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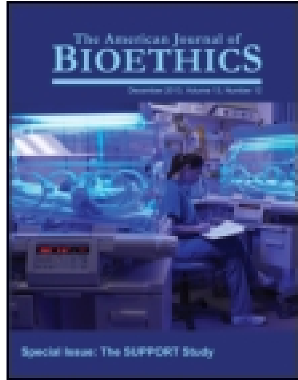

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Structuring a Written Examination to Assess ASBH Health Care Ethics Consultation Core Knowledge Competencies

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Target Article

Structuring a Written Examination to Assess ASBH Health Care Ethics Consultation Core Knowledge Competencies

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As clinical ethics consultants move toward professionalization, the process of certifying individual consultants or accrediting programs will be discussed and debated. With certification, some entity must be established or ordained to oversee the standards and procedures. If the process evolves like other professions, it seems plausible that it will eventually include a written examination to evaluate the core knowledge competencies that individual practitioners should possess to meet peer practice standards. The American Society for Bioethics and Humanities (ASBH) has published core knowledge competencies for many years that are accepted by experts as the prevailing standard. Probably any written examination will be based upon the ASBH core knowledge competencies. However, much remains to be done before any examination may be offered. In particular, it seems likely that a recognized examining board must create and validate examination questions and structure the examination so as to establish meaningful, defensible parameters after dealing with such challenging questions as: Should the certifying examination be multiple choice or short-answer essay? How should the test be graded? What should the pass rate be? How may the examination be best administered? To advance the field of health care ethics consultation, thought leaders should start to focus on the written examination possibilities, to date unaddressed carefully in the literature. Examination models—both objective and written—must be explored as a viable strategy about how the field of health care ethics consultations can grow toward professionalization.

Keywords: professional ethics, professional—patient relationship, virtues, regulatory issues, conflict of interest, education

There are at least four reasons why those who are interested in the professionalization of clinical ethicists and the standardization of clinical ethics consultation services[1] should seriously consider developing a written examination to evaluate educational core competencies. *First, there are accepted educational core competencies and those who profess these competencies should be assessed.* Since 1998 and 2009, respectfully, the American Society for Bioethics and Humanities (ASBH) has published its *Core Competencies for Health Care Ethics Consultation* (ASBH 2011a) and its *Improving Competencies in Health Care Ethics Consultation: An Educational Guide* (ASBH 2009). If there are knowledge and skills competencies, the field[2] has a sound basis on which to develop a mechanism to determine whether practitioners are truly competent. Based on recommendations from its Clinical Ethics Consultation Affairs (CECA) Committee recently, the ASBH board has considered the notion of certifying clinical ethics consultants but has opted instead to pursue a "quality attestation" credential—perhaps a prudent first step in the direction of certification to allow consultants to provide evidence of their professional competency to their home institutions (ASBH 2011b).

Second, several recognized authorities assert that an examination of some type is an essential element of a uniform

1. Terminology is difficult at times when debating "health care ethics consultation services" since those professionals involved do not completely agree on labels and scope. For purposes here, the focus on health care ethics consultation is directed toward conversations with patients and family members whose health care decisions may be impacted by recommendations offered by individual clinical ethics consultants (i.e., "clinical ethics consultation" or "case consultation"). How much any certification examination should focus on "case consultation" versus other types of health care ethics consultation must be clarified.
2. Currently, it seems appropriate to refer to the "field" of clinical ethics consultation, rather than the "profession." For a field to become accepted, it may be important to form a certification or accreditation body to support the enforcement of agreed-upon standards for those who perform services (Dubler et al. 2009).

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national credentialing process. In 2010, Martin L. Smith and colleagues proposed a four-step certification procedure that would lead toward professional recognition of individual clinical ethics consultants (ASBH 2013; Smith et al. 2010). One component of their proposal was the requirement that candidates seeking professional certification pass a standardized, peer-generated written examination that covers "domains of factual knowledge." Smith and colleagues have written that the core knowledge competencies booklets developed and published by the ASBH might prove to be the acceptable subject-matter benchmarks for creating test questions (ASBH 2009; 2011a). The written examination according to Smith and colleagues would be only one element of a four-part process necessary for a candidate to obtain certification.[3] The other three "steps" to be completed include (1) presenting a portfolio of cases in which the candidate was a lead consultant to a panel for review; (2) competently portraying an individual clinical ethics consultant in at least two "mock consultations" opposite an actor playing a patient or patient's representative in a "standardized" scenario; and (3) properly answering questions posed during an oral examination by peer-recognized health care ethics consultants.

In 2012, the Josiah Macy Jr. Foundation provided a grant to an ASBH-led initiative to consider a "quality attestation" credential as an initial effort toward or alternative to certification. (The Josiah Macy Jr. Foundation 2012) The initiative operates under the auspices of the ASBH and its immediate past president, Joseph J. Fins, MD, and grant principal investigator Eric Kodish, MD (Fins 2012). One proposal for achieving the attestation designation involves allowing candidates (prepared minimally at the master's level in a relevant field or discipline) to submit a case consultation portfolio for review by recognized experts and to pass an oral examination.[4] Moreover, before these certification and attestation ideas were suggested, a respected consensus panel endorsed the standardization of training and a uniform approach to the evaluation of clinical ethics consultation services (Dubler et al. 2009)

Third, a peer-generated examination designed to measure knowledge core competencies would help educators. Through either the attestation or certification of individual consultants as "qualified" based on peer standards, the Fins–Kodish and Smith and colleaegues processes if implemented would also assist educators and program developers in ensuring that appropriate curricula were in place to adequately prepare students interested in becoming individual consultants. One might argue that some educational programs are already teaching the relevant content upon which certification would be based. But at present there is no adequate gauge of how well the programs teach or evaluate the core competencies (White 2010). Regardless, given the background diversity of individuals currently performing clinical ethics consultations, there is considerable divergence of opinion about the kinds of educational programs and professional credentials necessary to be a candidate for certification, and whether certification and the move toward professionalization of health care ethics consultation are even a worthwhile endeavor (Bosk 2003). The professionalization of clinical ethics consultation still faces many challenges and unsettled questions. In fact, some might say that discussing examination types or models is premature, given that there is limited consensus about attestation, certification, or examination at all. But with the number of educational programs to "train" individual clinical ethics consultants growing, it seems appropriate to have oral and written standardized examinations and paradigm scenarios available to educators for purposes other than attestation or certification.

