

TEACHING AND ASSESSING *Professionalism:*



A PROGRAM DIRECTOR'S GUIDE



The American Board of Pediatrics
and
The Association of Pediatric Program Directors



Supported by the ABP Foundation

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Professionalism:

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PREFACE

Successful projects have certain elements in common: commitment, consensus, and creative leadership. The *Teaching and Assessing Professionalism: A Program Director's Guide* has been enriched by all three of these important characteristics.

Commitment for the project was first voiced by the Program Directors Committee of the American Board of Pediatrics (ABP), whose members felt that the concept of assisting program directors in teaching and assessing professionalism was a necessary and positive goal, and they have encouraged and worked on the process all along its path. The commitment of Gail A. McGuinness, MD, Executive Vice President of the American Board of Pediatrics, and James A. Stockman III, MD, President of the American Board of Pediatrics, has been sincere and unflinching. The American Board of Pediatrics Foundation also supported the effort by sponsoring a conference that was critical to advancing the project.

Success in achieving the critical element of consensus came from the Association of Pediatric Program Directors (APPD) and in particular from the work of Robert McGregor, MD, the APPD President. The APPD and ABP cosponsored a consensus conference that was held in February 2007 in order to bring interested parties from the APPD, American Academy of Pediatrics Resident Section, American Medical Association, and ABP Ethics Committee together. We profited from the expertise of four invited experts - Janet P. Hafler, EdD; Matthew Holtman, PhD; Patricia S. O'Sullivan, EdD; and David T. Stern, MD, PhD - who helped to define and refine the working document. Consensus came with further editing of this manual. The other consensus conference attendees included John T. Co, MD; Rachel Dawkins, MD; John G. Frohna, MD; Joseph Gilhooly, MD; Jacqueline J. Glover, PhD; Ann P. Guillot, MD; Alexander M. Holston, MD; Ernest F. Krug III, MD; Stephen Ludwig, MD; Robert S. McGregor, MD; Gail A. McGuinness, MD; Julia A. McMillan, MD; Leslie K. Mihalov, MD; Theodore C. Sectish, MD; Modena E. Wilson, MD; and Edwin L. Zalneraitis, MD.

Creative leadership was the final key component, and credit for this rests squarely with John Frohna, MD, who championed the effort and always found ways to bring the people, their ideas, and their interests together. John took on the role of senior editor but provided far more than the usual editor's title implies. He was the team quarterback and project cheerleader all in one. We are all truly indebted to John for his stewardship.

Final thanks must be expressed to all of the project members who wrote and rewrote chapters and expressed their ideas freely and elegantly. Our sincere thanks also to Pam Moore of the ABP staff, who held us all together with her skills and her everpresent smile, and to Phil Sweigart, the ABP Editor.

We hope the users of the guide will find it helpful in rekindling the flame of professionalism in trainees and faculty alike. It is a flame that is at the core of our work on behalf of children and their families.

Stephen Ludwig, MD
Chair, Program Directors Committee
American Board of Pediatrics

Chapter 1

Promoting Professionalism: An Introduction

Professionalism is an essential element of being a good pediatrician. This has been confirmed by the American Association of Medical Colleges for medical students, by the Accreditation Council for Graduate Medical Education (ACGME) for residents, and by the American Academy of Pediatrics (AAP) and the American Board of Pediatrics (ABP) for pediatricians.

There are many definitions of professionalism. For our purposes, we will use Stern's definition as highlighted in his book *Measuring Medical Professionalism*: "Professionalism is demonstrated through a foundation of clinical competence, communication skills, and ethical understanding, upon which is built the aspiration to and wise application of the principles of professionalism: excellence, humanism, accountability, and altruism."¹ This definition emphasizes the fact that professionalism is a behavior that must be demonstrated.

Purpose of This Workbook

Each year, program directors are asked by the American Board of Pediatrics to determine whether each resident in their program has met expectations in the area of professional conduct. In addition, the program director must certify that the resident has achieved competence in professionalism at the end of training in order for the resident to be eligible to take the certifying examination.

This workbook was created through a joint effort of the Association of Pediatric Program Directors and the Program Directors Committee of the American Board of Pediatrics in order to help program directors answer three questions:

- What are the important elements of professionalism?
- How can expectations regarding professional conduct be communicated to pediatric residents?
- What methods are appropriate for assessing professionalism during residency training?

This workbook lays out the dimensions of professionalism in pediatrics and provides suggested methods for teaching and assessing professionalism among pediatric trainees. The first five chapters outline aspects of professionalism as seen from different perspectives. In developing this workbook, we have attempted to follow the model described by Stern: "setting expectations, providing experiences, and evaluating outcomes."²

Setting Expectations

Setting expectations about professionalism begins at the institutional level - it must be part of the core values, part of the culture in which residents work. Numerous publications address elements of professionalism and how they should be taught and assessed. Perhaps the most important document that can be used to set expectations is *Medical Professionalism in the New Millennium: A Physician Charter*, initially published in 2002 and hereafter referred to as the *Physician Charter*.³ This document outlines three fundamental principles and ten professional responsibilities.

The three principles are:

Principle of primacy of patient welfare

This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician-patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.

Principle of patient autonomy

Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care.

Principle of social justice

The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.³

The ten professional responsibilities are:

- Commitment to professional competence
- Commitment to honesty with patients
- Commitment to patient confidentiality
- Commitment to maintaining appropriate relationships with patients
- Commitment to improving quality of care
- Commitment to improving access to care
- Commitment to a just distribution of finite resources
- Commitment to scientific knowledge
- Commitment to maintaining trust by managing conflicts of interest
- Commitment to professional responsibilities

These responsibilities are incorporated into the subsequent chapters of this workbook. Each chapter then provides specific examples of behaviors that exemplify professional conduct and those that demonstrate lapses in professionalism. We have adapted many of these behavioral statements from The Royal College of Paediatrics and Child Health document *Good Medical Practice in Paediatrics and Child Health: Duties and Responsibilities of Paediatricians*.⁴

Providing Experiences

Residents confront situations that challenge their professionalism on a daily basis, but they may need assistance to recognize the nuances of professionalism. Most faculty members consistently exhibit professional behaviors in their care of patients, but faculty development efforts may be required to highlight the varied components of professionalism.

In this workbook, we provide a number of suggestions for ways to teach professionalism. Formal opportunities for learning may occur in community-based rotations, in international rotations, during teaching rounds on the inpatient service, or with a skilled, experienced outpatient clinician. Other formal learning can take place in conferences, some of which may focus explicitly on professionalism issues (like those outlined in this workbook) and others that may incorporate aspects of professionalism, such as a mortality and morbidity conference. Each chapter has a series of vignettes, reflective exercises, and short cases that can be used in a noon conference or small group setting to stimulate discussion about professionalism. Program directors are encouraged to modify the cases to make them more applicable to a local setting.

One important consideration: educational opportunities must allow time for reflection. Faculty and residents need to gain additional experience in observing and reflecting on their own and others' behavior. Residents should be encouraged to share their stories during all teaching sessions. Although this is true for all aspects of learning, it is particularly crucial for advancing professionalism within a residency program.

Evaluating Outcomes

Program directors need to be able to document that residents are achieving competency in professionalism. Assessment measures ought to be valid and reliable. Fortunately, there are an increasing number of tools that can be used to assess professionalism. The use of critical incidents, peer assessment, patient assessment, and multisource feedback instruments (separately or combined into a portfolio) have enhanced the ability to assess professionalism. In the final chapter of this workbook, we discuss several of the more promising assessment methods and provide suggestions on the best ways to implement these in a residency program. The goal should be to include many perspectives on residents' professional conduct in the assessment. As with all competency assessments, evaluations collected by multiple evaluators over

time will provide a more complete appraisal of an individual.

Implementing a Professionalism Curriculum

Our hope is that program directors will use this workbook to help create and reinforce the culture of professionalism within the program. It may be helpful to set explicit expectations regarding professional conduct early in the intern year, using the topics covered in this workbook. Some program directors have used the orientation period to begin discussing professionalism and even helping residents to develop their own “code of conduct.” As the year progresses, discussions of issues such as teamwork, documentation practices (eg, procedure logs, completing evaluations, patient charting), and morbidity and mortality conferences can highlight professional behavior. Each of the chapters in this workbook could also be used as a foundation for a noon conference.

Beyond formal teaching about professionalism, it is clear that much of what is learned during medical training comes from the “hidden” curriculum, which Hafferty defines as the lessons that come from the structure, process, and content of the educational experience itself, including the organizational culture of the institution.⁵ Professionalism is taught in the middle of the night or in a passing interaction between hospital staff members. The culture of the institution and department can significantly influence professional behavior. Thus, it is critical for program directors to devote as much attention to the hidden curriculum as they do to shaping the formal curriculum.

Along the way, program directors are likely to detect lapses in the professional conduct of residents. “Lapse” is the preferred term for most professionalism issues for several reasons. First, it is generally recognized that professionalism is a characteristic of a behavior, not of the individual. Second, lapses in professional behavior occur in a context and often arise as a result of a conflict between two competing values.⁶ When lapses are identified, the appropriate faculty member or program director should bring these to the resident’s

attention. After discussion of the event, the resident should be given a clear description of the behavior in question and expectations for future professional conduct. This discussion should be documented in the resident’s folder. The resident should leave the discussion with the understanding that repeated lapses in professional conduct will be considered unacceptable. Further guidance for addressing serious professionalism problems is provided in Chapter 7.

Most residents come to their training with a general understanding of professional conduct, but they are unlikely to have been challenged with the stresses and competing priorities they will face during residency. This workbook acknowledges that professionalism, like many other aspects of residency training, is a developmental process. We are challenged to do more than simply identify egregious behavior. Rather, we must promote professionalism through the identification of professionalism lapses and the reinforcement of behaviors that distinguish professional conduct in all aspects of work and life during residency.

Professionalism must be incorporated in all aspects of our work as pediatricians. Demonstrating that we are competent in this essential domain is required during residency, must be documented at the time of initial Board certification, and is assessed as part of the ongoing maintenance of certification. We hope this workbook will be a useful resource for program directors, educators, and residents who are teaching and assessing professionalism.



“Educational opportunities must allow time for reflection...
it is particularly crucial for advancing professionalism.”

Chapter 2

Professionalism in Patient Care

Patient care is the core physician activity. Providing patient care with an understanding of professional responsibility and demeanor is at the heart of what is understood by both the public and other physicians to characterize the “good doctor.” Every medical student, resident, colleague, and patient can provide examples of physicians they admire because of the care they provide and their manner as they provide that care. Individual components of professionalism in clinical care, however, often are not identified. “Bedside manner” - the way a physician identifies with, converses with, and empathizes with a patient and the patient’s family - is important. But an empathetic, caring relationship is not enough. A physician who is loved by patients but who provides care based on unproven, anecdotal information is not providing professional clinical care. Similarly, the physician whose management decisions are based on the most recent, evidence-based information is not providing professional care if that care is not documented legibly or confidentiality of patient information is not respected.

The specific goals of this chapter are to describe the professional responsibilities of physicians regarding the medical care they provide for their patients, to provide examples of professional behavior and of lapses in professional conduct, and to suggest some exercises that can be used in discussions with residents about the many aspects of professionalism that are involved in everyday clinical care.

The following components from the *Physician Charter* relate to professionalism in clinical care:

- *Commitment to professional competence*
Achieving and maintaining competence involves commitment to lifelong learning and to maintaining clinical and team skills in the care of patients. Professionalism is one of the six core competencies defined by the Accreditation Council for Graduate Medical Educa-

tion and the American Board of Medical Specialties, but it is important to recognize that deficits in any of the other five competencies (patient care, medical knowledge, practice-based learning, interpersonal and communication skills, and systems-based practice) reflect a lack of professional commitment.

- *Commitment to honesty with patients*
Honesty with patients and their families includes not only informing them honestly about their condition (or their child’s condition) and the treatment you recommend, but also informing them honestly about adverse reactions to that treatment and about medical errors, whether or not those errors result in actual harm.
- *Commitment to patient confidentiality*
Trust and confidence of patients and families depend upon their knowledge that the physician will safeguard patient information. Confidentiality is particularly important, although it is sometimes more difficult to maintain, in the setting of electronic patient records and reporting systems. Although confidentiality must sometimes yield to overriding considerations of public welfare (eg, when harm may come to the patient or others), the patient and/or family should be informed of the intention to divulge clinical findings to appropriate authorities.
- *Commitment to maintaining appropriate relations with patients*
Appropriate emotional, physical, and financial boundaries should be maintained between the physician and his/her patients and their families. Patients and families are dependent upon the knowledge and decision-making of the physician. Their vulnerability and dependence should not be exploited.

- *Commitment to improving quality of care*
Continuous improvement of care involves not only ongoing, informed review of the medical literature and maintenance of clinical competence, but also working with colleagues, health care systems, and other professionals to improve patient safety, reduce medical errors, improve accessibility and efficiency of care, minimize overutilization and underutilization of medical resources, and improve health outcomes.

Behavioral Statements

The components of professionalism in patient care listed above provide general goals. In discussions with residents, it may be helpful to identify specific behaviors or practices that exemplify professionalism in this domain and some that would represent lapses of professionalism.

