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Ethical Legal

Ethical Concerns Identified by Physical Medicine and Rehabilitation Residents

Guest Discussants: Jennifer Earle Miller, MD, Alejandra Camacho-Soto, MD, Charles Amoatey Odonkor, MD, MA, Stella Ferker, MD
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Introduction

In a classic article, "Ethics in a Short White Coat: The Ethical Dilemmas That Medical Students Confront" [1], the authors highlight issues that were identified by trainees, and they conclude that "ethics presented as moral theory or a set of principles can only go so far: personal problems, culled from the daily events of students' lives and rooted in the complex social situation of the ward more thoroughly capture their consciences."

In this column, I would like to start an exploration of the ethical concerns that physical medicine and rehabilitation (PM&R) residents face. They are in unique position in the hospital, no longer a student and not yet an independent practitioner. The Accreditation Council for Graduate Medical Education program requirements for PM&R [2] acknowledge this transition, stating: "Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident."

The Accreditation Council for Graduate Medical Education (ACGME) has specified training requirements for ethics, including "competence in the evaluation and management of patients with physical and/or cognitive impairments, disabilities, and functional limitations, including … application of bioethics principles to decision making in the diagnosis and management of their patients." Professional responsibilities include an "adherence to ethical principles" such as demonstrating compassion, integrity, and respect for others; being responsive to patient needs that supersedes self-interest; being respectful of patient privacy and autonomy; and being sensitive and responsive to diverse patient populations. These responsibilities and competencies are important, but what are the practical ramifications? How do residents learn about the complex ethical, legal, social, and institutional contexts, and, moreover, what do they report as ethical concerns in their daily work?

I reached out to program directors across the United States and asked them to forward my request for brief responses to the following prompt:

> As a resident physician training in PM&R, what ethical and legal concerns have you faced? Has your thinking about this topic changed over time from your formal ethics education in medical school to now, as you confronted the demands of your residency? Please describe 1 or 2 specific ethical or legal concerns that you have faced—you can write these examples as a narrative using a case or discuss the topic in general with examples. Please explain either how you dealt with the dilemma/concern or what you see as potential solutions for dealing with the issue you have identified.

During their "transformation," residents struggle with situations unique to their role as well as larger issues that all of us working in rehabilitation grapple with and ponder. I selected 4 essays that cover a range of ethical issues. The first essay, by Jennifer Earle Miller, a resident at Spaulding Rehabilitation Hospital, addresses the ethics of practicing on patients, an issue that has often been discussed in surgery but less so in PM&R. The second and third essays, by Alejandra Camacho-Soto and Charles Odonkor, from the Rehabilitation Institute of Chicago and Johns Hopkins Medicine, respectively, address communication. Camacho-Soto writes about communicating expectations and encouraging acceptance of "the new normal," whereas Odonkor writes about communicating with patients who are being "difficult." The fourth contribution, by Stella Ferker, from Nassau Medical Center, addresses social justice and beneficence considering the impact of insurance status on the care we all provide as rehabilitation professionals.

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I am honored and excited to take over the reins for this column from my mentor, Kristi Kirschner, MD, who set a groundbreaking path in Disability and Rehabilitation Ethics. I aspire to continue Dr. Kirschner's legacy and to engage, challenge, and animate conversations about ethical and legal issues in PM&R. I welcome feedback to this column as well as ideas for future columns at dmukherjee@ric.org.

References

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The Ethics of Practicing on Patients

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"We need practice to get good at what we do. There is one difference in medicine, though: it is people we practice upon" [1]. As I recently read *Complications* by Atul Gawande, I was struck by his reflections on the necessity in surgical residency that residents practice on patients. It is an uncomfortable truth that more novice surgical trainees need to perform surgeries under the supervision of attendings to acquire the skills necessary to safely practice independently. Patients are informed of the resident's role to varying degrees but are nonetheless often naive to the amount of teaching and instruction that occurs while they are under anesthesia. In PM&R, our acquisition of interventional skills place residents in a different ethically challenging position: to practice on patients, but in contrast to surgery, do so while the patient is awake and involved.

Electromyography, chemodenervation, interventional spine procedures, trigger point injections, and palpation or ultrasound-guided joint and soft-tissue injections are skills regularly performed by physiatrists. The performance of these techniques improves with hands-on practice. Although residents often begin by practicing on models, co-residents, willing spouses, and even ourselves, mastery involves cultivating these skills in a clinical setting. Many patients I have encountered in training are accommodating; they knowingly get their care from academic medical centers where they expect trainee involvement. Others are less enthused. I have experienced patients decline any resident involvement, often before, although on memorably rare occasion, during a procedure. The attending can readily take over, but the exchange can leave the resident, perhaps already nervous about trying a new technique or refining a difficult approach, feeling uncertain or even regretful about their participation.

Now, as a fourth-year resident, I anecdotally have found tremendous variability in patients' acceptance of resident participation. In my experience, many stroke or spinal cord injury patients returning for botulinum injections or baclofen pump refills are willing to have a resident perform their procedure, especially if a resident was involved in their inpatient rehabilitation. Sports medicine clinic patients can demonstrate more reluctance, understandably not wanting to risk a potentially unsuccessful injection slowing their pain relief or return to sport. I have observed patients who present for ultrasound-guided procedures become more open to the resident performing their injection if the resident first wins their confidence by performing a successful (and less intimidating) diagnostic ultrasound. In some settings, resident participation is not even questioned: residents begin nerve conduction studies just like an electromyography tech without question of qualifications, only to later be joined by the attending for the needle examination. With greater-risk procedures such as cervical epidurals, there is understandable reason for careful consideration of resident participation.

As residents, there is a temptation to adopt a "when in Rome, do as the Romans do" attitude and follow the practices of the supervising attending. I find, however, an attending's style of broaching (or not broaching) the subject of the resident performing the procedure may vary from my own. Most often if this happens, I'll just take note of our minor variations and plan to act differently in my own future practice. Occasionally, I will interject more explanation about my role as a trainee, sometimes at the cost of getting more hands-on experience. I've seen attendings take numerous approaches, such as stating early in the encounter that the resident will perform the procedure, including reciting the resident's abilities (and occasionally inflating them), or proceeding with resident performance of the procedure as long as the patient doesn't object. Some attendings will delicately ask the patient how he or she feels about the resident performing the procedure, but very often this well-intentioned approach results in the patient expressing reservations. The opposite challenge (for the resident) exists as well; even in an academic setting, there occasionally are attendings who focus on clinical efficiency and let the resident be an observer for the day. This variability can make resident involvement inconsistent despite great teachers.