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Introduction for the Learner (Resident/Fellow)

Prior to your evaluation of competency

- Complete the web-based palliative care training program “Medical Resident Training in End-of-Life and Palliative Care” before you undergo this competency assessment. The training program is available on the UMMS Intranet, click on Physicians. The course is listed under “Helpful Links.” It is also available via the internet at http://134.192.120.12/canRes/htdocs/login.asp
  - Review Part 1 (Learning Objectives), Part 2 (Teaching Outline) and Part 3 (Evaluation Checklist) of this document THOROUGHLY so that you are aware of what is required of you.
- Review Unit V (Ethical and Legal Issues), Modules 1 (Ethical Principles) and 2 (Case study) of “Medical Residents Training in End-of-Life and Palliative Care” the Web-based palliative care training program.
- Ascertain that the attending/faculty member is certified to conduct the Palliative Care Competency Evaluation.

Field evaluation of competency

- During the course of the clinical rotation it is anticipated that you may have opportunities to demonstrate your competency in Breaking Bad or Sad News to a patient and/or family during morning work rounds with the attending, throughout the day or during times of night call or cross-coverage.
- Identify a faculty member to evaluate your competency – current service attending recommended, if s/he is certified to conduct evaluation.
- ASK FACULTY MEMBER TO REVIEW THIS COMPETENCY ASSESSMENT TOOL PRIOR TO YOUR PERFORMING THIS TASK.
- Discuss your preparation for this session (see first steps – “before talking to patient/family,” and “create an appropriate context,” below) with attending before going to see patient/family.
- Faculty must accompany and observe Resident.
- Faculty completes Evaluation Checklist (Part 3) and shares with you.
- You will also complete the self-evaluation portion of the Evaluation Checklist as a measure of competency in practice based learning.
- Evaluation Checklist must be signed by the Clinical Faculty Evaluator/attending and you (Resident/Fellow).
- Return Evaluation Checklist to Dr. Susan Wolfsthal, Internal Medicine Residency Director or Dr. Heather Mannuel, Medical Oncology Fellowship Director.

Introduction for the Clinical Faculty Evaluator

How to perform this competency assessment

A Medical Resident or Oncology Fellow has requested that you assess their competency in a selected palliative care domain during the time you are the Clinical Faculty Evaluator/attending physician on this service. To assist you with this evaluation, please do the following.

Preparing for field evaluation of competency

- Review this Competency Assessment Tool thoroughly including the Learning Objectives (Part 1), Teaching Outline (Part 2) and Evaluation Checklist (Part 3) prior to pre-discussion counseling with Resident (required).
- Review Unit V (Ethical and Legal Issues), Modules 1 (Ethical Principles) and 2 (Case study) of the Web-based palliative care training program, “Medical Residents Training in End-of-Life and Palliative Care.” The training program is available on the UMMS Intranet, click on Physicians. The course is listed under “Helpful Links.” It is also available via the internet at http://134.192.120.12/canRes/htdocs/login.asp (optional).

Format of competency evaluation

During the clinical rotation:

- Based on the Learning Objectives (Part 1), Teaching Outline (Part 2), and Evaluation Checklist (Part 3) of this document, evaluate whether the Resident or Fellow meets the Learning Objectives for this competency during the course of this clinical rotation.
- Provide constructive feedback to Resident throughout the rotation regarding this competency

End-of-rotation feedback:

- Review strengths and weaknesses of competency evaluation with Resident/Fellow
- Provide constructive feedback to improve Residents/Fellows’ performance and patient outcomes.

Complete Evaluation Checklist (Part 3 of this document)

- Share with Resident/Fellow; allow Resident/Fellow to make his/her own self-assessment of competency performance
- Clinical Faculty Evaluator/attending and Resident/Fellow must sign this Evaluation Checklist (Part 3)
- Resident/Fellow is responsible for returning Evaluation Checklist to Dr. Wolfsthal (Residents) or Dr. Mannuel (Fellows)
**Part 1: Learning Objectives**

Note to learner and Clinical Faculty Evaluator: The Learning Objectives are listed in terms of fulfilling the six ACGME core competencies, listed below; these are reflected in Evaluation Checklist in Part 3 of this document.