Fourth, examinations are traditionally used as a part of the process to credential professionals. Licensure and certification examinations are just two examples. Educators and credentialing authorities use examinations to prove that candidates have successfully learned objectives or met competencies. For good or ill, examinations are widely recognized indicators and must have some consensus societal value; otherwise, tests would have been abandoned outright for these purposes long ago. Just as some argue that adoption of a code of ethics is critical to public recognition of clinical ethics consultation professionals, some will also assert that legitimate uniformity and standardization as proved by some objective measure is also essential (Dubler et al. 2009; Kipnis 2009). When licensing and certifying boards first came into existence, there were few educational programs to train practitioners. Initially, qualification for medical licensure was established by affidavit showing that the physician had been engaged in practice for some arbitrary period of time or had graduated from a recognized school (Cohen and Nelson 2011). This may have been the appropriate measure in the early days of licensure, but historical patterns show that examinations very quickly replaced these relatively nominal standards (Hamowy 1979).

Although the possibility of having an examination has been widely discussed, to date no comprehensive models or examples of what a written test might look like have been offered, nor have the numerous specific problems associated with developing a statistically defensible examination been adequately addressed. In just thinking about the examination process, any number of questions may arise: Who might oversee the examination development? How might the examination costs be identified and borne? How might the examination proper be structured? Should the examination be multiple-choice, short-answer essay, both, or of some other type? How should examination subject-matter content be rationally apportioned? Who might draft and select the questions? How should the examination be

3. These steps appear very similar to medical specialty "board certification" requirements (Schiedermayer and La Puma 2012).

4. From this one might suggest that the Fins–Kodish "quality attestation" assessment includes two of the four Smith and colleagues components: the portfolio review and the oral examination. Perhaps, strategically for those interested in professionalization, the "attestation" credential appears to be a prudent initial step, with "certification" a possibility at a later date with the completion of the other components.

secured and administered? How should essay questions be graded? Who might arbitrate answer disputes? How should the pass–fail rate be established? Although there are many questions with which to grapple, we would expect reasonable answers will evolve from a consensus of peers in an open and transparent manner after much debate.

Perhaps good starting points central to deal with all of these challenges and issues are (1) substantive conversation about initiating an oversight process to offer a certifying examination to qualified candidates, and (2) the appraisal of a first draft of a written examination that might eventually be used to continue serious debate.

PRELIMINARY CONCERNS

Who Might Oversee the Process and Structure the Examination?

There is no professional body that wields national authority over those who perform clinical ethics consultation (Acres et al. 2012). To begin the move toward professionalization, as Smith and colleagues suggested, there must be a "board of examiners" or some similar entity (Smith et al. 2010). This group would be a "team of experts" responsible for overseeing the development and implementation of the examination process in cooperation with other collaborating expert teams and would be collectively accountable for any other "steps" in the certification process. For the group to be accepted as authoritative and credible corporately, it is critical that peers readily acknowledge that each examiner is a thought leader in the field known widely for clinical expertise, scholarly publications and contributions, and perceived professional reputation. Moreover, given the professional background diversity of those performing ethics consultations in the United States, the expert team must be multidisciplinary and innovative and include some with extensive consultation experience and leadership skills in offering accredited clinical ethics consultation educational programs (White 2010). An open selection process might be defined by the leadership of the more prominent organizations related to clinical ethics consultation education and practice. One might expect that since any who serve on the board will be perceived as having several conflicts of interests (for various and sundry reasons), their identification and selection should be fair and open (Spike 2009).

Who Might Sit for the Examination?

It will be a challenge to decide who may sit for the initial and subsequent certification examinations, given the broad range of professional backgrounds and years of experience among those who currently perform clinical ethics consultations (Cohen and Nelson 2011). Most basic to the proposed criteria would be establishing the minimum educational qualifications for ethics consultation related training and demonstrating a minimum experience performing consultations based on documented consultation reports (Tarzian 2009). For the medical specialty board examiners today, the issue is resolved pro forma: Candidates are typically accepted to sit for the certifying examination by showing completion (or near completion) of an accredited residency program. This raises the closely related question of clinical ethics consultation training program accreditation and the minimum level at which each one prepares their graduates. To the extent that there eventually evolve well-defined criteria for certification, it would seem that faculty members offering certificate, master's and doctoral programs, and fellowships related to clinical ethics consultation would design their curricula and provide instruction with those criteria in mind. Just like in other professions, it would be a constructive goal for future clinical ethics consultants to be prepared to sit for the certification examination upon graduation from an accredited educational program. A reasonable case can be made that accrediting educational training programs as a preliminary step make more sense than beginning with practitioner certification, since sooner or later training programs may have to prepare candidates to sit for the certification examination (Parsi and Kuczewski 2007).

How Much Might the Written Examination Cost Candidates?

Dealing with development, maintenance, and administrative costs and how these translate into charges for the examination will be an early critical matter for the examiners. As one can see from fees charged by several national organizations for statistically valid licensing and certifying examinations, standardized examinations are expensive (Table 1). The board of examiners may just set an examination fee based on some arbitrary scale (such as two or three times the annual membership dues to ASBH) and develop and administer the examination based on available income, or alternatively, seek grant funding to pilot an initial effort.

It remains unclear how many persons might seek certification initially. If the examiners elect to create a maintenance of certification program for time-limited certificate holders (as is done by some medical specialty boards), then there may also be some additional number who periodically seek retesting or recertification. Clearly the examiners will need to use best estimates in creating an initial budget.

