

# Impact of years of clinical practice on ethical decision making

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Impact of Years of Clinical Practice on Ethical Decision Making

Kristin Jo Campos

The University of Toledo

2012

## **Dedication**

This paper is dedicated to anyone who desires to do the right thing, and for the right reasons,  
to Professor Edinger Ph.D. for being my advisor and example of ethics in the real world,  
to Professor Gentry MPAS, PA-C, CM for being the voice of the students and her commitment  
to the PA profession,  
to Pamela Banner MOL, for her amazing efforts during clinical rotations,  
to my baby boy Branch for making me smile every day,  
to my husband Darren for being more than I could ever ask for; I hope you can retire now.

### **Acknowledgements**

I would like to thank everyone who participated in my survey. Thank you to Sheri Gentry MPAS, PA-C, CM, for proofreading my survey. Thank you to the Ohio Association of Physician Assistants, Patricia Hogue Ph.D., PA-C, and Kristi Hayes, Administrative Secretary for the PA program, for their help in distributing my survey. My appreciation goes to Jolene Miller, MLS, for her help with multiple aspects of my research. Thank you to Barbara Saltzman, Ph.D., MPH, for her help with the statistical analysis. Thank you would be an understatement in expressing my gratitude to Walter Edinger, Ph.D., for all of his amazing support and input.

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## Introduction

As physician assistants (PAs) and students, our decisions often have ethical implications. As students we are taught the “right thing” to do in certain situations. When it comes to ethical decision making, we are taught that accepting gifts can be problematic, not to have romantic relationships with your patients, not to lie or withhold information, respect patient autonomy and acknowledge your errors. As a student, the answers may seem obvious. But what happens when one is actually out there in practice? Will the situations be as clear? Many factors come into play when making decisions in clinical practice. Most students and PAs have had an ethics course at some point in their education. These courses teach students by presenting hypothetical scenarios. The reality of clinical practice may influence how one makes decisions and the process one uses to analyze ethical situations may evolve with their experiences.

Healthcare providers are faced with difficult decisions, some of which are a matter of life and death. For providers, the majority of these decisions are based on knowledge and current research. Decisions may not be as straight forward when the answers cannot be found in a textbook, through research, or when the answer needs to results from personal judgment.

This research study was designed to shed light on whether years of practice would have an effect on how one addresses ethical situations. The purpose of this research was not to determine what is ethical and what is not; the purpose was to determine whether the ethical judgments of PAs evolves with experience. Ethical decision making applies to all PA students and PAs of all specialties and experience levels. Although an individual person may know where their beliefs stand, it may be helpful to know where one’s peers stand on an issue; not as a comparison, but to know in general what appears ethical within this subset of the population with such unique experiences that shape who they are.

## Literature review

In a review of the literature, articles were found generalizing clinical ethics as an important topic of clinical medicine. Authors have stated the importance of recognizing what is ethical and what is not, sometimes stressing the consequences when ethical considerations are not addressed. Among the range of ethical issues encountered in clinical practice, this research study focused on integrity such as seen with the logging of continuing medical education (CME) credits, patient autonomy, acceptance of gifts for services, disclosure of medical errors, and the patient/provider relationship.

An article published in 1998 stated that the discipline of medical ethics was relatively new as it had only been studied for about thirty years (Welie, 1998). This means that as of now, the study of ethics in practice has been around for about forty years and yet there is still not a lot of quantitative research in ethics. This suggests that there is an opportunity for additional research looking at the actual application of ethical judgment in practice.

When clinical ethicists were introduced into clinical medicine, “some physicians worried that the intrusion of one more of a growing number of back-seat drivers would hamper or even undermine the trust that is essential to the patient-provider relationship” (Welie, 1998). Physicians at the time believed that they should be able to make decisions without outside interference. They opposed people outside the profession coming in to promote the discipline of ethics as something separate from what they already considered an ethical profession.

Providers are likely to have different views on the importance of ethical decision making. “Typically, the responsible and virtuous person will respond with appropriate and adequate, that is, moral actions: When someone is bleeding, we attend to her wounds; when someone is shivering, we hand him a blanket” (Welie, 1998). But ethics is something different. Ethics



involves deliberation when there is doubt about the right thing to do. A clinician may not have the benefit of weighing the different consequences of his actions; he must make a decision (Welie). After making their choices, clinicians can learn from the outcome in each case.

The problem is not a lack of ethics or morals, but rather conflicting views of more than one person (Welie, 1998). There may be a greater or lesser emphasis on one value over another. Practitioners may feel so strongly about their beliefs that they refuse to change their views or consider those of another. Yet, no matter what the provider's or another's opinion is, the interests of the patient should be the first consideration.

### **CMEs**

The purpose of continuing medical education, according to the American Medical Association (AMA), is to “maintain, develop, or increase the knowledge, skills, and professional performance and relationships a physician uses to provide services for patients, the public, or the profession” (Davis et al., 2009). CMEs benefit providers by helping them to stay current on advances in medicine as well as refreshing common knowledge, but the ultimate person to benefit from continuing education is the patient. When considering the ethics surrounding logging of CME hours, it is more than integrity of logging what one actually does; it is whether one would be dishonest concerning requirements that are set to benefit more than one's self.

### **Autonomy**

The importance of patient autonomy was part of the PA curriculum and in a review of the literature, many articles discussed the importance of patient autonomy as well as the negative aspects of autonomy. Interestingly, a few of the more recent research articles discussed the relationship between the amount and nature of patient autonomy versus patient outcome. One article addressed this idea using cancer patients as an example. Justification of non-disclosure is

based on the “fear of causing psychological morbidity to patients and their reluctance to find out the truth” (Shahidi, 2010). This article also mentions that some cultures believe that disclosure may cause more harm than good to the patient if they were to learn about a poor prognosis. In this sense, non-disclosure “can be ethically rationalized by the ethical principle of beneficence” (Shahidi), acting in the patient’s best interest.

Autonomy means self-rule, but when clinicians think about autonomy, the focus is on the need for the patient to be educated about their condition and the treatment options for the patient to be able to make a decision. In a review of articles, some authors argue that patients cannot fully understand their situation as they do not have the medical training the providers do. One article suggested informing the patient and presenting them with options to choose between, rather than making the decisions themselves (Entwistle, Carter, Cribb, & McCaffery, 2010). With the idea of shared decision making, a patient is not only given options, the provider must also determine the patient’s understanding of their options (Davies & Elwyn, 2008). Ultimately, the clinician wants what is best for the patient but to some patients, autonomy and control over their care may be as important as their actual outcome.

## **Gifts**

Whether or not to accept a gift from a patient is a topic that has been studied in general medicine and mental health practices. A common topic in the literature was that the culture of the person giving the gift needs to be considered. In a study performed by Chris Brown and Heather B. Trangsrud, the results showed that a psychologist was “more likely to accept gifts when the gift was inexpensive, informed by cultural context, and presented with gratitude for good work at the end of treatment” (Brown & Trangsrud, 2008). The “psychologists were more likely to decline gifts that were expensive, presented during treatment, and had a sentimental or coercive value” (Brown & Trangsrud).

The article, *Factors Associated with Acceptance and Decline of Client Gift Giving*, discussed a “slippery slope” that can occur when “well-intentioned boundary crossings progress over time into major violations” (Brown & Trangsrud, 2008). According to the article, boundary crossing includes receiving token gifts and mentions how acceptance of certain gifts may be a benefit to the patient therapeutically. By receiving small gifts, clinicians are taking an opportunity to connect with their patient or even increase their familiarity with the patient’s culture. The problem arises when a clinician accepts something that financially exploits the patient and this is considered boundary violation as it may have a negative impact on patient outcome. There is not an exact distinction of the boundary line as one would interfere with a clinician making the decision based on the relationship and cultural expectations of the parties involved.