**LEGEND to ACGME core competencies: http://www.acgme.org/Outcome**

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>ACGME Competencies</th>
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<tbody>
<tr>
<td>Analyze causes of conflicts arising between patients/family and the health care team regarding the use of “life-sustaining” medical treatments in terminally ill patients.</td>
<td>PC MK PBL&amp;I IPCS P SBP</td>
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<tr>
<td>List initial steps that can be used in managing conflicts between the health care team and patients/family.</td>
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<tr>
<td>Demonstrate proficient use of the initial steps in managing conflicts between the health care team and patient/family in clinical practice.</td>
<td>X X X X X X</td>
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<tr>
<td>Describe the term “medically ineffective” as it is written in Maryland law and/or in Federal law pertaining to practices at the VA medical center.</td>
<td>X X X</td>
</tr>
<tr>
<td>Compare and contrast the 1993 Maryland Health Care Decisions Act and laws pertaining to rights and liabilities of physicians in refusing to render medically ineffective or unethical treatments with VA statutes and policies pertaining to the same.</td>
<td>X X</td>
</tr>
<tr>
<td>Utilize Ethics Committees, Legal, Risk Management and other resources for guidance in responding to requests for unethical or medically ineffective treatments.</td>
<td>X X</td>
</tr>
<tr>
<td>Used the physician’s legal right to certify that “medically ineffective” treatments were being requested ONLY AFTER all other attempts to manage conflict have failed, and in compliance with UMMS or VA hospital policies.</td>
<td>X X</td>
</tr>
<tr>
<td>Describe UMMS policy and the recommendations of the UMMS office of general counsel regarding compliance with patient/proxy requests for futile medical care, including medically ineffective resuscitation.</td>
<td>X</td>
</tr>
<tr>
<td>Described VA policy and the recommendations of the VA of Maryland Healthcare System and the Baltimore VA Regional Counsel regarding compliance with patient/proxy requests for futile medical care, including medically ineffective resuscitation.</td>
<td>X</td>
</tr>
<tr>
<td>Outline a plan for addressing continued conflicts over requests for medically ineffective treatments at UMMS and the VAMC that is consistent with compassionate patient care, good medical practices, Federal and/or state laws, and the policies of the UMMS or the VA medical center.</td>
<td>X</td>
</tr>
<tr>
<td>Implement a plan for addressing continued conflicts over requests for medically ineffective treatments at UMMS and the VAMC that is consistent with compassionate patient care, good medical practices, Federal and/or state laws, and the policies of the UMMS or the VA medical center.</td>
<td>X X X X X X</td>
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</table>

Part 2: Teaching Outline for Learner and Clinical Faculty Evaluator

- Recommend reviewing Unit V (Ethical and Legal Issues), Modules 1 (Ethical Principles) and 2 (Case study) of “Medical Residents Training in End-of-Life and Palliative Care.” The training program is available on the UMMS Intranet, click on Physicians. The course is listed under “Helpful Links.” It is also available via the internet at http://134.192.120.12/canRes/htdocs/login.asp

- Recommend reviewing the following Competency Assessment Tools:
  - 1B The DNR discussion
  - 1C Conducting a patient/family conference

1. Introduction

The process of establishing treatment goals for patients at end of life frequently involves a patient/family conference where medical recommendations such as DNAR code status and switching the focus of care from curative or disease control to comfort/hospice care are made. Competency Assessment Tools (CATs) describing optimal ways for discussing DNAR code status and conducting a patient/family conference are available on the MAIN MENU. Following such meetings, medical team recommendations for palliative care and DNAR code status are often initially rejected by the patient or health care agent/proxy, but later as they have had time to assimilate the information, agreement with the medical recommendations is usually reached.

