

Project Professionalism

American Board of Internal Medicine



*Promoting
Excellence in
Health Care*

Project Professionalism is dedicated to promoting integrity within the specialty of internal medicine and the educational environment and among all internists and subspecialists. Its principles are committed to the enhancement of professionalism by the medical profession as a whole.

Project Professionalism is available online at <www.abim.org>; also learn more about medical professionalism and a new activity of the ABIM Foundation by visiting <www.professionalism.org>.

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Project Professionalism: Staying Ahead of the Wave

FUNDAMENTAL to the art and science of medicine, professionalism has been an intrinsic part of certification since the inception of the American Board of Internal Medicine (ABIM) in 1936. The fundamental principle of certification reflects a set of standards for physician competence in regard to knowledge, skills, attitudes, and behavior in the care of patients. It is that set of attitudes and values that constitutes the essence of professionalism. Since ABIM's mission is "to enhance the quality of health care available to the American public by continuously improving the process and maintaining high standards for certifying internists and subspecialists who possess the knowledge, skills, and attitudes essential for the provision of excellent care," the board has been increasingly concerned that recent changes in the health care delivery system have resulted in "stress surges" that can have a negative impact on the professional behavior of physicians. This concern is sharpened as physician reimbursement changes and health care is provided in a competitive environment of managed and prepaid care, threatening to reduce the status of patients to commodities rather than people with an affliction.

During the 1980s, ABIM recognized "humanistic qualities" as a defined and formal component of clinical competence and as a requirement for certification. Former ABIM President John Benson, MD, and Julius Krevans, MD, former Chancellor, University of California, San Francisco, along with members of the ABIM Subcommittee on Humanistic Qualities, spearheaded efforts to develop a simple, straightforward definition of these qualities — integrity, respect, and compassion — in regard to patient care.¹ In addition, ABIM proved that these qualities could be evaluated and documented in the training environment with the support of each residency and subspecialty program director and use of an effective evaluation system.²

GOALS AND OBJECTIVES

In 1990, ABIM established a project to enhance the evaluation of professionalism as a component of clinical competence and to promote the integrity of internal medicine. In large part, the project was motivated by changes, inside and outside the educational environment, eroding professional standards. The board wanted this effort to accomplish the following objectives:

- ◆ Define professionalism
- ◆ Raise the concept of professionalism in the consciousness of all within internal medicine
- ◆ Provide a means for program directors to inculcate the concepts of professionalism within their training programs
- ◆ Develop strategies for assessing the professionalism of residents and subspecialty fellows during training.

The project took form in 1992 with the appointment of a subcommittee that reviewed the literature, developed an issues list, asked questions, prepared a comprehensive syllabus, and organized workshops and symposia to explore those aspects of professionalism upon which the project would focus. Chaired by John Stobo, MD; the subcommittee included Jordan Cohen, MD; Harry Kimball, MD; Michael LaCombe, MD; and Geraldine Schechter, MD; and was staffed by Linda Blank.

These efforts led to the consideration of many issues including the profession's accountability to the public and itself, professional ethics (illustrated by dilemmas posed by pharmaceutical industry influences), fraud in research and the Medicare program, fraudulent board certificates and misrepresentation, conflicts of interest (such as self-referral), moral and ethical behavior in the clinical setting, greed, and lack of conscientiousness.

ACTIONS

From 1992 to 1994 the subcommittee developed a working definition of professionalism as well as a document for program directors and faculty to use in promoting the teaching and evaluation of professionalism in physicians during training. A series of workshops and symposia were also developed for national meetings of medical and subspecialty organizations to provide a broader framework for the project, promote a better understanding of the complexities and conflicts surrounding the concept of professionalism, and assure a diverse infusion of ideas.

Many individuals and groups outside ABIM were asked to review the products of Project Professionalism, including members of the ABIM Board of Advisors; participants at formal presentations to the Association of Professors of Medicine (APM); the Association of Program Directors in Internal Medicine (APDIM); the Association of American Medical Colleges (AAMC); the Society of General Internal Medicine (SGIM); the American College of Physicians (ACP)-American Society of Internal Medicine (ASIM); the Clinical Practice Section of the American Gastroenterological Association (AGA); the organization for Public Responsibility in Medicine and Research (PRIM&R); the Association for Behavioral Sciences and Medical Education (ABSAME); internal medicine residents, subspecialty fellows, and nurses at the University of Alabama at Birmingham; and internal medicine residents at St. Peter's Medical Center in New Brunswick, New Jersey. Moreover, the ABIM Committee on Evaluation of Clinical Competence provided an extensive critique of the work in progress, and in June 1994, the ABIM Board of Directors approved the project report and recommendations.

Project Professionalism has resulted in several publications (including this paper) advocating the role of certification in promoting the profession's integrity. Other contributions include a resource document aimed at program directors, clerkship directors, faculty, and housestaff, to promote professionalism within the educational environment. This document places special emphasis on signs and symptoms that erode professionalism, such as abuse of power and sexual harassment, conflicts of interest, professional arrogance, physician impairment, and fraud in research. Aids to professionalism are also described, including the importance of role models and mentoring.

Complementary to the resource document is a series of vignettes designed to illustrate quandaries of professionalism, specific assessment strategies for use in evaluating the professionalism of residency and subspecialty trainees, and a listing of suggested readings. In addition, the project reviewed ABIM, as well as other American Board of Medical Specialties (ABMS) member boards' experiences with fraudulent certificates and a spectrum of misrepresentation incidents.

The subcommittee has defined the core of professionalism as constituting those attitudes and behavior that serve to maintain patient interest above physician self-interest. Accordingly, professionalism, as the Board has defined it within the project's framework, aspires to altruism, accountability, excellence, duty, service, honor, integrity, and respect for others.

Although this project focuses on the patient, one additional goal is to recognize the unique importance of professionalism within the context of relationships between physicians and other health professionals, between specialties, and between professional organizations.

RECOMMENDATIONS

Finally, the project resulted in a series of recommendations for ABIM to pursue during the year ahead:

- (1) Publish the ABIM resource document on professionalism and distribute it to program directors; clerkship directors; key faculty members, including nurses; residents and subspecialty fellows; deans of medical schools; and medical organizations. The purposes of this document are to promote professionalism within the educational environment and describe ABIM standards.
- (2) Continue efforts to emphasize the significance of professionalism by sponsoring workshops and symposia at national meetings of medical organizations and subspecialty societies.
- (3) Develop multiple-choice questions on professionalism for board certification and recertification examinations (including the latter's self-evaluation process); identify professionalism as a separate category on the cross-content portion of the examination blueprint; and promote similar efforts within the national in-training examination for second-year internal medicine residents developed by the ACP, APM, and APDIM.
- (4) Remind program directors of their responsibility to ensure adequate verification of the backgrounds of prospective trainees (including relevant credentials), explanation of discrepancies in training or employment gaps, and explanation of past legal or criminal involvement. Professionalism requires rigorous adherence to established institutional procedures in order to verify that all candidates for residency and subspecialty fellowship positions are qualified and deserve appointment.
- (5) Highlight the expansion of board policy on revocation of certificates in conjunction with material misstatements or omissions of fact concerning an individual's certification or board eligibility status.
- (6) Publish ABIM's increasing experience with misrepresentation and use of fraudulent certificates and results of related ABMS surveys.

- (7) Encourage the community of certifying boards (ABMS members) to develop a standardized approach to address issues, policies, and physicians involved in misrepresentation and use of fraudulent certificates.
- (8) Monitor the impact on program accreditation of the *Program Requirements for Residency Education in Internal Medicine and the Subspecialties*, sections on professional ethical behavior and professionalism (see appendix); and offer revisions as appropriate.
- (9) Work with other professional medical organizations to promote standards for professionalism that will serve the public and the profession.

The medical profession has long enjoyed a special position in society. In the last few decades, however, accelerating advances in medical knowledge and technology have placed greater pressures on physicians to absorb and communicate information to patients and other health professionals. In the wake of these changes, demands and expectations of the public and the medical community have altered the perception of what being a physician really means. Unprofessional behavior and attitudes on the part of some physicians have eroded medicine's historically respected position.

Today, the medical profession stands at a crossroads. The direction it takes depends largely on its collective willingness to abide by a standard of excellence and behavior that requires a commitment to self-improvement and peer review. The fundamental principle of certification (and recertification) reflects such a standard and provides one channel for the medical profession to stay ahead of new waves of uncertainty.

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Excerpt from the PROGRAM REQUIREMENTS FOR RESIDENCY EDUCATION IN INTERNAL MEDICINE AND THE SUBSPECIALTIES

PROFESSIONAL ETHICAL BEHAVIOR

1. Physician Accountability

The training program must have mentors, role model clinicians, and a resident culture that demonstrates the values of professionalism, such as placing the needs of patients first, maintaining a commitment to scholarship, helping colleagues meet their responsibilities, a commitment to continued improvement and being responsive to society's health care needs. Residents should be given the opportunity to participate in community service, professional organizations and institutional committee activities.

2. Humanistic Qualities

Physicians must have the welfare of their patients as their primary professional concern. Thus the resident, faculty members and Program must demonstrate humanistic qualities that foster the formation of patient/physician relationships. These qualities include integrity, respect, compassion, professional responsibility, courtesy, sensitivity to patient needs for comfort and encouragement, and professional attitude and behavior toward colleagues. The written curriculum must emphasize the importance of humanistic qualities throughout the residency.

3. Physician Impairment

The residency program must instruct residents and faculty members in physician impairment, to include the recognition of, intervention in, and management of impairment such as alcohol and other substance abuse; depression; dementia; and other mental, emotional and physical disorders in their peers as well as the principles and methods of active intervention.

4. Professional Ethics

The training program must foster a commitment to professional ethics in residents that is demonstrated by a spirit of collegiality and a high standard of moral and ethical behavior within the clinical setting in the care of patients, in the education of residents, in conducting research and in interactions with pharmaceutical companies and funding organizations.

