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AUTHOR	Jensen, Gail M.
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ABSTRACT

The effect of clinical simulations on student learning in the teaching of ethics in a physical therapy curriculum was examined in a study of the experiences of 54 physical therapy students enrolled in a course in ethics in physical therapy practice. During the three-semester-hour course, the students participated in two clinical simulations that were referred to as standardized patient interactions. The first focused on the ethical dilemma of honoring patient autonomy when it may be in direct tension with promoting beneficence or good for the patient, and the second focused on the issue of physical locus of authority. The study data sources were as follows: the two videotaped SP interactions; two post-standardized patient interaction debriefing/self-reflection instruments; student peer and self-assessments; pretest/posttest scores on a self-efficacy survey tool; and ethics committee case consultation reports. Based on the structured debriefing sessions and videotaped standardized patient interactions, the study's author concluded that the standardized patient interactions provided the students with a more realistic, authentic experience that mirrors clinical reality and enhances the clinical credibility of ethics. As structured learning experiences, the standardized patient interactions gave students opportunities to grapple with uncertainty in the context of performance. (The bibliography lists 18 references. A self-efficacy precourse/postcourse survey tool is appended.) (MN)

Exploration of Critical Self-Reflection in the Teaching of Ethics: The Case of Physical Therapy

Gail M. Jensen, PhD, PT; Professor, Department of Physical Therapy; School of Pharmacy and Health Professions, Creighton University, Omaha, NE, 68178, gjensen@creighton.edu

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Courses in ethics or other areas of the humanities are present in health professions curricula but often the course content and learning experiences are seen by students to be in stark contrast to the intensity of the basic and clinical sciences. [1] Students quickly learn the lessons of the explicit and implicit curriculum – the strong focus on the "hard sciences" – the need to memorize and digest extensive amounts of information for academic survival often in striking contrast to more experiential and applied emphasis in the behavioral sciences. [2]

There is increasing discussion and call for an explicit focus on "professionalism" across the health professions as market forces continue to interfere with health care provider's obligations and responsibilities to serve the needs of patients and society. [3] Professionalism is seen as one of the key components linked to the continued movement in physical therapy education toward a doctoring profession. [4] Currently, 64 out of the 204 entry level educational programs in physical therapy award the doctor of physical therapy degree (DPT) upon completion. [5] In physical therapy there continues to be increased support and demand for curriculum focus on the moral and ethical development of students. [6] A proposed supplement to the American Physical Therapy Association's Normative Model of Physical Therapy Education focuses on professionalism and is grounded in these identified core values for the profession: accountability, altruism, compassion/caring, excellence, integrity, professional duty and social responsibility. [4]

Purtilo[7] recently called for the profession to do "ethical planting for future generations" and urged the profession to sow the seeds of care and accountability as the staple crops for preparing students to practice in an increasing complex health care system that is embedded in a shifting social landscape.

How do we best prepare students for meeting these challenges? How do we facilitate student awareness and insight into social, cultural, ethical and moral aspects of practice? Dewey[8] argued that "the object and reward of learning is continued capacity for growth and that students develop skills and habits of mind that will enhance their creativity and problem solving abilities with respect to the issues they are likely to meet. " The tools of ethics include developing "habits of thought" for reflection on complex, changing situations that are part of everyday practice. Facilitating reflective habits of the mind is a necessary, but difficult challenge in a professional education environment. [9]

Clinical simulations such as standardized patient encounters have been successfully used in medical education for teaching and evaluating students' clinical skills, interpersonal skills and clinical reasoning skills.[10] The use of standardized patients in physical therapy education is just emerging.[11,12] This project examines the effect of clinical simulations on student learning in the teaching of ethics in a physical therapy curriculum. The project is designed

using core concepts consistent with the scholarship of teaching and learning in an ongoing investigation of my own practice as a teacher. [13]

Framing the Question: My Personal Experience

Although I have been teaching in physical therapy education for over 20 years, my experience teaching ethics is more recent and well supported with the presence of a Center for Ethics and Health Policy on our campus. My colleague, Dr. Amy Haddad, a recent Carnegie scholar, has designed and implemented the use of standardized patients in the teaching of pharmacy ethics. She asked me if I was interested in trying something similar in physical therapy.