Examples of Exemplary Professional Conduct

- Demonstrates reliability, responsibility, and respect for patients and families, including appropriate verbal and nonverbal communication
- Optimizes comfort and privacy of patients when performing a history, physical exam, and procedures
- Maintains comprehensive, timely, legible medical records and correspondence
- Communicates collaboratively with colleagues and all health care providers, patients, and families to provide the best care for each patient
- Provides culturally sensitive care for all patients
- Recognizes potential conflicts between individuals, develops strategies for resolution, and advocates for patients
- Recognizes limitations of training and experience and seeks help appropriately
- Maintains patient confidentiality, especially in public areas
- Accesses available information to support clinical decision-making
- Demonstrates commitment to ongoing professional development through attendance at conferences and consulting medical literature
- Applies knowledge with attention to clinical outcome, cost effectiveness, risk-benefit, and patient/family preferences
- Responds to constructive feedback by improving behavior and/or skills
- Acknowledges errors in medical care; discloses them to colleagues, affected (or potentially affected) patients, and responsible authorities; and takes steps to prevent future errors
- Demonstrates appropriate boundaries for patient relationships

Examples of Lapses in Professional Conduct

- Provides unsupervised care of an infant, child, or adolescent without previous experience or training in the appropriate skills
- Excludes parents or other caretakers from involvement in management of their child's illness when there is no valid reason for doing so
- Provides treatment that is inconsistent with best practice or evidence without justification
- Documents information that does not accurately describe the patient's condition or the care provided
- Fails to ensure that patient records are legible
- Fails to consult a supervisor or a clinician who is more experienced in caring for the problems being confronted
- Provides preferential treatment of patients or families to the detriment of others, based upon considerations other than clinical need and available treatment
- Fails to recognize and apologize for discourtesy or for errors in treatment or judgment
- Fails to respond to a request by the family or by other professionals (nurse, social worker, physician colleague) to provide care for a patient for whom he/she is responsible

Behaviors That Warrant Immediate Intervention

- Exhibits repeated behaviors that exemplify lapses in professional conduct, such as those described above, despite feedback
- Willfully misrepresents clinical data in communication with other health care providers
- Willfully fails to ensure appropriate transfer of patient information such that patient welfare is put at risk
- Provides clinical care under the influence of alcohol or other intoxicant
- Becomes involved in illegal activities
- Participates in physical or verbal abuse toward colleagues, staff, patients, or family members
- Engages in sexual misconduct or violates appropriate physician-patient boundaries

Teaching Professionalism

Learning Objectives for the Residents

- Residents will be able to identify instances when personal circumstances can be at odds with professional values.
- Residents will be able to describe their own understanding of their professional responsibilities toward patients, families, and colleagues.
- Residents will begin to describe how their expectations and behaviors can serve as a model for colleagues.
- Residents will demonstrate, through discussion, that they appreciate that professionalism involves a wide array of responsibilities to themselves, their colleagues, their patients, their institution, and society.
- Residents will describe that professionalism is a set of skills that develop over the course of time/practice.

Teaching Strategies

Reflective Exercises

These reflective exercises can be used for individual reflection on professionalism issues or can be modified and discussed as part of a larger group meeting.

- After holding a discussion about professional responsibilities of physicians, ask residents to describe, in one page or less, an incident in which they were challenged with a decision that involved professionalism in the care of patients.
- Ask residents to describe an incident in which they observed exemplary professional conduct on the part of one of their colleagues.
- Using any of the vignettes below, ask residents to describe a similar real-life situation. Ask them to identify the conflicting values and what they learned from the situation.

Vignettes

The vignettes that follow were developed for use in a small group or noon conference setting to help stimulate discussions about issues of professionalism. Program directors are encouraged to expand upon these to reflect local issues and experiences.

Vignettes: Professionalism in Patient Care

1. You are on rounds with your attending, and one of the medical students is presenting. The student has been working very hard and doing a good job. The attending asks the student about the results of a laboratory test that the student was to have checked on. You know that the student did not have an opportunity to get the test results but the student responds by saying that the test was normal.

Points to consider during discussion

- What would you do if you were the senior resident?
- What would you do if you were the medical student?
- What are the potential consequences of ignoring the student's response?
- What is the downside of pointing out the student's behavior on rounds?

2. A resident in continuity clinic is informed by a nurse that a family has arrived an hour late for their appointment. The resident has refused to see the two children because her schedule is already backed up, and this mother is frequently late for appointments. The mother is upset that she is being turned away because her children's immunizations are already delayed.

Points to consider during discussion

- What if the mother is usually on time?
- What if the resident has personal plans after clinic?
- What if seeing the children would mean that the resident would miss noon conference?
- What if your clinic policy prevents late patients from being registered and the resident feels that policy is not appropriate?
- What is your reaction to this scenario?

3. You are called early Monday morning by the Emergency Department because one of your patients, a 10-year-old boy with insulin-dependent diabetes, was brought in dead on arrival. The boy's parents are divorced and have joint custody, with the mother having physical custody. The patient had spent every other weekend with his father. Both parents are in the ED when you arrive. The father explains they had a "great" weekend and went to a country fair. They went on lots of rides and enjoyed the food booths. The dad was a little bit worried that his son "overdid it," so he increased the regular and NPH insulin just before bedtime. His son was restless and sweating about 1:00 am, and the father gave him another 10 units of regular insulin. His son continued to be sweaty and then had a seizure during which he stopped breathing. Both parents are demanding to know why their son died. What do you say?

Points to consider during discussion

- Is it ever appropriate to lie to patients or families?
- Would you recommend an autopsy, even if it is not mandated by law?
- Would you discuss the patient's death and its cause with the parents together or separately?

4. A 6-month-old prematurely born infant you cared for in the NICU returns from surgery to the PICU. You learn that during surgery the endotracheal tube had been in the right main stem bronchus for several hours. You are no longer directly responsible for the infant, but the father continues to talk to you about his infant's progress. The next three weeks are stormy. The infant contracts RSV, improves, and then dies suddenly. The autopsy is unrevealing. The father asks you if anything went wrong.

Points to consider during discussion

- How does one balance responsibilities to patients/parents and colleagues/departments/institutions?
 - Are there resources available to help you disclose complications of the hospital course?
 - What if you believe that the problem with the endotracheal tube and the nosocomial RSV infection had nothing to do with the infant's ultimate death?
5. One of your resident colleagues is hospitalized because of a febrile respiratory illness. A friend, who is also in your program and who is at risk during the coming weekend to cover call for the hospitalized resident, tells you that he has checked your colleague's electronic record and that she will likely remain hospitalized for another week.

Points to consider during discussion

- What are some circumstances that would allow a physician to review a patient's chart if that physician is not actually caring for the patient?
6. You are on your hospital's elevator and you overhear another physician discussing the behavior of a parent of one of her patients.

Points to consider during discussion

- Whose responsibility is it to remind that physician about confidentiality?
 - What would you do in response to hearing this?
 - What if the physician is from another department?
 - What if the physician is a department chair?
7. As a first-year resident, you care for a 15-year-old boy with a malignancy. You develop a close relationship with him during your residency. By the time you are a PL-3 he is terminal, and he has begun to talk openly with you about dying. You have assured him that you will be there as a support for him whenever needed. He is admitted to the hospital conscious but close to death, and he asks one of the other residents to call you at home and ask you to come in. You are not on call, and you are on your way out the door to your 3-year-old daughter's dance recital.

Points to consider during discussion

- How appropriate is it for physicians to make promises to patients?
- What could you have done earlier to avoid this crisis situation?
- How will you decide in what circumstances patient needs might take precedence over family obligations?

8. A resident asks that one of his continuity families be reassigned to another resident. He explains that he just does not see eye-to-eye with the mother, who he believes does not follow his advice. He is frustrated with her and prefers that someone else take care of her child.

Points to consider during discussion

- What if the resident and the mother of the patient are of different races?
- What if the resident and the patient's family are of different religious groups?

9. An 8-month-old boy is brought to the Emergency Department because of an apparently painful right leg. You determine that the infant has suffered a fracture of the femur. When questioned, the mother cannot recall any trauma consistent with the degree of injury.

Points to consider during discussion

- What if the mother is one of the pediatric nurses?
- What if the mother has called your attending and he forbids you to call protective services?

10. You are a resident participating in continuity clinic in a community pediatrician's office. The pediatrician prescribes valproic acid for migraine headaches to one of the patients, but he does not advise the family of the risks and benefits. You ask, "Shouldn't you mention the possibility of liver damage or other complications?" The pediatrician replies, "That's just PDR stuff."

Points to consider during discussion

- What is your role relative to the pediatrician?
- What is your role relative to the patient's family?
- What are your concerns if the pediatrician is evaluating you?

Chapter 3

Professionalism With Physician Colleagues and Other Health Professionals

The professional development of physicians involves experience and reflection; experience increases content knowledge and skills, whereas the reflection on that experience improves self-knowledge and insight. Providing learners with role models who use and promote the use of reflection in their daily work will create the kind of environment that embodies professionalism as a core value. Thus, the culture of the work environment has enormous potential to contribute in a positive way to the formation of physicians during residency.

The two responsibilities outlined in the *Physician Charter* that are most relevant to this area of professionalism are:

- *Commitment to improve quality of care*
Quality improvement requires that physicians “work collaboratively as a member of the health care team to increase patient safety and reduce error.”³ To accomplish this, physicians need to value interdisciplinary teamwork and contribute effectively to team function to ensure optimal care to patients. Equally important is the team’s responsibility to examine its system of care on a continuous basis, accept responsibility for shortcomings and failures, and work together to improve the system.
- *Commitment to professional responsibilities*
As a member of a team, the physician must contribute to the overall functioning of the team by performing his or her share of the work in a way that builds on the contributions of other team members. Underlying this functional responsibility is a culture that embraces a genuine respect, value, and appreciation of the skills of all team members. Such a culture can help to create a safe patient care environment in which conflicting opin-

ions can be openly expressed and discussed in order to provide continuous improvement of care for patients.

It is important to consider professionalism in the context of being both a member and a leader of an interdisciplinary team. Teamwork involves ongoing collaboration, cooperation, and information sharing to ensure that the care provided best serves the interests of patients and families.

When serving as a leader of a team, the resident must demonstrate additional behaviors important to overall team functioning. It is critical to avoid abusing any power that may come with the title “physician” and instead use a leadership position to guide and facilitate team dynamics. Balancing supervision with independent decision-making is critically important for the safety of patients and the developmental growth of learners. The resident should take responsibility for matching task assignments to the capabilities of the individual team members so as to optimize care of the patient. As a leader, it is important to set an example for others in order to create a culture and context for professionalism. With leadership comes the added responsibility of teaching and evaluating colleagues. In regard to the latter, one must be truthful and accurate in order to provide the trainee with meaningful feedback to guide practice improvement.

Accountability is a critical element for teams to function effectively. It begins with self-awareness. Engaging residents in guided reflection that fosters awareness of personal biases, stresses, and limitations is critical to fostering professional interactions in the work environment. Taking time to reflect on interactions and behaviors, whether positive or negative, is an important characteristic of a professional and necessary for continued professional development.

Physicians are also accountable to other members of the profession. Assisting colleagues with daily work, completing tasks on time, and providing coverage in emergencies are some examples of how this aspect of professionalism can be demonstrated. Furthermore, physicians need to demonstrate respect for other physicians, across all disciplines. Negative comments made about a specialist or a referring physician diminishes the professionalism of all physicians.

Finally, physicians are accountable for each other. Professional responsibility does not stop with one's own practice. With the opportunity to self-

regulate comes the responsibility of taking the behavior of our colleagues seriously. When we witness unprofessional behavior, we have a duty to address this behavior so that remediation can occur. When working as part of a team, residents may witness unprofessional behavior on the part of peers or colleagues. Whenever possible this should be addressed with the individual. Because of the hierarchical nature of medicine, there should be a "safe" process for reporting unprofessional behaviors of more senior colleagues so as not to put residents in the uncomfortable position of addressing these issues directly.

Behavioral Statements

The components of professionalism with physician colleagues and other health professionals listed above provide general goals. It may be helpful to identify specific behaviors or practices that would exemplify professional conduct in this domain and some that would represent lapses of professionalism.