It may be impossible to sort out how much of the fees or charges are allocated for examination item preparation and validation, since many similar professional organizations have been administering tests for decades. Even with some functions of the examination process outsourced to commercial vendors (such as administering or grading a computerized test at local offices), item development remains a key and costly component. It is rumored that item writers for some national, standardized multiple-choice tests notoriously underestimate the time required. Some report that careful question crafting may only produce three to four items in 8 hours.

Moreover, the more tasks outsourced (e.g., psychometric analysis and review, and complicated video scenario production for "real-life, real-time" vignettes), the more expensive is the endeavor. The costs may be so prohibitive that it may not be reasonable early on for the examiners to suggest an examination modeled after the national

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Table 1. Charges for selected nationalized licensing and certifying examinations

National organization and examination	Charge
American Board of Pediatrics (ABP)	
Initial certifying examination in general pediatrics[1]	$2,225
Maintenance of certification reenrollment fee[2]	$1,125
National Association of Boards of Pharmacy (NABP)	
North America Pharmacist Licensing Examination (NAPLEX)[3]	$425
Multistate Pharmacy Jurisprudence Examination (MPJE)[4]	$200
National Board of Medical Examiners (NBME)[5]	
U.S. Medical Licensing Examination (USMLE) Step 1	$535
U.S. Medical Licensing Examination (USMLE) Step 2 CK	$535
U.S. Medical Licensing Examination (USMLE) Step 2 CS	$1140
U.S. Medical Licensing Examination (USMLE) Step 3[6]	$780
National Conference of Bar Examiners	
Multistate Bar Examination (MBE)[7]	Included as part of a state's bar examination

Note. Sources: 1. https://www.abp.org/ABPWebStatic/?anticache=0.18835573410615325#murl%3D%2FABPWebStatic%2Ftakeexamgp.html%26surl%3D%2Fabpwebsite%2Ftakeexam%2Fgeneralpediatricscertifying%2Fexamedatesandfees.htm (accessed December 15, 2012).
2. https://www.abp.org/ABPWebStatic/?anticache=0.18835573410615325#murl%3D%2FABPWebStatic%2Fmoc.html%26surl%3D%2Fabpwebsite%2Fmoc%2Fphysicianrequirements%2Ffees%2Ffees.htm (accessed December 15, 2012).
3. http://www.nabp.net/programs/examination/naplex/ (accessed December 15, 2012).
4. http://www.nabp.net/programs/examination/mpje/ (accessed December 15, 2012).
5. http://www.nbme.org/students/examfees.html (accessed December 15, 2012).
6. http://www.fsmb.org/usmle_fees.html (accessed December 15, 2012).
7. http://www.ncbex.org/multistate-tests/mbe/ (accessed December 15, 2012).

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licensing and certifying bodies with extremely high numbers of annual examinees. Startup costs may justify a pilot effort offering the examination only to recent graduates of programs that purport to train individual clinical ethics consultants using the ASBH core competencies, or refocusing efforts on program accreditation as an alternative to individual practitioner certification. Any attempt to offer an examination to a limited number, though, may be controversial if there is pent-up demand for certification of individuals who have been practicing in the field for some time.

For entrepreneurial examiners who must operationalize a testing system and balance financial realities, there may be interest in creating a mechanism to "grandfather" consultants immediately, who will pay a fee as part of a broader certification effort simply to raise enough capital to produce a statistically valid standardized test for those who follow. However, the "grandfathering" issue may be a professionalism matter too great for the examination board experts to resolve independently and satisfactorily.

How Much Time Might Be Required to Take the Written Examination?

Perhaps the key question to answer here is, how long does it take to demonstrate knowledge of core competencies on an examination? As noted in the Smith and colleagues schema, the written examination will be just one of four steps considered in the certification process. The written examination should have credibility as judged by the panel of experts. One might presume that the amount of time necessary to complete the written examination will be at least 2 hours and no more than 4. However, this will be an arbitrary decision and the examining board may prefer to rely on the advice of consultants experienced in professional licensing examinations in making this and other similar decisions.

One of the primary reasons for giving early consideration to how long the examination might be is to help with the preparation process. If the examination is 2 hours long rather than 1, then twice the number of questions—whether multiple-choice or essay—will be required. Similarly, it may take up to twice the time to grade the examination if it is short-answer essay. Added length multiplies the costs accordingly. These questions have other budgetary implications as well. For the short-answer essay format, the examiners may need to employ content experts at an hourly rate to grade the examinations.

How Might the Pass Rate Be Established?

One should recall that the examination suggested here is one to assess specific knowledge and minimum competency (i.e., criterion-referenced) as the medical specialty board examinations. The examination proposed is not an aptitude test to assess general knowledge for ranking or stratification purposes (i.e., norm-referenced) such as the SAT or ACT or GRE examination. In order for the examination to be meaningful and viewed as important to examinees, examiners, and other interested parties, must some candidates fail the test? Logically, if a person who has had no formal training or equivalent in clinical ethics consultation answers every question correctly, then one might reasonably presume that the examination cannot discriminate between the trained and untrained. Or, if a person who has had no experience or formal training in clinical ethics consultation answers every question correctly, then one might also presume that the examination does not validate that one with attestable "expertise" has any special competency or skill derived from

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the training or experience. If the examiners were to create an examination in which all examinees successfully passed, then there could be no assurance that the examination truly evaluated or assessed the examinees' core knowledge at a level different from the untaught or inexpert. Moreover, the worth or value of the examination would be questionable. These concerns beg the more basic and difficult question: How many should fail the examination?

National and state examination boards typically set their own pass rates. For example, about 95% of those who sit for examinations prepared by the National Boards of Medical Examiners (NBME) and the National Board of Osteopathic Medical Examiners (NBOME) pass the examination (National Board of Osteopathic Medical Examiners, 2010; van Zanten, Peters, & Frye, 2008). However, some of the medical specialty board certification examinations are far more rigorous and discriminating. For example, for the years 2009–2011, the pass rates for the General Pediatrics certifying examination given by the American Board of Pediatrics (ABP) to first-time takers ranged from 75.7% to 79.1% (American Board of Pediatrics 2011).