This competency tool is designed to address the very rare occasions where, following a patient/family conference and despite best efforts to manage conflict, the patient/health care agent/proxy persist in requesting procedures or treatments that are medically ineffective (or futile – see definition below).

To be proficient in this competency, it is not necessary for the learner to certify that the patient/agent/proxy’s treatment request is futile and write orders (e.g., DNAR) contrary to their wishes. A resident or fellow will be considered proficient if they exhibit skills in resolving conflicts while maintaining good rapport with the patient/agent/proxy and family, utilize the resources such as ethics committees and risk management, and are aware of a physician’s legal rights and encumbrances regarding refusal to employ medically ineffective treatments.

2. Causes of conflicts

Conflicts often arise from patient or family misunderstandings and misguided expectations about treatment outcome and the goals of care. Although recommended procedures for discussing code status and conducting a patient/family conference are available (see CATs 1B – The DNR discussion and 1C – Conducting a Patient/Family Conference), these guidelines are often not followed, which may lead to misunderstandings. Even when the DNR discussion or patient/family conference is done properly, there is a point during or after the conference when conflicts between the family and the health care team, or conflicts amongst family members, typically surface. Common reasons for such conflicts include the following:

- Grief/Time – family members have not had sufficient time to adjust psychologically to imagining their life without the dying person.
- Information – incorrect, misleading, or conflicting information regarding diagnosis, prognosis, and overall goals of care has been provided to the patient and/or family by other health care providers or by the medical team. Too often, we use technical language or jargon that is not understood by patients and families.
- Anger/Guilt – long lasting intra-family issues may disrupt or preclude logical decision making; in severe cases, the struggle you observe may be the result of long-standing serious family dysfunction – issues of past or current drug or alcohol dependence and/or physical, verbal or sexual abuse are common.
- Trust – if a patient or family does not have trust in the medical team, it is impossible to work together to develop a treatment plan.
- Culture – differences in culture, religion, socioeconomic status, etc. may all impede decision making. See CAT 4D on cross-cultural issues for strategies.

3. Managing Conflicts – initial steps

- If the patient or proxy/family were unable to concur with the medical recommendation, schedule a follow-up meeting:
  - Review the patient’s advance directives regarding health care instructions and if patient incapable of making an informed decision, the patient’s appointee as healthcare agent (this should have been done prior to the family conference or DNAR discussion if recommended procedures were followed – see the respective CATs on these topics).
  - Re-review overall patient prognosis and treatment goals with patient/proxy and family if necessary.
  - Correct any factual misunderstandings.
  - Be aware of reasons for a seemingly “irrational” refusal of DNAR status or other “irrational” treatment request: unrealistic goals, guilt, confusion concerning the therapeutic plan, mistrust of the physician, family differences, ethnic or socio-cultural differences, language barriers;
  - Clarify patient/family misconceptions that may exist regarding the nature and purpose of CPR or other “life-sustaining” therapies.
  - Utilize active listening – strive to maintain a civil discourse; ensure that your body language is open, conveying concern and empathy, re-state or paraphrase what people are saying to make sure you and others understand.
  - Provide an empathetic statement: “I can’t imagine how hard this must be…”
  - Keep the focus of the discussion on the patient’s well-being.
  - Ask other patient advocates – family, friends, clergy, nurses, social workers, palliative care team, ethics consultation – to become involved.
  - State directly that you (and the health care team) will not abandon the patient and family, and will assure the patient remains as comfortable as possible.
- In some cases, consider establishing a time-limited trial of continued life-sustaining treatments such as ventilator support – establish clear goals and a time line (e.g., improved cognition, improved pulmonary function).
- Use time as an ally – allow the patient/proxy and family to consider options; schedule follow-up meetings.