This issue is important beyond the mental health care setting. The article, “The Price of a Gift,” discusses the importance of the clinician to consider the intent behind the gift, monetary or other value to the patient, and the possible impact on the patient and their treatment if one were to either accept or decline the gift. “Practitioners are ethically obligated to consider patients’ best interests when deciding how to handle the offer of a gift” (Brendel et al., 2007). This article emphasizes that gift giving and acceptance needs to be considered on a “case-by-case basis” with all factors such as those mentioned above.

### **Medical Error**

The eighth leading cause of death in the United States is medical errors, causing more deaths than motor vehicle accidents, breast cancer, and AIDS (Goldberg, Kuhn, Andrew, & Thomas, 2002). The article, “Coping with Medical Mistakes and Errors,” discussed how practitioners have difficulty dealing with the consequences of their mistakes as medical errors often lead to increased morbidity and mortality. Errors are inevitable and yet the profession has

no standard way of helping its members cope (Goldberg, et al., 2002). This is important because if practitioners do not have a way to deal with their mistakes emotionally, they may be more likely to avoid disclosure, not only hiding their mistakes from others but also trying to avoid confronting it themselves.

“Our profession is difficult enough without having to bear the yoke of perfection,” Dr. David Hilfiker (Goldberg, et al., 2002). Physicians “tend to blame the system, other members of the health care team, or even the patient” (Goldberg, et al.). “The medical literature is unambiguous with regard to the ethical issue of disclosure of mistakes to patients. The physician is bound by the principles of nonmaleficence, beneficence, respect for autonomy, and justice to disclose errors that cause or may cause harm to a patient” (Goldberg, et al.).

According to the article, “Institutional Responses to Medical Mistakes: Ethical and Legal Perspectives,” not disclosing errors is a problem for three reasons: it interferes with the chance for the provider and their colleagues to learn from the mistake, it hurts patients by withholding information that may help their treatment decisions, and “fear of uncovering errors that might lead to litigation .....accounts for a decrease in the number of autopsies performed” (Thurman, 2001). “This decreases opportunities for the physician to learn, to comfort families with explanations of the patient’s death, and to alert families of discovered genetic risks; purposeful deception undercuts the trusting nature of the provider/patient relationship” (Thurman).

Informed consent is required by law in the United States. This obligation includes disclosing medical mistakes. In other words, there is a legal obligation to disclose mistakes because a patient cannot be fully informed without knowing the mistakes that occurred in their care (Thurman, 2001). Some institutions may not state directly that providers need to notify the patient of mistakes but they do require them to acquire informed consent which cannot be fully

given if the patient does not know the mistake occurred. Providers may fear malpractice lawsuits if they disclose an error but failure to disclose an error can result in separate action being taken against the clinician in addition to the malpractice or without having a case of malpractice.

### **Dating a Patient**

According to the American Academy of Physician Assistants' (AAPA) guidelines for ethical conduct, it is unethical for a PA to be sexually involved with patients, and possibly with former patients or key third parties such as spouses, partners, parents, guardians, or surrogates (AAPA, 2008). This type of situation is considered unethical due to the "imbalance of knowledge, expertise, and status." When a practitioner dates a person which fits into one of the descriptions listed above, increased vulnerability may develop due to "dependence, trust, transference, and inequalities of power" (AAPA, 2008).

Within the literature, there seems to be minimal contention that dating a current patient would be considered unethical. In the article, "Sexualization of the Doctor-Patient Relationship: Is it Ever Ethically Permissible?," the author mentions that the "long term emotional consequences of patients sexually involved with their doctor is likened to rape or incest and has been documented extensively" (Hall, 2001). While this does not mean that a sexual relationship could never occur without this effect, the author is merely stating that reports of successful relationships are not extensively documented, making them less likely. The debate however, is seen more when a provider dates a previous patient. The review of multiple studies show a consensus that sexual relationships are unethical, even if no longer a patient, as transference, "the unconscious assignment to others of feelings and attitudes that were originally associated with important figures," is still a factor (Hall).

The argument against relationships with former patients is that any privileged knowledge gained under the constraints of patient-provider cannot be “unlearned or forgotten” (Hall, 2001) . Further, this information may have been intimate details that one would not divulge so early in a romantic relationship (Hall, 2001). The American Medical Association (AMA) considers relationships with previous patients as unethical if the provider uses any information obtained while they were the provider to their advantage in the relationship (Coverdale & Turbott, 1997).

## Methods

The target population for this study was students matriculated into the University of Toledo Medical College's (UTMC) Physician Assistant program and PAs and PA students who are current members of the Ohio Association of Physician Assistants (OAPA). An online survey (Appendix 2), consisting of six demographic questions, five ethical scenarios and one comments option was constructed. A link to the survey was distributed by email to the PA students of UTMC and was provided by the OAPA in their email newsletter. The survey link was active from January 25, 2012 through February 29, 2012. There was no randomization scheme concerning the participants of this survey. There were no expected costs at the start of the research project but in order to include the number of questions desired in the survey, a package from the Survey Monkey site was purchased.

The independent variables to be measured were age, gender, specialties of practice, student or practicing PA, and years in clinical practice. The dependent variable was the likelihood of performing an act in each scenario. The use of the online survey tool, Survey Monkey, was used to collect the data. The research hypothesis was: The years in clinical practice will impact ethical decision making. The statistical hypotheses include: The null ( $H_0$ ) hypothesis: There will not be a statistically significant difference in ethical decision making based on the years in clinical practice; and the alternate ( $H_a$ ) hypothesis: There is a statistically significant difference in ethical decision making based on the years in clinical practice. The statistical test used was the Chi square test. Level of statistical significance was considered  $p < 0.05$ .

## Results

Please refer to *Figures 1-5* for demographic information.

For the specialties represented in this survey, Family Practice and Emergency Medicine were each indicated by 29.1% (n=30) of the respondents. The next highest response was for Other, 25.2% (n=26), and included the write-in responses of: Cardiology, Occupational Medicine, Pediatric Surgery/Trauma, Cardiothoracic Surgery, Hematology/Oncology, Urgent Care, Nephrology, Endocrinology, Physical Therapy, Public Health, Allergy/Asthma/Sinus Disease/Clinical Drug Trials, Intensive Care Unit, Pain Management, Bariatrics, Neurology, Trauma and Critical Care, Plastic Surgery, Neurosurgery, and Vascular Surgery. Other specialties involved in the study included Surgery, Orthopedics, Internal Medicine, Dermatology, Urology, Pediatrics, Geriatrics, and Obstetrics/Gynecology. The specific numbers of these specialties were not included in an attempt to maintain confidentiality of respondents who may be in specialties with so few PAs that they might be identifiable.

Please refer to *Figures 6-10* for total responses to scenarios.

In order to simplify reader understanding of the results, answer options were combined. Very likely and Somewhat likely were combined as one group: Likely. Not very likely and Never were combined as one group: Not likely.

### **Answers by years in school and practice**

In order to determine if there was a statistically significant difference between respondents of varying experience levels, Chi square tests were run for each ethical scenario comparing Professional level 1 (1<sup>st</sup> year PA students), Professional level 2 ( $\geq 2^{\text{nd}}$  year students), Professional level 3 (0-5 years in practice), and Professional level 4 ( $\geq 6$  years in practice). For all statistical analysis,  $p > 0.05$  meaning that in no scenario was there a statistically significant



difference in decision making seen based on years in clinical practice. For these values, see Tables 1-8.

### **Answers by Gender:**

Since it was hypothesized that there would be a statistically significant difference based on years in clinical practice, and this was not seen, statistical analysis was performed on multiple scenarios and demographics in order to determine if there was statistical significance in any combination. When looking at the results based on male versus female, the results are as follows: Whether they would log all CME hours without having attended all of them, 6.5% of males said they would; 24.8% of females said they would. For the question of whether they would downplay the risks of a procedure in order to persuade a patient to consent, 4.6% of males said they would; 21.7% of females said they would. When it comes to accepting gifts: Quilt, 73.5% of males would, 62.7% of females would; tickets to a sporting event: 35.3% of males would, 22.2% of females would; a stay at the patient's cottage: 9.1% of males would, 3.4% of females would; Cookies: 76.5% of males would, 79.7% of females would. For the questions of acknowledging a medical error to a patient, 11.8% of males would; 42.8% of females would. Whether one would report the violation of a colleague dating a patient, 11.2% of males would; 40.1% of females would. For all comparisons, Chi square tests were run and  $p > 0.05$  meaning there was no statistically significant difference between males and females for any of these ethical scenarios.