Pass rates on bar examinations vary notoriously depending upon the jurisdiction. For example, according to the National Conference of Bar Examiners, the pass rate for all those who sat for state bar examinations in 2011 ranged from 51% (California) to 94% (South Dakota) (National Conference of Bar Examiners 2012). In these instances, some may argue that the poor pass rates are a better example of how quotas are used to limit new professionals entering practice, rather than a valid measure of competency. There may be truth in this assertion.

In the recent past, it was not uncommon for states to establish passing scores for professional licensure by statute or regulation. For example, as late as 1998, the Tennessee Board of Pharmacy required that the successful candidate score at least 75% on the North American Pharmacist Licensure Examination (NAPLEX) written and administered by the National Association of Boards of Pharmacy (NABP) (Secretary of State, State of Tennessee 1998). One should note that a successful passing score set by statute or regulation may prove to be a handicap for some state boards since almost all licensure examinations are written, scored, and validated by national bodies with authoritative professional standing. But then, the state licensing board did have authority to shift the curve as was necessary to produce a locally desired pass rate anyway.

Out of a sense of justice and transparency, the health care ethics consultant examination board should set the minimum passing percentile score or raw number score before administering the examination. The cutoff pass–fail score will be somewhat arbitrary, but it must not be unreasonable and indefensible. If the board uses common statistical measures in considering question and examination validity and there is a normal score spread on the examination, then a passing score of about 75% or so seems reasonable. More directly, if the failure rate was established at one standard deviation below the mean (typically around 80% on most standardized tests) and there is a standard deviation of ±5%, then about 16% or 17% of examinees would fail the examination.

Table 2. American Society of Bioethics and Humanities core knowledge competencies topical categories

Moral reasoning and ethical theory
Common bioethical issues and concepts
Health care systems
Clinical context
The local health care institution
The local health care institution's policies
Beliefs and perspectives of local patient and staff population
Relevant codes of ethics and professional conduct
Relevant health law

Note. From American Society for Bioethics and Humanities (2011a).

EXAMINATION SUBJECT MATTER CLEARLY ARTICULATED

For examination purposes, it may be important for the examiners to further clarify the subject matter content beyond just saying that examinees should study materials addressed by the topics in the ASBH core educational competencies. Perhaps the examiners should weight the examination in a way that mirrors critical skills and knowledge as reflected in the competencies and practice. (See Table 2 for a listing of the knowledge topics covered in the knowledge competencies.) The examiners might allocate score points to the various major and minor topics based on peer understandings about the value of the material to skills development and work in the field. For example, the NABP alerts examinees sitting for their Multistate Pharmacy Jurisprudence Examination (MPJE) that about 84% of the test questions will deal with pharmacy practice and the law, about 13% of the questions with licensure, registration, certification, and operation requirements, and about 3% with regulatory structure and terms (National Association of Boards of Pharmacy 2012). Examinees would certainly benefit from this type of information as they study and prepare for the examination since they could ration study time proportionate to material emphasis.

POSSIBLE WRITTEN EXAMINATION FORMATS

One might expect that—regardless of format or type—each examination question posed should be objective, focus on a single concept or single concept grouping, and be clear and unambiguous. The examination board should vet each question individually so that any extraneous or irrelevant ideas and cultural bias are eliminated. However, examination security concerns may factor into wide dissemination of possible items. Moreover, the certifying examination does not have to be wholly one question type or the other. With either or both types of questions, the examiners may elect to pilot any examinations under consideration

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with Delphi groups or training programs as part of a cross-validation process. For purposes here only two question formats are reviewed: (1) single-answer multiple-choice, and (2) short answer or essay. Undoubtedly, there are other question types (e.g., multiple-answer multiple-choice questions and matching questions), but these types are not discussed here.

Moreover, there will be other special content issues with which examiners must grapple (e.g., institutional policies and local laws) regardless of format type used. These special problems may be settled more easily with one format versus another (such as asking those more familiar with one state's laws to grade short-answer or essay questions that deal with that state's surrogacy or advance directives statutes). The multiple-choice format is still an option with local content issues (the MPJE is state specific), but satisfactory resolution may require multiple equally reliable and valid examinations with additional administrative expense.

Single-Answer Multiple-Choice Questions Format

Advantages

The purpose of a written examination is to test the examinee's core knowledge of the subject matter relevant to clinical ethics practice. Factual information, which is noncontroversial, can be presented in a well-written multiple-choice examination. The advantages of a multiple-choice examination include: (1) Less time is needed to complete each question, permitting a more comprehensive range of topics; (2) there is more objectivity in scoring since no interpretation of answers will be necessary; (3) bias related to handwriting or rushed typewriting is eliminated; (4) various test questions are still possible that test factual information, context-specific data, and one best answer skills; and finally, (5) concerns about guessing can be largely reduced when there are four or five answer options (Brigham Young University Faculty Center 2001). Most professional licensing and certifying examinations are written in a multiple-choice format and are accepted standards for testing subject-matter content.

Whether or not a test taker understands the subject matter and can reasonably interpret the language and terminology as they apply to the practice of clinical ethics consultation is more fairly evaluated in an objective manner. Although the practice of ethics consultation involves the ability to apply knowledge and skills in practical and subtly nuanced ways, the written examination does not need to be the only mechanism for assessing these clinical skills. Rather, the oral examination and the review of an examinee's body of work, as suggested by Smith and colleagues, will better assess process skills. The core knowledge should distinguish shared understanding of "the same core areas of knowledge by all consultants" (Smith et al. 2010). Open-ended questions will deal with knowledge for which there is a clear consensus for the correct answer. A multiple-choice examination can be quickly scored electronically with multiple statistical analyses available to assure validity. Several online computerized examination tools can be easily adapted for multiple-choice test purposes. This format allows for multisite use and flexible test dates. While a multiple-choice examination cannot eliminate the chance of correct guessing, it seems unlikely that a test taker would easily pass a highly structured, well-constructed examination without a reasonable knowledge of the subject matter.