My ethics course has undergone continued revisions and re-design of learning experiences aimed at getting students engaged and committed to learning that appears to them to stand in strong contrast to the clinical science courses. Four years ago I implemented student-generated clinical case reports, an exercise in which they bring cases from their most recent clinical rotation and then use those cases for further analysis and development throughout the course. Last year I implemented ethics case consultations, where small groups of students discuss and analyze an ethics case, write counter case letters and write a final consultation report that applying ethical principles and consultation. While this learning experience brought active student involvement through the small group process, I had little insight into student thinking and reflections on how they arrived at their recommendations or proposed actions.

In the physical therapy program, we use a modified OSCE format to assess levels of student performance of clinical skills and safety measures prior to entry into clinical rotations. This examination occurs at the end of every semester of study, but has continued to emphasize performance of clinical science-based skills, while other aspects of clinical skills and interactions are not formally assessed.

I was particularly interested in finding out more about the experience of student learning in my teaching of ethics. I had been re-designing the course each year, integrating more interactive learning experiences, while student course evaluations expressed more interest and satisfaction with the course, I still had little insight into their understanding of ethics. I had the more traditional assessment of student learning, measures of what they know and apply through traditional testing, yet I still had little insight into student thinking about how they might actually analyze and address ethical situations. With the implementation of standardized patient learning experiences, I was interested in finding out more about assessment for student learning in the teaching of ethics. By that I mean finding out more about student understanding and application of the concepts,

principles and theories in the addressing ethical issues and resolution of real ethical situations.

The Context: Ethics course in Physical Therapy Education

The course is a three semester hour course in ethics, Ethics in Physical Therapy Practice. This course is part of an eight semester professional program that leads to a Doctor of Physical Therapy (DPT) degree upon completion. All health professions programs at Creighton University require a three hour course in ethics. This is consistent with the mission of Creighton University, a Jesuit institution, and School goals of preparing graduates who possess moral and ethical capabilities for the highest level of professional practice. Students are in the third year of the program and have participated in two, clinical experiences (total of seven weeks) prior to this term.

Method: Gathering the Evidence

Evidence for this case is from the experiences of 54 physical therapy students taking the ethics course during the 2001-2002 academic year. Data sources for the case include data gathered from students involved in the following: 1) two videotaped standardized patient (SP)interactions that center on ethical problems; 2) two post SP interaction de-briefing/self-reflection instruments; 3) student peer and self-assessments; 4) pre and post test scores on a self-efficacy survey tool; and 4) ethics committee case consultation reports.

A 12 item self-efficacy tool: This tool was developed by Larson and Haddad[14] and adapted for use with physical therapy students. Students indicate their perceived confidence from 0% (no confidence) to 100% total confidence on 12 items. The first five items address the overall course goals and the remaining 7 items address common ethical problems encountered in physical therapy practice. (appendix) Students were given this survey during the first class session and again during the last class session.

Standardized Patient (SP) Interactions: Two SP interactions were designed in consultation with a physical therapist working in rural practice. The blueprints for the two cases are grounded in actual practice experiences and modified for the SP process. The blueprints for the cases include: instructions for SPs, instructions for the student, peer and self assessment forms. There were two SP experiences, one takes place at the end of the fourth week of semester and the final experience at the end of week12.

Clinical Simulation #1: Beneficence and/or Patient Autonomy?

Bess/Ben Jones is an 82-year-old person who fell at home 8 months ago and fractured the right femur just above the knee. Because of a past medical history of osteoporosis, left hip fracture, diabetes, emphysema and congestive heart failure, the orthopedic surgeon felt at the time that surgery was to great of a risk to her/his life. The right leg was

set and placed in a long leg immobilizer. Bess/Ben received home health for 4 months and has received 2 weeks of outpatient with very little progress in gait, transfers, bed mobility, strength and range of motion partly because of a lack of cooperation. At the present time she has a daughter from out of state with whom she has lived since the injury, 2 sons and another daughter locally who refuse to let her move in with them. The out of state daughter would like to go home, but she knows that her parent is unable to care for her/him self. The family has asked you to meet with Bess/Ben to discuss further care options that will progress her/his Independence.