## **Discussion**

When discussing ethical issues in the classroom, the appropriate ethical solution is often clear. However, it may be less clear when clinical experience, relationships with patients, or other aspects of practice complicate the situation. Scenarios were selected that reflected a broad representation of the ethical issues faced by those in practice and ones that would apply to a range of specialties. An attempt was made to cover a spectrum of legal, professional and licensing issues while keeping the survey short in order to increase the response rate. Participants in the survey were also given the opportunity to leave comments for the ethical scenario questions. The majority of participants were physician assistants and of those, the majority have been practicing between 0-5 years. Of these same PAs, the majority are, or have been, practicing in family practice or emergency medicine. When starting out, it was hypothesized that the longer one was in clinical practice, their view of what was considered ethical might evolve with experience. While some of the results showed interesting differences, these differences were not statistically significant.

## **CME**

When looking at the results overall, 31.2% of respondents would log the CME hours even if they had not attended all of them. When comparing the results by years in clinical practice, surprisingly there was no major difference. Of those practicing 0-5 years, 34.6% would log all the CME hours and 37.0% of those practicing  $\geq 6$  years would. We anticipated that those practicing longer might feel there were other ways for them to stay updated and learn. Perhaps PAs of all years in practice see the value of having the CMEs and that their purpose is to benefit us as providers to our patients.

Also seen, was that more first year than second year students would take credit for all the hours (27.6% of first years and 14.3% of second years). To look at this information in another way, 1<sup>st</sup> year students: 27.6%, 2<sup>nd</sup> year students: 14.3%, 0-5 years in practice: 34.6%, and  $\geq 6$  years in practice: 37%. Of the comments explaining their response, one suggestion included collecting the material for review at home. If that was the case, perhaps the respondent felt the ultimate importance was on whether the information was learned or not.

The same question was looked at in terms of the other demographic information collected. When comparing PA versus students, 37.6% of PAs would log all of the hours and only 18.4% of students would. Interpreting the reasons behind these numbers is difficult. One might think that a PA would be less likely to log these hours because license could be revoked if caught. And the majority of the PAs would not accept credit for hours not attended at the CME event. But the number is still greater for PAs who would accept credit than for students. Perhaps fewer students would log these hours because the fear of punishment is stronger in a student's mind. Or perhaps students do not quite grasp or know all that is involved in keeping one's license.

When comparing the CME results by gender, 6.5% of males would log all of the hours compared to 24.8% of females, but was not statistically significant. Explaining this difference would require speculation. The reasons or difference between ethical decisions making for males versus females would be a potential area for future research.

### **Autonomy**

In the scenario designed to assess attitudes toward patient autonomy, 26.8% of all respondents would downplay the risks of a dissection repair in order to persuade the patient to consent to treatment. If comparing by years in practice, 26.0% of those practicing 0-5 years

would downplay the risks while 26.1% of those practicing six or more years would. With the years in practice seeming unlikely to play a role in this scenario, we compared first year and greater than first year students; 24.1% of first year students would downplay the results, while 35.7% of greater than or equal to second year students would. To look at this information in another way, 1<sup>st</sup> year students: 24.1%, 2<sup>nd</sup> year students: 35.7%, 0-5 years in practice: 26.0%, and  $\geq 6$  years in practice: 26.1%. The percentage of those that would downplay the risks are consistent except for the students in their second year or more of PA school.

There was only a minimal difference between PAs and students (25% of PAs would and 30.6% of students would downplay the risks). One might assume the student (being closer to the patient in perspective than to a clinician) may be more inclined to educate the patient and let them have a role in the decisions made concerning their health. Alternatively, the practicing PA may be focused more on acting in the best interest of the patient. When comparing the results based on the gender of the respondent, 4.6% of males would downplay the risk and 21.7% of females would. Unfortunately this survey was unable to distinguish the reasons for one approach versus another.

A few explanations were left in the comments section. These comments included justifying the action of “lying” in order to save a life; the idea that the patient needs to be fully informed about his condition in order to make a decision; many suggestions for the involvement of the family in the decision making and one person mentioned the importance of a living will or power of attorney. Overall, the comments emphasized that what is best for the patient is the priority. But “best interests” is not always clear. For one patient, full control over their healthcare decisions may be more important than a longer life; yet, a change of mental status can blur those lines. With so many responses suggesting family involvement or the patient’s wishes, this might

suggest that healthcare providers are consistently encouraging their patients to be open with others about their wishes and even to encourage sharing a copy of their living will.

### **Gifts**

One scenario was proposed to assess the response to various gifts that might be offered by a patient. The gift options varied from something personal and handmade, to things with more monetary value. When it comes to accepting something like a quilt, 65.4% of patients said that they would accept this gift. When breaking this down, 68% of PAs would while 61.2% of students would. For males versus females, 73.5% of males would and 62.7% of females would. When comparing years in practice, 56.4% of those 0-5 years in practice would and 78.3% in practice six or more years would. For students, 70% of first years would accept a quilt and 50% of second years would.

To look at this information in another way, 1<sup>st</sup> year students: 70%, 2<sup>nd</sup> year students: 50%, 0-5 years in practice: 56.4%, and  $\geq 6$  years in practice: 78.3%. There seems to be no pattern for time in practice to affect whether or not one would accept a personal gift such as a quilt. Perhaps this is one scenario where our decisions are made based on something we learned prior to PA school. One comment was that it would be rude in that person's culture to refuse a homemade gift. The majority of other comments stated that they would not want to offend or hurt the patient presenting the gift. Many also stated that in accepting such a gift, they would be sure the patient understood that the gift would in no way affect the care they received.

The participants were also asked if they would accept tickets to a sporting event or theatre show with 25.0% saying they would. Of these, 25% of PAs would and 25% of students would; 35.3% of males would, and 22.2% of females would; 25.6% of those practicing 0-5 years would and 26.7% of those practicing six or more years would; 25% of first year students would

accept the tickets and 28.6% of second year students would. It is interesting that of the different points to compare, there was very little variability among whether or not it was acceptable to accept gifts of such possible monetary value. Perhaps the fact that there would be less emotional involvement in turning away such a gift would make it easier to reject the gift by explaining to the patient the inappropriateness of the gift. The biggest difference or factor appeared again to be between males and females, but this difference was not statistically significant. The consensus among the comments was that something of this value would politely be turned down.

When asking whether or not one would accept a gift such as a stay in a patient's cottage, even fewer said that they would, only 4.6%. PAs and students alike both had less than 5% saying they would accept the gift. Once again, the biggest difference was between the males and females with 9.1% of males saying they would accept this gift and 3.4% of females. When looking at years in clinical practice, those in practice six or more years had 6.5% saying they would accept the gift versus 3.9% of those in practice 0-5 years. None of these differences were statistically significant.

Whether or not to accept something like cookies seems to be easier for the participants to decide with 79.1% saying they would accept cookies. When looking at PAs versus students, 84% of PAs would accept cookies and 71.4% of students would. For this one question, males and females were unusually close with 76.5% of males and 79.7% of females accepting cookies. This could be explained by the idea that cookies are something that can be shared with everyone involved in the patient's care, and less to do with any factor differences between males and females. When looking at whether or not years of experience influence the acceptance of cookies, we find that 79.3% of first years, 60.7% of second years, 79.5% of those practicing 0-5 years, and 84.4% of those practicing six or more years would accept cookies. This large majority

of people willing to accept cookies could be explained by the simple truth that people like cookies. Or this could be explained as people see a lower risk of harm in accepting something with such low monetary value and something that can be shared with others.