Disadvantages

Statistically valid single-answer multiple-choice questions are difficult to write. Experts have theorized that an ideal single-answer multiple-choice question item has a stem with four or five reasonable answer options, with 16 out of 20 examinees selecting the correct answer and 4 out of 20 examinees equally selecting one of the incorrect options (National Board of Medical Examiners 2012). Moreover, each question uniquely should discriminate between individuals who attained a high score on the examination as a whole and those who scored poorly overall, that is, have good item-total correlation scores.

The entire examination should be statistically reliable; that is, if students were to take the examination again, those who did well the first time would very likely do well the second time. Reliability might be established through internal consistency (e.g., Cronbach alpha) scores. However, given the range of topics covered on this examination, this might not be the better measure of reliability, which is best used for items using the same construct. It may be advisable to establish reliability and validity in pilot testing. Content experts—item writers—will provide initial validity; then construct validity testing through either test–retest or internal consistency analysis may provide evidence of reliability. It may take the results of thousands of examinations eventually to prove reliability and validity.

Examiners may wish to take advantage of innovative computer interfaces in offering multiple-choice questions (such as audio or video clips or encounter vignettes), but in the end the question format will still be a stem with one right answer from among several options. Production costs will of necessity be factored into innovative question formats using new technologies.

Multiple-choice question examinations typically have about 35 to 45 questions per examination hour. A typical 2-hour examination or examination period has about 75 to 90 questions, allowing examinees about 80 to 100 seconds per question. A multiple-choice question format requires several times more questions than the essay or short-answer format. It may be difficult for the examination board to develop the necessary number of multiple-choice questions within a reasonable period of time, particularly if the examination is to be offered electronically at a local testing center with individual questions randomly selected from a pool for each candidate, as some national professional examinations are offered. Hundreds of multiple-choice questions may be necessary for a sufficient question pool, even for one examination offering. For example, in preparing the state-specific portion (which is about 50%) of the MPJE, the NABP requests participating state boards of pharmacy to submit

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200 questions every 2 years to its question bank (National Association of Boards of Pharmacy 2012). Examinees sitting for the MPJE are allowed 2 hours at the computer to complete the test. There are 90 questions on the examination; 75 questions are scored and the other 15 are items included for future examination purposes or to assure statistical validity. There are multiple thousands of questions in the MPJE pool. Moreover, in large question banks like the MPJE, each question is categorized in several different ways to avoid subject-matter duplication and redundancy. Regardless, an appropriate question pool will be much larger than the 350- to 400-question bank suggested by Smith and colleagues (2010).

It may be that some candidates will not be as familiar with multiple-choice style examination questions. Candidates who may be licensed physicians, nurses, and social workers will have successfully passed multiple-choice question tests crafted by national examiners. In fact, with physicians, few may have ever taken essay or short-answer examinations during their training at all. However, others who may sit for a health care ethics consultant examination may be trained as attorneys, chaplains and pastoral care workers, and philosophers and have far less experience with the multiple-choice question format. Those more familiar with multiple-choice questions will probably know that correct options (1) are often longer or shorter than incorrect possibilities; (2) are usually grammatically perfect extensions of the stems; (3) typically use familiar terminology rather than unexpected language or technical terms; (4) are logical or reasonable rather than extremely illogical or nonsensical; and (5) are sometimes paired with opposite statements.

The questions must be highly structured, but guessing cannot be eliminated entirely. The answers are scored correct or incorrect with no opportunity for partial credit.

Typical Examination Questions

Presented next are a couple of examples of single-answer multiple-choice questions that deal with the definitions of medical futility and the doctrine of double effect:

> Mr. J has suffered a large hemorrhagic stroke. He is unconscious and is expected to never wake up or be able to interact with his environment if he survives this event. His family has elected to withdraw life support because they believe he would not want to live in this diminished state. The family considers further treatment to be futile. What kind of futility applies in this case?
>
> a. Quantitative futility
> b. Imminent demise futility
> c. Qualitative futility
> d. Unilateral futility
>
> The principle of "double effect" means:
>
> a. An action or treatment is ethically permissible if the outcome has two good effects even though one effect was not anticipated.
> b. An action or treatment is ethically permissible even though it may likely cause two bad effects.
> c. An action or treatment is ethically permissible even though it has both a good and a bad effect because there is intent is to cause the good effect.
> d. An action or treatment is ethically permissible even though it may cause pain or suffering because it is expected to have a good outcome overall.

A complete 25-question multiple-choice examination is provided in Appendix 1. (A complete examination is included rather than just a few prototypical questions, in order to show the extent of effort necessary to produce great numbers of questions essential for a statistically valid pool and to allow opportunity should interested persons wish to actually take a simulated test within a reasonable allotted time of 35 to 40 minutes.)

Short-Answer or Essay Questions Format

Advantages

This format is usually ideal for measuring understanding, application, and other more complex thought processes. Fewer examination items are typically required than for a multiple-choice format since more time is necessary in writing or typing responses. It may be possible to give partial credit for some answers; partial credit rather than an all-or-none credit for each question should permit sufficient discrimination with better score spread. Moreover, in thinking about an oral examination question pool—if one considers the "quality attestation" model or Smith and colleagues' four-step process further—the question bank for the both an essay test and an oral examination will probably be the same or at least very similar.

Disadvantages

Disadvantages to a short-answer or essay format include a more limited scope of topics, inefficient administration, and potential for bias in scoring exams. A short-answer or essay-style examination would likely have fewer questions in order to allow a test taker adequate time to complete the test, because it takes longer to formulate and present a written answer than to mark a box as would be done during a multiple-choice exam. The smaller number of questions on the examination means that the questions may not cover as broad a range of topics as can be covered in single-answer multiple-choice questions. Agreement about which topics belong on any test for clinical ethics consultants may be difficult, and perhaps more so with fewer questions possible to examine core knowledge of the subject matter. Furthermore, the range of answers that will be considered correct may be difficult to narrow, given the diversity of training programs and lack of uniformity even at advanced levels of education in clinical bioethics.

Scoring an essay examination is inefficient and time-consuming. It may be difficult to prove that the examination was fair since there may be a wide variety of possible correct answers for many questions. The risk of bias, particularly in a field that values diversity of opinion and experience as much as clinical ethics, cannot be minimized.

