatologists not involved in the station design, when there was  $\geq 80\%$  agreement regarding each item from the checklist, as previously described.<sup>6</sup> Two patient–actors were trained on how to behave during a medical encounter with candidates and how to rate CS; in addition, one evaluator was trained on how to rate the candidate’s performance using the checklist tailored to the station content and how to rate CS immediately after the candidate encounter with the patient.

### Statistical analyses

The descriptive statistical analysis was expressed as percentage, mean  $\pm$  SD and median (quartile 25–quartile 75) after a careful analysis of the distribution of variables.

A *p* value of  $\leq 0.05$  was considered significant. All tests were performed using the statistical package SPSS V.18.

## RESULTS

The 90 candidates had a mean ( $\pm$ SD) age of 32.7 years ( $\pm 2.2$ ), among whom 53% were women; 44 candidates participated in the 2018 accreditation process and 46 in the 2019 process.

### Candidate’s performance during the ICP

The mean  $\pm$  SD station score was  $8.1 \pm 1.3$  on a decimal scale. **Table 2** summarises data regarding candidate performance during the three tasks related to ICP. The majority of the candidates performed adequately in providing kidney biopsy benefits, but the percentage significantly decreased for providing an explanation of the procedure itself and mentioning potential (and relevant) complications. In addition, within each task, candidate performance varied.

### Informed consent permission

Only 16 candidates (17.8%) mentioned the legal perspective of the ICP, which requires signing a document.

### Performance at delivering bad news

During the ICP, only six candidates (6.7%) mentioned death as a potential complication. The patient–actor challenged the other

**Table 2** Number (%) of candidates who scored/performed specific items/tasks during the ICP

	Candidates who performed the task, n (%)
Provided potential benefits of kidney biopsy	89 (98.9)
Provided explanation about kidney biopsy (three items scored)	38 (42.2)
Provided an explanation about the test itself	90 (100)
Provided an explanation about how the biopsy s done	82 (91.1)
Provided an explanation about recommendations after the test	40 (44.4)
Potential complications (three items scored)	34 (37.8)
Mentioned bleeding	90 (100)
Mentioned pain	37 (41.1)
Mentioned any additional potential complication	83 (82.2)

\*†

84 candidates; among them, 48 (57.1%) responded affirmatively, 15 (17.9%) denied the complication, 19 (22.6%) did not provide a clear answer, and information from two candidates (2.4%) was missing.

### Candidate CS performances

The mean  $\pm$  SD patient–actor and evaluator scores were  $7.5 \pm 1.4$  and  $7.6 \pm 1.4$ , respectively, on a 0–9 scale. Both evaluators frequently rated candidate CS as superior ( $\geq 80\%$ ), although up to 69% of the candidates received negative comments from the patient–actor perspective about their performance (confused explanation, did not ask about patient’s name, failure to be empathic, anxiety when talking about death as a potential complication, no eye contact, medical jargon and lack of introduction about himself/herself).

## DISCUSSION

There is an increasing focus on the performance of doctors and a societal demand to ensure that they are fit to practice, a process known as competency. Physicians are expected to incorporate the current ethical discourse into their practice. Professionalism is demonstrated through a foundation of clinical competency, CS and ethical understanding,<sup>10</sup> which may have distinctive characteristics in the rheumatology field.<sup>11 12</sup>

Ethical competencies represent the simultaneous and complex integration of verbal, nonverbal, emotional and knowledge skills; accordingly, they are hard to assess. There is only one study published that describes the use of interactive stations designed to evaluate CS and professionalism in clinical scenarios that represent difficult patient dilemmas with ethical implications in rheumatology care. Berman *et al*,<sup>13</sup> used simulated clinic settings and provided an opportunity for rheumatology fellows to be observed for their professionalism and humanistic qualities. Their data revealed that the abilities to minimise medical jargon and to create a patient-centred empathic environment were perceived as two important components that make up the competency of professionalism.

During our national accreditation process, candidate performance was significantly poorer for providing complications and risks when compared with performance when providing benefits. In accordance, a minority of the candidates mentioned death as a potential risk associated with the renal biopsy; even

more, when candidates were challenged by the patient, up to 40% denied or did not make clear that death could eventually happen. This high percentage could be in part explained by the discomfort and uncertainty associated with breaking bad news to patients.