### **Medical Error**

The next proposed scenario entailed admitting a medical error to a patient with 53.2% of respondents saying that they would not tell a patient about their mistake. When comparing PAs to students, 56% of PAs and 49.0% of students would refrain from telling the patient. When comparing males to females, the largest variability was seen with 11.8% of males and 42.8% of females saying they would not tell the patient. Despite this large variability, these results were not statistically significant. For students, 58.6% of first years and 46.4% of second years would not tell the patient. Amazingly, 57.7% of 0-5 years in practice and 57.8% of six or more years in practice would not tell the patient. To better see if time in practice changes what one would do in this situation: 58.6% of first years, 46.4% of second years, 57.7% of 0-5 years in practice, and 57.8% of those with six or more years of practice said they would not tell.

The overwhelming similarity of the number of participants of all experience levels is quite interesting. The comments left by the participants varied more than the numbers. Comments from people admitting this happens, suggesting it was somehow the patients fault, reasoning for not admitting the mistake because it will not change what happened, to comments such as openness and honesty are the safest and best way to go for all involved. It has been suggested that patients are less likely to sue if they feel their practitioner was honest with them, but some may not want to take that risk. Respecting autonomy and making sure a patient is fully informed to make decisions about their healthcare may suggest they need to know about these mistakes.

### **Dating a patient**

A scenario was presented about a provider dating a patient. This question was about what the respondent would do if they knew a colleague may be acting inappropriately. Of the respondents, 51.0% said they would report this ethical violation; 48% of PAs and 55.1% of students would report the violation. In this final scenario, the biggest difference was seen with 11.2% of males and 40.1% of females stating they would report the relationship. Again, as stated before, with such a large difference in this group, further research would need to be done before any conclusions based on males versus females when concerning ethical issues could be drawn. Over half of both first and second year students, 51.7% and 57.1% respectively, would report a colleague. Another interesting result was that 53.8% of 0-5 years in practice would report the relationship, while fewer of those in practice six or more years, 46.7% would. This scenario drew comments from both extremes of opinions.

### **Other**

The problem in attempting to interpret this data is that most questions in ethics can be answered with, "it depends." Looking at the comments left for each of the ethical scenarios makes this even more apparent. The most significant difference in responses for these scenarios appears to be between males and females. This study was not designed to determine different factors among males and females to possibly explain their difference in opinions. Perhaps this is an area for a future study to be conducted.

Bias could be seen as research subjects were aware that the title of the study was "Impact of Years of Clinical Practice on Ethical Decision Making." This means that they were aware of what variable specifically that the researcher was trying to assess and this could have affected the way they answered this survey. Efforts were made to reduce the chances of error. All participants



took an identical online survey through a site that collected the results. Sources of error include that the link was sent to practicing PAs who had graduated from UTMC PA program but were now practicing out of state. An email was sent once this error was discovered, to specify the survey was for those currently in Ohio. The Institutional Review Board was notified of this breach in protocol. Only two responses on the survey were entered before this email was sent. It is not possible to be sure if either of them was practicing outside of Ohio.

The information obtained was through the use of the same online survey given by the same online program to each individual taking the survey so sources of error based on reliability are not seen. No efforts were taken to present internal consistency or reliability of respondent's answers as each question was only presented once. Content validity was affected as this survey was a narrow sampling of ethical issues that are faced in clinical practice with only five scenarios being presented. While keeping the survey short in order to increase response rate, the survey may have been too short to cover the wide range of issues faced by clinicians. Maturation was not a threat to the internal validity of this study as this was an independent variable that was measured. History, the effect of passage of time on the dependent variable, was not a threat to internal validity as the years in clinical practice was the dependent variable. Sampling, however, could be seen as a threat to validity as the group surveyed is not representative of the general population of PAs and PA students.

Population-related threats to external validity were seen in this study. The survey was only distributed to a select group of students: those currently enrolled at the University of Toledo Medical Center's Physician Assistant Program in Ohio and students who are members of the Ohio Association of Physician Assistants and receive their email newsletter. This select group is not likely to be representative of all of the PA students in all of the PA programs in all states

whose curriculum would vary as well as culture and experiences. The selection of PAs that were surveyed could also be considered a threat to external validity as the survey was only intended for PAs practicing in Ohio. Due to the fact that the sampling is a select group of people, the results of this study cannot be generalized to the larger population of PA students and PAs outside of Ohio. The sample was further limited to PAs who had attended UTMC's PA program, are practicing in Ohio, and still receive emails from the UTMC program and PAs practicing in Ohio who are members of the OAPA and receive their email newsletter. This survey was only distributed online so those individuals who are less inclined to use emails or computers would not have access to the survey. Individuals may not be subscribed to the OAPA's online newsletter or may no longer use their UTMC's PA school email. Another threat to external validity would be whether the knowledge that their answers would be made public could have affected some to answer differently based on what they felt seemed more ethical.

When answering questions of an ethical nature, there is no way to know if the fact that these results could be published or made public knowledge influenced one's answers. For example, would PAs choose the more ethical option if they were concerned about what the public would think if the results leaned more towards the unethical side? Perhaps students would answer with the more ethical options in order to appear trustworthy as a whole to their peers and future patients. Selection bias may also be present in that interest in ethics may limit who would respond to this survey.

## **Conclusion**

The intent behind this research was not to determine which decisions are ethical; but to compare what members of a particular group would do in these situations. While none of the survey results were statistically significant when viewed through statistical analysis, the intent behind ethical decision making is immeasurable and is significant to those affected by the outcomes. Perhaps whether something is deemed right or wrong depends on the intent behind the decision and less on the outcome. This was made evident by the many comments left explaining many participants' responses to each scenario.

Physician assistants are members of a young profession and perhaps this survey could be repeated again in 5-10 years as the number of PAs or length in practice increases allowing for greater chance of statistical significance. No matter what the results now, or in the future show, as physician assistants we have a responsibility to others and are bound by autonomy, beneficence, non-maleficence, and justice.

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## Tables

Table 1: Professional Level CME Comparison

	The conference you are attending is offering 20 CME credits. You are unable to attend the last few lectures, missing 3 hours worth of credit. How likely are you to log all 20 hours?				Total
	Very likely	Somewhat likely	Not very likely	Never	
1.00	2	6	14	7	29
2.00	2	2	15	9	28
3.00	6	13	22	9	50
4.00	6	11	18	11	46
Total	16	32	69	36	153

### Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.837 <sup>a</sup>	9	.654
Likelihood Ratio	7.674	9	.567
Linear-by-Linear Association	1.777	1	.182
N of Valid Cases	153		

a. 3 cells (18.8%) have expected count less than 5. The minimum expected count is 2.93.

- Professional level 1: 1<sup>st</sup> year PA students
- Professional level 2:  $\geq 2^{\text{nd}}$  year PA students
- Professional level 3: 0-5 years in practice
- Professional level 4:  $\geq 6$  years in practice

Table 2: Professional Level Autonomy Comparison

	<b>Eldon Dibling is a 75 y.o. long-term patient of yours that you have recently diagnosed with severe anxiety and depression related to his worsening medical conditions. Upon examination you suspect an aortic dissection which is confirmed by diagnostic testing. The dissection is in urgent need of repair but you know the patient would refuse while he is in his current depressed state. How likely are you to downplay the risks of the dissection repair in order to persuade the patient to consent to the repair, which you feel is his only chance to survive?</b>				Total
	Very likely	Somewhat likely	Not very likely	Never	
1.00	1	6	19	3	29
2.00	2	8	13	5	28
3.00	3	9	20	17	49
4.00	5	7	21	13	46
Total	11	30	73	38	152

## Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.689 <sup>a</sup>	9	.298
Likelihood Ratio	11.035	9	.273
Linear-by-Linear Association	.660	1	.417
N of Valid Cases	152		

a. 4 cells (25.0%) have expected count less than 5. The minimum expected count is 2.03.