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Professionalism in Medicine: Issues and Opportunities in the Educational Environment

INTRODUCTION

THE American Board of Internal Medicine is the organization responsible for certifying physicians committed to careers in internal medicine or the medical subspecialties. This mandate requires that the Board define, promote and assess all of the components within the domain of competence. Competence as an internist comprises not only medical knowledge, clinical judgment, and clinical skills including proficiency in performing certain procedures, but also the professional attitudes and behavior which are the foundation for success as a physician. While knowledge and technical skills are important, how they are used is more important. In recognition of this fact, the Board in 1980, turned its focus toward the importance and assessment of humanistic qualities (integrity, respect and compassion) in the training of physicians. This culminated in the inclusion of humanistic qualities as an essential component of clinical competence and in the requirement for program directors to evaluate and document the demonstration of these qualities during training in order for candidates to be eligible for certification.

A decade later, the Board embarked on a similar process to address professionalism. For several years, the Board has been concerned that changes in the health care environment produce stress that can negatively affect the professional behavior of physicians. This concern is sharpened as physician reimbursement is changing and health care is provided in a competitive environment of managed and prepaid care, threatening to reduce the status of patients to commodities rather than people with an affliction. Responding to these concerns, in 1990 the Board began a process to define professionalism; to raise the concept of professionalism in the consciousness of all in internal medicine; and to provide a means for program directors to inculcate the concepts of professionalism in their training programs and assess professionalism in their trainees.

This process evolved under the guidance of *Project Professionalism*, a subcommittee of the ABIM Committee on Evaluation of Clinical Competence. To achieve its goals, the subcommittee has defined the components of professionalism (including what constitutes unprofessional behavior), explored various approaches to portray vignettes emphasizing elements

and principles of professionalism, developed questions designed to assess aspects of professionalism on certification and recertification examinations, and in the educational context of conferences and small group discussions. The subcommittee also presented workshops and symposia at national meetings of professional medical societies to discuss professionalism.

The materials developed thus far are intended to provide a framework for standards for professionalism that one can hang a hat on. ABIM presents guidelines for ideal behavior while recognizing that the ideal is something we endeavor to achieve but do not always reach.

I. DEFINITION AND OBJECTIVES

Professionalism in medicine requires the physician to serve the interests of the patient above his or her self-interest. Professionalism aspires to altruism, accountability, excellence, duty, service, honor, integrity and respect for others. The elements of professionalism required of candidates seeking certification and recertification from the ABIM encompass:

A commitment to the highest standards of excellence in the practice of medicine and in the generation and dissemination of knowledge.

A commitment to sustain the interests and welfare of patients.

A commitment to be responsive to the health needs of society.

These elements are further defined as:

Altruism is the essence of professionalism. The best interest of patients, not self-interest, is the rule.

Accountability is required at many levels — individual patients, society and the profession. Physicians are accountable to their patients for fulfilling the implied contract governing the patient/physician relationship. They are also accountable to society for addressing the health needs of the public and to their profession for adhering to medicine's time-honored ethical precepts.

Excellence entails a conscientious effort to exceed ordinary expectations and to make a commitment to life-long learning. Commitment to excellence is an acknowledged goal for all physicians.

Duty is the free acceptance of a commitment to service. This commitment entails being available and responsive when “on call,” accepting inconvenience to meet the needs of one’s patients, enduring unavoidable risks to oneself when a patient’s welfare is at stake, advocating the best possible care regardless of ability to pay, seeking active roles in professional organizations, and volunteering one’s skills and expertise for the welfare of the community.

Honor and integrity are the consistent regard for the highest standards of behavior and the refusal to violate one’s personal and professional codes. Honor and integrity imply being fair, being truthful, keeping one’s word, meeting commitments, and being straightforward. They also require recognition of the possibility of conflict of interest and avoidance of relationships that allow personal gain to supersede the best interest of the patient.

Respect for others (patients and their families, other physicians and professional colleagues such as nurses, medical students, residents, and subspecialty fellows) is the essence of humanism, and humanism is both central to professionalism, and fundamental to enhancing collegiality among physicians.

A major responsibility of those training internal medicine residents and subspecialty fellows is to emphasize the importance of professionalism in the patient/physician relationship and to illustrate this by example.

The ability to affect attitudes, behavior patterns and ethical conduct in patient care must be recognized and used during residency and fellowship training — a time of unique clinical, educational and social experiences for physicians. It must also continue after training and throughout one’s professional career.

II. SIGNS AND SYMPTOMS

Seven issues that challenge or diminish the previously identified elements of professionalism are described below and include abuse of power, arrogance, greed, misrepresentation, impairment, lack of conscientiousness, and conflict of interest.

A. Abuse of Power

Traditionally, the medical profession has enjoyed a high level of respect. Yearly polls consistently indicate that the medical profession is second only to the clergy in the esteem afforded it by society. This respect offers tremendous power to physicians. When used appropriately, this power can accomplish enormous good and can establish a norm for behavior that is in society’s best interest. Patients, colleagues and society in general abide by what the profession does and says. When abused, this power can establish a norm for deviant behavior. These abuses can be insidious and may occur at several different levels:

- ◆ **Interactions with patients and colleagues** - The respect and trust placed in physicians by their patients and professional colleagues are something to be cherished and promoted and not abused. Not allowing patients to voice their wishes or contribute to decision-making is an abuse of power. Allowing financial and academic competitiveness to affect honest evaluation of one’s peers and trainees is an abuse of power. Using junior colleagues to enhance one’s own bibliography and advance one’s own academic career is an abuse of power, and so are actions that deliberately retard the academic development of junior colleagues in order to co-opt their work. The gratuitous denigration of junior colleagues also represents an abuse of power. There are many other examples.
- ◆ **Bias and sexual harassment** - The profession has a responsibility to ensure an environment in which all colleagues enjoy respect for their contributions and where they can advance to their full potential, irrespective of disability, ethnicity, gender, race, or religion. This responsibility involves eliminating both the large and small inequities that bias against the professional and personal development of individuals.
- ◆ **Breach of confidentiality** - Patients trust that comments which are made as part of the patient/physician relationship will be held in strictest confidence. This trust is not to be abused. Casual comments or discussion of details of patients’ situations in public (e.g., a crowded elevator or a cocktail party) represents an abuse of confidentiality. The physician must maintain the confidences of the patient and make disclosures only in the patient’s interest or when disclosure is a legal requirement.

B. Arrogance

Arrogance means an offensive display of superiority and self-importance. Arrogance denotes haughtiness, vanity, insolence and disdain. All of these qualities run counter to the demeanor of the professional. The ultimate result is the pretension of the arrogant individual to superior importance or rights.

Medicine itself, and the very process of medical education, can foster the development of arrogance in the physician. The training is long, arduous, and arguably inhumane. The mass of knowledge is seemingly limitless and impossible to master. Students are thus prone to assume an air of self-importance, having survived such an initiation. Arrogance in physicians may also be bred by the society of which they are part.

Arrogance destroys professionalism in three ways. First, it reduces the physician's ability to think for himself or herself. Second, it makes empathy for the patient difficult. Third, arrogance destroys professionalism by removing the beneficial role of self-doubt.

C. Greed

When money becomes a driving force, greed predominates and professionalism is eroded. Greed can be defined as the inappropriate aspiration of fame, power or money. If physicians are greedy, there is no room for understanding, compassion or other qualities necessary for the healing profession. When greed exists altruism, caring, generosity and integrity are compromised significantly.

The treatment of greed requires its recognition. Physicians must continually ask themselves whether their actions are guided by the best interests of their patients or their own financial interests. Curing greed requires constant diligence and a questioning of one's motives to ensure that one's actions are not based on personal financial gain.

D. Misrepresentation

In the context of unprofessional behavior, misrepresentation consists of lying and fraud. Lying is consciously failing to tell the truth. Lying is not simply relating an untruth, otherwise any erroneous statement is lying. Lying requires a conscious effort. Fraud is a conscious misrepresentation of material fact with the intent to mislead. Lying may be a borderline matter, but generally is not in the best interest of the patient even when the lie is intended to help the patient. For example, conjuring up a diagnosis so that a patient's hospital admission or length of stay can be justified is a lie which insidiously undermines the patient/physician

relationship. While the intent may seem to be in the best interest of the patient, the act is not.

Fraud occurs in both medical practice and research. Lying about which services are performed in order to obtain payments from insurance companies is an example of fraud. Misrepresentation of laboratory data or lying about experiments that are performed are examples of fraud.

E. Impairment

Few examples provide more vivid evidence of the urgent need to reassert the primacy of professionalism than does the specter of the drug-addicted, alcohol-dependent, or mentally impaired physician protected or unnoticed by colleagues and allowed to care for unsuspecting patients.

Physicians who are impaired in their ability to discharge their professional obligations must relinquish their responsibility in caring for patients; and professional colleagues must see to it that this standard is maintained. Impairment is, of course, not an all-or-nothing phenomenon. Extreme degrees of impairment may be easy to recognize, but marginal or slight impairment may not be readily detectable and honest disagreement may exist about whether or not it is even present. As a corollary, every physician should be trained to detect all varieties of impairment (especially at their earliest stages) as well as strategies for intervention.

Impaired physicians frequently cannot recognize their limitations and may not be able to acknowledge the existence of their impairment although others can see it clearly. Indeed, impairment from substance abuse, chemical dependency, alcoholism, dementia, or psychiatric illness is typically beyond the ability of affected physicians to recognize, and almost always beyond their ability to resolve adequately alone.

The natural reluctance to be the first person to draw attention to an impaired or potentially impaired colleague is perhaps the most significant problem associated with this aspect of medical professionalism. Many questions and rationalizations that inhibit prompt and appropriate action easily come to mind along with the suspicion that a colleague might be impaired. "What if I'm wrong?" "Maybe he's just having a bad day." "Surely someone who knows him better will act if anything is really wrong." "What will my colleagues think of me if I blow the whistle on her?" "He's got a family to take care of; I can't be responsible for driving them to the poorhouse." "If we all stick together, we can cover for her; we won't let anything bad happen to her patients."

Banishing the easy excuses for inaction is difficult but it is essential to fulfilling the profession's obligation to protect the public's interest. Impaired cognitive abilities due to organic or psychiatric illness are no less common among physicians than among the public at large. Substance abuse, likewise, may be more prevalent among physicians than among others because of the physician's relatively easy access to controlled substances and because of high levels of occupation-related stress.