Clinical Simulation #2: Physician Locus of Authority Issue

Dale/Deb is a 34-year-old person who was diagnosed with a nonmalignant tumor in his/her cervical spine at the C7-T1 level five years ago. He/she underwent a radical procedure to remove the tumor, but part of it was embedded in the spinal cord and he/she was left with some significant neurological deficits. Dale/Deb underwent outpatient physical therapy in your clinic 2 weeks after the initial surgery. At the time that he/she presented, Dale/Deb was wheelchair bound and his/her greatest goals were to be able to transfer and dress independently. After physical therapy intervention 5 years ago, Dale/Deb surpassed everyone's greatest expectations and was ambulatory with a quad cane and independent with all activities including ADL's and transfers. You have kept in touch with Dale/Deb and the wife/husband over the years and have kept tabs on his/her abilities. You have also seen him/her gradually decline over the past year. He/she has changed physicians twice because of insurance and differing opinions. You feel along with that Dale/Deb would benefit from physical therapy intervention, but his/her physician feels differently.

Students were given the instructions about the SP 5 minutes before their scheduled time. They were allowed 15 minutes for the entire interaction which included 10 minutes for the interview and 5 minutes for feedback.

Post Interaction De-Briefing/Self Reflection questions:
After completion of the interview, students then went directly to the computer room to respond to a series of self-reflection questions. These questions included:

1. What was the CENTRAL ethical issue you encountered?
2. At the end of the interview, why did you choose the action you did?
3. If you were the therapist in this case - what would you DO NEXT?
4. What still confuses you about this case?
5. What did you LEARN about YOURSELF from doing this encounter? (what can you do now that perhaps you can do now?)

Peer and Self-Assessment Tools:
Students then in groups of 6, along with a faculty facilitator, reviewed their video tapes and filled out peer and self-assessment forms. The assessment instrument was a checklist form that identified the core ethical areas for the case as well as professional duties. A second simple metaphor exercise was also used after the initial SP session. Students responded to the question:

"Participating in a SP session is most like _____?"

Data Analysis/Reduction

An evaluative case study design was used to describe, interpret, and analyze the learning experiences of students. The case study data base was created using student responses to the post interaction de-briefing tool, peer and self-assessments, and review of student videotapes and papers. A qualitative software package (NVivo2.1) was used for the initial coding and data reduction process. Pre and post test self-efficacy data was analyzed using a paired t-test and SPSS software version 11.0 for windows.

Emerging Findings

Reflections on Student Learning

First Standardized Patient Interaction
The Question of Uncertainty and Confidence

The first SP case presents a very common dilemma for physical therapists, honoring patient autonomy when it may be in direct tension with promoting beneficence or good for the patient. One of key elements in the case centers on the issue of patient adherence or ability to follow through with exercise programs and safety concerns. One of the challenges for therapists is being present, respecting the patient, yet listening to the concerns of the patient and family, while working together toward a mutually acceptable solution.

Student responses and reflections centered around issues of uncertainty and confidence. The specific coding categories for student responses and reflections were: 1) Struggle, frustration, problem focus, personal insight; 2) Struggle, personal insight, respect for the patient, and 3) No struggle, confident, knows the solution.

Struggle - frustration -- problem focus -- personal insight.
The majority of student responses were in the category of the student struggle, frustration, problem focus, and personal insight. Here students acknowledge the struggle and uncertainty of the interaction with the "stranger," that is followed by their expressions of some frustration with their inability to "fix the problem" and then a reflective focus on self and need to improve their skills. Here is an example of this approach from Kate:

> Kate: The problem in this case was that the patient did not want to go to a nursing home yet she could not do her ADLs....she was non-compliant.....I really wanted to try to provide the patient with independence and give her an ultimate last chance but it didn't work. I feel I am getting better at trying to understand the patient's needs.. I need to look at the bigger picture.

