

*Teaching, Promoting and Assessing
Professionalism Across the Continuum:*

A MEDICAL EDUCATOR'S GUIDE



THE AMERICAN BOARD *of* PEDIATRICS
AND
THE ASSOCIATION OF PEDIATRIC PROGRAM DIRECTORS



Editors

Nancy D. Spector, MD and R. Franklin Trimm, MD

Chapter Authors

Michael A. Barone, MD
Debra Boyer, MD
Ann E. Burke, MD
Carol L. Carraccio, MD
Jessica Fowler, MD
Patricia J. Hicks, MD
Joseph Gilhooly, MD
Jennifer C. Kesselheim, MD
Nicholas C. Kuzma, MD
Richard B. Mink, MD
Gail A. McGuinness, MD
Beth Rezet, MD
Adam A. Rosenberg, MD
Janet R. Serwint, MD
Richard P. Shugerman, MD
Nancy D. Spector, MD
R. Franklin Trimm, MD
Nicole R. Washington, MD
Yolanda H. Wimberly, MD
Suzanne K. Woods, MD

Acknowledgements

The editors acknowledge the foundational contributions of the initial editor, John G. Frohna, MD, and the original chapter authors:

Carol L. Carraccio, MD
John G. Frohna, MD
Ann P. Guillot, MD
Stephen Ludwig, MD
Gail A. McGuinness, MD
Julia A. McMillan, MD
Theodore C. Sectish, MD
Edwin L. Zalneraitis, MD

In addition, we would like to acknowledge the following organizations for their continued support:
Council on Medical Student Education in Pediatrics (COMSEP) and
Council on Pediatric Subspecialties (CoPS)

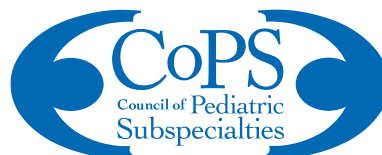


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Preface to the 2nd Edition

In his preface to the first edition of *Teaching and Assessing Professionalism: A Program Director's Guide*, Stephen Ludwig, MD wrote that the authors of this work hoped it would be useful in “rekindling the flame of professionalism ... that is at the core of our work on behalf of children and their families.”

Almost 10 years later, in the introduction to a new JAMA series on the teaching of professionalism, the editors wrote: “Despite the various definitions and multifaceted nature of professionalism, at its core, professionalism can be thought of as a set of behaviors that must be learned and practiced like any other skill, and they should be developed and refined continuously over a physician's practice lifetime. Much can be learned about professionalism by studying individual case scenarios. [In this way], physicians can learn more about how professionalism can guide them when they encounter challenging clinical situations, interpersonal issues, and ethical dilemmas.”¹

As the authors of this second edition of *Teaching, Promoting and Assessing Professionalism Across the Continuum*, we can find no better words than those above to convey both our intent and our hope for the current version of this guide.

We are indebted to Gail McGuinness, MD and to John Frohna, MD for their commitment to the original work as well as their drive to update this important teaching tool. It is a direct result of their guidance and encouragement that the second edition was undertaken and that important new chapters were added to the text. Just as essential to the successful completion of this project, Franklin Trimm, MD and Nancy Spector, MD were the senior editors who provided the focus, guidance and determination that brought all of us together into a functional team with a common mission. Without their thoughtful and timely leadership, this edition might never have made it to publication.

We are very appreciative of the financial and technical support of the American Board of Pediatrics in completing this project. Specifically, Kimberly Durham has been an invaluable leader for the authors, editors and staff through every step of the process. We are also indebted to Mike Adams for his technical expertise in transforming the original print version to a web-based tool that provides much improved usability and access.

Finally, on behalf of the entire project team, we are tremendously grateful to the chapter authors of the first edition who conceptualized the key elements of this work. Their original concept, design and content have gracefully withstood the test of time.

Richard P, Shugerman, MD
Chair, Education and Training Committee
American Board of Pediatrics

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Chapter 1: Promoting Professionalism: An Overview for Medical Educators

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

There are many definitions of professionalism. For our purposes, we will use Stern's definition as highlighted in his book *Measuring Medical Professionalism*: "Professionalism is demonstrated through a foundation of clinical competence, communication skills, and ethical understanding, upon which is built the aspiration to and wise application of the principles of professionalism: excellence, humanism, accountability, and altruism."¹ This definition emphasizes the fact that professionalism is a behavior that can be observed. Another important concept that is relevant to medical students, residents and fellows is professional identity formation described as "the moral and professional development of students, the integration of their individual maturation with growth in clinical competency, and their ability to stay true to their values which are both personal and core values of the profession."² Encouraging trainees to embrace both their personal principles and values as well as the core values of the profession facilitates their ability to navigate the inevitable conflicts that arise in the practice of medicine.³

PURPOSE OF THIS GUIDE

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

This guide was created initially through a joint effort of the Program Directors Committee of the ABP and the APPD in order to help program directors answer three questions:

1. What are the important elements of professionalism?
2. How can expectations regarding professionalism be communicated to pediatric residents?
3. What methods are appropriate for assessing professionalism during residency training?