- Professional level 1: 1<sup>st</sup> year PA students
- Professional level 2: >=2<sup>nd</sup> year PA students
- Professional level 3: 0-5 years in practice
- Professional level 4: >=6 years in practice

Table 3: Professional Level: Gifts-Quilt Comparison

	Homemade quilt				Total
	Very likely	Somewhat likely	Not very likely	Never	
1.00	7	13	5	4	29
2.00	3	11	8	6	28
3.00	12	18	11	9	50
4.00	15	21	3	6	45
Total	37	63	27	25	152

## Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.755 <sup>a</sup>	9	.293
Likelihood Ratio	11.822	9	.224
Linear-by-Linear Association	1.834	1	.176
N of Valid Cases	152		

a. 3 cells (18.8%) have expected count less than 5. The minimum expected count is 4.61.

- Professional level 1: 1<sup>st</sup> year PA students
- Professional level 2:  $\geq 2$ <sup>nd</sup> year PA students
- Professional level 3: 0-5 years in practice
- Professional level 4:  $\geq 6$  years in practice



Table 4: Professional Level: Gifts-Tickets Comparison

	Tickets to sporting event/theatre show				Total
	Very likely	Somewhat likely	Not very likely	Never	
1.00	1	6	12	9	28
2.00	2	6	9	11	28
3.00	3	8	18	21	50
4.00	4	8	18	15	45
Total	10	28	57	56	151

## Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.468 <sup>a</sup>	9	.982
Likelihood Ratio	2.516	9	.980
Linear-by-Linear Association	.026	1	.872
N of Valid Cases	151		

a. 4 cells (25.0%) have expected count less than 5. The minimum expected count is 1.85.

- Professional level 1: 1<sup>st</sup> year PA students
- Professional level 2:  $\geq 2$ <sup>nd</sup> year PA students
- Professional level 3: 0-5 years in practice
- Professional level 4:  $\geq 6$  years in practice

Table 5: Professional Level: Gifts-Cottage Comparison

	A weekend at their cottage				Total
	Very likely	Somewhat likely	Not very likely	Never	
1.00	0	1	6	21	28
2.00	0	0	4	23	27
3.00	0	3	9	38	50
4.00	0	3	12	31	46
Total	0	7	31	113	151

## Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.898 <sup>a</sup>	6	.690
Likelihood Ratio	5.092	6	.532
Linear-by-Linear Association	1.524	1	.217
N of Valid Cases	151		

a. 4 cells (33.3%) have expected count less than 5. The minimum expected count is 1.25.

- Professional level 1: 1<sup>st</sup> year PA students
- Professional level 2:  $\geq 2$ <sup>nd</sup> year PA students
- Professional level 3: 0-5 years in practice
- Professional level 4:  $\geq 6$  years in practice

Table 6: Professional Level: Gifts-Cookies Comparison

	Cookies				Total
	Very likely	Somewhat likely	Not very likely	Never	
1.00	17	6	3	3	29
2.00	12	5	7	4	28
3.00	30	13	3	4	50
4.00	31	7	5	2	45
Total	90	31	18	13	152

## Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.061 <sup>a</sup>	9	.272
Likelihood Ratio	10.475	9	.313
Linear-by-Linear Association	2.662	1	.103
N of Valid Cases	152		

a. 6 cells (37.5%) have expected count less than 5. The minimum expected count is 2.39.

- Professional level 1: 1<sup>st</sup> year PA students
- Professional level 2:  $\geq 2$ <sup>nd</sup> year PA students
- Professional level 3: 0-5 years in practice
- Professional level 4:  $\geq 6$  years in practice

Table 7: Professional Level Medical Error Comparison

	<p><b>You see a patient for her annual exam, including breast exam. You note a 2 cm mass in her right breast. In reviewing her record, you see she had a mammogram a little over a year ago and it was recommended to you that she return for a close follow-up in 6 months to watch an area in the right breast for any changes. There is no notation that the report and recommendation were ever given to the patient. You send the patient for an immediate mammogram. How likely are you to not acknowledge the missed follow-up?</b></p>				Total
	Very likely	Somewhat likely	Not very likely	Never	
1.00	10	7	10	2	29
2.00	9	4	13	2	28
3.00	9	18	13	10	50
4.00	10	16	16	3	45
Total	38	45	52	17	152

## Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.887 <sup>a</sup>	9	.126
Likelihood Ratio	13.890	9	.126
Linear-by-Linear Association	.476	1	.490
N of Valid Cases	152		

a. 2 cells (12.5%) have expected count less than 5. The minimum expected count is 3.13.

- Professional level 1: 1<sup>st</sup> year PA students
- Professional level 2:  $\geq 2$ <sup>nd</sup> year PA students
- Professional level 3: 0-5 years in practice
- Professional level 4:  $\geq 6$  years in practice

Table 8: Professional Level Reporting a Colleague Comparison

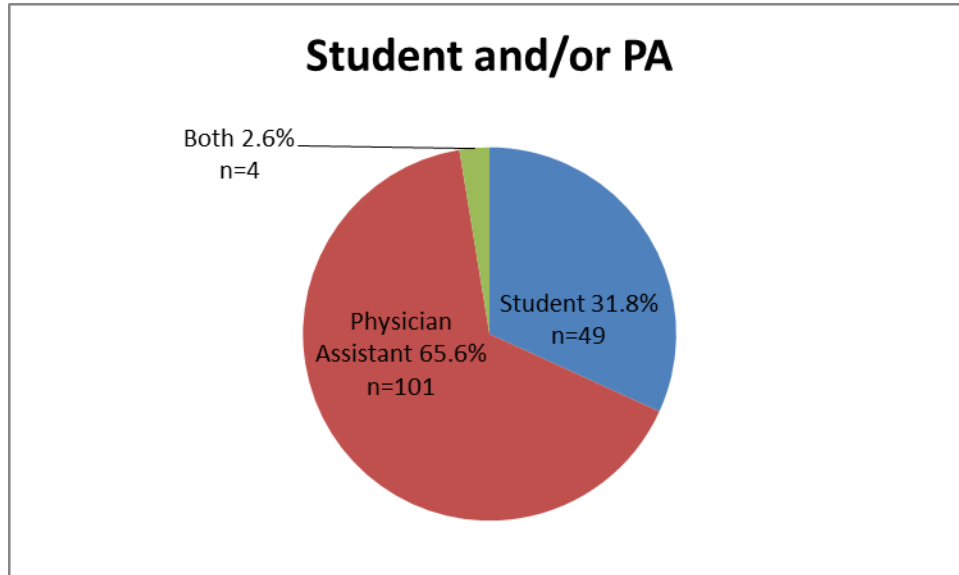
		You are out to dinner and see a fellow PA on a date with his patient. The following Monday at work, you voice your concern and he denies there is anything to worry about. Weeks later you see them at a coffee shop before work. At work a few hours later you confront your colleague once more. He admits that they are having an affair with no intentions of putting an end to the relationship. How likely are you to report this violation?				Total
		Very likely	Somewhat likely	Not very likely	Never	
Professional level	1.00	10	5	14	0	29
	2.00	5	11	11	1	28
	3.00	9	16	23	2	50
	4.00	4	17	22	2	45
Total		28	49	70	5	152