Struggle -- personal insight -- respect for the patient
A smaller cohort of students (n=7) had evidence of recognizing the struggle and uncertainty of the case along with personal insight and then an ability to bring that insight together with ethical principles as seen here with Don.

> Don: Patient autonomy was the central issue in this case. Also as a PT I did not want to do harm to the patient or the family and wanted to help them. At first, I was going off of what the family was saying was true but then it might not mean that the patient wasn't telling the truth but maybe there was a lack of communication. I had to think on my feet and I learned to give the patient the benefit of the doubt and try to think of how we could get to the underlying problem. I feel like I was able to maintain respect for the patient.

No struggle - confident -- knows the solution/judgmental
Another small cohort of students (n=8) experienced no reported struggle, was not confused about the case at all, and were very confident in their ability to resolve the based on their judgment of what needed to be done.

> Chris: The patient had desires that were in direct conflict with her overall well being and health status... I simply told the patient that we were going on with the family conference where we could hear the concerns of all involved. I learned that I can deal with an ethical issue on the fly and do that without stumbling over my words or thoughts.

Most of the students expressed moderate anxiety in response to their first SP experience. In the metaphor exercise, student responses describing their experience varied from responses like: The experience was most like -- "being stuck in a revolving door" or "having a root canal" to "being put on the spot and having to deal with it" or "a play performance without lines" to the experience seemed like "a real life patient interaction."

Second Standardized Patient Interaction
Emerging levels of confidence and humility: Students moving in difference directions

The second SP case, which occurred during week twelve of the semester, focused on another common ethical dilemma for physical therapists, a locus of authority issue, where the authority issue and tension lie between the recommendations of the therapist and the physician. Here student responses and reflections demonstrated strong evidence that they could identify the core ethical principles involved in this case.

Analysis of students' reflective, self-assessments on this second case revealed again, variation on perspectives of confidence with these four broad coding categories: 1) Emerging self-confidence, enhanced awareness; 2) Self-

confidence leading to negotiation and compromise; 3) Over confidence/arrogance leading to conflict; and 4) Critical reflection, humility on performance.

Emerging Confidence --- enhanced awareness

The greatest majority of student responses clustered in the category of emerging confidence and enhanced awareness. Here students acknowledged that listening and identifying the other person' s viewpoint turned out to be an effective tool. This led to discussion and negotiation with the physician, but with the caveat that they felt somewhat intimated and most expressed need to be more assertive. Here are examples from John and Marie:

> John: I learned that by listening and identifying with the other person's viewpoint, more can get accomplished than if you just try to push your opinion across.
>
> Marie: I learned I am able to stand up for a patient and gain a direct answer from a physician. I am also able to compromise and set up a situation so that both the physician and I are able to do what it best...I gained more confidence in myself because when talking to the physician - this is one group that still intimidates me.

Self-confidence leading to advocacy and resolution:

For a smaller number of students (n=5), they were self-confident, assertive and able to advocate for their patients as seen here in cases of Beth and Cliff.

> Beth: I learned it was very easy for me to be an advocate for my patient and to respect the confidence of a doctor in their decision making at the same time. I felt it was easy for me to diffuse the situation so that all parties would benefit.
>
> Cliff: The main thing I learned about myself is that I am getting into that mode where I seek to find the best possible solutions for my patients first and others second.

Over confidence leading to conflict

A few students confidently and strongly asserted themselves only to find themselves in more conflict with the physician.

> Ann: It is easy to make someone angry when you seem to be stepping on their toes! I react to denial of services with anger, but this will only throw fuel on the fire.
>
> Kim: I felt the MD felt the patient was his sole property and not acting in the patient's best interest and in this PT's opinion cause the patient more harm and longer recovery.

Critical reflection -- Humility

For another small cohort of students as they reflected on the second experience it was in direct comparison to their first experience, with some evidence of humility and critical self-reflection.