This version was updated by the Education and Training Committee of the ABP that includes member representatives from the Council of Medical Student Education in Pediatrics (COMSEP), Association of Pediatric Program Directors (APPD), and the Council of Pediatric Subspecialties (CoPS) and has been expanded to address the needs of the continuum of learners from students, residents, and fellows into continuous professional development. This guide is now presented in an online, electronic format to allow users to take advantage of certain features built into its design such as:

1. Being able to search by individual Competencies for linked content throughout the guide; and
2. Adapting specific content (e.g., Reflective Exercises or Short Cases) to use for a variety of types of educational sessions.

It also reflects the maturation of competency-based assessment as we begin to move towards entrustment decisions that are fundamental to the assessment of entrustable professional activities (EPAs).

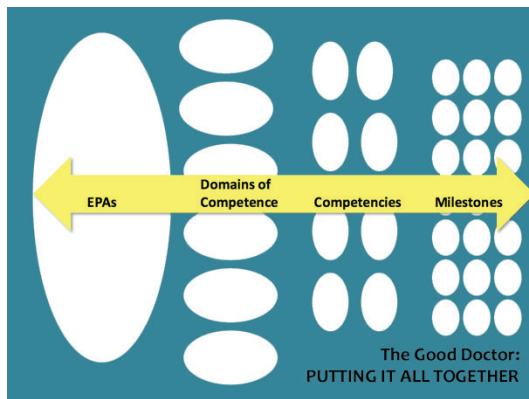


Figure 1 (as depicted by Burke, Carraccio, and Englander) illustrates the interactive continuum of EPAs with Domains of Competence, Competencies, and Milestones. To clarify terms in this Figure, Domains of Competence are the six original ACGME Competencies, examples of Competencies are illustrated by the chapters of this guide. The language related to competency-based education and training has evolved and we intend to continue to update this guide to remain contemporary and relevant. The pediatric competencies and their associated milestones referred to throughout this Guide include the full set included in the Pediatric Milestone Document, incorporating a number of additional areas not part of the subset reported biannually to the ACGME by residency and fellowship directors.

Three new chapters were added to the guide to focus on issues of increasing relevance to professionalism:

1. *Electronic Professionalism* — the far reaching effects of social media and the professionalism issues that cross into modern communications via this medium demand a stand-alone chapter
2. *Humanism within Pediatrics* — the emphasis on humanism as the heart of medicine requires special attention
3. *Trustworthiness: A Foundation of Professionalism* — this new chapter helps establish links between Milestones and Entrustable Professional Activities and, in doing so, highlights the developmental nature of professionalism and the importance of professional identity formation. Conceptualizing professionalism as a maturational process may help us mitigate some of the challenges that come with assessment.

This guide lays out the dimensions of professionalism in pediatrics and provides suggested methods for teaching and assessing professionalism among pediatric trainees. Chapters 2–8 outline aspects of professionalism as seen from different perspectives. In developing this guide, we have attempted to follow the model described by Stern: “setting expectations, providing experiences, and evaluating outcomes.”⁴

SETTING EXPECTATIONS

Setting expectations about professionalism begins at the institutional level – it must be part of the core values and part of the culture in which trainees work. Numerous publications address elements of professionalism and how they should be taught and assessed. Perhaps the most important document that can be used to set expectations is *Medical Professionalism in the New Millennium: A Physician Charter*, initially published in 2002 and hereafter referred to as the Physician Charter.⁵ This document outlines three fundamental principles and ten professional responsibilities.

The three fundamental principles are:

1. *Principle of primacy of patient welfare.* This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician-patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle.
2. *Principle of patient autonomy.* Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients’ decisions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care.
3. *Principle of social justice.* The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

The 10 professional responsibilities are:

1. Commitment to professional competence
2. Commitment to honesty with patients
3. Commitment to patient confidentiality
4. Commitment to maintaining appropriate relations with patients
5. Commitment to improving quality of care
6. Commitment to improving access to care
7. Commitment to a just distribution of finite resources
8. Commitment to scientific knowledge
9. Commitment to maintaining trust by managing conflicts of interest
10. Commitment to professional responsibilities

These responsibilities are incorporated into the subsequent chapters of this guide. Each chapter then provides specific examples of behaviors that exemplify professional conduct and those that demonstrate lapses in professionalism. We have adapted many of these behavioral statements from The Royal College of Paediatrics and Child Health document, *Good Medical Practice in Paediatrics and Child Health: Duties and Responsibilities of Paediatricians*.⁶