Developing an excuse for inaction in dealing with a colleague who is impaired also abdicates one's professional obligation. For example, needless deaths of physicians from drug overdoses might have been prevented if their professional colleagues who initially noticed the impairment had taken action to have the impairment addressed and the physician rehabilitated.

F. Lack of Conscientiousness

Lack of conscientiousness is a failure to fulfill responsibilities, and is incompatible with the essence of professionalism. Consider the physician who is committed to doing only the minimum, takes the most abbreviated history, waits for the x-ray report rather than views the x-ray personally, does not return the family's phone calls, visits with the chart rather than the patient, gets the latest information from the drug company representative and blames the bureaucracy for every problem.

The physician who is too busy, whose research is too important to commit the time and effort required for teaching responsibilities, who comes late to rounds, who misses preceptors' meetings with students, and who shifts care of patients to trainees not yet prepared for unsupervised responsibility also exemplifies a lack of conscientiousness, a loss of professionalism and deviation from expected standards.

Similarly, the physician who opts for the easy questions, who never gets around to submitting the data for publication, who does not show for committee meetings, or who shows but does not contribute, has forgotten the meaning of professionalism.

G. Conflicts of Interest

Recognition and avoidance of conflicts of interest represent a core issue of professionalism. The physician must avoid situations in which the interest of the physician is placed above that of the patient. A growing number of issues concerning conflicts of interest have damaged the professional reputation of the physician. Protecting personal advantage is seen as sacrificing the interests of patients and society for the physician's interest. Therefore, a renewed effort is needed in

educating medical students as well as physicians to recognize and understand the potential conflicts of interest in patient/physician and physician/society relationships and the necessity to avoid them.

The following examples of conflicts of interest can occur in medical practice:

- ◆ **Self-referral** is the ordering of laboratory tests, diagnostic procedures or treatment for a patient from businesses in which the physician has a financial interest. Many physicians who have such financial interests contend that their participation improves access or quality of care, but results of a number of studies suggest that physician-owned enterprises promote excessive use of diagnostic tests and treatments. Self-referral practices have the potential to increase total costs of health care in this country as well as to affect the physical and financial well-being of the individual patient. Only when fees are rendered for the care personally delivered by the physician or by those under the physician's direct supervision can conflicts of interest be avoided.
- ◆ **Acceptance of gifts.** Whether physicians should accept gifts from manufacturers of drugs and devices that are being prescribed by the physician, has been addressed by a number of medical and scientific organizations and authors. Although the physician may profess that the gifts are of minor value and play no role in influencing his or her prescription practices, the potential for undue influence is clear.

The American Medical Association and the American College of Physicians-American Society of Internal Medicine have indicated in their policy statements that personal acceptance of substantial gifts or subsidies from companies, such as payments for travel, lodging, or personal expenses to attend conferences or meetings is considered inappropriate professional behavior and is strongly discouraged. Similarly, subsidies for loss of work time to attend conferences or meetings should not be accepted. The temptation to accept such direct gifts are great, particularly for the physician who is still encumbered with medical school debts. Part of the reason that such practice may not seem unethical to physicians recently out of training is that many schools and hospitals permitted or even encouraged accepting various gifts and meals during conferences and on-call nights in exchange for listening to a sales pitch. Such practices should be eliminated or restricted.

- ◆ **Utilization of services** presents a potential conflict of interest because the patient must rely on the professionalism of the physician to recommend only the care and procedures appropriate. Inappropriate treatments, overcharging, and prolonging contacts with patients (repeated office and hospital visits) when no longer necessary for the management of the patient's symptoms or disorder are products of conflicts of interest not restrained by professionalism. The extreme of this situation is the prolonging of life with inappropriate intensive therapy. Achieving the optimum level of medical care requires continued rigorous self-examination as to the motivation and likely outcomes of projected procedures and treatments. This issue is a difficult one, encompassing such factors as the availability of technology, the fear of giving up too early, considerations of personal ethics, and the underlying tendency to practice what one knows how to do. Nevertheless, accountability to the patient demands that the physician place the patient's welfare first before any other motives. Conversely, patients can be neglected by the under-utilization of resources for diagnosis and treatment. This compromise of optimal patient care can arise out of the conflict of interest created when physicians' bonuses and salaries are linked directly to reducing patient care expenditures by limiting access to subspecialty consultation and expensive treatment options. In other salaried situations, disincentives to optimal care can occur through conflicting demands on the physician's time and attention and the "disincentive to work." In general, the inability of a patient to pay should never affect decisions as to what level of care should be provided.

The following are examples of conflicts of interest that can occur in the academic environment:

- ◆ **Collaboration with industry** has raised a number of concerns. Potential conflicts of interest are broad-ranging and affect the conduct of research, peer review of research, and the dissemination of the results of research. This issue is a particularly important one for investigators in biomedical research because of the loss of public trust and confidence when economic self-interest appears to replace scientific integrity.
- ◆ **Compromising the principles of clinical investigations.** There are many ways in which potential issues of conflicts of interest can appear to compromise the integrity of an investigator. Bias in research can be introduced when the investigator

or his or her immediate family has a financial interest in the sponsoring company or the product being investigated. The financial interest can take the form of a direct equity relationship, or acceptance of gifts and favors, or consultantships from the company. When results of research are being reported or reviews of other investigators' work are being undertaken, potential conflicts of interest must be fully disclosed. Although intellectual biases and rivalries are often readily apparent to scientists in peer review settings, information regarding potential financial conflicts of interest cannot be identified without full and specific disclosure.

III. AIDS AND BARRIERS TO PROFESSIONALISM DURING TRAINING

The environment in which the training and education of physicians takes place serves in many ways as the incubator of professionalism. Standards for professional and ethical conduct are beginning to be addressed within the formal curriculum of medical school. In addition, the ACGME Program Requirements for Training in Internal Medicine and the Subspecialties (see appendix, page 4), include a brief section on professional ethics and the importance of professionalism within the educational environment. Placing the term "professionalism" into the requirements for program accreditation sends a strong message regarding the importance the profession places on its standards. Conversely, some would argue that the erosion of the profession's standards has created the need to require that more attention be paid to professionalism within the formal curriculum. Following is a brief exploration both of enhancers that promote and the barriers that prohibit professionalism within the training environment.

A. Aids

The profession of medicine is recognized by society for its service to societal goals and its commitment to healing the sick. One of the responsibilities of medical education, specifically medical schools and postgraduate training programs, is to insure that its common and various components foster and enhance professionalism. This responsibility begins with the institution's mission statement, expands to the admissions policies and their related emphasis on experiences that students and housestaff bring to the educational environment, and encompasses the curriculum including clinical and professional ethics, social issues in medicine, community service activities, and longitudinal responsibilities for patients. It moves

on to student and housestaff evaluation, the promulgation of high standards and the rigor applied to reviewing and remediating substandard professional behavior. Finally, it is also reflected in the educational environment's dedication to collegiality, support of faculty development and formal mentoring programs, and formal recognition and reward of faculty, housestaff and student role models.

B. Barriers

The increasing expectations placed by the public and the profession on physicians can sometimes thwart the progress of one's professionalism. During training a variety of challenges arise that threaten professionalism. Many of these relate to chronic fatigue and sleep deprivation; stress and overwork; lack of confidence, self-esteem, and experience; difficult patients; chaotic, unstructured, unsupervised rotations; creative tension with other health professionals and lack of professionalism among housestaff; arrogant faculty; health risks to the profession; abuse of power; and family obligations. The educational environment may never be able to eliminate all of these barriers, but by their recognition, efforts may be successful in circumventing them and their potential damage.

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Professionalism Vignettes

The following twenty vignettes relate to various aspects of professionalism including the signs and symptoms that can erode physicians' professional behavior and values. These vignettes, developed by physicians, reflect actual experiences and, therefore, the occasional difficulty of clear-cut responses. Program directors, faculty, residents and subspecialty fellows can use the vignettes in a variety of ways within the educational environment. These include group teaching sessions and seminars, conferences, journal clubs, and grand rounds. It is recommended that the definition of professionalism, its components, and signs and symptoms (pages 5-9) be considered within the context of the discussion and debate generated by each vignette.

At the end of this section is a case study that presents distinct challenges to the educational environment and for professionalism. This actual case can serve to generate important discussion about standards and performance expectations regarding professionalism, specifically the issues of accountability, honor, integrity and respect for others.

1) A pharmaceutical company approaches you about a clinical research project involving your office patients. Your hypertensive patients will be eligible to be treated with a new angiotensin-converting enzyme inhibitor. The drug has just been released by the FDA. The object of the study is to evaluate risks and benefits in an unselected office population.

The pharmaceutical company will pay \$250 per patient for the expenses generated by the study and one year's salary for a data manager, and will supply the drug free of charge. Meetings to discuss the initiation of the study and follow-up results will be held in New Orleans and Honolulu. Your spouse also will be invited as the company's guest to attend these meetings since they will take you away from home.

Participating in this study would be considered appropriate professional behavior if:

- A. *Your patients sign an informed consent.*
- B. *Your patients sign an informed consent and your partners approve the study.*
- C. *An oversight committee of the hospital where you have privileges or your regional medical society approves the study.*
- D. *None of the above.*

Please provide justification for the answer selected.

2) You are practicing hematology and medical oncology in a suburb of a large metropolitan area. Currently, you refer your patients who require radiotherapy to one or two hospitals in the city depending on where the patients live and the type of problem. A radiotherapist whose knowledge and skill you respect informs you that she will be joining a for-profit national radiotherapy company that is thinking of locating in your area, and one which will bring both the latest equipment and upgraded service to your community. She informs you that an excellent opportunity now exists to invest in this company and that the larger the number of investors from the area the greater the likelihood the company will locate the unit in your community.

Which of the following statements most accurately assesses the possibility of conflict of interest regarding your investment in this company?