4. Continued Conflict – Rights and liabilities of physicians in refusing requests for medically ineffective resuscitation

A variety of treatments – e.g., aggressive cancer chemotherapy, bone marrow/organ transplantation, dialysis, and ventilator support – may be requested for terminally ill patients for whom these treatments would not be tolerated, would be harmful to them, or would not achieve the goals of care. Most commonly, requests for medically ineffective resuscitation are made, and dealing with this situation will now be discussed.

• If you believe the patient or proxy/healthcare agent are requesting treatments that are medically ineffective – that is, treatments that are a violation of good medical practice and/or cannot be expected to prolong quality life or to achieve the expressed goals of the patient – AND

• You have tried all the recommendations to manage conflict suggested above, it is crucial that you understand the laws and policies concerning ineffective resuscitation in Maryland, at UMMS, or at the BV AMC. In summary, although Maryland law and VA policy statements affirm that a physician should not be required to perform medically futile resuscitation, it is a violation of UMMS and VA policy for a physician to write a DNAR order contrary to the wishes of a patient or their proxy/family.

4A. Maryland Statutes

Maryland laws pertinent to advance directives and requests for medically futile ineffective treatments are contained in the Maryland Health Care Decisions Act (MDHCDA) of 1993. A summary of the act as amended through 2008 is also available.

Section VII of the Act regarding requests for medically ineffective treatments is summarized as follows:

“Physicians’ Authority: A physician need not provide treatment that the physician believes to be medically ineffective or ethically inappropriate.”

“Medically ineffective treatment is defined as treatment that, as certified [in writing] by the attending and a consulting physician to a reasonable degree of medical certainty, will neither prevent or reduce the deterioration of the health of an individual nor prevent the impending death of an individual.”

While the Act clearly states that a physician need not comply with the request for medically ineffective treatment (e.g., a request for full code status in a terminally ill, actively dying patient), the law requires us to honor requests for transfer of the patient to another provider, and to comply with the “medically inappropriate” request(s) if failure to comply would cause the death of the patient:

“Transfers: If a health care provider intends not to comply with the instruction of a [patient, surrogate or agent, the provider must inform the person giving the instruction of that decision and inform the person that he or she may request a transfer to another health care provider. Pending the transfer, a health care provider must comply with a legally valid request for treatment made by a competent patient, surrogate, or agent if failure to comply would result in the death of the patient.”

Herein lies a rub. If CPR was withheld from a terminally ill actively dying patient because it was deemed to be medically ineffective as defined above, then one could argue that failure to perform the requested CPR at the time of cardiopulmonary arrest did not result in the death of the patient, because CPR would be futile in this setting. This makes sense to us as medical practitioners, and the Maryland Attorney General’s Office has supported this view of the law. However, the situation has never been addressed by the courts, so it is hard to predict what would happen in an actual litigated case. Although the MDHCDA specifically provides immunity from all forms of liability to health care providers who follow its provisions (see statement below), the issue of whether immunity would apply in the situation described above is uncertain. (Remember, though, that a health care provider who does not have immunity under the Act still might have no actual liability.)

“IX. Legal Immunity. Health care providers who take actions based on the Act are immune from claims that the actions were unauthorized. Health care agents and surrogates who follow the Act when they authorize the withholding or withdrawal of life-sustaining procedures are immune from liability.

Given the above, when practicing medicine in the State of Maryland and faced with requests for medically ineffective treatments, and all efforts to resolve conflict fail, a physician can refuse requests for medically ineffective treatments by observing ALL of the following steps:

1. The ATTENDING PHYSICIAN AND a CONSULTING PHYSICIAN (often a physician member of the hospital’s Ethics Committee) must certify in writing that the treatment requested is medically ineffective.

2. The attending physician informs the patient, the patient’s healthcare agent or surrogate of the certification, and explains the treatment that will or will not be provided as a result of the certification (note: this step is usually accompanied by a breakdown in rapport between the health team and the patient/family).

