Perhaps these principles can explain what the doctors described in Van Norman's article were doing when they were breaking the rules about brain death. The conventional criteria that define brain death are not obscure; therefore, it is doubtful that the practitioners who falsely declared the patients dead were unaware. It would be unreasonable to view these two cases as simple errors and unwarranted to view them as intentionally criminal. What must have happened is that the bending of the clear rules was regarded as justifiable because of a consequentialist argument: "the ends justify the means," "no one is really hurt and lives might be saved," or "if this were my family I would want a dying and nearly dead person to be used to save a salvageable life." Here we see a direct conflict between the rules and the consequences in which physicians, imbued with a consequentialist ethic, followed a path that may break the rules but may save a life.

Obviously, the implications of these cases are more complicated than a simple consequentialist argument can resolve. Analyses of these complications may also differ because each individual has his or her own accepted moral standard. Some people may view an approach based solely on rules as complete and incontrovertible. This view is not very open to argument and is often justified by reference to religion. Within such a rule-based argument, there is no moral defense for the actions reported by Van Norman. Others of us may have scant sympathy for the outcome, may recognize the personal legal risk such rule-breaking might expose, and may avoid the act as unwise, but without significant moral overtones. Even a consequentialist might not accept the rule-breaking here as wise. For if it became known that the safeguards regarding brain death and transplantation were not inviolate, then other patients and families would avoid consenting to organ donation. So for the consequentialist concerned primarily with the long-term ends, the untoward consequence of fewer organs overall, which would affect many patients, would outweigh any benefit to the few recipients of the organs taken by violating the rules.

The cases described by Van Norman defied the accepted rules, could have bad societal consequences, and violated our medical traditions. To me that means that those actions were unethical. Yet I suspect that we all have some bit of sympathy for an outcome wherein no one is hurt and a life is saved. It may be that only by recognizing the conflict among rules, consequences, empathy, and tradition can we understand how to apply the principles of autonomy, beneficence, and justice so carefully presented by Van Norman.

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Oral Practice Examinations

Are They Worth It?

MODERN day society increasingly demands affirmation that physicians are capable medical practitioners. The public, health maintenance organizations, hospital credential committees, state licensing boards, group practices, and other organizations insist on competence, accountability, initial and maintained specialty board certification, continuing education, and so on. Graduate medical education programs have a major responsibility to assess the competence of their residents. Through appropriate and careful faculty evaluation of resident performance, these programs may have the best opportunity during a physician's entire professional life to assess competence. Unfortunately, relatively little effort has been made to determine the best methods for such assessment. The article by Schubert *et*

al.[1] in this issue of ANESTHESIOLOGY is a major contribution in this area. This lengthy article is not particularly easy to read and at times requires wrestling with a "foreign language" because of the considerable volume of technical detail, unfamiliar terminology, and statistical analysis. Nevertheless, it contains a great deal of valuable information. The article reports on a 5-yr period, 1989–1993, during which 190 residents participated in 411 oral practice examinations (OPEs). The authors then examined the reliability and validity of mock oral examinations as an indicator of the progress residents have made toward achieving the ability to practice medicine independently.

OPEs serve many purposes. They can facilitate education by stimulating residents to read, ask questions, and seek broad clinical experience. Residents and junior faculty preparing for the oral examination of the American Board of Anesthesiology find it stressful to be examined by individuals with whom they currently associate, hence the added motivation to study to avoid embarrassment. OPEs help to prepare individuals for "the real thing" and may reduce stress by familiarizing those taking the examination with the general setting and format of oral examinations and by providing coaching on how to improve communication skills, effectively present ideas and opinions, organize thought processes and answers, and portray confidence *via* body posture and eye contact. Mock oral examinations may also provide a valid mechanism to help assess a resident's progress in the program and overall competence when used in conjunction with assessment by faculty in the clinical setting, patient outcome, and performance on in-training examinations.