- A. *Your investment will pose no conflict of interest for you because the new radiotherapy unit will offer superior treatment and be available to your patients.*
- B. *There is a possibility of a conflict of interest which requires that you inform your patients of the investment.*
- C. *Your investment will pose no conflict of interest if you avoid referring your patients to the new radiotherapy unit.*
- D. *There will be no problem of conflict of interest for you if the investment is made by your spouse.*
- E. *An investment will pose a conflict of interest and you should not make it.*

Please provide justification for the answer selected.

3) A drug company invites you as its guest to attend a gala dinner. As part of the evening activities an after-dinner speaker will present a 30 minute lecture on the company's newest product, an antibiotic. What would your response be?

- A. *Decline the invitation since the affair is promotional and not educational.*
- B. *Attend the dinner but leave before the after-dinner presentation.*
- C. *Ask who else will be attending before making your decision*
- D. *Ask what will be served for dinner before making a decision.*

Please provide justification for the answer selected.

4) Payment for an admission of a patient of yours is denied by the Medicare/PRO and your hospital's Utilization Review Committee (URC) approaches you about the appeal. They feel that the admission, in retrospect, was inappropriate, and that the patient should have received an admission denial. You strongly disagree with their impression (a difference of opinion they support, since it may help the appeal). You feel that your patient was unable to care for herself at home, had experienced several falls, had no one with her during waking hours, was suffering from early Alzheimer's disease, and clearly required supervised care. The URC informs you that this alone does not qualify your patient for acute care, that the admission will be denied, and that the hospital will be penalized severely because of past denied admissions. In addition, they indicate that you will be penalized as well, because of previously questionable admissions.

The URC asks whether, during the appeal, you could mention a diagnosis that you had failed to document but one which would serve to qualify the patient for acute admission.

Your best answer to this situation should be:

- A. *At the appeal, argue as above without adding any additional information.*
- B. *Tell the appeals board you were concerned about the patient's incipient decubiti.*
- C. *Readmit the patient from the nursing home and order a CT scan of the brain and a neurology consult to rule out treatable causes of dementia.*
- D. *Tell the URC that you had inadequately documented symptoms and findings on the patient's medical record and will be filing an addendum to the record.*
- E. *Ask the patient's family to accompany you and the hospital representative to the appeals board.*

Please provide justification for the answer selected.

5) During your teaching rounds with the housestaff team, a male faculty member comes up to the group, places his arm around the waist of a female houseofficer and thanks her for the terrific job she did taking care of one of his patients. You sense that the houseofficer is made uncomfortable by the gesture. An appropriate first response on your part would be:

- A. *Do nothing, on the basis that the faculty member was simply showing his appreciation for a job well done.*
- B. *Report the incident to the program director as an example of sexual harassment.*
- C. *Tell your colleague, the faculty member, that you thought the gesture was inappropriate and that you were made uncomfortable by it.*
- D. *Ask your colleague, the resident, if the gesture made her uncomfortable.*
- E. *Ask the resident if there are actions she would like you to take on her behalf.*

Please provide justification for the answer selected

6) Your patient with Type I IDDM, whom you have cared for during the past twenty years is brought to the emergency department dead on arrival. Her distraught husband explains that his wife had been feeling quite well until the day of her death. The two of them had taken a long ride through the country that day, stopping occasionally for snacks. Because of this “cheating,” her husband explains that she took additional insulin at mid-day, and again late in the afternoon. They then had a big dinner including dessert, and returned home at about 9:00 PM. Shortly thereafter, she took one additional dose of mixed NPH and regular insulin so she would avoid another admission for ketoacidosis.

According to the husband, his wife began groaning, shaking, and sweating at about 3:00 AM. She was “sweating buckets and making no sense” he says, and fearing she was “going into coma,” he gave her an additional 10 units of NPH and 15 units of regular insulin, waiting a half-hour for a response and then calling the ambulance. The husband now feels terribly guilty over allowing his wife to eat so much the day before and for “throwing her diabetes off.” He looks at you with a level stare and demands to know why his wife died. Had he done everything possible, was there more he could have done?

Your best answer to the patient's husband should be:

- A. *Explain to him that his wife died from complications of excessive insulin administration and hypoglycemia.*
- B. *Report this as a death of unnatural causes and set in motion a coroner's inquest.*
- C. *Tell him his wife died of diabetic coma, and there was nothing more he could have done for her.*
- D. *Explain that his wife brought about her own demise through ignorance of her own disease, and that he is not to blame.*
- E. *Tell him that she died of a heart condition and her diabetes, and there was nothing further he could have done.*

Please provide justification for the answer selected.

7) A long-time patient of yours comes to the emergency room asking to see you. He lives in a remote area in substandard living conditions and with inadequate nutrition, but has long valued his independence. He has no family, no neighbors, and as a loner, avoids establishing friendships.

His complaint is that he is cold. He is out of wood, cannot keep warm at night, and fears he will freeze to death. He asks for your help.

On examination, as always, he is unkempt, has poor personal hygiene, smells of tobacco and alcohol, and has one single area of frostbite on his left great toe. He is not intoxicated. His temperature is 98.4° F, BP 146/88, HR 74. He has a right carotid bruit and a gr. II/VI apical pansystolic murmur, both of which you have documented in the past. He has never had, and does not now have any symptoms referable to these findings. The remainder of his examination is normal.

The single best solution to your patient's problem is to:

- A. *Have social service see him for purposes of arranging boarding home placement.*
- B. *Arrange for admission to the alcohol detoxification unit.*
- C. *Admit him to the hospital with a diagnosis of transient ischemic attacks and peripheral emboli.*
- D. *Arrange for psychiatric admission for agoraphobia.*
- E. *Call the County Commissioner and arrange for the town to buy your patient fuel.*

Please provide justification for the answer selected.

8) A new internist comes to town and is asked to become part of the physicians' laboratory (owned by 13 internists). The lab is high quality, highly professional, reliable, and prices are 10% below other laboratories in the area. The internists share the lab profits totaling about \$2500 each per quarter. The patients are told they have a choice of labs and that their physician has a financial interest in one of them. The new internist joins the laboratory.

In your opinion, is the internist demonstrating ethical behavior? If yes, why? If no, why not?

Please provide justification for the answer presented.

9) Your daughter is scheduled to graduate from high school this afternoon. As you are completing your morning hospital rounds and are preparing to sign out to a colleague, one of your long-time patients enters the emergency room with severe substernal pain. The ER physician feels that the situation warrants a work-up to rule out an acute myocardial infarction.

You enter the ER and a partner in your group practice is already there preparing to evaluate the situation. Because you know him to be competent and conscientious, you have no compunction about proceeding ahead with your personal plans.

When you see the patient to reassure him that the problem will be handled well by someone in whom you have complete trust, your patient pleads with you to stay and see the matter through. "I will feel so much better if you are here," he tells you with evident apprehension. What will you do?

- A. *Stay with the patient and miss your daughter's graduation.*
- B. *Reassure the patient as fully as possible that your associate will do an excellent job and leave to attend the graduation ceremony.*
- C. *Leave for the high school, but call back at intervals and plan to return to the hospital if the patient is not doing well, even if it means missing the ceremony.*
- D. *Provide other alternatives.*

Please provide justification for the answer selected.

10) You are an internist in a moderate-sized community hospital two hours away from a major teaching hospital. One of your long-term patients has benign prostatic hypertrophy and possible carcinoma of the prostate. Although you regard the urologist on staff as competent, he is not the specialist to whom you would go if you were in the same situation. What will you do?

- A. *Refer your patient to the local urologist on the premise that the management will be good enough.*
- B. *Offer your patient the option of seeing a urologist of national stature at the regional teaching hospital.*
- C. *Discuss your concerns with the local urologist and let him make the decision of whether to refer.*
- D. *Provide other alternatives.*

Please provide justification for the answer selected.

11) A long-time patient of yours requests a note from you documenting a non-existent illness in order to recover cancellation penalties from the airlines on a nonrefundable ticket.

Is compliance with this unsubstantiated request ethical behavior? How would you respond if your patient is a major benefactor to the department of medicine or to the medical center?

Please provide justification for the answer presented.

12) A 45-year-old father of three children who has been your patient for many years has end-stage heart disease presumably due to idiopathic cardiomyopathy. You are convinced that without a heart transplant he will die within a few months. Your recommendation that he be covered financially for the procedure has been rejected by the relevant insurance agency because your state has established a set of priority ratings for medical procedures, and heart transplant ranks so low that it fails to qualify in this instance. What will you do?

- A. *Accept the societal decision and help your patient and his family through the terminal stages of his illness.*
- B. *Urge the patient to seek private financial help from the community by going into debt, and by imposing on relatives in order to have the transplant.*
- C. *Urge your hospital and the transplant surgeon to provide the care at the least possible cost to the patient even though your hospital is in dire budgetary straits.*
- D. *Publicize your patient's dilemma and attack your state's policy on rationing health care.*
- E. *Select another alternative.*

Please provide justification for the answer selected.

13) You have practiced internal medicine in an urban community throughout your career. The community has deteriorated economically and your professional income barely covers your office costs and premiums for malpractice insurance. You will be 62 years old in several months and financially, can retire comfortably. It is unlikely that another physician can be recruited to the community. What will you do?

- A. *Stay on because you feel you have a moral responsibility to the people you serve.*
- B. *Leave the practice recognizing your frustration with a declining income and increased paper work and aggravations associated with practice in that setting.*
- C. *Opt to mobilize and commit community leaders to establish a local health care facility.*
- D. *Conclude that your patients will be able to receive reasonable care from the local municipal hospital and clinics and proceed with retirement.*
- E. *Provide other options.*

Please provide justification for the answer selected.

14) You are a senior member of the division of general internal medicine in your medical school. You are overcommitted with responsibilities imposed by a massive effort to increase hospital bed occupancy, by the time required to serve on the search committee for a new chair of medicine, by being the head of a major project for the state medical society, and by family pressures.

A fourth-year medical student who has been accepted at your hospital for residency training in internal medicine, asks you to help her initiate and implement a study of the impact of managed care regulations on the quality of care received by patients in your hospital.

Intuitively, you feel that the data to be derived from such a study will be "soft and inconclusive". You are not aware of a likely source of funds for the study, and you do not see where your activities can be curtailed to accommodate this bright, well motivated student. What will you do?