3. If the patient/agent/surrogate objects to the decision to withhold or withdraw treatment, the health care providers must:
   a. Inform the patient/agent/surrogate that he/she may request a transfer to another provider AND
   b. Make reasonable efforts to transfer the patient to another health care provider who will honor their treatment requests (note: the best of these efforts are usually unsuccessful) AND
   c. Pending transfer, comply with the decision/requests of the patient/agent/surrogate if failure to comply would likely result in death of the patient.
4. A DNAR order may be written if the physician and medical institution are jointly agreed and prepared to respond to legal challenges that failure to perform CPR resulted in the death of the patient. Ethically, the physician may be caught in the bind of wanting to practice good medicine (provide comfort care and no CPR for a terminally ill patient) but subjected to the combined pressure of unreasonable patient/family demands and fear of litigation.

4B. University of Maryland Medical Systems (UMMS) and Maryland Medicine Comprehensive Insurance Program (MMCIP) Policies

When caring for a terminally-ill patient at UMMS and faced with requests for medically ineffective treatments, and all efforts to resolve conflict fail, we recommend:

4. Notify UMMC Risk Management – 8-4704. Historically, in the cases where the medical team deems that CPR would be futile, and when faced with patient or surrogate requests for full code status our Risk Management team interprets that failure to do the requested CPR may be viewed in a court of law as resulting in the death of the patient, thus voiding our legal immunity to prosecution. As the legal arm of the MMCIP, Risk Management usually recommends compliance with the patient’s or proxy’s request.

5. For further guidance, consult Dr. Henry Silverman and the UMMS Ethics Committee – cell phone 443-562-5143, and the UMMS Office of the General Counsel 8-9700. As the legal arm of UMMS, the Office of the General Counsel, similar to Risk Management, typically recommends compliance with the patient’s or proxy’s request in these situations until: (i) the objections of the patient or surrogate have been resolved; (ii) a guardian for the patient has been appointed; or (iii) court order is obtained for the CPR order (or the withdrawal or withholding of life-sustaining care).

4C. VHA and VA of Maryland Healthcare System (VAMHCS/BVAMC) Policies

Current VA policy regarding DNR orders are found in VHA Handbook 1004.3, “Do Not Resuscitate (DNR) Protocols within the Department of Veterans Affairs (VA).” This document states:

a. “If a competent patient requests that a DNR order not be written or instructs that resuscitative measures should be instituted, no DNR order shall be written.”

b. For incompetent patients, “Should the patient’s representative object to entry of a DNR order, no such order will be written.”

A report issued in December 2000 by the VA National Ethics Committee (NEC) entitled “Do-Not-Resuscitate Orders and Medical Futility” recommended that this policy be changed to allow DNR orders to be written over patient/proxy objections in the case of medical futility. In response to the NEC report, the VA of Maryland Healthcare System (VAMHCS) issued a policy memorandum (512-00/PS-012) in February 2008 which spelled out the rights of the attending physician not to provide medically futile resuscitation. Although this memorandum allows attending physicians to certify in a given case that resuscitation would be medically ineffective, it falls short of allowing VAMHCS physicians to write DNR orders over the objection of the patient/proxy/family. The policy memorandum defines medically ineffective resuscitation as follows:

Medically Ineffective Resuscitation: (Medical Futility) is resuscitation that, to a reasonable degree of medical certainty, will not prevent the continued deterioration of the health of a patient. Resuscitation may be regarded as futile if it is highly likely to merely preserve a persistent vegetative state or permanent unconsciousness or to require permanent hospitalization in an intensive care unit (ICU). This determination cannot be based on an assessment of the patient’s quality of life, which requires a value judgment.

The VAMHCS policy memorandum continues to state:

k. DNAR and Medically Ineffective Treatment:

(1) The refusal by a competent patient or surrogate decision-maker to consent to the entry of a DNR order does not require the Attending Physician to provide medically futile resuscitation. The patient or his surrogate decision-maker must be made fully aware that the physician is not required to respond to demands that are inconsistent with the practice of good medicine. Where appropriate, family members or clergy may help the patient understand the clinical situation. An Ethics Advisory Committee consultation should be requested to help clarify these issues.