> Joe: I still get a bit too confrontational when I see my point and no one else's. That happened in the first case too. I need to calm down a bit and compromise. That would be a good thing to work on in my life and career.
>
> Deb: I learned something very important through this encounter, the power of listening. In my last interactions, I did very little listening and this put me a poor position to decide what was best for the patient. By making sure I listened this time I gained a lot more from the experience.

Summative Impressions

Students final narrative self-assessments demonstrated that they are more confident in their ability to identify ethical issues, they have greater insight into their communication skills, and are eager to apply these skills in clinical practice.

> Beth: I believe I learned a great deal about myself during these experiences. I found some areas of weakness that I can address, as well as some strengths I can continue to enhance. I have also seen myself grow from the first interaction to the second.
>
> Ron: I have a greater understanding of how to identify, analyze and deal with ethical issues in the clinic. I still have room for improvement in my communication skills and hope that will come with experience.
>
> Jill: This course has been a launching pad for me in a couple of ways. First of all the tools we have used to identify ethical issues and initiate a course of action will continue to be invaluable. I feel I have always intended to be a person of high moral integrity but not been able to act on my convictions. I feel I have a better grasp on defining where I stand in practice and become an effective advocate for my patients and myself.

Student scores on the *Self-Efficacy Survey* demonstrated a statistically significant difference on every item of the self-efficacy survey between beginning and end of the course assessments. The range of mean scores for self-efficacy items on the survey was (43 to 74) for the pre course assessment and (79 to 88) on the post course survey. Those items that demonstrated the greatest change were the questions that focused on analysis and resolution of ethical problems using application of theories and principles:

Q 4:With adequate information, how confident are you that you could propose a justifiable solution to an ethical problem in clinical practice?

Q 5: How confident are you that you could accurately use ethical principles and theories to support a specific resolution to an ethical problem?

The item with the highest mean scores was Q1: How confident are you that you could identify an ethical problem in a written case study. There was no significant difference found between male (n=20) and female (n=34) responses.

Over the course of the semester, students demonstrated increased competence in their ability to apply ethical concepts and principles to paper cases. This was evident in the written ethics committee consultation reports that required connections of ethical principles and theory in the analysis of the case and in support of committee recommendations.

Broader Significance: Reflections on the Teaching of Ethics

The broader significance of this project has to do with me, the teacher, and my reflections on what I am learning about students learning in the teaching of ethics.

Facilitating Learning: Insights into Authenticity, Reflection and Transformative Learning

Prior to the implementation of the first standardized patient activity, I had expected that the "richest data" from students would be generated from the small group de-briefing sessions where students were in groups of 6 with a faculty facilitator but I was wrong. I found that most of the time in the small group de-briefings was spent on observing the video tapes and filling out forms. The students looked to the faculty member for the answers versus generating their own discussion. I then found in reading student de-briefing responses done immediately after the session that I had for perhaps for the first time in my teaching career insight into students thinking/reflecting on their actions. Here is what I recorded in my field diary kept throughout the course.

> I was on a plane returning from Boston and was thoroughly engaged in readings these de-briefing papers and writing multiple comments. Funny - it was not the drudgery that I often feel in how many more papers do I have to read. In fact, the man sitting next to me - said you know you should be reading a book not grading papers. I said - well interesting - in that this happens to be really fun and very exciting for me.

Although I have spent the last 15 years priding myself in the role of advocate for promoting methods of facilitating reflection in my students, this became a critical incident for me. I will never forget that moment of my own personal insight as I

realized that I had a deeper understanding of what students were actually thinking.

For the students, I believe the standardized patient interaction provides a more realistic, authentic experience that mirrors clinical reality. For physical therapy students, I believe this kind of experience enhances the *clinical credibility* of ethics. The experience also places a different emphasis on ethical case analysis that goes beyond analysis of a paper case or discussion of media clip. Students in the SP experience are at the center of the action/interaction as part of a "lived experience." The structured de-briefing questions students responded to immediately after the interaction, appear to facilitate further student reflection on the SP process and provided me with insight into their reflective process.