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Bias may result when graders must deal with unappealing response styles. Though the answers may be technically correct, reasonable graders may score questions differently because of subjective impressions. Given the potential for bias among examination scorers, the examiners should institute an appeals process before offering the examination. Appeals may delay the reporting of all scores. Anticipating concerns, examiners may wish to review automatically any examinations that fail by the margin of error.

The expense and time commitment critical to scoring lengthy essay examinations may not be warranted if a multifaceted Smith and colleagues model is followed. In a world where many written examinations are administered electronically at testing centers and scores are generated in a matter of minutes, it could be seen as archaic and cumbersome to return to a mechanism where multiple reviews are needed.

Sample Examination Questions

Here are a couple of examples of short-answer or essay questions that deal with the definitions of medical futility and the doctrine of double effect:

> Identify and define two senses of medical futility and briefly explain how each might or might not be grounds for limiting treatment, in spite of requests by surrogates to continue.
>
> Give an example of "double effect."

A complete 25-question short answer essay examination is provided in Appendix 2. (Again, a complete examination is included rather than just a few prototypical questions, in order to show the extent of effort necessary to produce great number of questions essential for a valid pool and allow opportunity should interested persons wish to actually take a simulated test within a reasonable allotted time of 60 to 75 minutes.)

RECOMMENDATION AND CONCLUSION

In summary, there are advantages and disadvantages to both the multiple-choice and short-answer essay formats for the certification examination. Both types will take time to prepare and to grade. The multiple-choice format would take more time to develop and to sustain (for example, in maintaining a fresh bank of questions), but far less time to grade objectively; on the other hand, the essay examination would take less time to prepare and much more time to properly evaluate. With the essay examination, the expert graders will have to deal with possible bias in grading since the determination of pass or fail may ultimately be a judgment call by the board. At the very early stage of the individual clinical ethics consultant certification process—as the examiners are preparing the first examination—perhaps both formats should be used. Some content (e.g., the state-specific statutes) might be better asked as essay; other materials might be more appropriate in the multiple-choice style. The examiners would thus gain valuable experience with both written format types. Even though more time may be required in the short term to score the examination fairly, the examination board may require less money for administration and operations.

The scope of the discussion here is relatively limited. Hopefully it will raise more questions than settle. Conversations about budget and business plan development and test reliability and validity are sketchy at best and are mentioned more to highlight the difficulties rather than to resolve concerns. Should the examiners wish to employ outside financial and test construction and administration experts to offer advice about how to deal with some issues, many might welcome that approach as astute and sagacious. The item content and pass–fail issues with which the board must contend will be problematic and troublesome enough.

Many conversations about a competency-based examination for health care ethics consultants will generate disagreements (Bishop, Fanning, and Bliton 2009). But the helpful discussion should begin (Baker 2009). To advance the field of health care ethics consultation, thought leaders should start to focus on the written examination possibilities, to date not carefully addressed in the literature. Examination models—both objective and written—must be explored as part of a viable strategy about how the field of health care ethics consultations can move toward professionalization.

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APPENDIX 1—SINGLE ANSWER MULTIPLE-CHOICE QUESTION EXAMINATION

Please select the one best answer for each question and mark your answer sheet by filling in the appropriate lettered circle completely.

1. *Autonomy*, as it is used in biomedical ethics, is best defined as:
   a. The right to seek medical treatment.
   b. The right to refuse medical treatment.
   c. The authoritative stance of a physician toward a patient.
   d. The right of capacitated persons to make their own choices.
2. Dr. D is considering recruiting research subjects to test a new life-saving drug. The drug may have some unpleasant side effects, but will potentially save thousands of lives. Dr. D decides not to disclose all of the potential side effects to his research subjects in order to increase participation in his study. A deontological analysis of this problem would likely state:
   a. Because of the potential benefit to society, this is ethically permissible.
   b. Because the outcome is likely to be beneficial, this is ethically permissible.
   c. Because the action violates the duty to tell the truth, this is not ethically permissible.
   d. Because the research subjects may be harmed, this is not ethically permissible.
3. During a shortage of flu vaccine, deciding to provide the vaccine to pregnant women and children instead of to