Examples of Exemplary Professional Conduct

- Follows institutional policies and procedures
- Demonstrates self-awareness and the ability to be self-critical in reflecting on practice
- Accepts feedback from others and develops goals for improvement
- Implements strategies that have the potential to lead to practice improvement
- Works collaboratively and cooperatively as a member of a health care team
- Recognizes and acknowledges the patient as an important member of the health care team
- Leads with respect and fair treatment of colleagues
- Provides appropriate guidance and help to team members when entrusted with supervisory responsibilities
- Takes on extra work, when appropriate, to help the team
- Accepts responsibility for negotiating conflict and bringing about conflict resolution at the appropriate time and in the appropriate setting
- When supervising, ensures the safety of patients by not allowing team members to go beyond their limits of knowledge and skill in delivering care
- Accepts the responsibility of teaching colleagues by developing the knowledge base, skills, and attitudes necessary to be a competent teacher
- Gives appropriate feedback to peers regarding improvements in behavior that will enhance professionalism
- Arrives on time for scheduled activities and appointments
- Accepts responsibility for assigned coverage duties or, in the event of an emergency, arranges appropriate coverage
- Demonstrates appropriate boundaries for relationships with other professionals
- Addresses lapses in professionalism or reports them to appropriate authority

Examples of Lapses in Professional Conduct

- Disregards feedback from others that would be helpful in setting learning goals
- Does enough to get by but does not take on extra work when the need arises
- Fails to notify supervisors of inability to work in a timely manner
- Fails to ask for or address patient input (to the extent possible based on individual patient needs and clinical circumstances) in making decisions
- Does not demonstrate the leadership that is necessary in matching task assignments to the level of expertise
- Neglects to define the roles and responsibilities of each team member when functioning as a team leader
- Does not always distribute work assignments in a way that is fair to all team members
- Fails to demonstrate the leadership skills that are necessary to enable mechanisms for directing individual and system problems through appropriate channels
- Avoids responsibility to negotiate conflict among team members
- Accepts responsibility for negotiating conflict, but does this at inappropriate times and/or places (ie, witnessed by patients and families)
- Ignores the opportunity to acknowledge and incorporate the expertise of other team members in enhancing patient care
- Does not expend the effort to acquire the knowledge, skills, and attitudes that are necessary to demonstrate competence as a teacher
- Shirks responsibility to help identify coverage in cases where assigned duties cannot be carried out
- Ignores responsibility to address or report lapses of professionalism
- Fails to notify an attending physician when resident coverage is inadequate and patients are endangered
- Fails to engage in critical self-reflection

Behaviors That Warrant Immediate Intervention

- Exhibits repeated behaviors that exemplify lapses in professional conduct, such as those described above, despite feedback
- Engages in prejudicial behavior by favoring particular colleagues on the basis of culture, beliefs, race, gender, sexual orientation, or religion
- Leads through humiliation tactics or harassment

Teaching Professionalism

Learning Objectives for the Residents

- Residents will advocate for collaboration to improve care, reduce medical errors, increase patient safety, and optimize outcomes of care.
- Residents will identify the elements of professionalism that contribute to the effective functioning of a team, including physicians, other health professionals, and students.
- Residents will be able to identify lapses in professional behaviors in the work environment and mechanisms for addressing these lapses.

Teaching Strategies

Reflective Exercises

These reflective exercises can be used for individual reflection on professionalism issues or can be modified and discussed as part of a larger group meeting.

- After holding a discussion about professional responsibilities of physicians, ask residents to describe, in one page or less, an incident in which they were challenged with a decision that involved professionalism in relationships with other physicians or health care personnel.
- Using any of the vignettes below, ask residents to describe a similar real-life situation. Ask them to identify the conflicting values and what they learned from the situation.

Vignettes

The vignettes that follow were developed for use in a small group or noon conference setting to help stimulate discussions about issues of professionalism. Program directors are encouraged to expand upon these to reflect local issues and experiences.

Vignettes: Professionalism With Physician Colleagues and Other Health Professionals

1. The resident on sick call is called by the chief resident and told that she needs to come in and cover for a sick colleague. The sick call resident explains that she cannot come in because she has not arranged a baby-sitter for her own children. She says that it is impossible to keep a baby-sitter on alert for the whole month in case she gets called in. She asks the chief resident to call in somebody else and says that she will cover next time provided she has ample warning.

Points to consider during discussion

- Assume that you are the chief resident. How would you respond to this resident? What if the resident were male? What if this is the first time? What if this is a chronic problem?
 - If you decide that efforts to get this resident to come in at this point in time are futile, what do you say to the next resident that you call to come in when they ask why the sick call resident is unavailable?
2. A respected and well-liked division chief approaches one of your peers for a prescription for meperidine for his headaches. He explains that he has been too busy to get to his own physician for a new prescription and today his headaches are particularly bad. When the resident sheepishly says that she would rather not write the prescription, the faculty member nervously withdraws the request and apologizes.

Points to consider during discussion

- Imagine that your peer comes to you for advice about what she should do. Do you get involved or steer clear of the situation?
3. You are assigned to a ward team where the four interns on the team rotate call and cover each other's patients every fourth night. The morning after one specific colleague takes call is always chaotic and stressful. He says the night is too busy for him to followup on labs, imaging studies, etc. You and the other two interns have been coming in earlier and earlier to compensate so that rounds still go smoothly. You are halfway through the rotation and decide it is easier to continue to cover for the intern than raise concerns.

Points to consider during discussion

- Is this the most professional action plan?
- What is the role of the interns in addressing this behavior?
- Suppose the senior resident is unaware of the situation because the interns have done such a good job of covering. One morning, toward the end of the rotation, a student on the team makes the senior aware of what has been happening. In addition to confronting the problem intern, he confronts the other three interns for their unprofessional behavior, saying that they are accountable for addressing professional lapses of their colleagues. Are the remarks of the senior resident justified?

4. One of your fellow residents returns from his semiannual review of evaluations with the program director and is quite upset about the interaction. According to the resident, the program director told her that her professionalism was in question because she did not engage in required learning activities to improve quality of care, such as creating a learning plan or participating in her clinic quality improvement project. The resident feels that she has done a good job of taking care of her patients and that the program director is judging her on things that “don’t really count.”

Points to consider during discussion

- How broad should the definition of professionalism be?
- Do the assignments that the resident has neglected constitute a lapse of professionalism? If so, how would you respond to your colleague?

5. As the senior resident on the ward, you are asked by the department quality improvement committee to help address the issue of timely patient discharges. They inform you about an upcoming meeting and ask your advice about which key players should be invited to the meeting.

Points to consider during discussion

- Who would you invite if there was a similar problem on your ward team and why?
- Identify the attributes and behaviors of your group that will be important in effecting positive change to address this issue.

Chapter 4

Stress and Its Impact on Professionalism

Stress pervades pediatrics residency programs. Studies indicate that the prevalence of burnout is significant among all residents, ranging from 55% to 76%.⁷ Professional behavior is particularly threatened during times of burnout. Stress caused by a combination of factors including sleep deprivation, the pressures of the work environment, the vulnerabilities (lack of knowledge and experience) of residents inherent in the training process, and the acuity and complexity of patients.

The ways in which stress can influence professionalism may include a lack of commitment to one's professional responsibilities or a state of detachment in providing clinical care, a lack of insight and failure to recognize when one is practicing in an impaired state, and a state of tension in attempting to balance one's personal and professional life. In addition to the impact that stress has on the individual, stress within a patient care team can have a substantial impact on team members and team function. The aim of this section is to raise awareness and promote understanding about the impact of stress on professional behavior in individuals and team members.

The *Charter's* preamble contains an explicit statement demanding that the interests of patients be placed above those of the physician. This demand may at times be the basis for the state of tension that exists as an individual attempts to balance personal and professional life. The *Physician Charter* addresses stress and its impact on professionalism in several sections:

- *Principle of primacy of patient welfare*
One of the fundamental principles of the charter is that physicians are expected to be dedicated to serving the interests of the patient, not allowing market forces, societal pressures, or administrative exigencies to compromise this principle. Implied, but not stated, is the importance of not allowing one's personal life to impact adversely the primacy of patient welfare.
- *Commitment to professional responsibilities*
This responsibility includes the obligation to participate in the process of self-regulation, including remediation and discipline of members who have failed to meet professional standards. Maintaining high standards for professional behavior even under times of stress is a responsibility that we share for ourselves and for our colleagues. Recognizing and reporting lapses in professional conduct through the appropriate professional channels is an element of this commitment.

Behavioral Statements

The components of professionalism and the impact of stress listed above provide general goals. It may be helpful to identify specific behaviors or practices that would exemplify professional conduct in this domain and some that would represent lapses of professionalism.

Examples of Exemplary Professional Conduct

- Demonstrates a commitment to professional responsibilities, even during periods of stress, by making a personal commitment to a respectful workplace, working collaboratively with other members of the health care team, engaging in self-assessment, and accepting external scrutiny to maintain professional standards
- Maintains poise during difficult interactions with patients/families or colleagues
- Recognizes risk factors and signs of burnout, depression, drug and alcohol abuse, and mental health disorders
- Recognizes the importance of confidential reporting of impaired professionals within their institution
- Accesses support services and treatment for self and others
- Balances personal and professional commitments by discharging professional responsibilities effectively to another practitioner so as to provide continuous and high-quality patient care
- Recognizes the potential for tension and proactively addresses issues before a crisis erupts
- Develops methods for personal self-assessment

Examples of Lapses in Professional Conduct

- Demonstrates disruptive or disrespectful behavior in the workplace: abrupt, dismissive comments to staff; angry interchanges with staff; or gestures or body language that convey frustration or anger
- Communicates with colleagues in a hurried or incomplete manner regarding a patient
- Ignores a colleague's obvious distress or impairment
- Fails to ask for help when too fatigued to complete work

Behaviors That Warrant Immediate Intervention

- Exhibits repeated behaviors that exemplify lapses in professional conduct, such as those described above, despite feedback
- Behaves in a disruptive manner leading to a hostile workplace environment as evidenced by multiple complaints from team members
- Practices with an impairment and is unwilling to seek help or treatment
- Fails to meet professional obligations (duty to a patient) on the basis of an unresolved conflict between personal and professional responsibilities

Teaching Professionalism

Learning Objectives for the Residents

- Residents will understand and appreciate the impact of stress on professionalism as it relates to a lack of commitment to or frank detachment from one's professional responsibilities.
- Residents will identify signs of impairment (in themselves or other professionals) and know where to seek further intervention.
- Residents will recognize and respond to personal stress that might interfere with professional responsibilities.
- Residents will recognize the state of tension that develops in attempting to balance one's personal and professional life.

Teaching Strategies

Reflective Exercises

These reflective exercises can be used for individual reflection on professionalism issues or can be modified and discussed as part of a larger group meeting.

- After holding a discussion about professional responsibilities of physicians, ask residents to describe, in one page or less, an incident in which they were challenged with a decision that involved professionalism in stressful situations.
- Using any of the vignettes below, ask residents to describe a similar real-life situation. Ask them to identify the conflicting values and what they learned from the situation.

Vignettes

The vignettes that follow were developed for use in a small group or noon conference setting to help stimulate discussions about issues of professionalism. Program directors are encouraged to expand upon these to reflect local issues and experiences.

Vignettes: Stress and Its Impact on Professionalism

1. Your son is scheduled to graduate from high school this afternoon. You have finished seeing all of your patients and are trying to get out of the office when you receive a call from the Emergency Department that a child with asthma whom you follow has just been admitted with severe respiratory distress. The mother is insisting that you be contacted to come in because you are the only one who has been able to keep her son out of the hospital.

Points to consider during discussion

- How will you handle this dilemma?
- In retrospect, is there anything you could have done differently to avoid this predicament?

2. You are a resident who is presenting a case to your attending, and you detect alcohol on the attending's breath. Her speech seems a bit rapid, but she is clear and lucid.

Points to consider during discussion

- What if this resident were a surgical resident or attending?
- What if the patient was your child?

3. A fourth-year medical student is completing a rotation as a sub-intern in the PICU. Her performance has been outstanding, and the senior resident on the service has already submitted an evaluation. It is the last day of the rotation, and she arrives at work obviously intoxicated and unable to care for her patients appropriately. The senior resident, without knowledge of the attending, sends her home to "sleep it off." She receives Honors for the course. Approximately five months later, at the Resident Selection Committee, two resident members describe the incident and recommend that she be excluded from the list of potential candidates for the residency program.

Points to consider during discussion

- What other courses of action could the senior resident in the PICU have taken five months previously?
- What should the program director do at the present time?
- Should this incident affect her ranking in your program?
- What is the obligation to the medical student?

4. During the second year of your pediatric residency, you gradually observe that one of your resident colleagues has become less responsible in his patient care duties and attends conference less often.

Points to consider during discussion

- What is your responsibility if one of your colleague's behavior changes?
- What are possible reasons for changes in behavior?
- What if you suspect the behavior is secondary to the use of alcohol or an illicit drug; a result of depression; a result of physical illness?

5. Dr. Z is the senior resident on the ward team. Recently, he was overlooked for a fellowship position in nephrology in the Department of Pediatrics and is moving out of the area to start a nephrology fellowship in another institution. During resident work rounds, he makes a glib remark about the nephrology service attending: “He is such a compulsive idiot. It is not necessary to follow the electrolytes so frequently. It is obvious that the patient is improving.” The medical student and intern on the team appear uncomfortable with his remark.

Points to consider during discussion

- Assume that you were the intern on the service and wanted to convey your discomfort to the senior resident.
 - What standards of professional behavior were breached?
 - What does the term “respectful workplace” mean to you?
 - How does this remark affect a collaborative working relationship?
 - How would you approach the senior resident, and what words would you use?
6. One of your senior resident colleagues arrives late each morning for morning report and does not check in with the night team as she is supposed to do in her role as ward supervisor. In addition, you notice that she seems withdrawn and anxious. She shares with you the fact that she is really burned out, is unhappy with her career choice, and just wants to get through residency so she can work part time and travel. She admits that she is not sleeping well and has “no interest in things.”

