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Dr. David Soffer serves as a neonatologist at Omaha Children's Hospital and the University of Nebraska Medical Center. He completed neonatology and bioethics fellowships at Harvard Neonatal-Perinatal Fellowship Program and at Harvard's Center of Bioethics. He received his MD from Semmelweis University of Budapest, Hungary. Dr. Soffer completed his pediatric residency training at the Zucker School of Medicine at Hofstra/Northwell Health Children's Hospital. His Academic interests focus on bioethics. Specifically on instilling and assessing ethical principles, interpersonal competence, and knowledge in medical trainees who counsel parents of critically ill newborns.

The Development of The Pediatric Ethics & Professionalism Assessment Tool (Pedi-EPAT)

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Disclosure Statement

- I have no conflicts of interest or disclosures

Introduction

- As per the ACGME training program requirements:
  - Bioethics must be addressed in the formal curriculum of pediatric training programs
  - Pediatric residency/fellowship programs are required to evaluate trainees for “high standards of ethical behavior” – ***ACGME Milestone Project***

Objectives

Develop and validate a pediatric ethics and professionalism assessment tool (Pedi-EPAT) that :

- Incorporates ACGME milestones, various ethical frameworks & professionalism

- Could be used in simulated and real, observed settings in pediatrics

- Could facilitate pediatric resident/fellow evaluation and competency tracking

Pediatric Ethics & Professionalism Assessment Tool (Pedi-EPAT)

How well does the learner do the following?

PREPARATION for INTERACTION	YES	NO	N/A
1. Convenes team huddle prior to family meeting to promote team collaboration			
2. Knows child's name and sex/gender (if applicable)			
3. Ensures appropriate participants are invited & present for family meeting (e.g. family support, consultants, chaplains, social workers) whenever possible so that family has access to essential & accurate information in a supportive environment			
4. Sits down (conference/bedside) when feasible			

OPENING of DISCUSSION	YES	NO	N/A
5. Gives proper introduction/identification to family			

	1: Novice	2: Developing competancy	3: Competant	4: Proficient	5: Expert	N/A
6. Demonstrates knowledge about child's medical & social history to guide and inform the discussion.						
7. Establishes family understanding at the start of the meeting						
8. Elicits/negotiates shared goals for the conversation with family						

GATHERING of INFORMATION	1: Novice	2: Developing competancy	3: Competant	4: Proficient	5: Expert	N/A
9. Encourages family to express hopes, wishes, concerns and questions						
10. Attempts to elicit family preferences/perspectives						

BUILDING of RELATIONSHIP with the FAMILY	YES	NO	N/A
11. Actively listens (e.g. no interruptions, no pagers/phones, no multi-tasking etc.)			
12. Demonstrates respect for patient and family			
13. Displays transparency with the family			

	1: Novice	2: Developing competancy	3: Competant	4: Proficient	5: Expert	N/A
14. Responds appropriately to emotional and non-verbal cues						
15. Acknowledges conflict if present; deescalates conflict as needed & appropriate						
16. Demonstrates empathy, compassion						
17. Puts family at ease to the extent possible						
18. Demonstrates sensitivity to diversity among families (race, ethnicity, faith)						

SHARING of INFORMATION	YES	NO	N/A
19. Avoids medical jargon, uses terms preferred by family			
20. Recognizes the need for available resources (2nd opinion, clergy, ethics consult or legal counsel)			

	1: Novice	2: Developing competancy	3: Competant	4: Proficient	5: Expert	N/A
21. Accurately conveys the seriousness of the patient's condition/prognosis						
22. Informs family of all reasonable/ethically permissible options (including withholding/withdrawal of life sustaining treatment, transfer to another facility, if applicable)						
23. Provides balanced information (e.g. risks/benefits, positives/negatives, potential abilities/disabilities)						