## Chi-Square Tests

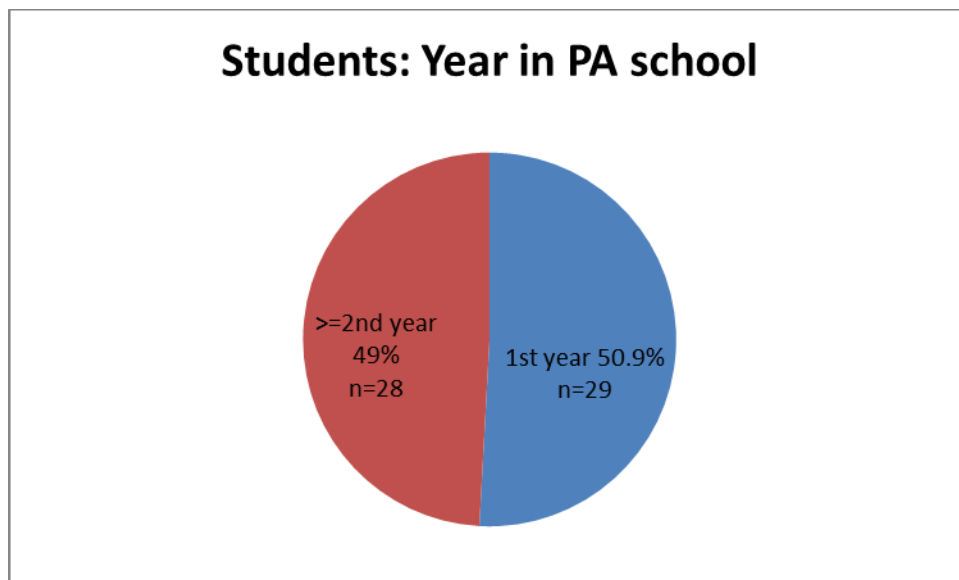
	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.783 <sup>a</sup>	9	.291
Likelihood Ratio	11.783	9	.226
Linear-by-Linear Association	3.396	1	.065
N of Valid Cases	152		

a. 4 cells (25.0%) have expected count less than 5. The minimum expected count is .92.

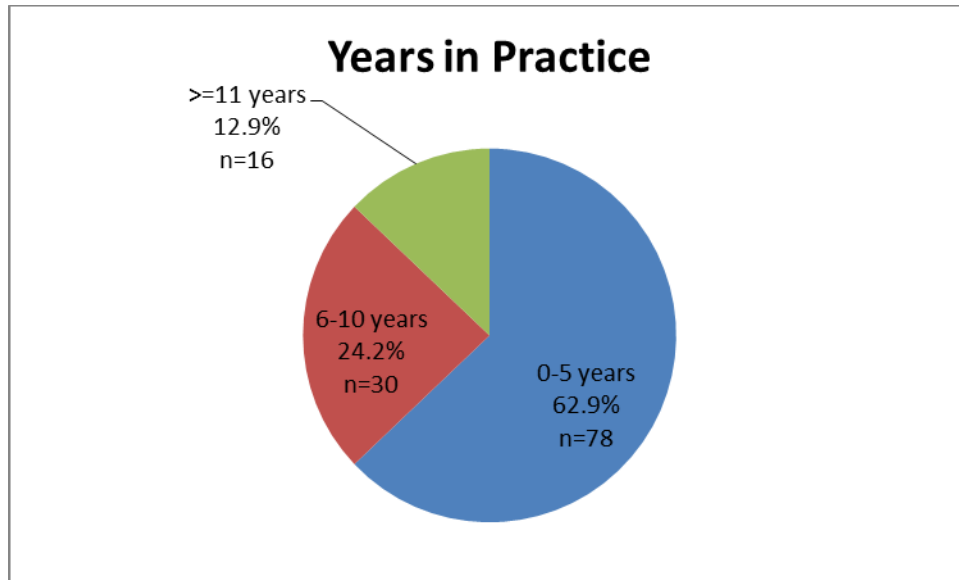
- Professional level 1: 1<sup>st</sup> year PA students
- Professional level 2:  $\geq 2$ <sup>nd</sup> year PA students
- Professional level 3: 0-5 years in practice
- Professional level 4:  $\geq 6$  years in practice