Points to consider during discussion

- Assume that you want to help her seek counseling for depressive symptoms. What are her risk factors?
 - What are the symptoms of depression?
 - How would you approach the senior resident?
 - If you do not feel comfortable bringing up this issue, what other ways could you bring this issue forward in a confidential manner? Who else could you approach? Is there a “Well-Being Committee” at your institution?
7. The holiday schedule was just posted in the residency program office and you have been scheduled to work during the Christmas holiday for the second year in a row. Your spouse was upset last year because you were on-call Christmas Eve and post-call on Christmas Day, and it was a particularly busy night on-call. You and your spouse left the family Christmas party early so that you could get some sleep and get up early to pre-round. You are not looking forward to informing your spouse about this year’s holiday schedule.

Points to consider during discussion

- Assume that you are this resident and are conflicted about what to do. Think about how you feel about the choice of schedules, how your spouse will feel, and what you want to do next.
- Do you approach the chief resident about the schedule?
- Do you accept the schedule as is and not make an issue out of it?

Cases

Case 1 What's Up With Mary?

Mary has arrived late for morning report every day for the past week. She is the ward supervisor and is responsible for three interns and two medical students. Residents have complained to the chief resident that she has never checked in with the overnight call team on any of these mornings for the handoff that is required. According to the interns on the team, Mary has not conducted any teaching sessions, has ignored the medical students, and seems detached from patients and her work.

A fellow senior resident has real concerns for Mary's well-being and wants to approach the chief resident to convey her concerns, but she feels ambivalent about the situation because the ward rotation is a really tough month and follows the intensive care rotation. She wonders if it is just a transient situation and feels uncomfortable saying anything to the chief, but she eventually does approach the chief resident.

The chief resident asks Mary to come to the office to discuss her role and responsibilities on the ward rotation. During the meeting, Mary expresses the feeling that she is burned out and overwhelmed and just wants to be finished with the program so that she can moonlight as a hospitalist and travel. She acknowledges that she has been unable to attend morning report or obtain sign-out because she has had difficulties with sleep and repeatedly slept through her alarm. She also claims that she is disinterested in her work and is not happy with the program in general. The chief resident outlines the expectations of the role of ward supervisor: attending morning report, obtaining a proper morning sign-out, conducting regular teaching sessions, supervising medical students, and being dedicated to the highest quality patient care. Mary flatly states, "I will try to be better, but I do not really care!"

The chief resident contemplates what she should do next. She decides that the program director needs to be informed, tells Mary that she is concerned about her, and gives Mary information about the resources available for confidential counseling. Mary protests, "I am not crazy or depressed. I am just tired of being a resident!" Later that day the program director pages Mary to arrange a meeting.

Case 1

What's Up With Mary?

Guiding Questions

1. If you were the chief resident, how would you initiate the conversation with Mary about her lapses in professionalism?
2. If you were the program director, what should be done next?
3. What other issues does this case bring up in your opinion?

Case 2

Amanda's Nerves Are Frayed

Amanda was the intern on call covering a busy ward service. Her pager had not stopped ringing all evening with calls from the floor nurses: “Karen has a fever of 101°F”; “Jim just vomited”; “Jeremy’s albuterol treatment just finished and he’s still tachypneic.” Amanda couldn’t wait for her call to end.

As she was about to go check on Jeremy, her patient with asthma, her senior resident Lara called from the Emergency Department. “I have a couple of patients waiting to be admitted. One of them needs a lumbar puncture. Could you come help me?”

At the same time one of the floor nurses called. Brittany, a patient who had been hospitalized for weeks for a second round of chemotherapy, wanted to speak with Amanda. Brittany was anxious about her chemo, and her mother felt that only Amanda would be able to calm her. Brittany asks to speak to Amanda almost every time she is on call. Although honored that Brittany and her family felt so comfortable with her as a physician, Amanda was feeling overwhelmed. Talks with Brittany could take “forever,” rarely lasting less than 30 minutes. How could she see Brittany and take care of the two admits in the ED plus the many calls from the floor?

Amanda decided to check on Jeremy first. She noticed that he was still tachypneic but otherwise stable. In the middle of discussing the plan with Jeremy’s mother, one of the nurses came into the room: “Can I get an order for acetaminophen for Julia in 513 with RSV? Her temperature is 100.8°F.”

Amanda was furious! Why was she being interrupted for such a trivial order when she was obviously so busy? Amanda snapped at the nurse, “Of course you can give her acetaminophen. Now stop bothering me.” The nurse shouted back, “Why are you yelling at me? I’m only doing my job.”

Case 2

Amanda's Nerves Are Frayed

Guiding Questions

1. What are the lapses in professionalism illustrated by this case? What contributed to this event and how could these factors have been dealt with more effectively?
2. Discuss the case from the viewpoint of the parent.
3. Discuss the case from the viewpoint of the nurse. What are the repercussions for the resident? What if the nurse hesitates to call in a more critical situation?
4. Discuss system issues, such as staffing issues at night, how to balance being compassionate/empathetic under time constraints, and unrealistic expectations of different members of the team.
5. Discuss the resident's responsibility to call for help if she thinks patients may be endangered by insufficient staffing.

Case 3

An Uncomfortable Situation in the ED

You are a second-year resident in the Emergency Department for the month of February. You have really enjoyed the experience and feel you have finally found your niche and would love to do a Pediatric Emergency Medicine fellowship. The fellowship is competitive to get into and you know that getting a good letter of recommendation will really help your application. Monday evenings are always the busiest, and this Monday night is no different. All the rooms are full and there are 30 patients waiting in the lobby. The good news is that you are working with Dr. Miller, one of your favorite attendings. The other supervising physician tonight is the second-year fellow, Dr. Redd. You have heard that he is smart and sees a lot of patients. You try to speak with him as your shift starts, but he walks right past you muttering something about “clinic patients.”

The first patient you see is a baby who is brought in by the mother for respiratory difficulty. The nurses have already placed an oxygen mask on the baby. After completing a brief history and physical exam you immediately present the case to Dr. Miller. This is a 10-month-old, previously healthy infant who began vomiting two days ago and now is having difficulty breathing. His past medical and family histories are negative. He lives with his parents who both smoke. Your exam revealed a moderately dehydrated infant who is tachypneic but whose lungs are clear. He was seen by his pediatrician and referred to the ED to rule out pneumonia. His pediatrician requested a chest x-ray and CBC. You are suspicious that the patient may be in DKA because of the respiratory pattern and you tell Dr. Miller that you would like to start a fluid resuscitation. When starting the IV, you ask the nurse to quickly check the glucose. The glucometer reading is greater than 700 and Dr. Miller helps you order the appropriate labs and treatment. Dr. Miller is so impressed with your evaluation that she calls it to the attention of Dr. Redd. He immediately asks who the pediatrician is. You tell him Dr. Rogers sent in the patient. Dr. Redd laughs and says, “That guy is an idiot and I’m surprised he hasn’t killed someone yet! You should have seen him when we were residents.”

Case 3

An Uncomfortable Situation in the ED

Guiding Questions

1. Is this kind of comment ever acceptable? What if it were intended as a joke?
2. Can you excuse this comment because of stress and burnout?
3. How do you respond to the fellow?
4. What if you are Dr. Miller?
5. What if you are Dr. Redd?

Chapter 5

Professionalism and Society

In order to maintain and improve children's health, we must have a commitment to the broader community in which children are raised and nurtured and in which their care is provided. In recognition of this, there has been a long history of advocacy in pediatrics. Pediatricians have been committed to public health and welfare since the founding of the specialty.

Pediatricians must practice within the professional mandates of society. They should also be committed to developing and using their skills and competencies to improve the health of children broadly throughout the profession and in the community at the local, state, and national levels.

The *Physician Charter* states that "professionalism is the basis of medicine's contract with society," defining the fundamental principles as patient welfare, patient autonomy, and social justice. The following components defined in the charter are part of the professional commitment of pediatricians to society:

- *Commitment to improving access to care*
All patient care decisions must be made without regard to personal views about a patient's lifestyle, cultural beliefs, race, ethnicity, gender, sexuality, disability, age, or socioeconomic status. Decisions about medical care must be based only on clinical judgment, patient needs, and the likelihood of effectiveness. The pediatrician must work with patients and families individually and at the community level to ensure that access to adequate pediatric health care of a uniformly proper standard is provided, and that this is available to all members of the community. The pediatrician should be able to assess and address barriers to access to care, including barriers based on geography, cultural differences, economic forces, legal restrictions, and educational differences. To optimize access, the pediatrician should de-

liver culturally sensitive care that meets the specific needs of the patient and family.

- *Commitment to a just distribution of finite resources*
Pediatricians must seek ways to address the limited health care resources available so that those resources are not misused or overused. Pediatricians should continuously examine resource utilization as part of their routine practice and work to distribute limited resources fairly.
- *Commitment to scientific knowledge*
The pediatrician must, in every type of practice, promote the establishment of high scientific standards and the research needed to improve the scientific basis of practice. The pediatrician is expected to support the appropriate use of new scientific knowledge. Even if the individual pediatrician is not personally creating new knowledge, the recognition and responsible use of new knowledge must be part of his/her practice. Every pediatrician must be aware of and be able to assess and use organized evidence in everyday decision-making. Pediatricians who are engaged in research or whose patients are participating in research must ensure full disclosure, obtain proper consent, and ensure confidentiality. Principles of informed consent for participation in research must be well known and used in conversations with patients involved in research.
- *Commitment to maintaining trust by managing conflicts of interest*
Pediatricians and pediatric organizations must not compromise their responsibilities for personal or organizational profit or advancement. The pediatrician must be particularly cautious in interactions with for-profit medical industries such as pharmaceutical companies, equipment manufacturers, and

nutritional firms. There is a special risk of conflict of interest for those in positions of leadership or those recognized as expert in their area of research or practice. When pediatricians develop relationships with medical industries, those relationships should be disclosed in all of their roles as leaders. These roles may include interpreting research results, assessing others' research, expressing editorial opinions, creating health care guidelines or standards for care, or serving as editors or reviewers of scientific journals.

Behavioral Statements

The components of professionalism and society listed above provide general goals. In discussions with residents, it may be helpful to identify specific behaviors or practices that exemplify professionalism in this domain and some that would represent lapses of professionalism.

Examples of Exemplary Professional Conduct

- Advocates for individual patients
- Provides a high standard of care for patients of diverse backgrounds
- Works at all levels to promote access to care
- Recommends care that is mindful of cost and limited resources
- Allocates health care resources without bias
- Conducts or supports the ethical conduct of research and other scholarly activities
- Ensures full disclosure, informed consent, and confidentiality in research
- Works to eliminate all conflicts of interest in practice
- Discloses all potential conflicts of interest in practice
- Discloses all potential conflicts of interest in leadership roles

Examples of Lapses in Professional Conduct

- Demonstrates prejudicial behavior based on race, ethnicity, religion, disability, gender, age, socioeconomic status, or lifestyle, particularly when such prejudicial behavior is distressing to parents and families
- Overtly demonstrates cultural insensitivity, especially if with conscious intent and without remorse
- Intentionally distorts or misrepresents medical evidence in the development of practice guidelines or medical policies
- Fails to take all reasonable steps to protect confidentiality of patients who are participating in research
- Accepts gifts from industry or patients/families with an implied or explicit outcome that changes patient care
- Fails or refuses to participate in advocacy for the legitimate needs of patients
- Fails to disclose conflicts of interest to the public or in the course of patient care, when those conflicts of interest affect that care
- Refuses to seek legitimate support for patients and families, such as in gaining access to needed resources

Behaviors That Warrant Immediate Intervention

- Exhibits repeated behaviors that exemplify lapses in professional conduct, such as those described above, despite feedback
- Falsifies research data in any public presentation or publication of that research
- Fails to obtain IRB approval or consent for research
- Coerces any patient participation as a subject in research in any way, including misrepresenting benefit or possible harm to that patient
- Fails or refuses to participate in the legal process designed to protect the welfare of children and their families
- Fails as an opinion leader to disclose relationships to industry

Teaching Professionalism

Learning Objectives for the Residents

- Residents will be able to identify barriers in access to care and formulate ways to address them.
- Residents will recognize and address the misuse and overuse of resources and will strive for fair distribution of resources.
- Residents will promote the advancement of scientific knowledge through properly conducted research and will commit to knowing, assessing, and properly applying new knowledge.
- Residents will learn to maintain public trust by recognizing and avoiding conflicts of interest and by avoiding misuse of their position.

Teaching Strategies

Reflective Exercises

These reflective exercises can be used for individual reflection on professionalism issues or can be modified and discussed as part of a larger group meeting.

- After holding a discussion about professional responsibilities of physicians, ask residents to describe, in one page or less, an incident in which they were challenged with a decision that involved professionalism and the broader impact on society.
- Using any of the vignettes below, ask residents to describe a similar real-life situation. Ask them to identify the conflicting values and what they learned from the situation.

Vignettes

The vignettes that follow were developed for use in a small group or noon conference setting to help stimulate discussions about issues of professionalism. Program directors are encouraged to expand upon these to reflect local issues and experiences.

Vignettes: Professionalism and Society

1. One of your continuity clinic patients, a 3-year-old boy, is brought by his mother to see you. When you enter the examination room you are also introduced to a 6-year-old girl, the stepsister of your patient. The mother explains that the older sister has just come to live with them, having spent the first years of her life with her grandmother. It is two days before school is to begin, the child needs immunizations before she can be enrolled in school, and she is not yet registered on the mother's Medicaid policy. The mother asks that you immunize her daughter using the brother's Medicaid number.