While there is evidence of student reflection, do we have evidence of critical self-reflection and transformative learning? Transformative learning occurs when there is critical self-reflection. Mentkowski and colleagues[15] propose a theoretical model for transformative learning. The model identifies four domains of growth for learners: reasoning, performance, self-reflection and development. (Figure) The north-south dimension of the model refers to the direction of attentional focus which goes from a focus on internal world of self to a focus on external world and need for competence. The east - west dimensions of the model moves from a focus on self and the structure of a person to a becoming more contextualized with an emphasis on performance and self-reflection.

In professional education we have significant emphasis on the external dimension of competence and the domains of **reasoning** and **performance.** Most professional curricula spend extensive time and energy on development of students' declarative knowledge, clinical reasoning skills, and competent performance. Successful learners, however, must develop a meaningful view of self as a foundation for competent reasoning and performance. This is done through continued growth in the domains of **development** and **self-reflection**.

The standardized patient interactions, as structured learning experiences, provide students with opportunities to grapple with uncertainty in the context of performance. In addition, structured assessment activities provide a framework for reflections on self and reflections on self as a professional. In this case study, students did focus on self with emerging and varying levels confidence and critical self-reflection.

Do we have evidence of mindfulness? Epstein[16] believes that the presence of critical self-reflection depends on the presence of mindfulness. In this case, there is evidence that students who are quick to solve the "the ethical issue or see it as a problem to fix" – often end up judging the patient, with little or not evidence of self-monitoring and evidence of potentially unmindful practice. For some students, there strong "talking" skills and ease conversing with patients was a potential barrier for critical self-reflections. For the majority of students, the focus remains on self-insight and awareness.

Implications for Teaching Ethics: Reflection on Pedagogical Content Knowledge

This case is also about exploring and learning more about pedagogical content knowledge.[17] Shulman[18] first described this form of content knowledge –

> ...embodies the aspects content most germane to its teachability....the ways of formulating and representing the subject to make it comprehensible to others.....the conceptions and preconceptions that students of different ages and backgrounds bring with them to the learning.[18,p114]

Identifying and describing the pedagogical content knowledge of the teaching of ethics in professional programs has to do with questions about student learning and understanding. What are the most useful "forms of representation" of ethical ideas? What elements are most likely to facilitates student understanding and application of core ethical concepts in actual practice? Does the use of standardized patients in the teaching of ethics help "cultivate" students ability to be mindful?

In closing, I believe this ongoing investigation and case formulation is raising more questions for me about my teaching and student. For me, this seems like the beginning of a very long conversation about the teaching of ethics. I look forward to that conversation....

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Self Efficacy Pre and Post Course Survey Tool

Directions: Please rate how confident you are to perform the following tasks by circling the appropriate number – from 0% indicating no confidence to 100% indicating total confidence.

1. How confident are you that you could identify an ethical problem in a written case study?
   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

2. How confident are you that you could identify an ethical problem in an actual clinical setting such as a hospital, outpatient clinic, or rehabilitation center?
   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

3. In analyzing a patient problem, how confident are you that you could differentiate between an ethical problem or other kinds of problems such as miscommunication?
   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

4. With adequate information, how confident are you that you could propose a justifiable resolution to an ethical problem in clinical practice?
   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

5. How confident are you that you could accurately use ethical principles and theories to support a specific resolution to an ethical problem?
   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

6. Assume that you are in a clinical position and corporate facility where you find out that you must continue physical therapy interventions (treatment) and billing with patients after you believe they have reached their goals. How confident are you that you could resolve this ethical problem?
   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

7. Assume that you are in a face-to-face interaction with a physical therapy peer whom you suspect has a substance abuse problem. How confident are you that you could resolve this ethical problem?
   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

8. Assume that you are in a face-to-face interaction with a health professional with whom you disagree about end-of-life care for one of your patients. How confident are you that you could resolve this ethical problem?
   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