- A. *Proceed with the project, hoping that somehow it will work out and produce useful results, because you want to encourage this medical student's spirit of inquiry.*
- B. *Share your low expectations for the study results and your reasons, explain the tightness of your schedule, and politely decline to participate.*
- C. *Delegate this responsibility to a colleague whose activities you regard as less demanding and less urgent.*
- D. *Advise the student to do additional reading and thinking about the proposed research, to redesign the study, and then make a commitment to the project when the plans have improved.*
- E. *Provide other options.*

Please provide justification for the answer selected.

15) The director of a research team, a professor, writes up the results of a collaborative experiment. He includes, as co-authors, all those who worked directly on the project. In addition, he includes as co-author, the secretary hired to help administer the grant under which the experiment was conducted. The secretary had no direct involvement in the experiment but the director justifies her inclusion as co-author by making the vague assertion that she provided "editorial help." The director is also involved in an ongoing sexual liaison with the secretary, a liaison meant to be clandestine but known to the members of the research team.

Discuss the appropriateness of each of the following lines of action for the members of the research team and select the best choice.

- A. *Do nothing, on grounds that the incident falls in a "gray" area and that to do anything would disrupt cooperation within the team and jeopardize its future work.*
- B. *Confront the director collectively.*
- C. *Report the incident to the director's chair or dean.*
- D. *Report the incident to the program officer of the granting agency that supports the project.*
- E. *Provide other options.*

Please provide justification for the answer selected.

16) As chairman of the department of medicine in a large academic health center, you are recruiting an internationally recognized physician-scientist to direct one of your divisions. You want to entertain him at one of the best restaurants in town, recognizing that other institutions are vigorously recruiting him as well and ultimately the high cost of the evening is justified. Reservations are made at a superb restaurant. When you, the candidate, and two other division directors enter the restaurant, you are surprised to see six of your PGY-2 and PGY-3 residents and their spouses enjoying dinner with a drug representative who has promotional material for the company's latest product on the table beside him.

What is the appropriate action for you to take?

- A. *Proceed to their table, introduce yourself to the pharmaceutical representative, exchange pleasantries with your housestaff and their spouses, then go to your table.*
- B. *Proceed to their table, greet your housestaff and their spouses, introduce yourself to the pharmaceutical representative and politely ask to join the group for dinner.*
- C. *Greet your housestaff and their spouses as you pass their table and send your bill to the drug representative.*
- D. *Request that the drug representative leave immediately and let the housestaff members pay their bill.*
- E. *Request a meeting the next morning with the drug representative and report this incident and previous warnings over breach of departmental policies to his supervisor.*
- F. *None of the above.*

Please provide justification for the answer selected.

17) You are on vacation and having lunch at a small town restaurant. As you leave your table you notice a woman in her mid-thirties fall out of her chair to the floor. As her friends are attempting to pull her back into the chair, you walk over to intervene. You encourage them to lay her down flat on the floor and prop up her legs. It is clear that the woman is unconscious. As you kneel beside her and take her pulse (which is 85), her three friends state, "Don't worry, she'll be just fine. There's nothing to worry about here. She hasn't had anything to eat in five days, and she just had two drinks with us."

You notice on your brief physical exam that she is now awake, although she is not initially responding to your questions. Over the next several minutes, with coaxing, you obtain the following history from the patient:

She is a 35-year old nurse who is married to a physician. She has been depressed for some time. She has never been on antidepressant medication nor seen a psychiatrist. Her depression has been so severe that she has lost all interest in eating over the past five days, and her husband, a physician, has administered IV fluids at home over the last few days. In addition to the two mixed drinks that she recently consumed, she also took two 0.5 ml. Xanax tablets that morning. She says that she has not received a prescription for this medication from a physician, and in fact, is not seeing a physician at the present time.

Her friends insist that no medical intervention is needed but that her husband be paged. When her husband calls the restaurant, the local EMS also arrives. The husband informs the restaurant owner that he will be there in 20 minutes, and that his wife should not be taken to a hospital, the nearest one being 80 miles away.

At this juncture:

- ◆ *What issues face you as a physician in this situation?*
- ◆ *What, if anything, would you do at this point?*

Because of your concern for this woman's health you ask to talk to the husband, express empathy and explain your brief clinical evaluation of his wife. From your own personal experience, you reflect on the difficulty it can be as a physician to manage a mental health problem in a family member. You strongly urge him to have his wife obtain both medical and psychiatric care immediately from a physician other than himself.

The husband responds, "Don't worry, everything is being taken care of, I'll be there in 20 minutes." Since the EMS team seems to have the situation under control and the husband is on his way, you pay your bill, leave the restaurant and continue to your vacation destination.

- ◆ *Are there any new issues that now face you as a physician?*
- ◆ *What responsibility, if any, do you have regarding this woman's health?*
- ◆ *What, if anything, would you do at this point?*

The next day, you feel compelled to contact both the state medical society and the state licensing board and register a formal complaint and expression of concern, both for the physician and for his wife.

- ◆ *Was this course of action appropriate?*
Please provide justification for all answers.

18) You are the principal investigator of a large, federally-funded clinical trial in cardiology. You oversee a staff of research assistants, all recent college graduates, who manage the patient visits, medication and the data collected. Extensive data are collected daily from the clinic patients, creating an intense but exciting environment. You ask a newly hired research assistant to develop a database by the end of the day so that you can analyze data regarding the patients' cholesterol levels for a paper you've been working on. You perform the analyses and find a result supporting your hypothesis. Subsequently, the paper is accepted for publication.

Seven months later just before the paper is to appear in the journal, another research assistant notices a discrepancy between a datapoint from this database and the original raw data. Upon investigation, you find that about 15% of the numbers are incorrect. You confront the research assistant who created the database. He admits he felt very pressured to get the project done in time and thought that since the database was so large, making up a few numbers wouldn't affect the results. You quickly correct the data error, re-do the statistical analysis, and find that the results continue to support the hypothesis, though no longer significantly.

What option would you select?

- A. *Terminate the research assistant even though his work has been superb, and he now knows the consequences of his poor judgment.*
- B. *Reprimand him and report the incident to personnel.*
- C. *Immediately notify the journal and retract the publication.*
- D. *Immediately notify the journal that there was a statistical error in the paper and provide the correction.*
- E. *Do not report the incident to anyone because the original hypothesis is still supported, although more modestly.*

Given the same scenario but after statistical reanalysis, there is no difference in the significance of the results and its strong support of your hypothesis, would you reprimand the research assistant?

Please provide justification for the answers selected.

19) As a practicing physician in a small town of 60,000 people, you and 40 other physicians receive a request from the Public Health Director that he is looking for volunteers to screen adolescent patients with potentially sexually transmitted diseases and/or other patients who might seek confidentiality and may not have the means to pay for medical care. Volunteers are guaranteed at least \$35 for each encounter, if there is no patient insurance. You and one other physician volunteer. Accordingly, the Public Health Director makes an announcement in the local newspaper that your services are now available. The following day, you receive three phone calls from irate patients who state that they no longer will attend your practice because they are bothered by "these kinds of people who might have diseases that they can catch." In spite of your reassurance that your new patients do not have transmissible diseases, your longtime patients remain angry.

What would you do? Please provide justification for your answer.

20) In the context of managed care, economic profiling and selection of physicians, you receive a letter from the local HMO which states that in order for the HMO to be approved by the National Committee for Quality Assurance (accrediting organization for HMOs), you are requested to send photocopies of your office records of ten patients over the last year. The letter also states that when the patients became members of the HMO, they signed a release for all records from both the hospital and doctors' offices.

In replying to the HMO, you indicate that you require explicitly informed consent for release of records and that since the process is a profile of quality care you will release the records providing the patients' names are deleted. The HMO responds by requesting the photocopies with the names and by stating that an informed consent release is not required. You reply again with the same information, the HMO then writes that unless you respond within the next two weeks you will be dismissed from the HMO. Fourteen percent of your gross practice income is from this HMO.

What would you do? Please provide justification for your answer.

The Case of Dr. E

Certain references in this actual case have been changed to maintain anonymity. The sequence of events, decisions and outcome are reported as they occurred. In using this case for group discussion, please consider the questions at the end of the case, provide answers and justification for those answers.

Background: Medical school graduate, matched as PGY-1

Performance: During his first 1 1/2 years in the residency program Dr. E was described as a “star performer” on nearly every rotation.

Critical Incident: Nineteen months into the residency, a subspecialty program to which Dr. E had applied for fellowship training found a number of discrepancies on his curriculum vitae, specifically in his list of publications where only 1 of 10 listings could be confirmed.

Confrontation: The residency program director was informed and brought this information to Dr. E's attention; he denied any deliberate dishonesty contending that “it was just a case of sloppiness.”

Investigation: The program director uncovered more sloppiness when he could not verify other highly regarded memberships, such as MRCP, also listed on Dr. E's CV.

Next Steps: The program director then initiated the following: 1) A faculty advocate was assigned to Dr. E for support; psychiatric counseling also was arranged. 2) The Clinical Competence Committee was informed and charged to weigh evidence with respect to the resident's integrity, taking into account the responsibilities of both the resident and the program to society, to the board, and to other fellowship programs, since the residency had written letters of recommendation for Dr. E. 3) He was informed that the situation was serious and the outcome could potentially lead to his dismissal from the residency program.

Deliberations: The committee gleaned insight into Dr. E's behavior, learning that he “grew up in a different country whose social system precluded his participation in academic medicine in that country; and that he was bitter about receiving no academic credit for his clinical research while in England.”

Responses: During the committee meeting, Dr. E stated he “took full responsibility for everything that had transpired and blamed no one else” except another colleague who miscommunicated to him that the articles were published. Under questioning about his membership in the Royal College of Physicians in England, he admitted that he should have stated clearly that he was MRCP *eligible* and not an actual member.

Status: After its first meeting, the committee reached no decisions; however, many members felt Dr. E had willfully misrepresented himself to the residency and fellowship programs and should be summarily dismissed. The committee decided to consider the issues further and meet again in two weeks.