Points to consider during discussion

- Is following the mother's request a valid way to improve access to care?
- How does not following the mother's request affect access to care?
- What are your alternatives?

2. You are a senior resident supervising an intern's encounter with a 15-year-old girl in the Emergency Department. The intern has done a very nice job of gaining the teenager's trust, and the adolescent has disclosed to the intern that she may be pregnant. After confirming an early pregnancy, the intern comes to you for guidance in referring the patient for prenatal care. You ask whether the patient has considered abortion. The intern states that she (the intern) is Catholic and adamantly refuses to present abortion as an option to the patient.

Points to consider during discussion

- How do you reconcile personal beliefs with medical decision-making?
- How does this difference in beliefs affect access to care?
- What are your options for this patient?
- What are your options in working with the resident?

3. A patient comes in with a seizure after being placed on phenobarbital. In the Emergency Department the phenobarbital level is 0. The mother explains that she is not giving the phenobarbital and produces a bottle of liquid with which she is treating the child's seizures. She reports that she was told at the Botanica not to give the phenobarbital and to give the herbal liquid instead.

Points to consider during discussion

- How would you try to reach a compromise with this family?
- What is the role for child protective services?

4. A resident reports to his faculty mentor that he has no interest in doing any special activities with underserved communities internationally, in the US, or even in his community. "I already do enough for poor people every day. I don't need to do anything more on my own time. They are just lucky we are here for them," he says. A nearby faculty member overhears the conversation and agrees with the resident.

Points to consider during discussion

- How should the faculty member proceed with the resident?
- Does the resident or the faculty member have an obligation as advocate?
- What is an appropriate response to the faculty member who agrees with the resident?

5. Residents at your hospital are provided free pharmaceuticals for immediate family members as a benefit of employment by the hospital. A resident has been writing prescriptions for sumatriptan for his sister, using the name of his wife. When this comes to the attention of the chief resident and the resident is confronted, his response is: “The hospital isn’t paying me enough for my services, so there’s nothing wrong with my obtaining free medication for members of my family.”

Points to consider during discussion

- What are the laws regarding prescription fraud?
- Who else might be affected by a physician who writes such a prescription?
- What should the chief resident do?

6. You are the senior resident in the pediatric Emergency Department when a 10-year-old girl who sustained severe anoxic brain damage during a complicated delivery is brought for evaluation of increasing seizure activity at home. She is the parents’ only child, and they care for her meticulously. They have never been willing to consent to a “do not resuscitate” order. You plan to consult the child’s neurologist to discuss her anticonvulsant medications, but the parents want her admitted to the hospital and have requested an MRI scan of her head.

Points to consider during discussion

- How do you deal with parental requests for laboratory or diagnostic tests you feel are unwarranted?
- How would you deal with a perception of discrimination on the basis of handicap or other basis?
- What if you felt that admission and the MRI were indicated, but others disagreed?

7. The hospital has a cost-effectiveness guideline in place and one of the admitting faculty members refuses to follow it. “I disagree with the pathway. It’s not the way I practice. I don’t do cookbook medicine,” she says.

Points to consider during discussion

- What if the faculty member’s way of treating seems to the resident to be consistent with other guidelines?
- What if the only issue was that the faculty member’s care was “just” less cost-effective?
- What are the resident’s options?
- What if the faculty member’s way of treating seems to the resident to be inconsistent, eg, she treats friends in one way and poor patients in another?

8. A mother wants a resident to write a letter saying that the power company needs to turn her power back on for medical reasons.

Points to consider during discussion

- Should the resident support the request?
- What does the resident need to know?
- How should the resident proceed?

9. A resident or other provider fails to obtain proper informed consent (ie, not explained at all, explained improperly, not witnessed or without a proper interpreter present) for a study entrant because the resident was too busy or the resident did not understand the protocol.

Points to consider during discussion

- Does the response to the lack of informed consent differ according to whether the resident was intentional about it?
- If the resident did not understand the protocol, what would be a good response to the resident?
- Was the resident responsible for the informed consent?
- What are the resident's options?

10. A resident does not agree with a particular study being offered to a minor participant.

Points to consider during discussion

- Is it permissible to refuse to help with the study?
- Is it permissible to discourage (actively or passively) candidates from participating?
- To whom can the resident appeal?

11. A resident reports on rounds that the literature says a particular plan of care is proven to be superior. Later, it is found that the resident either does not have a citation or the abstract was misquoted or it was misinterpreted.

Points to consider during discussion

- What should be done?
- What if it was a faculty member misquoting or misinterpreting a study?
- What if the erroneous report seems deliberate in order to "make a point?"
- What if this is not the first time such a discrepancy has been discovered?

12. You are a practicing pediatrician who has recently completed residency training. You have a high debt load, and you and your spouse have not had a real vacation in many years. You are approached by a pharmaceutical representative to enroll your patients in a trial testing a new antibiotic. You are told that you will be paid \$300 for each patient enrolled.

Points to consider during discussion

- What does the pediatrician need to consider?
- What does the pediatrician need to disclose to patients?
- How should the pediatrician proceed?

13. The representative from one of the major formula companies makes you, as chief resident, an offer to provide free lunches for residents at their Friday noon conference.

Points to consider during discussion

- Does your institution have a policy regarding CME and free food?
- What are the obligations you have to the pharmaceutical company?
- How should the chief resident proceed?

14. A patient's family offers you expensive tickets to an event.

Points to consider during discussion

- Is it okay to accept the tickets?
- What if the family asks a favor of you in seeing a child at a special time or providing a note to exempt the child from physical education?
- Is there a circumstance where this could be acceptable?
- What are the possible responses?

15. The cardiologists at your hospital own and operate the cardiac laboratory. They are the primary providers responsible for referrals for tests, and they generate income from these activities.

Points to consider during discussion

- Is this acceptable?
- What and to whom do they need to make disclosure?
- What steps do they need to take to show that they are not changing practice for personal gain?

16. A pharmaceutical company wants to support you as a principal investigator in a drug trial.

Points to consider during discussion

- What must you disclose to patients to whom you prescribe this drug?
- What must you disclose to those reading the results of your study?
- What must you disclose to editors wanting you to review other studies involving treatments in this area?

17. You care for a 7-year-old girl with mild mental retardation and cerebral palsy, most likely related to prematurity. The girl is enrolled in a special school program and is transported to school by a van each day. The mother requests that you write a letter attesting to the fact that she cannot work because of her daughter's medical condition.

Points to consider during discussion

- What information do you need to have before responding to her request?
- What if you feel the mother can work while her child is away?
- How might your response affect the care of the child?
- How would you proceed?

18. A resident receives a subpoena to testify in a suspected child abuse case or write an affidavit.

Points to consider during discussion

- How can the resident respond?
- What if the resident is due to be on duty in the PICU or on vacation at the time of the proceeding?
- What if the resident is due to be at her child's music recital?
- What resources are available to the resident?

Chapter 6

Professionalism Beyond Residency

The first professional responsibility listed in the *Physician Charter* is the commitment to professional competence. Throughout this workbook, we have emphasized that pediatricians must be committed to lifelong learning and ensure that they continue to have the skills to provide high-quality care. Professionalism itself is not a competency to be achieved. It is a developmental process that continues throughout the life of a physician. Each and every day, in each encounter and at every decision-making point, the physician must confront the issue of the ideal professional behavior and try to achieve that ideal. Professionalism should not be focused just on the very unusual and serious unprofessional behaviors that are demonstrated by a few. It is a challenge for every physician to improve his/her skills of healing and comforting patients and families. Although we begin to teach and shape professional behavior in medical school and during residency and fellowship training, the lesson is never fully learned. After training, residents will be responsible for their professionalism without the constant vigilance of teachers and role models.

Thinking About the Future

As residents begin to think about life after residency, they will begin to see that professionalism issues will continue to arise throughout their careers. They will also likely realize that they need to self-monitor their behavior. When working through the material in this chapter, program directors may want to begin by asking the residents to project their thoughts into the future and consider the following three questions:

How will you know that you are doing a good job?

Physicians should always continue to question whether they are doing a good job. This process of self-reflection and self-assessment is the critical step in maintaining professionalism. As physicians move from medical school, through residency or fellowship training, to an

independent practice position, they will move from a situation where others reflect on their professionalism to an environment in which they are responsible for their own assessments and actions. There are hard questions: Am I doing a good job? How do I know? In an academic setting, there may be some system of performance evaluation. In a group practice, there should be efforts among colleagues to assess quality. Is the care being delivered up-to-date? Is work being benchmarked? Are patients leaving care? How is the practice regarded in the community? There may be external benchmarks, but there must also be a system of internal measures.

Ask patients and their families for their opinions, as they are the ultimate test of effectiveness. It is a bit daunting to ask, but their answers will likely be reassuring and may give some clues on how to make the practice even better.

How can you find support for your professionalism?

There are many ways to find help with professionalism efforts. One way is to remain active with a local, regional, or national professional organization. Membership in the American Medical Association (AMA), Academic Pediatric Association (APA), American Academy of Pediatrics (AAP), and local pediatric societies are good ways to find peer support.

It is also important for physicians to find a mentor either in the community or from past professional contacts. A mentor may continue to be a sounding board even if the physician is not in day-to-day contact. Discussing issues, problems, and positive and adverse events with a mentor is helpful in monitoring professionalism.

A few individuals may have major issues with their professionalism. Drug and alcohol abuse, unhealthy patient or peer relationships, or legal problems may emerge. In these cases, physicians may turn to hospital-based wellness committees or state-run programs for treatment and monitoring. It is always better for physicians to enter such a program voluntarily and seek help before there is an untoward effect from one's actions that might affect the physician, his/her family, or most importantly, the patients.

What if you change careers or enter a new type of practice?

Changing careers or reentering pediatrics after a significant break is a likely scenario for many pediatricians. This is a time when there must be an extra emphasis on professionalism. New roles require a retooling, not only in knowledge base and communication styles, but also in performance expectations. Again, the role of a mentor or advisor is critical. A senior colleague or a peer can be made aware of the need for feedback. Also, physicians should set aside time for self-reflection or even engage in keeping a journal that describes the transition and the difficulties that might be faced.

Professionalism Issues for the Future

There are several places where professionalism is included in the assessment of physicians: state licensing, medical staff privileging or credentialing, obtaining liability insurance, enrollment in insurance plans of third-party payers, and maintenance of certification. In each of these areas, efforts are made to assess the professionalism of pediatricians. If there are serious lapses in professionalism, the physician may be prohibited from achieving the approval needed to work as a pediatrician.

State Licensing

In the United States, all states and the District of Columbia have the authority to issue medical licenses. They also have the mandate to issue licenses for non-physician medical

personnel. The states set the requirements for licensure and the penalties for practicing without proper authorization. States also establish criteria for suspending or revoking a license. There is also a Federation of State Medical Boards of the United States (FSMB). The FSMB is an organization that brings the states together to facilitate their work. Recently the FSMB has developed an electronic notification system - Disciplinary Action Notification System (DANS) - to share real-time information between the states and the members of the American Board of Medical Specialties. In this way, certifying boards can be quickly notified about any license suspension or revocation. To maintain certification in pediatrics, one must have a valid, unrestricted state license.

Hospital Credentials

Every hospital is required to establish bylaws that codify qualifications for staff membership and areas of practice. A graduating resident will need to apply for staff privileges at every hospital where patient care will be provided. There are often forms to be completed that include questions about any unprofessional behavior, and character references are also routinely sought. Hospitals have the right to revoke staff privileges according to hospital bylaws. The Joint Commission on Accreditation of Health Care Organizations (JCAHO) reviews the hospital bylaws to be certain that they properly protect the public.

Liability Insurance

When seeking liability insurance, insurers will also assess a pediatrician's professional conduct through a series of questions that must be completed upon application. Insurance may be declined due to past episodes of unprofessional behavior. Insurers and hospitals must report adverse information to either of two national data banks. The National Practitioner Data Bank (NPDB) collects reports of liability payments made on behalf of health care professionals regardless of whether the payment was the result of a verdict or a settlement. The

Healthcare Integrity and Protection Data Bank (HIPDB) receives reports about health insurance and business practice fraud and abuse.

Third-Party Payer Contracts

Similar to the categories above, third-party payers will also ask program directors and training institutions to verify completion of training as well as past episodes of unprofessional behavior, lapses in training, instances of program modification, or special oversight of a trainee.

Maintenance of Certification

The medical profession must work to ensure that all of its members are competent. All the medical specialties recognized by the American Board of Medical Specialties (ABMS) have developed procedures for initial certification and for ongoing maintenance of certification. The American Board of Pediatrics (ABP) is at the forefront of this effort. Its vision and mission is to assure the public that pediatricians have the knowledge and skills necessary to provide quality care and that they maintain these skills over a lifetime of practice. At the time residents complete their pediatric training, the program director is asked to attest to clinical competence and professionalism. Thereafter, there are other mechanisms to ensure that pediatricians are acting in professional ways worthy of the public trust.