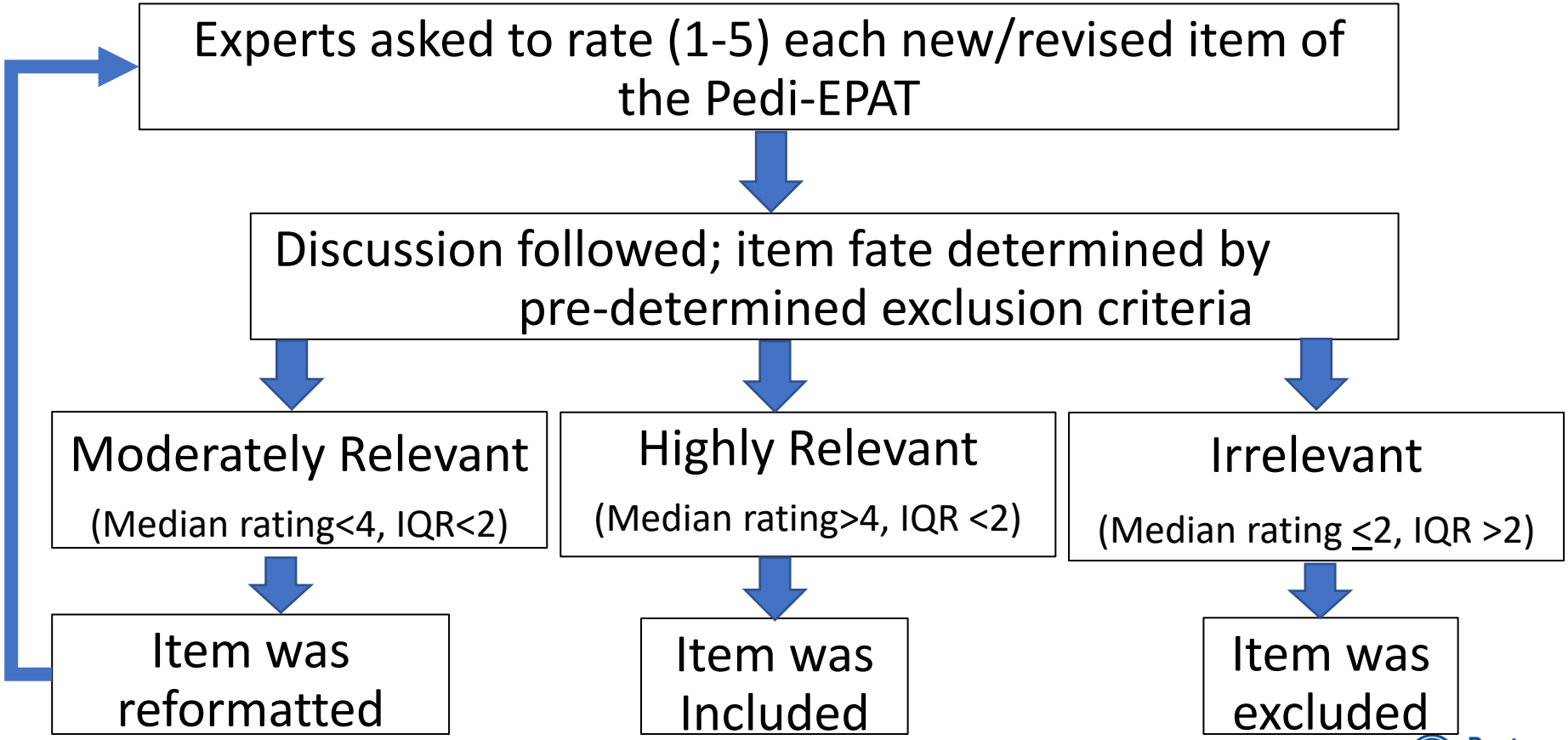
APPLICATION of SHARED DECISION-MAKING with the FAMILY	1: Novice	2: Developing competancy	3: Competant	4: Proficient	5: Expert	N/A
24. Attempts to elicit family's preferred level of involvement in decision-making						
25. Addresses family's concerns and answers questions clearly						
26. Acknowledges uncertainty and/or unknowns						
27. Attempts to reach mutual understanding with family						
28. Fosters shared decision making that serves the family's goals & values consistent with ethical norms regarding the child's best interests & protection from clear harm.						
				YES	NO	N/A
29. Obtains informed parental permission (consent)						