(2) If the Attending Physician determines that resuscitation would be futile, the physician must document the reasons for this decision in the patient’s medical record. Physicians at the patient’s bedside may make a determination to withhold or terminate CPR.

The wording of this policy is not straightforward and needs some interpretation. Although the policy says “the refusal by a competent patient or surrogate decision-maker to consent to the entry of a DNR order does not require the Attending Physician to provide medically futile resuscitation,” it says nothing to the effect that a DNR order may be written over the objection(s) of the patient or proxy or family. The policy basically requires that the patient for whom resuscitation would be futile remain at full code status until the time of cardio/pulmonary arrest. At that time, the policy states “physicians at the patient’s bedside may make a determination to withhold or terminate CPR.”

When faced with requests for medically ineffective resuscitation at the BVAMC, the recommended procedure is:

1. The ATTENDING PHYSICIAN certifies in writing (by a note in CPRS) that the treatment is medically ineffective (note – this differs from certification of medically ineffective treatment requests in Maryland hospitals, where two signatures – the attending and a consultant physician – are required). It is recommended that the attending physician consult with VA Ethics Committee prior to certifying that the requested treatment is medically ineffective. The VA Ethics Committee pager is 410-447-4735. The VAMHCS Ethics
Consult Team website is: http://vaww.vamhcs.med.va.gov/Departments/IntegratedEthics/default.htm

2. The patient or his/her surrogate decision-maker “must be made fully aware that the physician is not required to respond to demands that are inconsistent with the practice of good medicine,” and that certification to this effect has been entered in the chart (this may result in a breakdown of the doctor-patient relationship – patients/proxies should be given to option of transferring to another healthcare provider).

3. The patient remains at full-code status.

4. In the event of cardiopulmonary arrest, attending physicians at the patient’s bedside may make a determination to withhold or terminate CPR. If the arrest happens in the middle of the night, or at a time when attending physicians are not available, the patient will be treated as any other patient with full-code status.

Relevant VA policies can be found in the following VHA Handbook sections:
- 1004.01, “Informed Consent for Clinical Treatments and Procedures;”
- 1004.02, “Advance Care Planning and Management of Advance Directives;”
- 1004.3 “Do Not Resuscitate (DNR) Protocols within the Department of Veterans Affairs (VA);”
- 1004.06 “Integrated Ethics;”

Other sources for VA-relevant guidance or policies:
- Website for VHA policies: http://www1.va.gov/vhapublications/publications.cfm?Pub=2
- Intranet site for VAMHCS Policies: http://vaww.vamhcs.med.va.gov/QuickLinks/FormsPoliciesSOPs/policies/index1.htm
- Do-Not-Resuscitate Orders and Medical Futility: A Report by the National Ethics Committee of the Veterans Health Administration (December 2000)
- VAMHCS POLICY MEMORANDUM 512-00/PS-012, February 2008
- National Center for Ethics in Health Care:
  Internet: http://www.ethics.va.gov/
  Intranet: http://vaww.ethics.va.gov
  Telephone: 202-501-0364
- VA Regional Counsel Contact information:
  Baltimore office: 410-605-7600
  DC office: 202-530-9420

References


Pope TM. Legal briefing: Medical futility and assisted suicide. The Journal of Clinical Ethics. 2009;20(3):274-286. (extensive bibliography with this paper)


National Center for Ethics Do Not Resuscitate Orders: http://www.ethics.va.gov/docs/net/DNR_FAQs_20050701.pdf
**Part 3: Evaluation Checklist**

Learner name: ________________________________  Evaluator/Attending: ________________________________

- Resident PGY Level: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5
- Fellowship Year: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5

Rotation Site: [ ] Inpatient Cancer Center  [ ] Inpatient GIM  [ ] Oncology Clinic  [ ] Continuity GIM clinic  [ ] Other