In order to maintain certification by the ABP, a diplomate must demonstrate that he or she has a valid, unrestricted medical license. If a license is restricted in any way by a State Licensing Board due to a disciplinary action taken against the holder of the license, then the ABP certificate is subject to revocation. The ABP has revoked certificates on the basis of disciplinary actions. The majority of these revocations fall into three categories: impairment due to chemical or substance abuse; incompetence/negligence; and sexual misconduct and violations of appropriate physician/patient boundaries. Other less frequent

causes of disciplinary action include conviction of a crime, inappropriate prescribing, Medicaid/Medicare fraud or other fraudulent misrepresentations, and other miscellaneous restrictions on the practice.

The maintenance of certification process goes beyond the aforementioned established measures of professionalism. It also includes a measure of cognitive expertise (successful completion of the ABP secure examination), measures of knowledge building to self-assess one's commitment to life-long learning, and measures of quality improvement to assess performance in practice.

Behavioral Statements

The components of professionalism beyond residency listed above provide general goals. In discussions with residents, it may be helpful to identify specific behaviors or practices that exemplify professionalism in this domain and some that would represent lapses of professionalism.

Examples of Exemplary Professional Conduct

- Participates actively in maintenance of certification
- Constructs and participates in a lifelong learning plan
- Surveys peers and patients about the quality of care being delivered
- Participates in hospital-based, commercial, or organizational (eg, AAP) continuing medical education activities
- Maintains hospital staff privileges
- Participates in community-based child advocacy activities
- Completes charts, reference letters, patient forms, and recommendation letters in a timely fashion
- Continually strives to improve care

Examples of Lapses in Professional Conduct

- Engages in unethical or illegal practices
- Promotes the business of medicine above duty to patients
- Engages in discriminatory hiring practices
- Conducts practice without regard to monitoring quality or safety
- Practices without adequate liability insurance
- Continues to care for patients the same way that he/she was taught during residency

Teaching Professionalism

Learning Objectives for the Residents

- Residents will describe the dimensions of professionalism beyond the period of residency training.
- Residents will describe the implications of professionalism lapses.
- Residents will explain methods for evaluating their own professionalism.
- Residents will be able to develop a lifelong professionalism plan to enhance their lifelong learning plan.
- Residents will know how to find help and support with issues of professionalism into the future.
- Residents will consider the many ways their professionalism will be tested and how to maintain high standards.

Teaching Strategies

Reflective Exercises

These reflective exercises can be used for individual reflection on professionalism issues or can be modified and discussed as part of a larger group meeting.

- After holding a discussion about professional responsibilities of physicians, ask residents to describe, in one page or less, how they will monitor their professionalism in the future.
- Using any of the vignettes below, ask residents to describe a similar real-life situation. Ask them to identify the conflicting values and what they learned from the situation.

Other Educational Strategies

1. Hold a teaching session to review the state licensing regulations and obtain, review, and discuss a list of reasons for license revocations. The American Medical Association publishes these in State Medical Licensure Requirements and Statistics, and each state has license revocation information on its Web site.
2. Hold a meeting with residents to discuss what form of professional misconduct requires the program director to report unprofessional behavior to the ABP. What is a minimum threshold?
3. Perform a confidential written exercise that requires residents to describe an unprofessional behavior they have seen in an attending and indicate what they would have done in a similar situation.
4. Gather a group of senior faculty for a discussion about the professionalism challenges they face in an effort to serve as role models for residents.
5. Observe physician-patient interactions from movies or television and discuss the issues of professionalism that are raised.

Vignettes

The vignettes that follow were developed for use in a small group or noon conference setting to help stimulate discussions about issues of professionalism. Program directors are encouraged to expand upon these to reflect local issues and experiences.

Vignettes: Professionalism Beyond Residency

1. You are on the Credentials Committee of your hospital. You read in the local newspaper that one of the members of the hospital staff has been arrested for child pornography. There has not yet been a hearing or sentencing.

Points to consider during discussion

- What should you do?
- Do you bring this to the attention of your Credentials Committee?
- Do you contact the physician to get their side of the story?
- Do you contact the state licensing board or the ABP?
- Do you have an obligation to protect a colleague or potential child victims?

2. A physician in your town is in a pediatric practice and advertises that she is a board-certified pediatrician, but you note on a routine check of credentials that she is no longer certified since she did not recertify. Nonetheless, she seems to be a competent pediatrician and good colleague.

Points to consider during discussion

- Is this a problem?
- Should you contact the ABP?
- Is it important to let parents in your community know?

3. You refer your patients to a busy pediatric gastroenterologist, but you never receive any written reports or consultation notes for your files. This makes it difficult to know what treatment plan needs to be followed. You have mentioned this to the gastroenterologist, but he just does not respond.

Points to consider during discussion

- Is this an issue of professionalism?
- What should you do about it?
- Should you change consultants?
- Will complaining to the hospital CEO help?

4. You note that one of your partners prescribes oxycodone very liberally by your standards. You are not sure if he just has more patients with pain or this is his practice “style.” You are concerned but feel on one hand that this is not your business. On the other hand, some of his patients come to you for refill prescriptions and that makes you feel uncomfortable.

Points to consider during discussion

- How will you deal with this?
- Is this a quality of care issue?
- Is this a possible variation in style?
- Should you mind your own business?

Cases

Case 1 A Patient Lost

Bill comes into his office early to find a desk covered with messages, charts, and forms. This is a typical Monday morning for him, with one or two hours to clear his desk before starting on the next round of patients. It has been particularly tough this month because of winter viruses that have filled the office with acutely ill patients in addition to the usual well-child checks. One of these viruses has affected him, and he too is feeling a bit ill.

Bill sorts through a stack of lab reports, circling abnormal values and writing notes to the nurse about how to follow up. Next, he signs off some forms and prescription refills. One and a half hours into his day, he already feels that he has done a day's work.

Next, he shuffles through messages and finds a note from Mrs. Jones, the mother of 3 ½-year-old Anna, whom he has cared for since birth. There have been many well-child checks, minor illnesses, and some behavioral problems. He is surprised by the message, which states that "Mrs. Jones called on Friday and asked that we transfer little Anna's records to the practice of another pediatric group." "I wonder why they are transferring," he muses sadly. He thinks back to interactions he has had with the child and parents and cannot come up with anything out of the ordinary. Was there a conflict about a bill or an interaction with a nurse? Bill writes a note to his office staff: "Please copy the records of Anna Jones and send to Dr. X" yet he can't help but wonder why the family wishes to transfer.

Time is passing and there are many more messages to get through before the office officially opens and many more families that want to come to him. Nevertheless, the Jones request bothers him and he asks the nurse to pull the Jones chart. Should he call the mother? Time to move on.

Case 1

A Patient Lost

Guiding Questions

1. What is your duty to patients who are leaving your practice?
2. Why is Bill troubled by this situation? Should he be?
3. Is this something Bill should look into further or should he write it off as an issue of patient autonomy?
4. Is there a threshold for the number of patient transfers that you would find unacceptable?

Case 2

Professionalism After Residency

Dr. Mike White, a 34-year-old general pediatrician, was trained at the local children's hospital prior to joining Starr Pediatrics Practice. Starr Pediatrics enjoys an excellent reputation and is located in the affluent suburbs with an outstanding payer mix.

Dr. White typically sees twenty patients per morning session and last week noted after a single morning session that three patients seen that morning had been referred to Dr. Johnson, the new chief of pediatric gastroenterology at the children's hospital. Dr. White notes that each of the three patients seen by Dr. Johnson had undergone some sort of endoscopic procedure with biopsies. He only knows this because the pathology reports of normal biopsies are in the record. He has not received any follow-up letters from Dr. Johnson. Ironically, as Dr. White was reflecting upon these facts, Mrs. Reyes called to thank Dr. White for the timely referral of her daughter Selma to Dr. Johnson.

Mrs. Reyes was very impressed with the care and attention her daughter received at the recent visit. She also reported that she was especially impressed that she got an appointment within the week, because she had been told that the wait time is normally greater than six weeks. "You must have a great connection with Dr. Johnson," Mrs. Reyes told Dr. White.

Dr. White thinks "how timely" and tells his partners that Dr. Johnson seems to be serving their practice well; patients are satisfied and seem to get almost preferential service.

Three weeks pass when Shirley, Dr. White's most experienced nurse, asks for a referral for her 3-year-old son Charlie, who has had ongoing constipation issues despite medications. Dr. White thinks the problem is probably compliance and control issues but agrees to refer Charlie to Dr. Johnson. After Charlie sees Dr. Johnson, Shirley calls and requests a second opinion because she doesn't want Charlie to have to undergo the recommended colonoscopy. Shirley says, "It is just constipation. I was only looking for an easier laxative to use."

Dr. White also feels a bit uncomfortable about the recommendation for what may be an unnecessary procedure. He remembers that Dr. Spect, who was a resident with him and, who subsequently went across the state to the prestigious gastroenterology fellowship program at the University Children's Hospital, has recently joined Dr. Johnson's group. Dr. White thinks that she is the best resource to get the true story. He calls Dr. Spect, but she is on family medical leave. He also calls Dr. Kerwin, another friend from residency, who practices in the community health center in the poorer section of town. He asks if Dr. Kerwin has any similar concerns about Dr. Johnson. Dr. Kerwin reports that Dr. Johnson is not a good communicator and seems reluctant to endoscope his patients. Dr. Kerwin has started to use another private pediatric gastroenterologist for his referrals.

Case 2

Professionalism After Residency

Guiding Questions

1. What is your duty to know the practice of the physicians to whom you refer?
2. After receiving multiple normal biopsy reports, what options, if any, should you pursue? Internal chart audit? Call the referring doctor? Call the department chair?
3. What if you learn that the numbers of endoscopic procedures exceeds the standard of care?
4. Does preferential scheduling of your patients reflect good business or is there another agenda? Does it matter?
5. Since his patients seem happy, should Dr. White be concerned about the lack of follow-up correspondence?
6. What if you perceive that the pattern of endoscopies correlates with patient insurance?
7. What is the appropriateness of contacting Dr. Spect?

Case 3

Lifelong Learning

Part I

Dr. Susie Jones gathers up her belongings and copies of her pediatric journals from her office on the way out to the car to drive home. It has been a long day and is now 8:00 pm. She stopped seeing patients at about 5:30 pm. From 5:30 to 8:00 pm, three of the four members of her practice group gathered together over a pizza for their biweekly journal club. The topic of tonight's session was "Review of Asthma Guidelines" recently published by the American Academy of Pediatrics. While driving home Susie reflects on how lucky she was to find the practice in which she is currently working. After finishing residency training two years ago, she interviewed at a number of different practices and made a decision to choose her current practice because the group was relatively young and they seemed committed to keeping up to date and practicing high-quality pediatrics. They were a collegial group and went out of their way to share new information that they learned with one another. When Susie arrives home at about 8:30 pm, she has to put the final touches on packing for her family, which includes a 7-year-old and a 5-year-old. They will be accompanying her and her husband to Orlando for the annual AAP meeting, the first she has been able to attend since beginning practice two years ago. She is excited about the meeting, the setting, and the chance to spend some fun time with her husband and children. It is also important to acquire 25 CME credits, as her state medical license is due to be renewed soon.

Susie plans to attend as many sessions as possible and is particularly interested in the Red Book Committee Session on New Immunizations; however, the Red Book meeting conflicts with a beautiful, sunny day and 7-year-old Sam wants to go to Disney World. There is also an evening session scheduled on cultural competence and Susie plans to attend this, as a number of immigrant families have recently joined the practice. Her husband, however, surprises her with an invitation to dinner for just the two of them and has made arrangements for their children to be cared for by an on-site babysitter. And so it goes for the rest of the meeting. Susie is able to attend several hours of sessions, but not nearly what she had originally planned.

On arrival back in the office several days later, Susie accesses PediaLink online and enters her hours of attendance at the AAP conference, 25 CME credits as is required for her to maintain her license.

Case 3

Lifelong Learning

Part II

One week later, Susie is back at work in her busy practice. It is a Friday afternoon and she usually tries to attend grand rounds at the local university hospital, as do other members of the practice, in order to obtain their CME credits. It has been a bad day. Several unexpected ill patients arrived, and she is still trying to get caught up on paperwork from the four days spent at the AAP conference. She asks her partner Mary Jane, who is planning to attend grand rounds, if she would sign her in and bring back any handouts that are distributed. She asks if Mary Jane could fill her in on the content of the conference at the time that their practice has its next educational session.

Case 3

Lifelong Learning

Guiding Questions

1. How does one balance personal and professional obligations?
2. If Susie is keeping up with the medical literature with her practice journal club and providing high-quality care, can claiming the CME credits be justified?
3. What if Susie consciously sets aside time to read about new immunizations and cultural competence after returning from the AAP meeting?

Chapter 7

When a Resident Is Not Meeting Expectations Related to Professionalism

By far the vast majority of trainees will have no problems with passage through the developmental stages of professional development. They will move from being medical students, whose course of learning and behavior were guided by others, to a mode of learning and professional behavior that is self-directed. Rarely, there will be a trainee who needs extra guidance and perhaps even external control. Even more rarely, you may encounter an individual who is not suited for a professional career in pediatrics and who has escaped the normal screens in place to protect patients and the public at large. These are most challenging situations for a program director. They are fraught with interpersonal stress, institutional and program upheaval, and occasionally legal entanglements. When unprofessional behavior occurs, it is up to the program director to determine the weight of the infraction and to chart a course of action. What follows in this chapter are some suggested guidelines.