Bad news in medicine is defined as any information that produces a negative alteration to a person's expectations about their present and future.<sup>14</sup> Withholding bad news from patients has been associated with the paternalistic model of patient care.<sup>15</sup> This model has been recently replaced by one that emphasises patient autonomy and empowerment and requires the full disclosure of information.<sup>16</sup> Nonetheless, strong paternalistic attitudes can still be seen, particularly in the Latin American region,<sup>17</sup> where the imbalance in social status and education between the patient and the physician favours a high power–distance culture.<sup>18</sup> Baile *et al*<sup>19</sup> applied a survey of the practice of disclosure of a cancer diagnosis by oncologists to patients and found that doctors from developed countries were less likely to withhold unfavourable information from patients. Similar to our results, Fallowfield *et al*<sup>20</sup> showed that the content of a consultation may influence a doctor's ability to assess how well they communicated with a patient; in a comprehensive study that analysed doctor performance during more than 3000 consultations, performance was worse when palliative treatment was being discussed compared with potentially curative treatment.

A second important finding of our study was the discrepancy in the ICP and its legal dimension, which was mentioned by a minority of the candidates. There is a conceptual distinction between both dimensions; the former has an ethical and deontological character of respect to the patient's autonomy, and the latter has an additional legal character.<sup>2</sup> Beauchamp and Childress, highlighted that informed consent should be understood as a continuous process over time and the common view that the signed form is the essence of the consent should be dismissed.<sup>21</sup>

Third, CS were rated in the majority of the candidates as superior by both evaluators, although negative comments about candidate performance were noted by the patient–actor in a substantial proportion of the evaluations. CS are now recognised as an important component of professionalism and ethical competencies. A competency framework for shared decision making with patients identifies listening and communicating as essential for building a partnership.<sup>22</sup> In addition, a recent systematic review showed that doctor–patient relationship and communication influence healthcare outcomes<sup>18</sup>; additional studies have shown that the CS curriculum improves competency ratings.<sup>23,24</sup> According to our findings, it seems reasonable to propose a progressive and dedicated CS-based curriculum throughout the rheumatology residency.

Limitations of the study need to be addressed. First, we report the results of a short station that limits the testing of the candidate's ability to address complex ethical problems. Second, we report results from two consecutive accreditation processes. Third, the station represented a clinical scenario with ethical implications related to a procedure that is not routinely performed by rheumatologists; trainees may have felt that is not their role to be involved in the ICP. Last, the discrepancy between performance in communicating benefits and risks could be attributable to additional factors such as lack of trainee's knowledge about the potential implications of the biopsy, omission bias or even trainees understanding that extremely low-risk but high-impact complications should not be discussed in ICP.

## CONCLUSIONS

The field of rheumatic disease is fraught with a wide variety of ethical issues. Today, the law, medical ethics and society demand that rheumatologists incorporate the current ethical discourse into their practice. Our study identified areas for improvement in ethics competency performance in candidates undergoing a national accreditation process in rheumatology. It seems reasonable and necessary to include an ethics competency framework in the curriculum throughout the rheumatology residency.

**Contributors** V P-R, CA A-S and E A-H were responsible for objective clinical structured examination conception. All the authors contributed to data collection, data analysis and interpretation. V P-R and I C-Y drafted the manuscript. All authors provided a critical revision of the manuscript and approved the final version of the manuscript. V P-R is the guarantor.

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**Competing interests** None declared.

**Patient consent for publication** Not required.

**Ethics approval** We are reporting the performance of trainees in rheumatology, at a medical ethics station, during a national accreditation process, of which the results must be officially reported on an annual basis to the medical community and the society. In our country, accreditation is mandatory to work as a specialist, and information from certified specialists must be public and updated on an annual basis. Candidates agree upon application to the national accreditation process that the Mexican Accreditation Council for Rheumatology will analyse their performance and publish the results. In the manuscript, all data from candidates were deidentified, and no personal information was available at any point.