At its second meeting, the committee developed the following recommendations: 1) physicians who wrote letters recommending Dr. E were requested to communicate with those programs and retract their initial recommendation of him for subspecialty fellowship positions, 2) the committee requested that it receive a copy of Dr. E's explanation to the fellowship programs, and 3) Dr. E be notified (before going on his two week vacation) that no decision on his status in the residency program had yet been reached.

Unfolding Events: Just prior to leaving for vacation, the resident's advocate was informed by Dr. E that “he knowingly falsified the publications on his CV.” Dr. E then informed the program director and left to be married in his country.

The committee held its third meeting to continue its adjudication of: 1) falsification of citations on two different CVs sent to numerous institutions over the past two years, 2) misrepresentation of Dr. E's credentials, and 3) possible continued deception by Dr. E to the committee.

The committee was then charged to determine the seriousness of the offenses and to provide recommendations to the department chairman and the program director.

In addition, the committee was informed that according to institutional due process procedures, the program's ultimate decision could be appealed through the medical director's office and a formal hearing held.

Remediation Plan: The committee reviewed the following plan developed by the program director (*ex officio committee member*):

- Keep Dr. E in the program.
- Require formal psychiatric evaluation from an outside professional (not with Dr. E's supportive therapist whose responsibility is to the patient.) As part of the evaluation, determine whether Dr. E's behavior is a single episode of deceit or can transfer to patient care.

- Require Dr. E to perform at least 200 hours of volunteer service to the biomedical ethics institute at the affiliated university and to produce a (publication quality) manuscript regarding fraud in residency.
- Require Dr. E to coordinate a medical center grand rounds regarding scientific and residency fraud.
- Scrutinize Dr. E's behavior until his completion of residency training, warning that he will be summarily dismissed if any episode of dishonesty occurs.
- Monitor carefully Dr. E's communications over the next 18 months. (Require him to provide the program with copies of any communications and/or applications he submits to other programs and outside agencies.)
- Place a formal communication in his file, similar to the retraction letter the program mailed to fellowship programs, and provide to any requesting agency.
- Recommend Dr. E for board certification if all of these requirements are met and no other problems are identified.

Decisions: The committee conveyed its findings in a letter to Dr. E stating: 1) the seriousness of academic dishonesty, 2) the inconsistencies of his CV, and 3) the implications for continuing in the program.

The committee chose not to terminate him from the program because it concluded that it would not be in the best interests of Dr. E, the public, or the training program. The committee viewed "this episode as a serious mistake from which Dr. E would learn and never repeat."

The committee agreed with the remediation plan and recommended to the program director that he request Dr. E's compliance with it.

Outcome: Dr. E met with an outside psychiatrist for a formal psychiatric evaluation; the psychiatrist reported to the program that he believed Dr. E's behavior may have represented a single episode of deceit and was supportive of the remediation plan.

The program director served as Dr. E's attending physician on the general medicine service for two months. He delayed his decision to substantiate credit for Dr. E's R-2 year.

There were no other clinical or administrative incidents in which Dr. E demonstrated lack of integrity or dishonesty in either his second or third year of training.

He completed his 200 hours of volunteer service to the biomedical ethics institute and submitted his manuscript on fraud in residency for journal publication. This spring his program director will recommend Dr. E for eligibility to take the ABIM certification examination. The program director predicts Dr. E will easily pass the examination since he performed very well on the national in-training examination.

Dr. E's intention to establish a career in one medical subspecialty has now changed to a different medical subspecialty. A letter from the program director delineating the facts of Dr. E's misrepresentation of credentials was provided to all subspecialty fellowship directors Dr. E contacted. Subsequently, Dr. E obtained a subspecialty fellowship position within the department of medicine where he had his residency training. He will begin that training this summer.

Indicate your level of agreement regarding how the case was handled:

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

Some Questions to Contemplate

- 1) How much scrutiny should each prospective training program applicant and related curriculum vitae undergo prior to acceptance by the program director?
- 2) What are the program's responsibilities to society, to the certifying board, to those who wrote letters of support for Dr. E, and to the subspecialty training programs to which he applied? How well were these responsibilities fulfilled by the program?
- 3) Once confirmation of misrepresentation occurred, should the program director have referred the case of Dr. E for review and recommendations by an independent committee within the institution but outside the department of medicine?
- 4) Did allowing Dr. E to continue training in the residency program send a message to other residents and faculty that the consequences of discovered dishonesty and fraud are minimal? Is the program's reputation and level of quality diminished in the opinions of others (residents, teaching faculty, other training programs) by the actions it took regarding Dr. E?
- 5) What resources are available to programs for remediation of this problem, and what determines successful remediation?
- 6) What are the legal and ethical consequences of allowing someone who knowingly defrauded numerous programs over a period of years to continue in the program?

Strategies for Evaluating Professionalism

Strategies for evaluating professionalism are outlined below. The first section generally reflects ongoing activities in most training programs. The second section describes approaches to evaluate the impact of renewed emphasis on professionalism within the educational environment. The third section is a first step in identifying specific behaviors that are clearly unprofessional.

I. EVALUATING INTERNAL MEDICINE RESIDENTS AND SUBSPECIALTY FELLOWS

- Rely on multiple observations by multiple evaluators.
- Use peer evaluation and professional associate ratings form (PARs) to assess components of professionalism (see page 22).
- Develop a self-assessment questionnaire regarding components of professionalism for use by houseofficers and attending faculty.
- Develop a critical events file and/or use feedback cards for trainees to document both positive and constructive comments (see page 25).
- Expand traditional performance evaluation forms to incorporate components of the definition of professionalism and descriptors of standards, and promote formal evaluation and documentation of trainees' research performance (see page 27).
- Incorporate professionalism items (multiple choice and/or essay questions) into departmental in-service examinations.
- Encourage inclusion of professionalism items on national in-training and board certification examinations.

II. EVALUATING INTERNAL MEDICINE RESIDENCY AND SUBSPECIALTY PROGRAMS

- Survey program directors to assess the awareness and impact of related recommendations on both curriculum and evaluation of professionalism.
- Expand the Residency Review Committee for Internal Medicine Program Requirements for Training in Internal Medicine and the Subspecialties to include specific content experiences on professionalism and monitor compliance through program accreditation decisions.
- Monitor and track requests for ABIM resource documents and peer reviewed publications on professionalism.
- Use ABIM Hospital Visit Program to assess and monitor quality of related curricular components,

compliance and documentation of evaluation of trainees' professionalism.

III. IDENTIFYING UNPROFESSIONALISM IN PHYSICIANS

The demonstration of professionalism by residents and subspecialty fellows is expected as part of the requisite clinical competency for certification and is evaluated as a continuum throughout the training experience. Since all of the attributes of professionalism cannot be tested on a written or oral examination — patterns of behavior, as observed within the educational environment — play an important role in making these determinations. Recognizing that the focus of this document has been to define professionalism, the following descriptors serve to identify behavior which is unacceptable for meeting the standards of professionalism inherent in being a physician. Page 29 provides a simple, straightforward approach to help program directors document and remediate these behaviors.

Unmet professional responsibility

- Needs continual reminders about fulfilling responsibilities to patients and to other health care professionals
- Cannot be relied upon to complete tasks
- Misrepresents or falsifies actions and/or information, for example, regarding patients, laboratory tests, research data

Lack of effort toward self-improvement and adaptability

- Is resistant or defensive in accepting criticism
- Remains unaware of own inadequacies
- Resists considering or making changes
- Does not accept responsibility for errors or failure
- Is overly critical/verbally abusive during times of stress
- Demonstrates arrogance

Diminished relationships with patients and families

- Lacks empathy and is often insensitive to patients' needs, feelings and wishes or to those of the family
- Lacks rapport with patients and families
- Displays inadequate commitment to honoring the wishes and wants of the patient

Diminished relationships with health care professionals

- Demonstrates inability to function within a health care team
- Lacks sensitivity to the needs, feelings and wishes of the health care team

Professional Associate Ratings: A Practical Approach to Peer Evaluation

As part of a study of the predictive validity of certification, funded by the ABIM, Dr. Paul Ramsey and his colleagues at the University of Washington developed an evaluation form for use by professional associates.¹ Self-administered questionnaires were designed to assess humanistic qualities, communication skills, and selected aspects of clinical skills. Results of this study indicate that peer ratings provide a practical method to assess humanistic qualities, communication skills and the professionalism of internists and subspecialists.²

Based on the encouraging results of the predictive validity study, a second study was funded by the ABIM to explore possible sources of bias affecting peer ratings and to better characterize qualities.³ Results from the second study suggest that peer ratings provide a reliable assessment of medical knowledge, problem solving skills, and management of complex problems, as well as humanistic qualities (integrity, respect, and compassion) and the ability to manage psychosocial aspects of illness when 10 or 11 ratings per physician subject are obtained.

One criticism of peer ratings has been that assessments are perceived to be influenced by interpersonal relationships and may therefore merely reflect “popularity”. The results suggest, however, that the ratings are not biased in a substantial manner by the relationship between the physician subject being evaluated and the peer completing the evaluation. The results also provide some support for the validity of peer ratings as measures of physicians’ humanistic behavior, professionalism and overall clinical competence.

Further results of these studies with practicing internists suggest that peer ratings can provide a feasible and reproducible measure of performance.⁴ As importantly they can also be used for valuable feedback to physicians about their performance. The sample form that follows can be used to provide peer ratings of selected aspects of the clinical skills, humanistic qualities, and professionalism of residents and subspecialty fellows as well as practicing physicians, and to serve the credentials and privileging committees of hospital/healthcare organizations by documenting competence at the local level.

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1. Ramsey PG, Carline JD, Inui TS, Larson EB, LoGerfo JP and Wenrich MD, Predictive Validity of Certification by the American Board of Internal Medicine. *ANNALS OF INTERNAL MEDICINE*, 1989;110:719-726.
 2. Carline JD, Wenrich MD, Ramsey PG, Characteristics of Ratings of Physician Competence by Professional Associates. *EVALUATION AND THE HEALTH PROFESSIONS*, 1989;12:409-423.
 3. Ramsey PG, Carline JD, Inui TS, Larson EB, LoGerfo JP, and Wenrich M, Assessment of the Clinical Competence of Certified Internists: Final Report to the ABIM. Seattle: University of Washington, June 1990.
 4. Ramsey PG, Wenrich MD, Carline JD, Inui TS, Larson EB, and LoGerfo JP, Use of Peer Ratings to Evaluate Physician Performance. *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION*, 1993; 269:1655-1660.