It is important to say a few words about documentation related to professionalism issues. It is critical for the program director to document the conversations, meetings, and actions involved in any professionalism action. This documentation should be placed in a separate and nondiscoverable file. If further action is needed the program director will want to have this record in place. There may be future inquiries regarding whether the trainee ever had a break in training or any unusual monitoring. These questions often appear on credentialing or licensing forms. The proper answer to these questions depends on the severity of the professional lapse. A single lapse could be considered part of a resident's developmental process, but residents should know that serious professional problems will require a notation on future credentialing forms. Program directors may

also want to meet with a resident who is having trouble in the presence of a third party such as a chief resident or assistant program director. This may be necessary for the program director's own protection.

What Actions May Be Taken

Counseling – Lapses in professional behavior are often the result of stress, anxiety, depression, and exhaustion. These are the enemies of professional conduct, and someone who is generally functioning well may lapse because of such external forces. The program director's first course of action may be to try to identify any of the aforementioned conditions and to see if they can be alleviated or at least diminished. Counseling by a mental health professional may be very helpful in returning a resident to his/her baseline of professional behavior. Guidance should be offered by the program director, but counseling should be left to a qualified external professional.

Remediation – In some instances, the program director and the trainee may want to establish a contractual remediation plan. Such a plan would specify tasks or criteria that the trainee must fulfill before returning to a position of good standing within the program.

Leave of Absence – At times it may be necessary to recommend or even enforce a leave of absence for an individual resident. When behaviors fall to a level that may be harmful to the trainee or potentially to a patient in the trainee's care, a leave should be instituted. There should be program and institutional guidelines in place that give the program director authority to take this action. A leave requires that the trainee seek the kind of help that he/she needs in order to return safely to work.

What Constitutes Egregious Action

Some behaviors constitute serious breaches in professionalism. These might include:

- Willful misrepresentation of clinical data
- Providing care while under the influence of alcohol or drugs
- Involvement in illegal activity
- Physical or verbal abuse directed toward patients, families, colleagues, or staff
- Sexual misconduct or violation of appropriate physician-patient boundaries
- Humiliation or harassment
- Prejudicial behavior
- Failing to notify supervisors of inability to work
- Falsification of research data
- Failure to disclose ties to industry
- Coercion of a patient to join a research study
- Refusal to participate in a legal process designed to protect the welfare of children

Consideration of Context and Pattern of Behavior –

It may be appropriate to consider the context in which unprofessional behavior occurs and whether the lapse is a single event or part of a pattern of behavior. There is clearly a gradation in the seriousness of offenses. Consideration can be given to the meaning of that episode for the individual trainee and the program. The program must articulate what constitutes acceptable and clearly unacceptable behaviors. Some have suggested that residents themselves establish guidelines for a program's code of conduct.

When Context Does Not Matter – There will be some instances in which absolute legal and ethical standards have been breached and which require that action be taken regardless of context or pattern of behavior. Such acts might include physical assault, sexual misconduct, and wanton harm of patients or their families.

What to Do About It

Consultation – In these difficult situations the program director will want to request consultation from departmental and hospital administrative consultants. In many cases, the hospital attorney will need to be informed and consulted. Some hospitals may have ethics boards, graduate medical education committees, or other constituents of a due process procedure.

Documentation – In more egregious cases of professional misconduct that may result in criminal or civil litigation, an even higher standard of documentation is required.

Physician Impairment Program – In many states, there are specific physician impairment programs, particularly for cases of substance abuse. These programs are very helpful in providing sufficiently rigorous surveillance and specific referral resources to avoid loss of license and/or board certification.

Involvement of Law Enforcement – In some cases, the hospital may choose to notify law enforcement officials about specific violations of criminal law such as assault, robbery, or drug sales.

Notification of the American Board of Pediatrics –

A program director has the responsibility to notify the ABP if a lack of professionalism has been identified during training and whether, at the completion of training, it should mandate the withholding of permission to take the certifying examination. Although reporting may occur at any time, the ABP requires program directors to evaluate the clinical competence and professionalism of residents at the end of each year of training on the tracking roster. If an unsatisfactory evaluation is given for professionalism, the resident must repeat the year of training or, at the discretion of the ABP and recommendation by the program director, complete a period of observation. A resident or fellow who receives an unsatisfactory evaluation for professionalism receives no credit for that year of training, unless the program director provides evidence as to why a period of observation would be more appropriate than a repeat year of training. If a period of observation is acceptable and the resident is at the end of his/her training period, this observation will extend into a subsequent training period, such as during a subspecialty fellowship or during a physician's initial period in practice. A plan for remediation must be developed and submitted to the ABP for approval. Observation plans for lapses in professionalism are developed on a case-by-case basis. The observer must provide an assessment of clinical competence with particular attention to professional attitude and behavior at the end of the agreed upon period of observation. Less than satisfactory performance in professionalism will be grounds for continued denial of credit for training and result in a disapproval to take the certifying examination. Additional information can be obtained by contacting the ABP.

Chapter 8

Measuring Professionalism

“Professionalism is not what you do every time, but what you do over time.” David T. Stern, MD, PhD

There is much debate over whether professionalism is a trait or a state. Although there are some aspects of professional behavior that were “learned in kindergarten,” the professionalism we are trying to assess pertains to the context in which residents are working. When a resident demands that the ultrasound technician come in from home to perform a study on a patient in the middle of the night, is he advocating for the best interest of his patient or is he communicating poorly with his colleagues? A resident who spends the night holding the hand of a dying patient is not available to help her team admit a new patient. Is she showing compassion for patients or is she shirking responsibilities to her team?

It is in these contexts, with these kinds of conflicting values, that the professionalism of residents is measured.⁸ When these conflicts are resolved successfully, residents should receive positive feedback on their behavior. If there is a lapse in professionalism, residents should reflect on their behavior and receive feedback that will help improve their professionalism over time.

Although the American Board of Pediatrics asks for a summative assessment of professionalism on the final verification form, most assessments of professionalism during residency will be formative. These assessments ought to come from multiple evaluators in multiple settings. Combined with self-assessment and self-reflection, these evaluations provide important feedback to foster residents’ professional development.⁹

Recent reviews of tools available to assess professionalism reveal few robust tools with good reliability or validity,^{10, 11} but a number of tools have promise. For this workbook, we have chosen four assessment methods that we believe could be integrated into residency programs: critical incidents,

peer assessment, a professionalism mini-evaluation exercise (P-MEX), and multisource assessment instruments (which would include patient assessments). We do not recommend the use of the global, end-of-rotation evaluations as a primary tool for measuring professionalism because they are often too general to provide meaningful feedback for this domain. However, the utility of the global evaluation could be improved with faculty development efforts and the incorporation of specific feedback from peers, other health professionals, and patients.

We reviewed the literature and developed a consensus about the relative strengths and weaknesses of each assessment tool. For each of these, we describe how it could be used by residency programs, where it can be found, and what areas of professionalism it assesses. We also highlight any studies that address the tool’s reliability and validity. Following each description, we summarize the key characteristics of the assessment tool in a table.

Critical Incidents

Critical incidents can serve as a window into the professionalism of residents, and they can be used to assess any area of professionalism. They can be identified through a phone call or e-mail to the program director. Some programs have a specific Praise/Early Concern Card (see sample from the American Board of Internal Medicine at the end of this chapter) that can be completed by faculty or peers to provide written documentation of a critical event. Notation of these incidents could also be specifically requested on the global monthly evaluation form.

Program directors should develop a specific process for addressing these critical incidents with residents. If the critical incident is positive, the res-

ident should receive appropriate positive feedback to indicate that the program values this behavior. If it is a negative incident, the resident should receive specific feedback and have a chance to address it with the program director. In either case, the resident should have the opportunity to reflect on the event.

Some of the strongest assessments of validity regarding critical incidents come from work in undergraduate medical education. Papadakis and colleagues evaluated the use of a Physicianship Evaluation Form and found that students for whom a form was submitted or who were the subjects of comments about unprofessional behavior that would have warranted a Physicianship Form were more than twice as likely to be subsequently disciplined by a state medical board.^{12, 13}

If programs wish to incorporate critical incidents, they need to develop a consensus and culture among the faculty to support their use. Faculty development should include 1) identifying for faculty the behaviors, both positive and negative, that should be reported, and 2) encouraging faculty to document the behavior of residents, especially if an incident is negative.

Critical Incidents

Feasibility

- Low-cost evaluation; can be done on paper or via a Web-based system; faculty development would facilitate use

Reliability/Validity

- Studies document correlation with discipline by state medical board for students about whom serious concerns were raised; no good data on reliability

Comments

- Consider use of Praise/Early Concern Card developed by the ABIM

Peer Assessments

Peers often have a distinct perspective on professional behavior because they can observe and provide feedback on professional attributes such as conscientiousness, respect for patients and health professionals, effective communication, and acceptance of responsibility.⁹ Peer assessments have been used very successfully in a number of medical schools.

A study of medical students at several institutions found that a peer assessment system must be 100% anonymous, feedback should occur immediately, the focus should be equally on unprofessional and professional behaviors, and data should be used formatively to reward exemplary behavior and to address repetitive negative lapses.¹⁴ Although there is no standardized peer assessment for professionalism, it may be helpful to have residents participate in defining the items that should be included on the assessment instrument. This process will increase buy-in of the residents and also help generate consensus about professionalism expectations. In addition, given the smaller size of residency programs compared with medical schools, consideration might be given to having residents complete peer evaluations on residents from other classes (eg, PL-1s evaluate PL-3s and vice versa) rather than those in the same class.

Programs can use a peer assessment tool to evaluate professionalism by incorporating elements of professionalism into existing peer assessments or by developing a free-standing assessment for professionalism. Some educators have advocated a separate evaluation for professionalism, both to avoid bias from other areas (such as clinical competence) and to emphasize the importance of professionalism.¹⁵

Research on the reliability and validity of peer assessments indicates that between six and eleven peer assessments are necessary to achieve a reliability coefficient of 0.7. Overall, peer rating systems appear to have a high level of reliability.¹⁶ Although there is no “gold standard” for professionalism against which to compare these assess-

ments, there is good support for face, content, construct, and predictive validity. In addition, most studies indicate that peer assessments address unique aspects of professional behavior.

Peer Assessments

Feasibility

- Resources required for distributing and collecting data; will add to overall evaluation response burden for the residents

Reliability/Validity

- Six to eleven evaluations can produce reliability coefficient of 0.7; no “gold standard” for validity of assessment, but has face, content, and construct validity

Comments

- Involving residents in developing the instrument can increase their buy-in

Professionalism Mini-Evaluation Exercise

The Professionalism Mini-Evaluation Exercise (P-MEX) is a promising new tool developed by educators at McGill University.¹⁷ It is based on the successful mini-clinical examination tool (mini-CEX) developed by the American Board of Internal Medicine and consists of 24 items designed to assess professional behaviors. Although it was originally developed for use with medical students, the investigators have now expanded its use to residents. The original evaluation form was published in *Academic Medicine* (2006;81:S74-8) and a revised version is included at the end of this chapter.

The psychometric properties of this tool were solid during its initial testing with medical students. It demonstrated good content and construct validity. Evaluations from ten to twelve raters result in a reliability coefficient of 0.8, but the confidence intervals were small enough for most evaluation purposes with as few as six to eight raters. Qualitative evaluation has also suggested that this tool can stimulate reflection on behavior.¹⁷

P-MEX

Feasibility

- Relatively easy to implement after initial training with the form; requires faculty time for observation of resident-patient interactions

Reliability/Validity

- Good content and construct validity; use of ten to twelve raters provides a reliability coefficient of 0.8

Comments

- Covers the full range of professional behaviors

MultiSource Assessment

A multisource assessment (also called a 360-degree assessment) collects feedback from several different types of raters (eg, patients, peers, nurses, clerks, supervising physicians). It is an ideal way to include the patient’s voice in the assessment of residents.

The preferred format for multisource evaluations is a core set of items evaluated by all raters, along with other items that might be answered by selected groups of evaluators. Multisource assessments are well-suited to evaluating professionalism (and other competencies such as interpersonal and communication skills) across all domains: in clinical care, in the work environment (including an assessment of how stress impacts professionalism), and in society (eg, how well residents advocate for the needs of patients).

A multisource instrument developed by Musick has been used to assess professionalism and other behaviors.¹⁸ The National Board of Medical Examiners (<http://professionalbehaviors.nbme.org>) is piloting another tool that can be used for medical students, residents, and practicing physicians. Because of the complexity of distributing, collecting, and analyzing these instruments, electronic systems are recommended by most assessment experts. It may be difficult for programs to implement a full multisource evaluation system all at

once, but rolling out parts of the system over time may make this method more feasible.