**Figures**

*Figure 1: Student and/or PA*

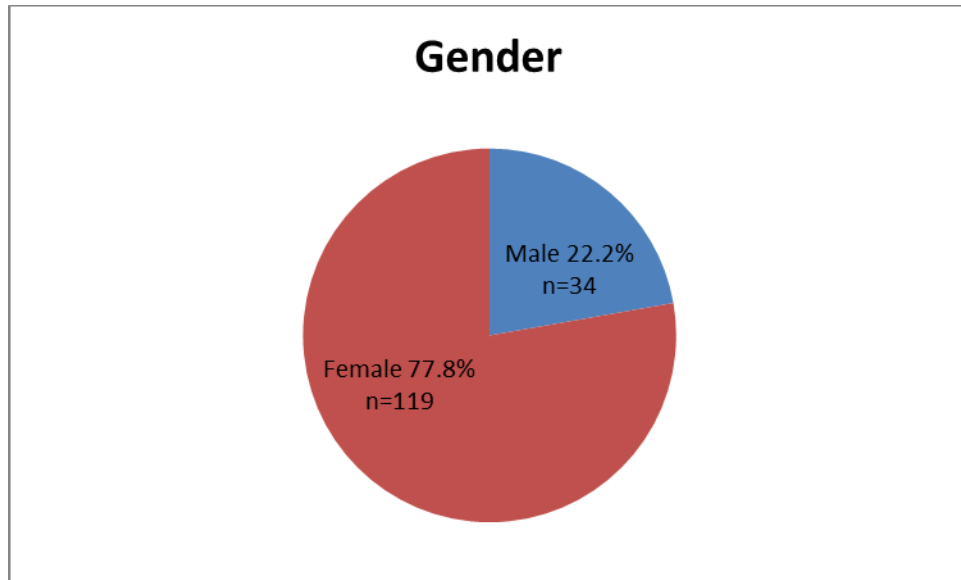


*Figure 2.* Students: Year in PA school

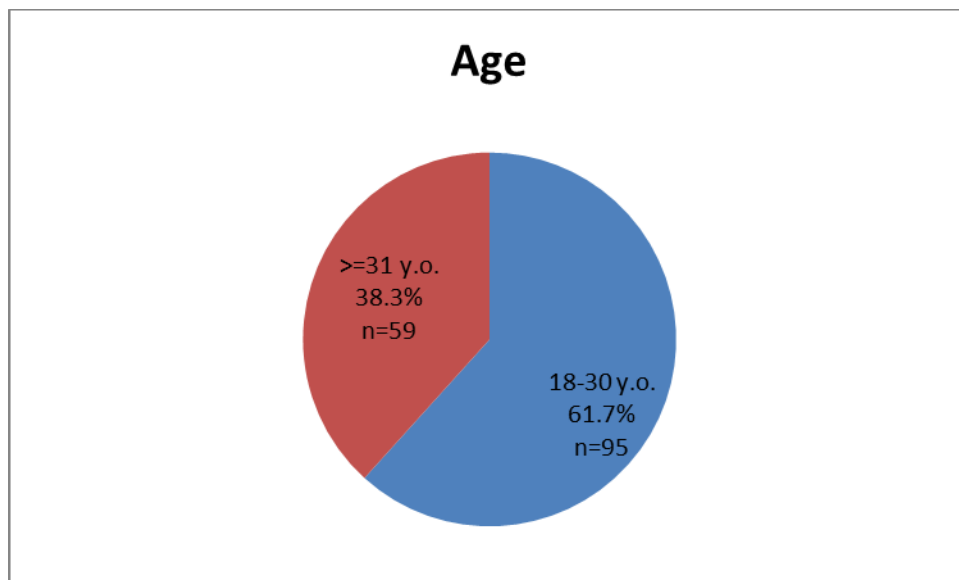


*Figure 3.* Years in clinical practice





*Figure 4. Gender*



*Figure 5. Age*

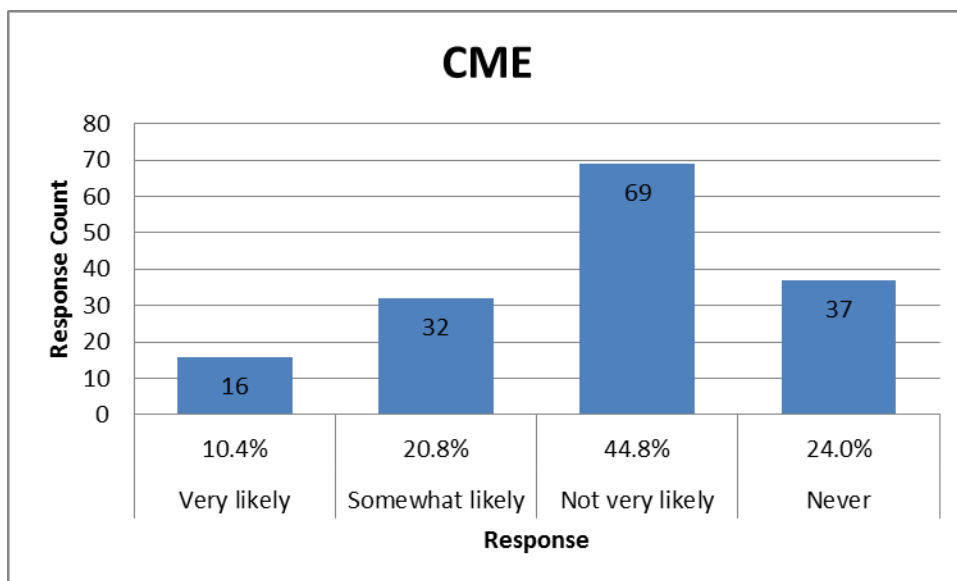


Figure 6.CME: Would accept credit for hours not attended

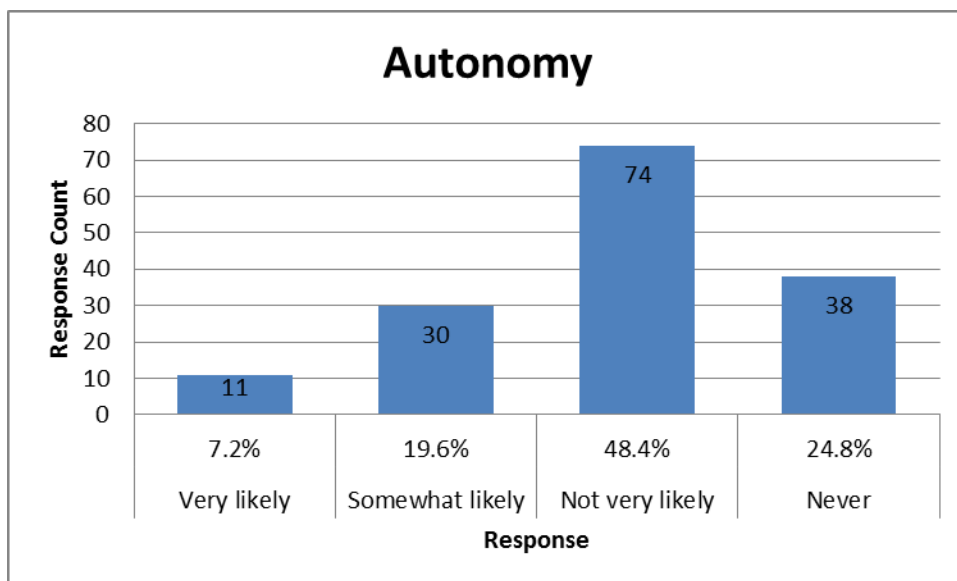


Figure 7. Autonomy: Would downplay risks of procedure

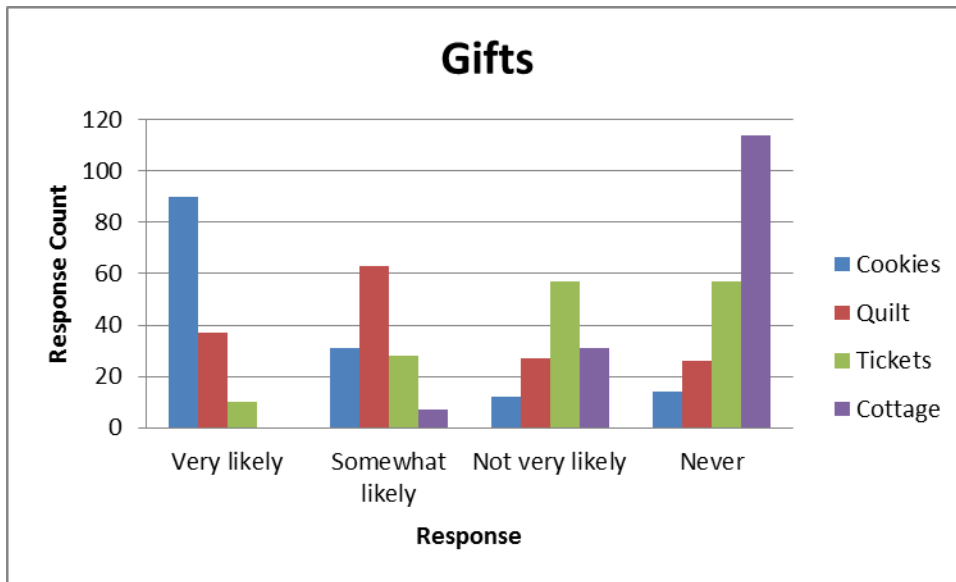


Figure 8. Gifts: Would accept gift from a patient

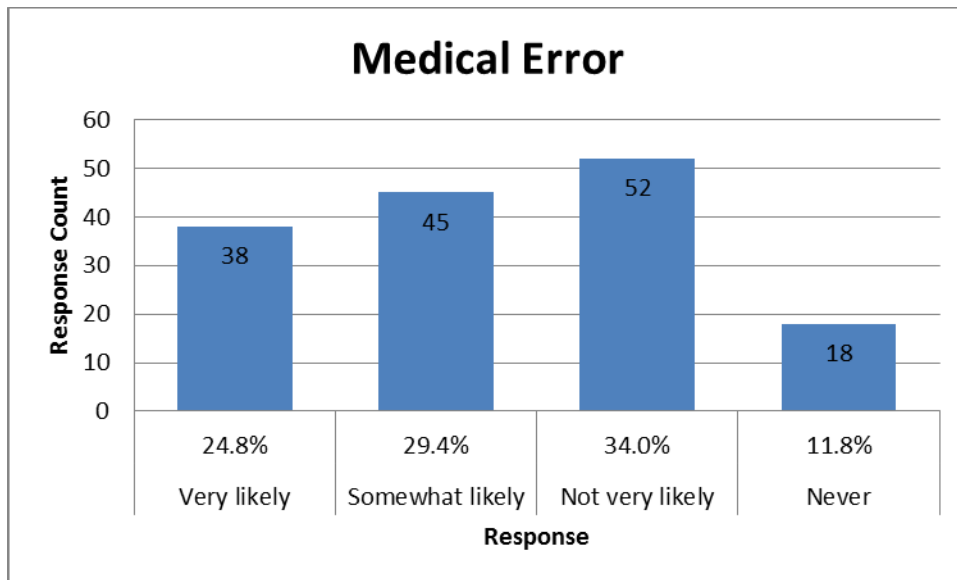


Figure 9: Medical error: Would not disclose a medical error

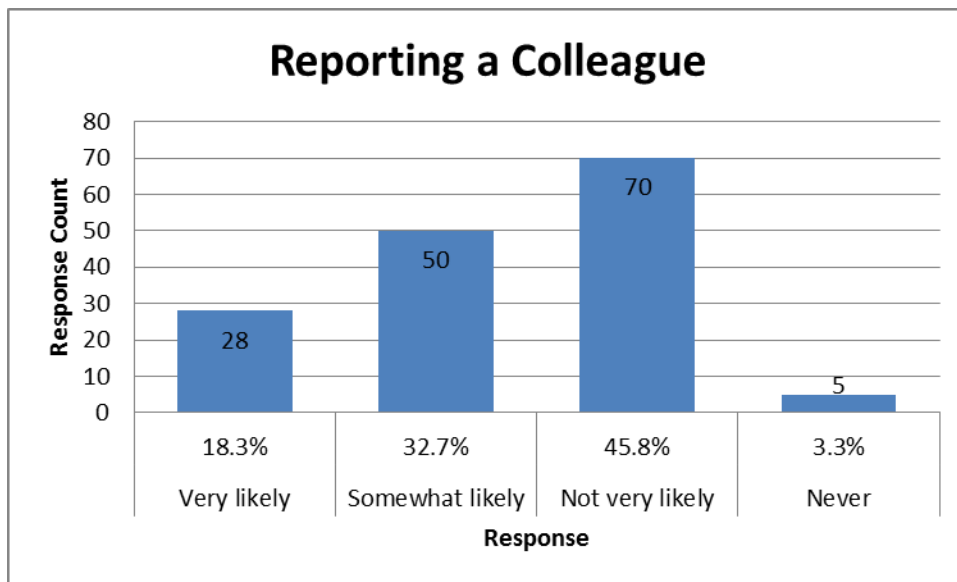


Figure 10. Sexual misconduct: Would report a colleague for an inappropriate relationship

## Appendices

### Appendix 1: Cover Letter

Please read below for information concerning your rights as a research subject. The survey begins on the next page.

Completing this online survey is voluntary. Your decision to complete it will signify your voluntary consent to take part.

#### ADULT RESEARCH SUBJECT - INFORMED CONSENT FORM (Impact of Years of Clinical Practice on Ethical Decision Making)

Principal Investigator: Walter Edinger (faculty); 419-383-5657; Walter.Edinger@utoledo.edu  
Student researcher from the University of Toledo, Kristin Campos; 419-383-5408;  
kristin.campos@utoledo.edu

**Purpose:** You are invited to participate in the research project entitled, Impact of Years of Clinical Practice on Ethical Decision Making which is being conducted at the University of Toledo under the direction of Walter Edinger. The purpose of this study is to remind PAs and students of the importance of ethics in clinical decision making.

**Description of Procedures:** This research study will take place in Ohio. The survey should take approximately 5-10 minutes to complete in one session. You will be asked to complete a questionnaire in which you will review ethical scenarios and determine your most likely response for that situation.

After you have completed your participation, the research team will debrief you about the data, theory and research area under study and answer any questions you may have about the research.

**Potential Risks:** There are minimal risks to participation in this study. No names will be collected. Answering the surveys might cause you to feel upset or anxious. If so, you may stop at any time.

**Potential Benefits:** The only direct benefit to you if you participate in this research may be that you will learn about how ethical scenarios may not have one correct answer. You may learn more about ethics in clinical practice. Others may benefit by learning about the results of this research.

**Confidentiality:** The researchers will make every effort to prevent anyone who is not on the research team from knowing that you provided this information, or what that information is. Although we will make every effort to protect your confidentiality, there is a low risk that this might be breached.

**Voluntary Participation:** Your refusal to participate in this study will involve no penalty or loss of benefits to which you are otherwise entitled and will not affect your relationship with The



University of Toledo or any of your classes or membership with the Ohio Association of Physician Assistants. In addition, you may discontinue participation at any time without any penalty or loss of benefits.

Contact Information: Before you decide to accept this invitation to take part in this study, you may ask any questions that you might have. If you have any questions at any time before, during or after your participation you should contact a member of the research team (Walter Edinger, 419-383-5657 or Kristin Campos, 419-383-5408).

If you have questions beyond those answered by the research team or your rights as a research subject or research-related injuries, the Chairperson of the SBE Institutional Review Board may be contacted through the Office of Research on the main campus at (419) 530-2844.

**Appendix 2: Survey**

1. Student and/or Physician Assistant
  - a. Student
  - b. Physician Assistant
  - c. Both
  - d. Neither
2. Students: Year in PA school
  - a. 1<sup>st</sup> year