MEETING SUMMARY AND CLOSURE	YES	NO	N/A
30. Provides summary of meeting			
31. Outlines next steps/objectives for next meeting			
32. Debriefs with the relevant care team after family meeting, solicits feedback			

LEARNER SUPERVISION ASSESSMENT					
33. In supervising this trainee, how much did you (the evaluator) participate in the task?	1: Requires full supervision ("I did it")	2: Requires constant direction ("I talked them through it")	3: Some independence but requires intermittent direction ("I directed them from time to time")	4: Independence but unaware of risks, still requires supervision ("I was available just in case")	5: Complete independence ("I did not need to be there")
34. If you were to supervise this trainee again in a similar situation, which of the following statements aligns with how you would assign the conversation?	1: Allowed to observe ("Watch me do this")	2: Full supervision coactivity with supervisor ("Let's do this together")	3: Full supervision with supervisor in room ready to step in as needed ("I'll watch you")	4: On-demand supervision with supervisor immediately available, all components of the conversation double-checked ("You go ahead and I'll double check all of the components")	5: On-demand supervision with supervisor immediately available, key components of the conversation double-checked ("You go ahead and I'll double check key components")

Comments:

Methods- Development: Modified Delphi Process



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Inter-rater Reliability

- 6 raters
- ‘Frame of Reference’ training for tool raters
- 3 Simulated scenarios of different pediatric sub-specialties
  - Neurology, Neonatology and Pediatric Intensive Care
- Kendall's coefficient of concordance for inter-rater reliability analysis among raters.

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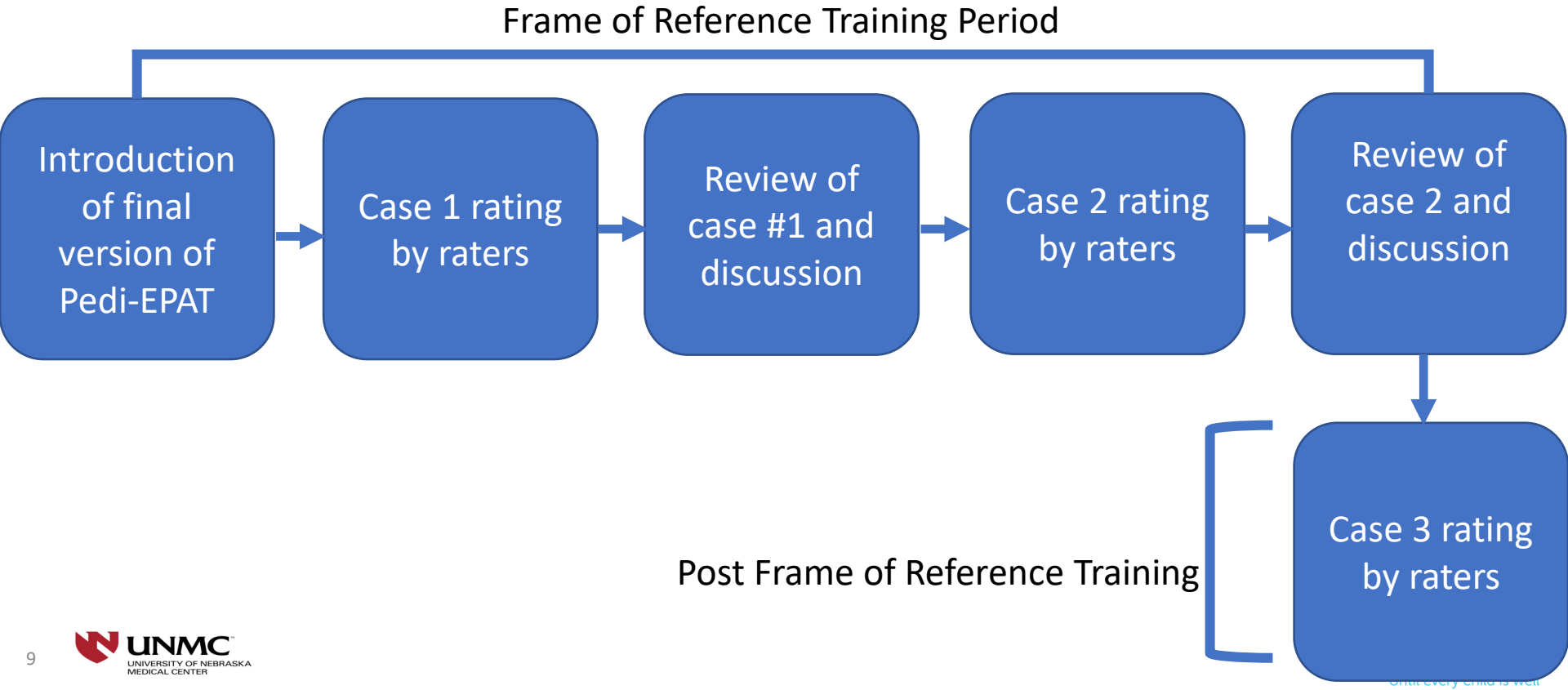
Frame of Reference Training