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## REFERENCES

- 1 Sturman E. The capacity to consent to treatment and research: a review of standardized assessment tools. *Clin Psychol Rev* 2005;25(7):954–74.
- 2 Marqués-Filho J. Informed consent in rheumatology care practice. *Rev Bras Reumatol* 2011;51:175–83.
- 3 Singer DA, Donnelly MB, Messerschmidt GL. Informed consent for bone marrow transplantation: identification of relevant information by referring physicians. *Bone Marrow Transplant* 1990;6(6):431–7.
- 4 Hahn BH, McMahon MA, Wilkinson A, *et al*. American College of rheumatology guidelines for screening, treatment, and management of lupus nephritis. *Arthritis Care Res* 2012;64(6):797–808.
- 5 - Bertsias GK, Tektonidou M, Amoura Z, *et al*. European League against rheumatism and European renal association European dialysis and transplant association, joint European League against rheumatism and European renal association-European dialysis and transplant association (EULAR/ERA-EDTA) recommendations for the management of adult and paediatric lupus nephritis. *Ann Rheum Dis* 2012;71.
- 6 Pascual Ramos V, Medrano Ramirez G, Solis Vallejo E, *et al*. Performance of an objective structured clinical examination in a national certification process of trainees in rheumatology. *Reumatología Clínica* 2015;11(4):215–20.
- 7 Available: [ordenjuridico.gob.mx/Documentos/Federal/pdf/wo11037.pdf](http://ordenjuridico.gob.mx/Documentos/Federal/pdf/wo11037.pdf)
- 8 National Kidney Foundation. A to Z health guide. What is a kidney biopsy?.
- 9 Fallowfield L. Giving sad and bad news. *Lancet* 1993;341(8843):476–8.
- 10 Stern DT. *Measuring medical professionalism*. New York: Oxford press, 2006.
- 11 MacKenzie CR, de Melo-Martin I. Ethical considerations in chronic musculoskeletal disease. *Curr Rev Muskuloskelet* 2015;8(2):128–33.
- 12 Caplan L, Hofferker L, Prochazka AV. Ethics in the rheumatology literature: a systematic review. *Arthritis Rheum* 2008;59(6):816–21.
- 13 Berman JR, Aizer J, Bass AR, *et al*. Fellow use of medical jargon correlates inversely with patient and observer perceptions of professionalism: results of a rheumatology OSCE (ROSCE) using challenging patient scenarios. *Clin Rheumatol* 2016;35(8):2093–9.
- 14 Fallowfield L, Jenkins V. . Communicating sad, bad and difficult news in medicine. *Lancet* 2004;363(9405):312–9.
- 15 Oken D. What to tell cancer patients: a study of medical attitudes. *JAMA* 1961;175:1120–8.
- 16 Breen G-M, Wan TTH, Zhang NJ, *et al*. Improving doctor-patient communication: examining innovative modalities vis-a-vis effective patient-centric care management technology. *J Med Syst* 2009;33(2):155–62.
- 17 Pascual-Ramos V, Contreras-Yáñez I, Ruiz D, *et al*. Attitudes about principle of autonomy in Hispanic patients from a dynamic early rheumatoid arthritis cohort. *Clin Exp Rheumatol* 2019;37(4):608–14.

- 18 Riedl D, Schübler G. The influence of doctor-patient communication on health outcomes: a systematic review. *Z Psychosom Med Psychother* 2017;63(2):131–50.
- 19 Baile WF, Lenzi R, Parker PA, et al. Oncologists' Attitudes Toward and Practices in Giving Bad News: An Exploratory Study. *J Clin Oncol* 2002;20(8):2189–96.
- 20 Fallowfield LJ, Jenkins VA, Beveridge HA. Truth may hurt but deceit hurts more: communication in palliative care. *Palliat Med* 2002;16(4):297–303.
- 21 Beauchamp T, Childress R. *Principles of biomedical ethics*. 6th edn. Oxford: Oxford University Press, 2009.
- 22 - Clyne W, Granby T, Picton C. A competency framework for shared decision-making with patients. Achieving concordance with taking medicines, 2007. Available: <http://www.ehealthnurses.org.uk/pdf/Prescribing%20Competency%20Jan%202007.pdf> [Accessed 20 May 2019].
- 23 Pascual-Ramos V, Flores-Alvarado DE, Portela-Hernández M, et al. Communications skills in candidates for accreditation in rheumatology are correlated with candidate's performance in the objective structured clinical examination. *Reumatología Clin* 2019;15:97–101.
- 24 Ramaswamy R, Williams A, Clark EM, et al. Communication skills curriculum for foreign medical graduates in an internal medicine residency program. *J Am Geriatr Soc* 2014;62(11):2153–8.