9. Assume that you are in a face-to-face interaction with a patient who has been told by the physician that he has a shoulder problem and upon examination and evaluation you find that the patient has a primary cervical problem referring pain into the shoulder. How confident are you that you could resolve this ethical problem?
   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

10. Assume that you are in a face-to-face interaction with a patient who does not adhere with your prescribed exercise regimen and you believe is ready to return to work, yet the patient appears to be malingering. How confident are you that you could resolve this ethical problem?
    0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

11. Assume that you are in a face-to-face interaction with a physical therapist who does very poor documentation often late and sometimes is unable to accurately record what actually happened during the treatment session. How confident are you that you could resolve this ethical problem?
    0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

12. Assume that you are in a face-to-face interaction with a patient who is not safe to perform independent ambulation and return to home alone yet insistent upon making her own decision. How confident are you that you could resolve this ethical problem?
    0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

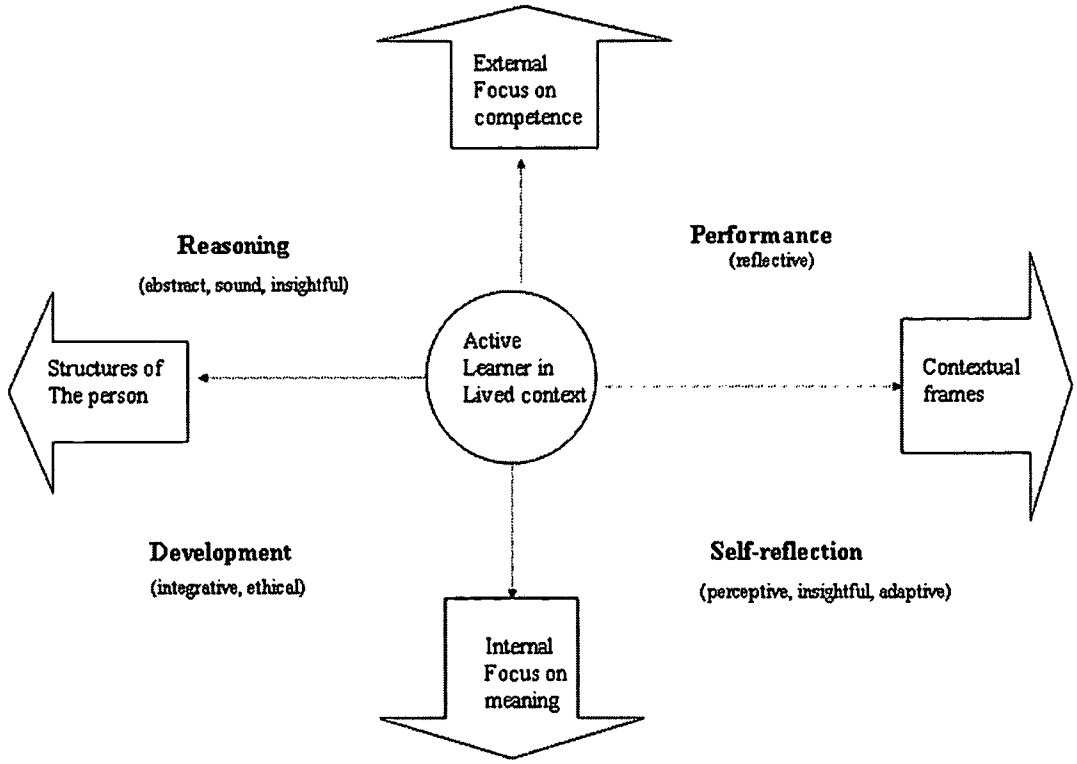

Figure. Model of transformative learning. Adapted from Mentkowski and associates[15]

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Author(s): Gail M. Jensen	
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Signature:	Printed Name/Position/Title: Gail M. Jensen, PhD, Professor
Organization/Address: Dept of Physical Therapy, 2500 California Plaza, Creighton University, Omaha, NE 68178	Telephone: (402) 280-3727 FAX: (402) 280-5602
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