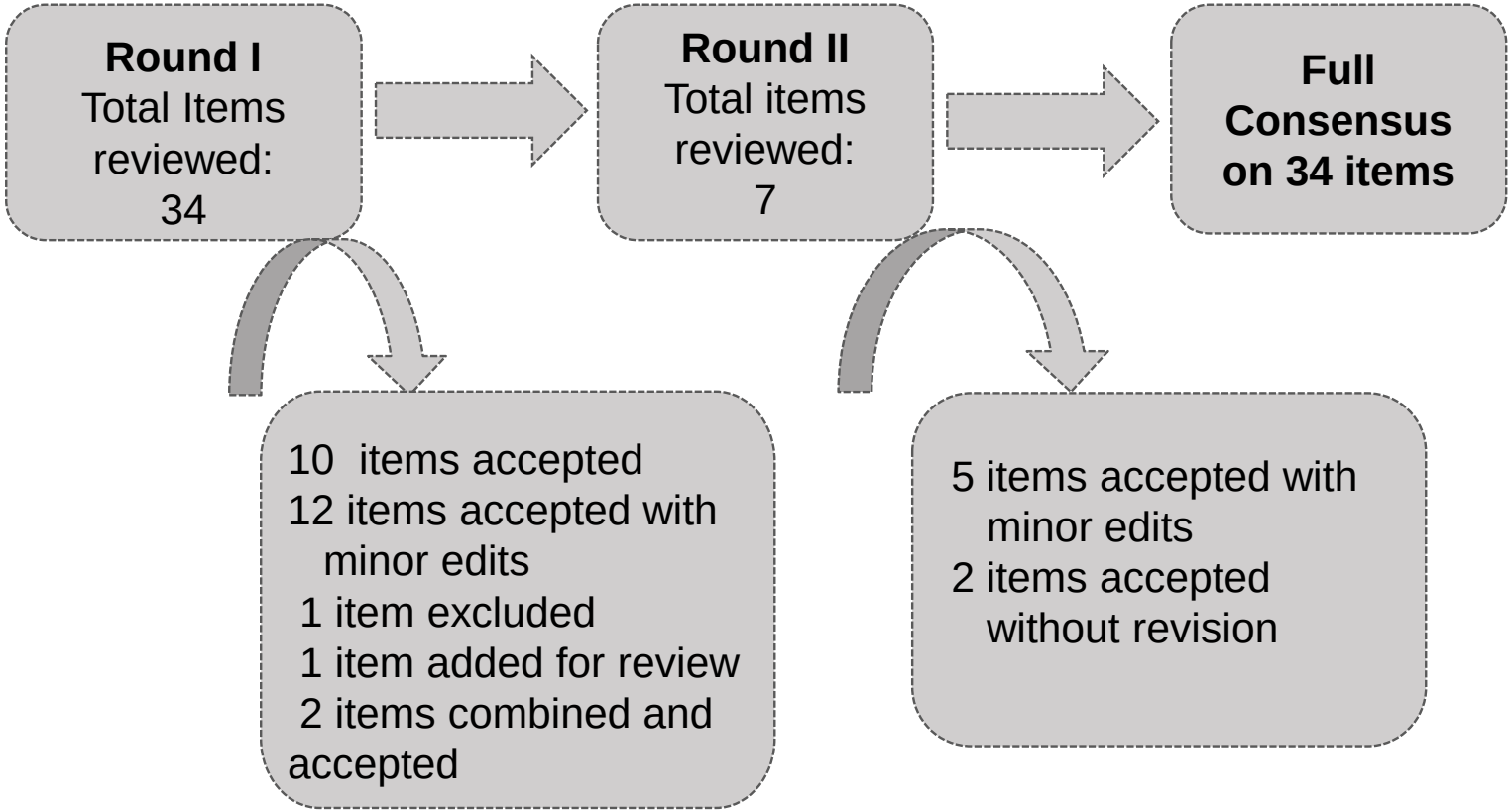


Results- Delphi Participants Characteristics

Participant Gender (n=11)	**n (%)**
Female	**4 (36%)**
Male	**7 (64%)**
Expertise (%) *	
Clinical Ethics	5 (45%)
Medical Education	3 (27%)
General Pediatrics	1 (9%)
Law	1 (9%)
Neonatology	3 (27%)
Nursing	1 (9%)
Pediatric Emergency Medicine	1 (9%)
Pediatric Hematology/Oncology	1 (9%)
Pediatric Intensive Care	1 (9%)
Pediatric Neurology	1 (9%)
Pediatric Radiology	1 (9%)
Social Work	1 (9%)

** Several of the participants are experts in multiple disciplines*

Modified Delphi Process



Results – Inter-rater reliability

	Video Simulation Case	Kandell's Coefficient of Concordance (W)	P value
During- Frame of Reference Training	1	0.35	<0.05
	2	0.33	< 0.05
After Frame of Reference Training	3	0.34	<0.05

W >0.3- Moderate agreement
>0.6- Strong agreement

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Frame of Reference Training: Differences Between Participants and Experts' Scores

Scoring point discrepancy between raters and experts	Pre-FOR training n (%)	Post-FOR training n (%)
0	37 (34.26%)	45 (41.67%)
1	48 (44.44%)	41 (37.96%)
2	18 (16.67%)	19 (17.59%)
3	5 (4.63%)	3 (2.78%)

n = number of ratings made by 6 raters out of 108 items. (p>0.05, Fisher's exact test). FOR= Frame-of-Reference.

Discussion

- The Pedi-EPAT is a novel, validated formative competency-based tool that may provide constructive feedback to trainees throughout their medical training that correlates with ACGME milestones
- It distinguishes itself from other assessment tools in medicine:
  - It uses several methodologies and medical ethics frameworks to assess moral reasoning
  - Includes items that map to ethics domains that are often excluded from other existing professionalism assessment instruments
  - The Pedi-EPAT was developed specifically for pediatrics.

Limitations

- Despite intentionally inviting potential participants of diverse backgrounds and gender for this study, most were white males.
- Increased level of agreement between the Pedi-EPAT developers and the raters using FOR training, the differences in discrepancies were statistically insignificant.
- Low-moderate inter-rater reliability among the participating raters.
- The Pedi-EPAT will need to be studied in practice, both in simulated and clinical settings, to assess tool use, feasibility and applications.

Future Directions

- Quality improvement initiative to implement the Pedi-EPAT in pediatrics/pediatric sub-specialties to improve trainee participation/leadership in meetings, as well as frequency and quality of feedback.