the elderly because this will provide the greatest benefit to society would be an example of which philosophical perspective?
   a. Eugenics
   b. Deontology
   c. Utilitarianism
   d. Natural Law
4. In bioethics literature, the "Baby Doe" case reference is which landmark case?
   a. An infant born with Down syndrome and had a surgically repairable tracheoesophageal fistula which was left unrepaired at the parents request to allow the infant to die.
   b. An infant born with multiple birth defects, including spinal bifida and hydrocephalus for which parents declined surgical intervention with the expectation the infant would die.
   c. An infant born with anencephaly who was brought repeatedly for emergency treatment which was believed to be futile by hospital providers.
   d. A previously healthy child who choked on a balloon resulting in persistent vegetative state (PVS), and the child's father disconnected the ventilator after threatening staff with a gun.
5. A written clinical ethics consultation note ought to address what elements before placing the note in the chart?
   a. Demographic data, consultant contact information, predicted medical outcomes, patient preferences, ethical dilemma, plan for follow up
   b. Demographic data, name of attending physician, informants, requesting individual, medical indications, contextual features, patient preferences, quality of life issues, ethical issues, recommendation
   c. Demographic data, advance directives, documentation of decisional capacity, legal concerns, recommendations
   d. Demographic data, attending physician, discipline of requesting individual, medical problems, contextual features, anticipated future quality of life, and recommendations
6. The rights of human subjects in biomedical research were first addressed formally in which of the following documents?
   a. The 1902 American Medical Association (AMA) Code of Ethics
   b. The Nuremberg Code (1947)
   c. The Declaration of Helsinki (1964)
   d. The 1847 AMA Code of Ethics
7. Mrs. D has been diagnosed with aggressive lung cancer. She states she does not want any treatment. What kind of right is Mrs. D expressing?
   a. A negative right
   b. The right to autonomy
   c. The right to care
   d. A positive right
8. Determining capacity generally requires:
   a. The ability to state one's name, date of birth, and next of kin.
   b. The ability to complete an interview with a psychiatrist or psychologist.
   c. The ability to express preferences, and to identify an agent who will voice these preferences.
   d. The ability to express an understanding of one's options and the consequences of a given decision.
9. Surrogate motherhood is most criticized because it:
   a. Shifts the burdens of pregnancy to vulnerable women.
   b. Potentially harms children who may be confused about parents.
   c. Commoditizes children by implying they are goods to be traded.
   d. Limits the reproductive liberty of male partners.
10. Mr. J has suffered a large hemorrhagic stroke. He is unconscious and is expected to never wake up or be able to interact with his environment if he survives this event. His family has elected to withdraw life support because they believe he would not want to live in this diminished state. The family considers further treatment to be futile. What kind of futility applies in this case?
   a. Quantitative futility
   b. Imminent demise futility
   c. Qualitative futility
   d. Unilateral futility
11. What administrative supports would NOT best enable a clinical ethicist to perform his or her job effectively?
   a. Whistleblower protection to prevent fear of reprisal
   b. Infrastructure support such as time, space, access to resources
   c. Legitimizing clinical ethics services through inclusion in bylaws and senior administration support
   d. Linking ethics service outcomes to reimbursement and patient census
12. Which character trait is generally considered to be important for success as a clinical ethics consultant according to the American Society for Bioethics and Humanities (ASBH) guidelines?
   a. A strong sense of spirituality
   b. The ability to empathize with others
   c. Identifying the right answer when they hear it
   d. Willingness to take risks
13. Which statement best defines the goals of health care ethics consultation as put forth by the American Society of Bioethics and Humanities (ASBH)?
   a. Improve institutional profitability by reducing overall patient length of stay and address moral distress
   b. Assure that appropriate surrogates are identified for each patient and enhance understanding of the surrogate decision-making process

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c. Improve health care and outcomes through the identification, analysis, and resolution of ethical issues as they emerge in clinical cases
d. Provide reasonable recommendations that attending physicians can implement at the patient's bedside

14. According to American Society for Bioethics and Humanities (ASBH) guidelines, should patients and surrogates be notified that an ethics consultation has been requested?
    a. Yes
    b. No
    c. Not necessarily, it is case dependent
    d. After advising the attending physician
15. According to American Society for Bioethics and Humanities (ASBH) guidelines, should the attending physician always be notified that an ethics consultation has been requested?
    a. Yes
    b. Not necessarily, it is case dependent
    c. Yes, but only if the issue requires physician input
    d. No, a chart note is adequate notification
16. All of the following are reasonable techniques for gathering information about a patient for whom an ethics consultation has been requested EXCEPT:
    a. From the person making the initial request.
    b. From a review of the patient's medical record.
    c. By reading the patient's advance directives.
    d. By researching the patient's treatment options.
17. A surrogate decision maker is someone who:
    a. Is employed by the health care facility to assist incapacitated patients.
    b. Is designated to make health care decisions if the patient is unable to do so.
    c. Is always designated by the patient as a health care proxy or agent.
    d. Helps a patient fill out advance directive forms.
18. Physician-assisted death (or physician-assisted suicide) and euthanasia:
    a. Are legal in Montana, Oregon, Vermont, and Washington.
    b. Are generally viewed as morally and legally different.
    c. Permit doctors to administer lethal medication to terminally ill patients.
    d. Are ethically and legally permissible as long as the physician remains passive.
19. The principle of "double effect" means:
    a. An action or treatment is ethically permissible if the outcome has two good effects even though one effect was not anticipated.
    b. An action or treatment is ethically permissible even though it may likely cause two bad effects.
    c. An action or treatment is ethically permissible even though it has both a good and a bad effect because there is intent to cause the good effect.
    d. An action or treatment is ethically permissible even though it may cause pain or suffering because it is expected to have a good outcome overall.
20. You are the ethics consultant responding to a call on a medical unit where staff are concerned about a patient's family members arguing over who should be the primary decision maker for Mrs. A, a 78-year-old woman without capacity who needs surgery. Mrs. A's son and daughter are present and agree to meet with you; both express open hostility toward each other. From the options listed below, to begin mediation at this meeting you:
    a. Give each person the opportunity to speak uninterrupted.
    b. Discuss why they are so angry at each other.
    c. Ask each person what they understand would be best for Mrs. A.
    d. Explain how stressful their fighting is for the nurses.
21. Mr. D is rushed to the emergency room from his nursing home where he lives after staff found him unresponsive in his wheelchair. Mr. D has end stage Alzheimer's and severe arthritis. At the emergency room, he is in respiratory distress and on the verge of requiring intubation. It is not clear what is causing the respiratory distress yet. Documents sent by the nursing home include a living will, completed almost 10 years ago, which states the patient does not wish to have "heroic measures" undertaken to save his life. Two adult daughters are listed as next of kin; one daughter, Mary, is listed as the designated health care proxy. Mary cannot be contacted at this time to clarify what Mr. D would likely want in this situation. The emergency department physician has telephoned the other daughter, Krista, who says she isn't sure what her father would want, but feels staff should do what they can to save his life. The doctor requests an ethics consultation and asks for any recommendation quickly since the patient is declining. Based on the known information you recommend:
    a. Calling the nursing home immediately to see what they think should be done in the patient's best interests.
    b. Proceeding with the intubation to allow time to determine the underlying cause of Mr. D's respiratory distress.
    c. Withholding intubation based on the living will because intubation is considered "heroic," and the health care proxy is unavailable.
    d. Proceeding with intubation but advise the team move slowly to see if the patient's proxy makes contact.
22. Maintaining confidentiality and privacy are very important concerns that are balanced against state interests as in reporting:
    a. Felony convictions.
    b. Abnormal genetic tests.

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c. Suspected child abuse.
d. Mental health treatment.