Insert Professional Associate
Rating Form here.

Use of Praise Card/Early Concern Note

The Praise Card/Early Concern Note (see example, reverse side) is designed to enhance feedback by a) providing *praise* or *early concern* about the performance and professional behavior of residents and subspecialty fellows, and b) facilitating the flow of information from the teaching faculty to the program director and the trainee. It also can serve as a memory jog to the evaluator who can use the card to note observed performance and behavior and incorporate that information into the trainee's evaluation form.

Though illustrated as two separate forms, the praise card/early concern note has been printed on packets of double-sided 3x5 cards which can be used by attending physicians on general medicine and subspecialty inpatient services, in ambulatory care clinics, and in long-term care facilities. Packets including envelopes are provided to programs by the ABIM at no cost. These cards are used by 40% of internal medicine training programs, and have been introduced in subspecialty training programs.

In some programs this card has been adapted for use by others who evaluate housestaff performance, such as chief residents, subspecialty fellows and nurses. Program directors are encouraged to modify these cards accordingly.

To maximize its usefulness, program directors should discuss the straightforward purpose of this card with the faculty, residents and subspecialty fellows at department and division meetings, orientation sessions, and retreats.

Prior to each rotation, when routine material about the clinical service and teaching assignment is sent to the attending physician, a small packet of cards, return envelopes, and a recapitulation of the purpose of the card should be included.

As each card is completed, the faculty member should return it in an envelope to the program director for review and feedback to the houseofficer.

Insert Professional Associate
Rating Form here.

Insert Praise Card/Early
Concern page here.

Professionalism and Evaluation of Research Performance

During the past few years increasing emphasis has been placed on the importance of the research environment within the framework of residency and subspecialty fellowship training. The *Program Requirements for Residency Education in Internal Medicine* developed by the Residency Review Committee for Internal Medicine contain specific language that define expectations for residents to demonstrate some form of acceptable scholarly activity that may include original research, comprehensive case reports, or review of assigned clinical and research topics.¹

For subspecialty training, the *Program Requirements for Residency Education in the Subspecialties of Internal Medicine* require that programs must ensure meaningful, supervised research experience with appropriate protected time for each trainee while maintaining the essential clinical experience. Trainees must learn the design and interpretation of research studies, responsible use of informed consent, and research methodology and interpretation of data. Programs must also provide trainees with instruction in the critical assessment of new therapies and of the medical literature.²

This emphasis on research within the educational environment is especially relevant given the increasing recognition by the professional research community for its need to develop and uphold standards that are broader than those addressed by the governmental regulatory and legal framework for dealing with misconduct in science.³

The *Project Professionalism* document includes a brief bibliography on these issues along with the acknowledgment that the vast majority of training programs provide no formal evaluation of trainees' research performance and no documentation. The following form is a preliminary effort to begin to formalize that critically important assessment process and to call attention to the profession's responsibility. Program directors are encouraged to adapt the form according to the needs of their trainees and the related research environment. Completed forms should be included in the trainee's departmental file.

The development and content of the form is an outgrowth of ideas and concepts presented at the *Conference on Educating for the Responsible Conduct of Research: The Mandate, the Intent and the Means*, (November 2-3, 1994, Boston, Massachusetts) sponsored by Public Responsibility in Medicine and Research, Association of American Medical Colleges, National Institutes of Health Office of Extramural Research, Tufts University School of Medicine and Harvard Medical School Division of Medical Ethics.

1. *Graduate Medical Education Directory*, 2001-20025, page 104, American Medical Association, Chicago.

2. *Ibid*, page 110.

3. National Academy of Sciences, National Academy of Engineering, Institute of Medicine *Convocation on Scientific Misconduct*, (Statement) June 6-7, 1994, Washington, DC.

Insert Evaluation of Research
Performance Form here.

Professionalism Remediation Summary Form

Because issues related to unprofessional behavior are both difficult for program directors and faculty to address and bothersome to document, they often are put aside until they build to a point of awkward confrontation or consistent complacency. A systems approach to evaluation is particularly useful to program directors in facing these challenges. This approach is based on a set of principles that underscore the importance of using strategies for managing information about the progress and performance of residents and subspecialty fellows during training. More detailed information on the systems approach is available in the *ABIM Guide to Evaluation of Residents in Internal Medicine*.

When program directors encounter residents or subspecialty fellows who present significant problems of professionalism, the Professionalism Remediation Summary should be used to help formulate and document the course for the trainee's expected improvement. This form is designed specifically to describe the problem(s) identified, and to document the program's remediation plans and the trainee's progress and outcome. A copy of the summary form is on the back of this page. In using the form, it is helpful for both the trainee and the program director to share a common understanding of the behaviors deemed unprofessional and problematic, and examples of these are described below.

DESCRIPTORS OF UNPROFESSIONALISM

As part of the requisite clinical competency for certification, physicians are expected to demonstrate professionalism. Since all of the attributes of professionalism cannot be tested on a written or oral examination — patterns of behavior, as observed throughout the continuum of training and within the educational environment — play an important role in making these determinations. Recognizing that the focus of the *Project Professionalism* document is to define professionalism, the following descriptors serve to identify behavior which is unacceptable for meeting the standards of professionalism inherent in being a physician.

Unmet professional responsibility

- Needs continual reminders about fulfilling responsibilities to patients and to other health care professionals
- Cannot be relied upon to complete tasks
- Misrepresents or falsifies actions and/or information, for example, regarding patients, laboratory tests, research data

Lack of effort toward self-improvement and adaptability

- Is resistant or defensive in accepting criticism
- Remains unaware of own inadequacies
- Resists considering or making changes
- Does not accept responsibility for errors or failure
- Is overly critical/verbally abusive during times of stress
- Demonstrates arrogance

Diminished relationships with patients and families

- Lacks empathy and is often insensitive to patients' needs, feelings and wishes or to those of the family
- Lacks rapport with patients and families
- Displays inadequate commitment to honoring the wishes and wants of the patient

Diminished relationships with health care professionals

- Demonstrates inability to function within a health care team
- Lacks sensitivity to the needs, feelings and wishes of the health care team

Insert Professional
Remediation Summary
Form here.

Annotated and General Bibliographies

This section provides the original annotated and general bibliographies from 1994-1995 on professionalism. Subsequently, through the Medical Professionalism Project, sponsored by the ABIM Foundation, ACP-ASIM Foundation and the European Federation of Internal Medicine, <www.professionalism.org> was established and includes an extensive annotated bibliography on professionalism which is updated monthly.

Blumenthal D. The vital role of professionalism in health care reform. Health Affairs. Spring (I) 1994, pp. 252-256.

While some in the medical profession equate professionalism with autonomy and fear that health care reform may erode that autonomy, the author asserts that not only are professionalism and autonomy not the same things but that unless organized medicine pays attention to its members' behavior, the profession's autonomy will become a moot point. Under the President's 1994 health care reform proposal, the author believes that both medicine's professionalism and its autonomy can be preserved by the observance of a standard of behavior which includes, at least, altruism, a commitment on the part of organized medicine to self-improvement, and peer review.

Ingelfinger FJ. Arrogance. N Engl J Med. 1980; 303:1507-1511.

Two forms of arrogance exist: arrogance of knowledge (the physician who uses medical jargon his patient probably won't understand) and arrogance of ignorance (the patient who doesn't understand but won't ask). Making decisions without sufficient information is a form of arrogance. Failure to recognize one's limitations is another. The superior scientist or doctor always leaves room for doubt. The author also stresses "beneficial arrogance", paternalism/leadership on the basis of knowledge. Examples of destructive arrogance: paternalism with insolence and a lack of empathy, arbitrariness, vanity, making decisions without admitting a lack of scientific basis for the decision.

Kassirer JP. Medicine at center stage. N Engl J Med. 1993;328:1268-1269.

Since the mid 20th century, the medical profession has continued to lose the respect it commanded in the past. This has happened because medicine is confused about its identity: Is it a profession or a business? Many factors have shifted the emphasis to a marketplace mentality, often causing conflicts of interest which must be effectively dealt with. In the arena of health care reform, when physicians are asked for their position, their response must be on behalf of the patient. If self-interest or perverse financial incentive is eschewed, recommendations made by medicine will be heard, and the high esteem doctors once enjoyed will begin to be restored.

Paine LS. Managing for organizational integrity. Harv Bus Rev. 1994;72:106-117.

Citing well-known examples of the difference between the corporate philosophies of integrity and compliance, the author draws a clear picture that conduct not in violation of any law is not necessarily conduct that is ethical. In the integrity approach, a company recognizes the value of suggestions from all levels of management and enables employees to make responsible decisions. The compliance approach, in which the letter of the law is met, is reactive, the objective being to prevent criminal misconduct on the part of a company's management. The author suggests that by encouraging exemplary conduct an organization may have found the best avenue to prevent damaging misconduct.

Racy J. Professionalism: Sane and insane. J Clin Psy. 1990;51:138-140.

Professionalism is defined, focusing on human altruism as the centerpiece of any, but especially, the medical profession. This article points out the results that can occur when professionalism is sacrificed to self-service, neglect of self-discipline, or an inordinate quest for perfection. He emphasizes Thomas Browne's famous quote: "I desire rather to cure his infirmities than my own necessity."

Reade JM and Ratzan RM. Yellow journalism: Advertising by physicians in the Yellow Pages. N Engl J Med. 1987;316:1315-1319.

Since the Federal Trade Commission opened the door for physicians to advertise in the Yellow Pages, a number of concerns related to truth in advertising have arisen, specifically physicians representing themselves as specialists without appropriate credentials to do so and protection of a generally uninformed public from unethical persons. In 1983 researchers from Harvard Medical School and University of Connecticut School of Medicine discovered that 12 percent of physicians advertising themselves as specialists were board-eligible, not ABMS board-certified, concluding that as the Yellow Pages present the potential for misleading the public, the ABMS should consider setting standards to assure continued credibility of the medical profession.