- Electronic platform for the Pedi-EPAT

- Continuing Medical Education (CME) opportunity for providers to use the Pedi-EPAT

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Delphi Participants & Pedi-EPAT Raters :

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- Brian Carter MD
- Heather French MD, MEd
- Charlotte Harrison RN, JD, PhD
- John Lantos MD
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- Mark Mercurio MD, MA
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Funding Resources

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Thank You For Your Attention..

For questions, please reach out:

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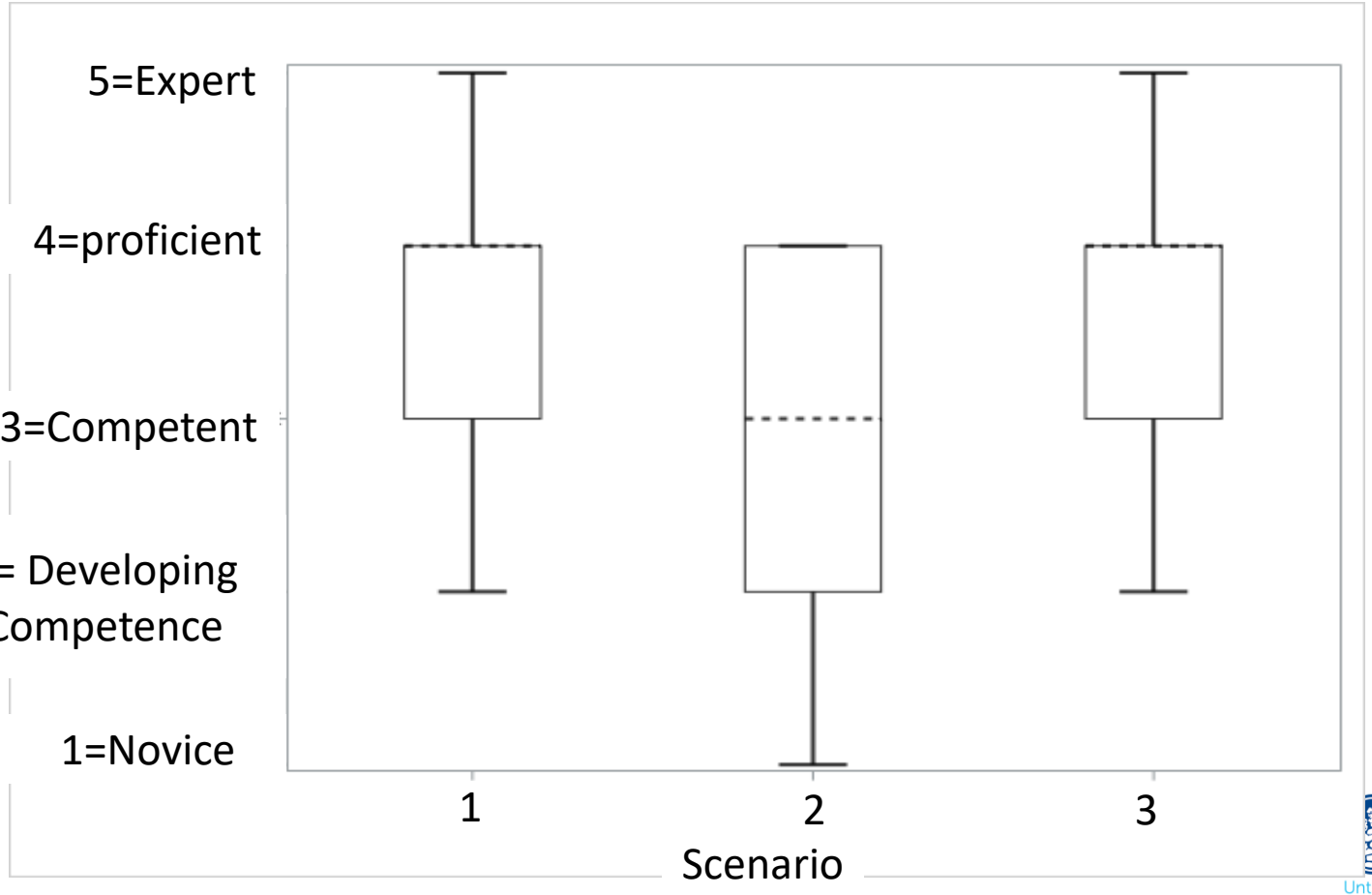
Likert Scores Per Video Simulation Case