Please rate the trainee's competency/skills/knowledge/attitude using the following scales:

<table>
<thead>
<tr>
<th>For competency/skills</th>
<th>For knowledge and attitudes (e.g., Medical Knowledge)</th>
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</thead>
<tbody>
<tr>
<td>4 = Competent to perform independently</td>
<td>4 = Superior</td>
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<tr>
<td>3 = Competent to perform with minimal supervision</td>
<td>3 = Satisfactory</td>
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<tr>
<td>2 = Competent to perform with close supervision / coaching</td>
<td>2 = Below average</td>
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<tr>
<td>1 = Needs further basic instruction</td>
<td>1 = Insufficient – needs further learning</td>
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<td>n/o = not observed</td>
<td>n/o = not observed</td>
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</table>

**OBJECTIVES**

**Patient Care; Interpersonal and Communication Skills**

- 4 3 2 1 n/o  n/o  Demonstrated use of initial steps used in managing conflicts between the health care team and patients/family in clinical practice.

- 4 3 2 1 n/o  n/o  Implemented a plan for addressing continued conflicts over requests for medically ineffective treatments at UMMS and the VAMC that is consistent with compassionate patient care, good medical practices, Federal and/or state laws, and the policies of the UMMS or the VA medical center.

**Overall Performance:**

<table>
<thead>
<tr>
<th>Cannot Evaluate</th>
<th>1 to 3 Unsatisfactory</th>
<th>4 to 6 Satisfactory</th>
<th>7 to 9 Superior</th>
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**Medical Knowledge**

- 4 3 2 1 n/o  n/o  Analyzed the causes of conflicts arising between patients/family and the health care team regarding the use of "life-sustaining" medical treatments in terminally ill patients.

- 4 3 2 1 n/o  n/o  Listed initial steps used in managing conflicts between the health care team and patients/family.

- 4 3 2 1 n/o  n/o  Discussed the term "medically ineffective" as it is written in Maryland Law or in Federal statues pertaining to practices at the VA medical center.

- 4 3 2 1 n/o  n/o  Compared and contrasted the 1994 Maryland Health Care Decisions Act and laws pertaining to rights and liabilities of physicians in refusing to render medically ineffective or unethical treatments with VA statutes and policies pertaining to the same.

**Overall Performance:**

<table>
<thead>
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**Systems Based Practice**

- 4 3 2 1 n/o  n/o  Utilized Ethics Committees, Risk Management and other resources for guidance in responding to requests for unethical or medically ineffective treatments.

- 4 3 2 1 n/o  n/o  Described the recommendations regarding futility decisions made by the UMMS office of general counsel.

**Overall Performance:**

<table>
<thead>
<tr>
<th>Cannot Evaluate</th>
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**Conflict Resolution: Managing Requests for Medically Ineffective Treatments**

**Professionalism**

4 3 2 1 n/o Used the physician’s legal right to refuse to employ “medically ineffective” treatments ONLY AFTER all other attempts to manage conflict have failed.

<table>
<thead>
<tr>
<th>Overall Performance:</th>
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<th>4 to 6 Satisfactory</th>
<th>7 to 9 Superior</th>
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**Resident/Fellow strengths:**

**Resident/Fellow areas for improvement:**

**Overall impression:** Did the Resident/Fellow demonstrate competency in a manner so as to do no harm?

<table>
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<tr>
<th>Overall impression:</th>
<th>Cannot Evaluate</th>
<th>1 to 3 Unsatisfactory</th>
<th>4 to 6 Satisfactory</th>
<th>7 to 9 Superior</th>
</tr>
</thead>
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</tbody>
</table>

**Resident/Fellow self-evaluation of performance:** May comment on any of the above checklist items or other reflections on performance; perceived strengths, and need for improvement and learning.

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Clinical Faculty Evaluator/Attending

Clinical Faculty Evaluator/Attending – PRINTED NAME/DATE

Resident/Fellow

Resident/Fellow – PRINTED NAME/DATE