As presented in the article by Schubert *et al.*, the OPE differs in several ways from the examination of the American Board of Anesthesiology (ABA). The authors used the format employed by the ABA before 1997. The new ABA examination places more emphasis on perioperative medicine, especially the postoperative period, which could be completely ignored and thereby omitted in the old format. This difference does not detract from the effort Schubert *et al.* make to validate their own OPE with regard to evaluating resident performance. Clearly, a greater possibility for a "halo effect" exists when faculty who know the candidates conduct the examinations. Associate examiners in the ABA system have no knowledge of a candidate's place of training, practice type or location, performance as a resident, previous evaluations, or personality. Schubert *et al.* provide some reassurance that familiarity with the candidates did not significantly affect the results by finding "acceptable agreement" between live and taped overall numerical scores and pass–fail scores. The ABA does not use the overall numerical scores, a process whereby each subquestion receives equal weight. The ABA system weights each subquestion on the basis of the examiner's judgment of its importance and the time devoted to the subquestion. The scoring system used by Schubert *et al.* could produce different pass–fail results on identical examinations, but it is unlikely to have altered the conclusions of this study. Although some faculty members at the Cleveland Clinic serve as associate examiners for the ABA's oral examinations, other faculty who are less familiar with oral examinations also participate. Although the inter-rater reliability results fail to show significant differences in scoring between examiners, possible differences between examiners in how the examination is conducted were not addressed. All ABA associate examiners attend orientation sessions and workshops specifically directed toward different levels of examiner experience each time they participate in the oral examination. This process of continuing education for associate examiners influences examination style, the effectiveness of questions asked, grading, and so on.

Practice oral examinations require considerable time, effort, and expense for the programs that conduct them. Are OPEs really worth it? Schubert *et al.* examined 5 years' experience with OPEs and their reliability, consistency, and validity at the Cleveland Clinic. The results provide convincing evidence of success by demonstrating substantial internal consistency and reliability. The positive correlation of OPE scores at their institution with in-training examination scores, faculty evaluations, and other indicators of resident preparedness seem to affirm that OPEs can represent a reasonably valid tool for assessing resident performance.

Teaching programs must work to improve the education provided to residents in anesthesiology. Examining our methods of teaching is an important part of improving residency training and the physicians educated in them. So often we assume that what we do has value. Many programs conduct OPEs year after year without

This Editorial View accompanies the following article: Schubert A, Tetzlaff JE, Tan M, Ryckman JV, Mascha E: Consistency, inter-rater reliability, and validity of 441 consecutive mock oral examinations in anesthesiology: Implications for use as a tool for assessment of residents. ANESTHESIOLOGY 1999; 91:288–98.

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carefully investigating their efficacy. I commend the authors for studying their own OPE process and demonstrating that OPEs can serve effectively as one measure of the resident's progress toward independent practice and specialty board certification.

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Clinical Concepts and Commentary

IN THIS issue of ANESTHESIOLOGY we initiate a new section: Clinical Concepts and Commentary. This section originated with a suggestion made by one of the journal's Editors, Dr. Alex Evers. His concept was enthusiastically and unanimously supported by the Editorial Board because it offered an opportunity to further "reach out" to a segment of our readership that on occasion perceives that its needs are insufficiently addressed. Our intent is to publish brief (2-4 pages) reviews and commentary focused on clinical topics that (1) are novel or do not lend themselves to a more lengthy review; (2) require more rapid dissemination than afforded by the usual medical intelligence or review article; or (3) are controversial. In all cases, the goal of the section is to inform and aid the clinician in a succinct, authoritative manner. As the section title implies, the articles will offer not only syntheses of available information (and indicate where data are lacking), but also provide a forum for the presentation of authors' opinions.

The section will contain an additional new feature: color illustrations, which will also be available for downloading from the ANESTHESIOLOGY web site (www.anesthesiology.org). It is hoped that these illustrations will be used subsequently in many presentations. We specifically encourage such use.

We begin this new endeavor with a contribution from an Editor, Dr. James Eisenach, on the use of combined spinal and epidural analgesia in obstetrics,[1] a relatively recent technique that is somewhat controversial. Among other articles scheduled to appear in the Clinical Concepts and Commentary section are reviews of the clinical implications of the American Society of Anesthesiologists Closed Claims Project; a series on myocardial ischemia: preoperative assessment, intraoperative detection, and perioperative prevention and treatment; and transfusion-related immunomodulation. Thus far, the Editorial Board has selected the topics and authors. With the initial article now in print, we anticipate the receipt of unsolicited articles. We welcome not only articles, but also suggestions by the readership for future topics. Because we plan to publish one article each month, not all suggestions or submitted articles can be accommodated.

The process for submission, peer review, and the standards for these articles will be identical to that for other manuscripts published in ANESTHESIOLOGY, except that the manuscripts should be submitted to Dr. Richard Weiskopf, the Section Editor, and they will be screened for suitability of subject matter. Authors contemplating writing an article for this section are encouraged to contact

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