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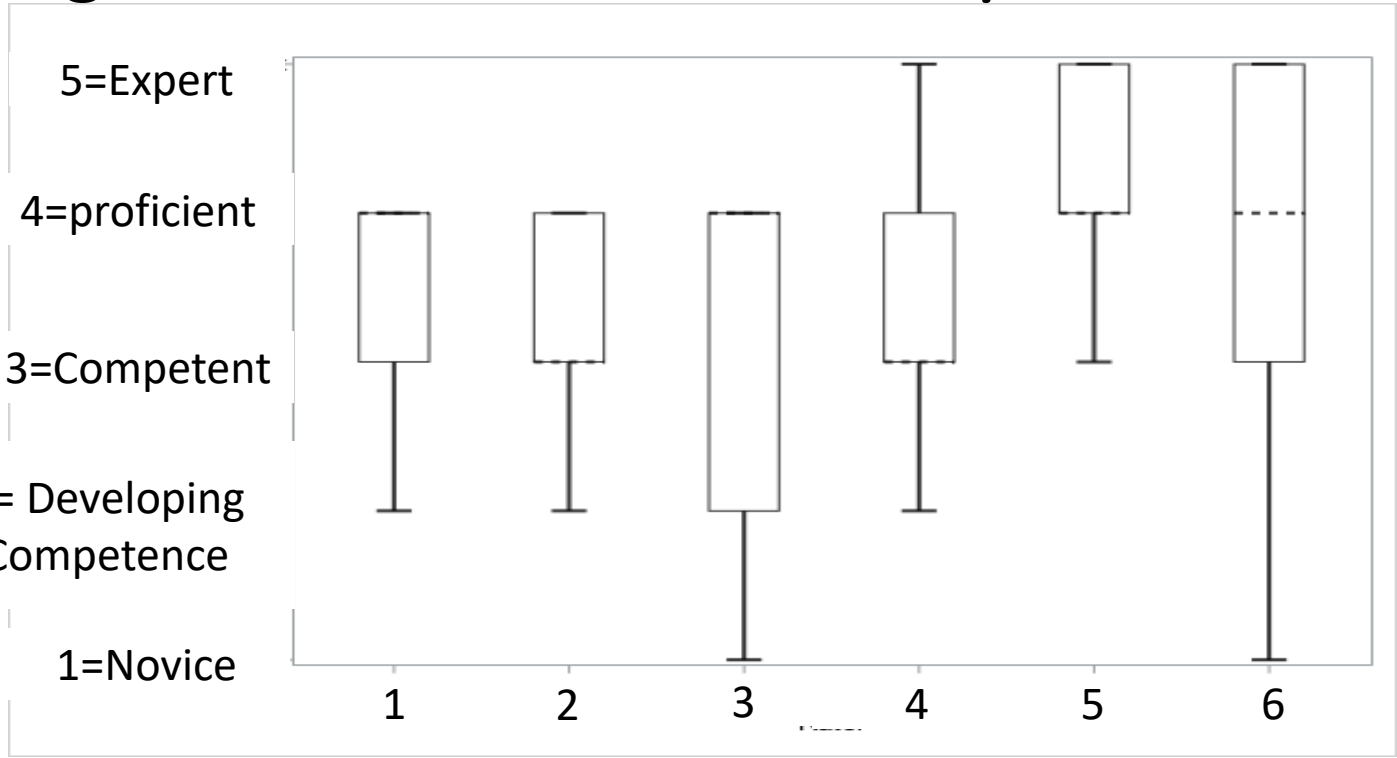
Range of Likert Scores Given by 6 Raters



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