23. Mr. M has had a stroke and currently lacks capacity to make decisions. He has advance directives and his wife Mrs. M is his designated health care agent. Mrs. M follows the instructions provided by Mr. M in his advance directives. Mrs. M is applying which standard for decision-making?
a. Substituted judgment
b. Best interests
c. Autonomy
d. Informed consent

24. Baby G was born with a heart defect. It is not life threatening, but requires surgical repair to prevent future medical problems. Baby G's parents agree to the surgery because they feel this is the right decision based on the risks and benefits including an improved quality of life for the infant. Which standard for decision-making are the parents applying?
a. Informed consent
b. Nonmaleficence
c. Substituted judgment
d. Best interests

25. Mr. C is in the ICU on a ventilator following a serious motor vehicle accident (MVA), which caused multiple, extensive trauma. After one week he is vent dependent and in multisystem organ failure so he is not expected to survive beyond the ICU. His authorized surrogate believes he would not want his life prolonged only to die in the ICU on artificial life support, so in consultation with the attending physician a decision is made to withdraw the ventilator. Mr. C is expected to die after withdrawal of the ventilator but it is possible he could continue to breath a short time. To ensure that he is kept comfortable and does not suffer from air hunger, the physician will administer morphine, which could have the effect of suppressing respiration and if so hastening Mr. C's death. This plan is morally defensible because of the:
a. Doctrine of material cooperation.
b. Doctrine of double effect.
c. Principle of beneficence.
d. Principle of respect for persons.

APPENDIX 2—SHORT ANSWER OR ESSAY QUESTION EXAMINATION

Please answer each question in the space provided (no more than 200 words). To the extent possible please use complete sentences or succinct phrases depending on the question asked.

Moral reasoning and ethical theory

1. Give three examples of how distributive justice is a predominant principle or feature of a case and how it must be taken into account in resolving a bedside clinical ethics dilemma.
2. There is often a tension between a physician's obligation to the principle of respect for patient autonomy and the obligation to the principle of beneficence. This tension must often be weighed in ethics consultations by the ethics consultant. In a situation where a patient is refusing lifesaving treatment against the physician's advice, briefly describe two ways a brief hypothetical case of this type could result in diametrically opposite ethics recommendations. Explain your reasoning.
3. Explain how triage is a form of "rationing."

Common bioethical issues and concepts

4. Explain what is meant by "assent" in the context of caring for a pediatric patient.
5. Define *therapeutic exception* as commonly used in bioethics case discussions. Give an example.
6. Give an example of "double effect."
7. List five pertinent facts that a physician must share with the patient in order to obtain valid informed consent.
8. List and discuss three features of the Hippocratic Oath.

Health care systems

9. Give five key differences or similarities between the Medicare and Medicaid programs.
10. Explain the historical background of institutional review boards (IRBs).

Clinical context

11. Compare and contrast two of the four typical "trajectories of dying" commonly seen in clinical medicine. Recall that the phrase "trajectories of dying" is used by researchers such as June Lunney and Joanne Lynn to describe patterns of functional decline at the end of life, see Lunney JR, Lynn J, Foley DJ, Lipson S, Garalink JM. Patterns of functional decline at the end of life. JAMA. 2003;289(18):2387–2392.
12. Identify and define two senses of medical futility and briefly explain how each might or might not be grounds for limiting treatment, in spite of requests by surrogates to continue.
13. Imagine that you are the clinical ethics consultant on call and are requested to see a patient in the intensive care unit. When you arrive, the attending physician describes the dire situation of an elderly man in his late 80s with end stage heart disease. In spite of repeated discussions with the surrogate about the need for a do-not-resuscitate (DNR) order, the surrogate insists that an attempt be made. The patient's own wishes are not known. The attending believes cardiopulmonary resuscitation (CPR) would be medically inappropriate as it would cause harm and provide no benefit for this patient. When you ask what the plan is, in case the patient has a cardiac arrest, the attending physician says: "Well, we aren't going to move too quickly, that's for sure—we'll make a few gestures at CPR and then tell the family we did everything we could." State precisely how you would actually verbalize your response to this

attending physician in order to give him sound ethical advice. (Don't make a general recommendation—write out exactly what you would say in real time if you were in this situation.)

The local health care institution

14. After identifying the name of your local institution and giving a short description of about its size and services as well as its city and state (or province) location, describe how the institutional health care ethics committee is constituted or structured and offer three suggestions that might improve its organization, governance, or operation.

The local health care institution's policies

15. List the names or categories of five policies that may be considered essential institutional "ethics policies" for a local hospital.
16. After identifying the name of your local institution and giving a short description of about its size and services as well as its city and state (or province) location, briefly describe the policy which informs the clinical team about the process to be used to identify the appropriate surrogate decision maker for an adult patient who lacks decision making capacity.

Beliefs and perspectives of local patient and staff population

17. List five national or local entities, organizations, or persons that might be able to help a patient with completing advance planning documents.
18. Recommend steps in the following situation: A 10-year-old Navajo boy is in the hospital with a terminal diagnosis of astrocytoma unresponsive to surgery and chemotherapy. The team believes that palliative and hospice care at this point is indicated. The parents are open to conversation about hospice care but insist on remaining in the hospital until the child dies because in their culture and belief system if the child dies at home "his spirit will be trapped within the four walls and he'll never ascend to the Great Spirit."
19. List five hospital committees, entities, or services that might interface with the institutional ethics committee and might have overlapping interest or jurisdiction in assisting patients in resolving ethical dilemmas.

Relevant codes of ethics and professional conduct

20. Explain briefly the role of the Joint Commission in promoting ethics services within accredited health care organizations.

Relevant health law

21. Explain the difference between *confidentiality* and *privacy*.
22. Give five reasons as to why or why not it might be helpful to ask the organization's lawyer to serve as a member of the institutional ethics committee.
23. List three "landmark" aspects or holdings of Cruzan v. Director, Missouri Department of Health, 110 SCt 2841 (1990).
24. Explain how a durable power of attorney for health care (DPAHC) differs from other powers of attorney (POAs).

Skills and knowledge in "non-case" consultations

25. Give three examples of "non-case" consultation requests.

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