Spivey BE. Professionalism, specialization, and competition. Am J Ophthal. 1990;110:668-695.

The transition from generalism to specialization, from individual to group (i.e. competitive) practice has denigrated the once-honored position held by physicians in the public's eye. Over the last 40 years there has been not only a distancing of physicians from their patients, but also a loss of focus and cohesiveness within the medical community. By continuing their education, by educating the public, and by making themselves "accessible, accountable, affordable, and compassionate" -- in short, more humanistic -- the profession can avoid unwanted regulations and practices that may otherwise be demanded by the public and government. In essence, physicians should rededicate themselves to "the ministry of medicine."

Wheeler HB. Shattuck Lecture: Healing and heroism. N Engl J Med. 1990;322:154-158.

At the 100th Shattuck Lecture to the Annual Meeting of the Massachusetts Medical Society in Boston in 1990, The author described the origins and development of several heroes in medicine — the prominent physician members of the 18th and 19th century Shattuck family and William Osler, the fourth Shattuck Lecturer. He suggested that what made all of these men heroic was their humanism which is "largely an art of words and attitudes". Dr. Osler, in particular, practiced medicine with "brotherly love" and his passion for knowledge, essential qualities for anyone aspiring to be a truly great physician that should be instilled in physicians-in-training so that these qualities become a part of their every day practice.

Adams P. Friendship as therapy. Healing. 1992;1:3-5.

The author suggests that cultivating closer personal relationships between physicians and patients is a viable alternative to the status quo. By developing friendships with patients, physicians can lower the walls that have in recent years divided the caregiver from the care recipient while promoting healing and a general sense of well being.

Ficklin FF et al. Faculty and house staff members as role models. J Med Edu. 1988;63:392-396.

An important facet of the education process, role-modeling -- teaching by example is essential for the stimulation of intellectual curiosity. In the medical education setting, a good role model ideally exhibits and students emulate appropriate behaviors — bedside manner, analytical thinking, decision making, and leadership — qualities that have a direct impact on patient care. Recognizing and rewarding effective role models should be part of any medical school's philosophy since the ultimate goal — students' professional identity and their future practice of medicine -- reflects on the institution as a whole.

Relman AS. What market values are doing to medicine. The Atlantic Monthly. March 1992, pp. 99-106.

Historically, there has existed a social contract between the public and the medical profession under which physicians are called upon to provide the best medical care possible without expectation of financial gain in return for certain privileges. However, today's health care system is clouded by uncontrolled commercialism and self-interest which threaten to endanger that contract. The author adjures physicians to examine their motives and accept responsibility for their part in the escalating health care crisis, urging them to remember their pledge "to benefit the sick" "uninfluenced by motive of profit" and to join the efforts of government and the public to reform the reputation of the profession.

Reynolds PP. Professionalism and residency reform. Bulletin of the New York Academy of Medicine. 1991;67:369-377.

Professional development in residents is often impeded by a number of stresses, chief among them sleep deprivation and long hours. These, in addition to the sheer volume of information and technology to be absorbed, multiple procedures, and inadequate study time, give rise to an important issue: Exactly what is the purpose of residency — the preparation to practice medicine or meeting the service needs of the hospital? By creating a balanced didactic and clinical curriculum grounded in an environment conducive to providing both education and service, the values, knowledge, and skills required for effective health care delivery can be instilled in residents and will lead to the maturation of the individual as a professional. Such reforms should come from within, not be imposed by external forces, in order to maintain the integrity of the profession.

Senhauser DA. On professionalism. Jour College of American Pathologists. July 1978, pp. 402-403.

The advent of technology has changed the time-honored definition of professionalism from one who engages in a vocation or occupation requiring a long period of intense study to anyone who performs specialized work for pay. As the subtleties of medicine become increasingly open to public scrutiny, there will be corresponding pressure for the profession to either voluntarily regulate itself or endure regulation from without. A secondary but equally as important factor for the professional community to bear in mind is the need for continuing education so that the knowledge base, managerial as well as scientific, of members does not stagnate.

Summers JW. Doing good and doing well: Ethics, professionalism, and success. Hospital & Health Services Administration. March/April 1984, pp. 84-100.

Hospital CEOs are often viewed in an adversarial light by both hospital boards and employees and medical staff. This article offers administrators constructive alternatives to alleviate ill-will and resistance during periods of change in their facilities' corporate culture and achieve long-term solidarity to their facilities' mission. Implicative is the importance of administrators to exhibit the same humanistic qualities expected of physicians and other health care workers.

Medical Ethics

Anderson C. NIH laboratory admits to fabricated embryo research, retracts paper. Nature. 1992;357:427

In 1991 a research paper on mouse embryo development was published in *Cell* (1991;64:1103); 15 months later the lead author confessed to having fabricating data after it was discovered in an independent study that the results were irreproducible. As a consequence, a retraction has been printed, the lead author's candidacy for a doctoral degree at Georgetown University Medical Center has been withdrawn, and Harvard Medical School has formed an advisory committee for the purpose of investigating the matter. Several schools of thought have arisen out of this matter. Some feel that "the episode proves that scientists can . . . police themselves." Others feel that the prevalence of fraud in science requires constant vigilance.

Crane M. How a hired gun's lies caught up with him. Medical Economics. August 3, 1992, pp. 42-49.

In 1986 the defense attorney in a malpractice suit revealed that the prosecution's medical expert had falsified his CV in order to promote himself as an expert witness. As a result, the attorney pursued censure by the AMA and the state medical boards licensing the physician. Despite the physician's attempts to fight the reprimands, the various boards determined that expert witness testimony is akin to giving a second opinion, regardless of the condition of the patient (in this instance the patient was dead). However, as indicated in the side bar to this article, this is not always the case: The Missouri Court of Appeals recently held that a doctor giving testimony is not diagnosing and treating the sick, although physicians who testify falsely while under oath could be subject to criminal prosecution for perjury.

Fins JJ. The hidden costs of market-based health care reform. Hastings Center Report. May-June 1992, p. 6.

The 1980s saw the rise not only of health care costs, but also the rise of market-driven health care reform. Whereas once physicians primarily concerned themselves with the practice of medicine, some have become captivated by the financial aspects of medicine. The author suggests that professionalism may have been sacrificed along the way.

Rossiter EJR. Reflections of a whistle-blower. Nature. 1992;357:434-436.

In the capacity for Chairman of the Ethics Committee of Deakin University at Geelong, Australia, Dr. Rossiter uncovered the perpetration of a fraud involving the falsification of credentials as well as the publication of questionable study results. Having called the matter to the attention of the university dean and the ethics committee, the author found his own professional scruples from time to time called into question. His life was threatened, and he met with open hostility from colleagues.

The author admits that the price is high in fighting for truth and justice in the academic world. In his words: ". . . All stages of research must be guarded by vigilant people who must act without fear of the consequences of what they do."

Rothstein J. Medicine and the market. Hastings Center Report. May-June 1992, p. 40.

As part of a continuing research program, a Hastings Center sponsored research group met in March 1992 to discuss the potential loss of medicine's professional ethos to the business aspects of the discipline. The fundamentals of commerce were delineated for the group in a historical context. Future meetings will study the threats of the market to medicine, as well as options and their implications for medicine, the market, and society.

*Gender Discrimination/
Sexual Harassment*

Donovan KA. Wake up to sexual harassment in the workplace: Investigating the charges. The Stock Market. Winter 1992;11-15.

The author quotes from the 1964 Civil Rights Act as a stepping stone to a legal definition of both quid pro quo and hostile-work-environment sexual harassment.

Fox MH et al. Wake up to sexual harassment in the workplace: Starting a gender awareness program. The Stock Market. Winter 1992;11-15.

This article examines philosophies behind current corporate policies on sexual harassment, as well as steps in setting up effective gender discrimination prevention programs. A brief description of various behaviors viewed as sexual harassment is offered, as well as the different avenues open for redress of grievances and training techniques available.

Komaromy M et al. Sexual harassment in medical training. N Engl J Med. 1993;328:322-329.

A small study of a limited sample of residents from one program that reports the critical finding of sexual harassment at least once during their training experiences. The study illustrates gender differences in levels of harassment and articulates the reasons why incidences frequently go unreported. Simply recognizing the impact such behavior has on the training environment may help other programs take action to address these issues before they become statistics for another study.

Niven D. The case of the hidden harassment. Harv Bus Rev. March-April 1992, pp. 12-23.

The accidental disclosure of sexual harassment in a hypothetical case is reviewed by five professionals who offer their opinions for appropriate handling of the situation.

Sandhoff R. Sexual harassment: The inside story. Working Women. June 1992, pp. 47-51 and 78.

Two surveys, one sent to readers of Working Women and another to human resources executives of the Fortune 500, revealed that there is a heightened awareness of sexual harassment in the workplace. While executives generally believe their companies' sexual harassment policies work, readers assert that filing complaints is tantamount to committing "career suicide". Readers also responded that the year's political elections would see repercussions of the Anita Hill-Clarence Thomas hearings. The article goes on to state, based on statistics, who gets harassed, why harassment exists, and outcomes. Included are six steps developed by a Seattle consulting firm to stop sexual harassment on the job.

Educational Environment and Curriculum

Benson JA. Rationalizing chaos. Am J Med. 1993;95:5-9.

In order for the medical community to respond with a greater sense of professional accountability to the public, it is the author's belief that curriculum reform must accommodate emerging new disciplines by anticipating their affect on the structure and composition of departments of medicine and residency training programs. Even though the introduction of emerging disciplines is likely to cause initial instability and require reorganization, in the author's view the medical profession can and must adapt a new logic of organizing its teaching, practice, and national organization.

Reynolds PP. Reaffirming professionalism through the education community. Ann Int Med. 1994;120:609-614.

A thoughtful publication that reexamines the role of the educational environment in fostering professionalism during medical training. Through an extensive review of the literature, barriers to professionalism in medical education and patient care are identified and defined. In addition, a curriculum outline on medical professionalism is included which the author has used successfully in teaching components of professionalism to medical students, residents, and faculty.

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