The advantage of this tool is that several perspectives can be obtained and the formative feedback can be useful for residents. One disadvantage however, is that a large number of evaluations is required to provide a reliable measure of performance. The number of raters required for good reliability of Musick's or the NBME's tools is unknown at this time. However, a classic study indicated that fifty or more patient evaluations of a resident's humanistic qualities were required to obtain the same reliability as ten to twenty evaluations by nursing staff.¹⁹

MultiSource Assessments

Feasibility

- High-cost evaluation; requires system to distribute and collect from a variety of sources; need to develop database to analyze data
- Future may bring opportunities to integrate an assessment into an existing Web-based evaluation system

Reliability/Validity

- Need a large number of patient evaluations for high-stakes decisions, but this method is well-suited to formative feedback
- No good data yet on reliability

Comments

- NBME instrument is a promising tool, and more data will be forthcoming

Praise Card

Subject: Praise Card about Physician Performance
From: Program Director

Please complete and submit this card to me when you wish to praise the performance and/or professional behavior of a physician colleague. This information will be conveyed to the physician and noted in the departmental file.

Name of Physician: _____ Date: _____

My praise about the performance of this physician is based on his/her demonstration of exceptional ability in the following: (please √)

- | | |
|---|--|
| <input type="checkbox"/> clinical judgment | <input type="checkbox"/> humanistic qualities |
| <input type="checkbox"/> clinical skills | <input type="checkbox"/> professionalism |
| <input type="checkbox"/> medical knowledge | <input type="checkbox"/> team management and leadership |
| <input type="checkbox"/> communication skills | <input type="checkbox"/> critique of medical/scientific literature |
| <input type="checkbox"/> teaching | <input type="checkbox"/> conduct of research |

Comments: _____

Name: _____ Phone: _____

Early Concern Note

Subject: Early Concern Note About Physician Performance
From: Program Director

Please complete and submit this card to me when you have any concerns about the performance and/or professional behavior of a physician colleague. This information will be used confidentially and constructively to help the physician.

Name of Physician: _____ Date: _____

My concerns about the performance and/or professional behavior of this physician are based on: (please √)

- critical incident
- gut level reaction
- series of "red" flags

I have discussed my concerns with the physician Yes No
I feel uncomfortable discussing my concerns with the physician Yes No
Please call me about these concerns Yes No

Comments: _____

Name: _____ Phone: _____

PROFESSIONALISM MINI-EVALUATION EXERCISE

Evaluator: _____

Resident: _____

Level: (please circle) **PGY1 PGY2 PGY3 PGY4 PGY5 PGY6**

Setting: **Ward Clinic ER ICU**
Other _____

N/A UN BEL MET EXC

Listened actively to patient					
Showed interest in patient as a person					
Recognized and met patient needs					
Extended him/herself to meet patient needs					
Ensured continuity of patient care					
Advocated on behalf of a patient					
Demonstrated awareness of own limitations					
Admitted errors/omissions					
Solicited feedback					
Accepted feedback					
Maintained appropriate boundaries					
Maintained composure in a difficult situation					
Maintained appropriate appearance					
Was on time					
Completed tasks in a reliable fashion					
Addressed own gaps in knowledge and/or skills					
Was available to colleagues					
Demonstrated respect for colleagues					
Avoided derogatory language					
Maintained patient confidentiality					
Used health resources appropriately					

► Please rate this resident’s overall professional performance during THIS encounter:

UNacceptable BELow expectations MET expectations EXCeeded expectations

► Did you observe a critical event? no yes (comment required)

Comments:

Evaluator’s signature: _____

Resident’s signature: _____

Date & Time: _____

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Annotated Bibliography

[AAP Committee on Bioethics](#). Professionalism in pediatrics: Statement of principles. *Pediatrics* 2007;120:895-7.

This article outlines the principles of professionalism in pediatrics. This is accompanied by a more detailed report by the Committee on Bioethics in the same issue of *Pediatrics*, pages e1123-33.

[ABIM Foundation](#). American Board of Internal Medicine, ACP-ASIM Foundation. American College of Physicians-American Society of Internal Medicine, European Federation of Internal Medicine. Medical professionalism in the new millennium: A physician charter. *Ann Intern Med* 2002;136:243-6.

The article outlines the fundamental principles of professionalism and ten professional responsibilities for physicians. The Charter has been adopted by all of the ABMS Boards, including the American Board of Pediatrics. It is the foundation for this workbook.

[Accreditation Council for Graduate Medical Education](#). Advancing education in medical professionalism. Accreditation Council for Graduate Medical Education, 2004. (Accessed at http://www.acgme.org/outcome/implement/Profm_resource.pdf.)

This is an educational resource developed by the ACGME to help program directors teach and assess professional behavior. Some sample evaluation instruments are reviewed.

[Arnold L](#). Assessing professional behavior: Yesterday, today, and tomorrow. *Acad Med* 2002;77:502-15.

This article provides a comprehensive review of various methods for assessing professional behavior among medical students and residents.

[Arnold L, Shue CK, Kalishman S, et al](#). Can there be a single system for peer assessment of professionalism among medical students? A multi-institutional study. *Acad Med* 2007;82:578-86.

This article reports the results of a survey of medical students from four schools on the characteristics of a peer evaluation system that they would find valuable. The authors found that students prefer a system that is 100% anonymous, provides immediate feedback, focuses on both unprofessional and professional behaviors, and uses peer assessment formatively. They also desire a system that rewards exemplary behavior and addresses serious repetitive professional lapses. The need for an environment that is supportive of professionalism is also stressed.

[Arseneau R, Rodenburg D](#). The developmental perspective: Cultivating ways of thinking. In: Pratt DD, ed. *Five Perspectives on Teaching in Adult and Higher Education*. Malabar, FL: Krieger Publishing; 1998:105-49.

This article addresses key principles in a developmental perspective on medical education. It is a good article for anyone thinking about teaching.

[Association of American Medical Colleges](#). Compact Between Resident Physicians and Their Teachers. AAMC, 2006. (Accessed September 3, 2007, at <http://www.aamc.org/meded/residentcompact>.)

This document highlights the commitments that faculty and residents must make to each other in order to foster a high-quality educational and patient care environment. It is a corollary to the document developed by the AAMC for use between medical students and their teachers.

[Baldwin DC, Jr., Daugherty SR, Rowley BD](#). Unethical and unprofessional conduct observed by residents during their first year of training. *Acad Med* 1998;73:1195-200.

This article reports on the results of a survey of 571 first-year residents and their observations of unethical and unprofessional conduct by peers or superiors. Not surprisingly, these behaviors are too frequent. The authors also reported that these observations have an inverse correlation with resident satisfaction.

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This article compares ratings of pediatric residents by faculty, nurses, and patients. In this study, nurses had greater ability to assess and provide feedback regarding communication skills and professionalism. Families and attending physicians reported greater difficulty evaluating residents in a number of areas.

[Brinkman WB, Geraghty SR, Lanphear BP, et al](#). Effect of multisource feedback on resident communication skills and professionalism. *Arch Pediatr Adolesc Med* 2007;161:44-9.

The authors randomized a group of pediatrics residents to feedback or no feedback from evaluations that were completed by attending physicians, nurses, and patients. Those who received feedback had improved scores (compared to baseline) from nurses, while those who did not receive the feedback received lower scores from nurses. Scores from the family also increased for the group who got feedback, but this was not statistically significant.

[Cohen JJ](#). Professionalism in medical education, an American perspective: From evidence to accountability. *Med Educ* 2006;40:607-17.

This article reviews the current state of the teaching and assessment of professionalism in medical education. The author stresses the need for performance assessment using multiple evaluators and multiple methods.

[Coulehan J](#). Today's professionalism: Engaging the mind but not the heart. *Acad Med* 2005;80:892-8.

The author argues that the medical education environment is hostile to altruism and a number of other qualities that are essential to professionalism. He proposes a comprehensive plan to change the culture of medical education and to address the tension between self-interest and altruism.

[Cruess RL](#). Teaching professionalism: Theory, principles, and practices. *Clin Orthop* 2006;449:177-85.

This is one in a series of articles in this issue of Clinical Orthopedics and Related Research that addresses professionalism. This article addresses how professionalism is taught at McGill

Medical School. It is primarily focused on medical students, but there are a number of strategies that could also be used for resident education.

[Cruess R, McIlroy JH, Cruess S, Ginsburg S, Steinert Y](#). The professionalism mini-evaluation exercise: A preliminary investigation. *Acad Med* 2006;81:S74-8.

This is the original article describing the use of the professionalism mini-evaluation exercise (P-MEX). Initially tested in medical students, it appears to have very good psychometrics. It would be relatively easy to incorporate this instrument into a residency program.

[Engel KG, Rosenthal M, Sutcliffe KM](#). Residents' responses to medical error: Coping, learning, and change. *Acad Med* 2006;81:86-93.

This article presents the results from in-depth qualitative interviews with residents who were involved with a medical error. Residents have a profound emotional response to these events. The authors call on program directors to create environments in which these events can be addressed safely and professionally.

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This article outlines a very useful framework for thinking about professionalism lapses. It has served as the foundation for much of the subsequent work in this area.

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This interesting article qualitatively explores students' reasons for making decisions in difficult professional situations. It describes the disavowed curriculum, the concept that there are certain behaviors (such as promoting the needs of the individual or team over the needs of the patient) that are shunned by the medical profession. By recognizing these conflicts, faculty may be able to help students and residents reason through these difficult situations.

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This article describes the use of a portfolio for the assessment of professionalism in medical students.

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This is one of the key articles in the series on professionalism in this issue of Clinical Orthopedics and Related Research. The author provides a concise overview of the literature as it relates to definitions of professionalism.

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This is one of several articles in this issue of Academic Medicine that addresses the ways in which institutions can change the culture to influence the "hidden" curriculum and enhance the importance of professionalism in the learning environment. The University of Chicago targeted medical students, residents, and faculty in developing its roadmap.

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This monograph, published by the AAMC, reviews medical professionalism and how it ought to be incorporated into medical education at all levels.

[Kalet AL, Sanger J, Chase J, et al](#). Promoting professionalism through an online professional development portfolio: Successes, joys, and frustrations. *Acad Med* 2007;82:1065-72.

The authors describe their experience with a Web-based portfolio for medical students that included narrative reflection, self-assessment, and goal-setting. The variation in students' experience and satisfaction with the portfolio highlights the complexities of implementing a portfolio-based assessment for professionalism.

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The authors describe their curriculum for introducing principles of professionalism into a pediatrics residency. Their curriculum is incorporated into their annual five-day intern retreat, during which eleven sessions are devoted to addressing key professionalism issues.

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In this study of three medical schools, students nominated peers who exemplified three characteristics: clinical competence, caring, and community service. Counting nominations is a reliable way to identify students for recognition in these areas.

[Musick DW, McDowell S, Clark N, Salcido R](#). Pilot study of a 360-degree assessment for physical medicine & rehabilitation residency programs. *Am J Phys Med Rehabil* 2003;82:394-402.

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This was the original paper to connect unprofessional reports from medical school with subsequent disciplinary actions by state medical boards.

[Papadakis MA, Osborn EH, Cooke M, Healy K](#). A strategy for the detection and evaluation of unprofessional behavior in medical students. *Acad Med* 1999;74:980-90.

This article describes the use of critical incidents in the evaluation of professional behavior of medical students.

[Papadakis MA, Teherani A, Banach MA, et al](#). Disciplinary action by medical boards and prior behavior in medical school. *N Engl J Med* 2005;353:2673-82.

This paper expands on prior work in this area and extends the analysis to three medical schools. The strongest association between unprofessional behavior and subsequent disciplinary action by the medical boards was seen for those students who were described as irresponsible or as having a decreased ability to improve their behavior.

[Regehr G, Eva K](#). Self-assessment, self-direction, and the self-regulating professional. *Clin Orthop* 2006;449:34-8.

The author discusses the inaccuracy in many self-assessments and the implications of this for how professionals engage in self-regulation.

[Royal College of Paediatrics and Child Health](#). Good Medical Practice in Paediatrics and Child Health: Duties and Responsibilities of Paediatricians. Royal College of Paediatrics and Child Health, 2002. (Accessed at http://www.rcpch.ac.uk/doc.aspx?id_Resource=1744.)

This document was developed to describe the principles of good pediatrics practice in all aspects of professional work. The document includes a description of each area, along with behavioral statements of what is acceptable behavior and what represents unacceptable practice.

[Shanfelt TD, Bradley KA, Wipf JE, Back AL](#). Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med* 2002;136:358-67.

This paper describes a high level of stress and burnout among internal medicine residents. Residents who reported burnout were also more likely to report sub-optimal patient care.

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In this retrospective cohort study of medical students, failing to complete required course evaluations and failing to report immunization compliance were significantly associated with future professionalism issues noted by a medical review board.

[Stern D, Papadakis MA](#). The developing physician: Becoming a professional. *N Engl J Med* 2006;355:1794-9.

The authors describe a thoughtful approach to teaching and assessing professionalism. This is worthwhile reading for all program directors.

[Stern DT, ed](#). *Measuring Medical Professionalism*. New York, NY: Oxford University Press; 2006.

An interesting and well-written book, this multiauthored text is a key resource for those interested in the academic approach to the teaching and assessing of professionalism.

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[Woolliscroft JO, Howell JD, Patel BP, Swanson DB](#). Resident-patient interactions: The humanistic qualities of internal medicine residents assessed by patients, attending physicians, program supervisors, and nurses. *Acad Med* 1994;69:216-24.

This article compared the results between evaluations of residents by nurses, attending physicians, and patients. The results indicate that ten to twenty nursing evaluations achieved the same level of reliability that was achieved with fifty or more evaluations from patients.