  - b. 2<sup>nd</sup> year
  - c. 3<sup>rd</sup> year
  - d. 4<sup>th</sup> year
3. Physician Assistants: Years in clinical practice
  - a. 0-5
  - b. 6-10
  - c. 11-15
  - d. 16-20
  - e. 21-25
  - f. 26-30
  - g. 31-35
  - h. 36-40
  - i. >40
4. Specialties, past or present, in which you have practiced (mark all that apply)
  - a. Family Practice
  - b. Internal Medicine
  - c. Emergency Medicine
  - d. Surgery
  - e. Pediatrics
  - f. Geriatrics
  - g. Orthopedics
  - h. OB/GYN
  - i. Dermatology
  - j. Psychiatry
  - k. Gastroenterology
  - l. Urology
  - m. Other (please specify)
5. Sex
  - a. Male
  - b. Female
6. Age
  - a. 18-30
  - b. 31-40
  - c. 41-50
  - d. 51-60
  - e. >60

7. The conference you are attending is offering 20 CME credits. You are unable to attend the last few lectures, missing 3 hours worth of credit. How likely are you to log all 20 hours.
  - a. Very likely
  - b. Somewhat likely
  - c. Not very likely
  - d. Never
8. Eldon Dibling is a 75 y.o. long-term patient of yours that you have recently diagnosed with severe anxiety and depression related to his worsening medical conditions. Upon examination you suspect an aortic dissection which is confirmed by diagnostic testing. The dissection is in urgent need of repair but you know the patient would refuse while he is in his current depressed state. How likely are you to downplay the risks of the dissection repair in order to persuade the patient to consent to the repair, which you feel is his only chance to survive?
  - a. Very likely
  - b. Somewhat likely
  - c. Not very likely
  - d. Never
9. How likely are you to accept a gift from a patient (or how often do you accept such gifts)?
  - a. Homemade quilt
    - i. Very likely
    - ii. Somewhat likely
    - iii. Not very likely
    - iv. Never
  - b. Tickets to sporting event/theatre show
    - i. Very likely
    - ii. Somewhat likely
    - iii. Not very likely
    - iv. Never
  - c. A weekend at their cottage
    - i. Very likely
    - ii. Somewhat likely
    - iii. Not very likely
    - iv. Never
  - d. Cookies
    - i. Very likely
    - ii. Somewhat likely
    - iii. Not very likely
    - iv. Never

10. You see a patient for her annual exam, including breast exam. You note a 2 cm mass in her right breast. In reviewing her record, you see she had a mammogram a little over a year ago and it was recommended to you that she return for a close follow-up in 6 months to watch an area in the right breast for any changes. There is no notation that the report and recommendation were ever given to the patient. You send the patient for an immediate mammogram. How likely are you to not acknowledge the missed follow-up?
  - a. Very likely
  - b. Somewhat likely
  - c. Not very likely
  - d. Never
11. You are out to dinner and see a fellow PA on a date with his patient. The following Monday at work, you voice your concern and he denies there is anything to worry about. Weeks later you see them at a coffee shop before work. At work a few hours later you confront your colleague once more. He admits that they are having an affair with no intentions of putting an end to the relationship. How likely are you to report this violation?
  - a. Very likely
  - b. Somewhat likely
  - c. Not very likely
  - d. Never
12. Other comments

## Abstract

**Objective:** The purpose of this research was not to determine what is ethical and what is not, but to determine whether the ethical judgments of physician assistants (PA) evolve over time.

**Methods:** An online survey of 6 demographic questions, 5 ethical scenarios and 1 comments option was constructed. A link to the survey was distributed by email to the PA students of University of Toledo Medical Center (UTMC) and by the Ohio Association of Physician Assistants (OAPA) in their newsletter.

**Results:** There were 154 participants in this survey including first year and greater than first year PA students and also practicing PAs of a variety of years in practice. Chi square tests revealed all p values to be  $>0.05$ .

**Conclusion:** When analyzing the results, there was no statistically significant difference seen when comparing the years of experience or when results were compared based on other variables such as gender.