PROVIDING EXPERIENCES

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

In this guide, we provide a number of suggestions for ways to teach professionalism. Formal opportunities for learning may occur in community-based rotations, in international rotations, during teaching rounds on the inpatient service, or with a skilled, experienced outpatient clinician. Other formal learning can take place in conferences, some of which may focus explicitly on professionalism issues (like those outlined in this guide) and others that may incorporate aspects of professionalism, such as a mortality and morbidity conference. Each chapter has a series of vignettes, reflective exercises, and short cases that can be used in a conference or small group setting to stimulate discussion about professionalism. These individual teaching strategies can be accessed in each chapter or by searching by competency online. Program directors are encouraged to modify the cases to make them more applicable to a local setting. In addition, it is our hope that educators will build on the educational materials in this guide to develop innovative strategies to create and implement curricula and assess the impact of the curricula on learners.

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

EVALUATING OUTCOMES

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

of an individual. As valid and reliable tools are developed through research around assessment of competencies, milestones and entrustable professional activities, we will need to adapt accordingly in order to provide the most meaningful assessment of professionalism.

IMPLEMENTING A PROFESSIONALISM CURRICULUM

Our hope is that medical educators will use this guide to help create and reinforce the culture of professionalism within medical student and GME programs. It may be helpful to set explicit expectations regarding professional conduct early in training, using the topics covered in this guide. Some clerkship and program directors have used the orientation period to begin discussing professionalism and assist students, residents and fellows in developing their own “code of conduct.” As the year progresses, discussions of issues such as teamwork, documentation practices (e. g., procedure logs, completing evaluations, patient charting, logging duty hours), and morbidity and mortality conferences can highlight professional behavior. Each of the chapters in this guide could also be used as a foundation for a short educational session or incorporated into a longitudinal curriculum focusing on humanism and professionalism and wellness.

Beyond formal teaching about professionalism, it is clear that much of what is learned during medical training comes from the “hidden” curriculum, which Hafferty defines as the lessons that come from the structure, process, and content of the educational experience itself, including the organizational culture of the institution.⁷ Professionalism is taught in the middle of the night or in a passing interaction between hospital staff members. The culture of the institution and department can significantly influence professional behavior. Thus, it is critical for program directors to devote as much attention to the hidden curriculum as they do to shaping the formal curriculum.

Along the way, medical educators are likely to detect lapses in the professional conduct of trainees. “Lapse” is the preferred term for most professionalism issues for several reasons. First, it is generally recognized that professionalism is a characteristic of a behavior, not of the individual. Second, lapses in professional behavior occur in a context and often arise as a result of a conflict between two competing values.⁶ When lapses are identified, the appropriate faculty member or program director should bring these to the trainee’s attention. After discussion of the event, the trainee should be given a clear description of the behavior in question and expectations for future professional conduct. This discussion should be documented. The trainee should leave the discussion with the understanding that repeated lapses in professional conduct will be considered unacceptable. Further guidance for addressing serious professionalism problems is provided in Chapters 9 and 10.

Most students, residents and fellows come to their training with a general understanding of professional conduct, but they are unlikely to have been challenged with the stresses and competing priorities they will face during medical school, residency and fellowship. This guide acknowledges that professionalism, like many other aspects of training, is a developmental process and is context specific. We are challenged to do more than simply identify egregious behavior. Rather, we must promote professionalism through role modeling, setting explicit expectations, identifying professionalism lapses, implementing remediation plans and reinforcing behaviors that distinguish professional conduct in all aspects of work and life.

Professionalism must be incorporated in all aspects of our work as pediatricians. Demonstrating that we are competent in this essential domain is required during training, must be documented at the time of board certification, and is assessed as part of the ongoing maintenance of certification. We hope this guide will be a useful resource for medical educators and trainees who are role modeling, teaching and assessing professionalism.

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Chapter 2: Professionalism in Patient Care

The specific objectives for this chapter are to:

1. Describe the professional responsibilities of physicians with regards to the care they provide for their patients,
2. Provide examples of these professional behaviors as well as lapses in professional conduct in a way that complements *The Pediatrics Milestone Project*,¹
3. Provide some exercises that can be used in discussions with trainees about the many aspects of professionalism that are involved in everyday clinical care.

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

The following components from the American Board of Internal Medicine Foundation *Physician Charter*² relate to professionalism in patient care:

- *Commitment to professional competence.* Achieving and maintaining competence involves a commitment to lifelong learning and maintaining clinical and team skills. Professionalism is one of the domains of competence defined by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties, but it is important to recognize that deficits in any of the other domains (patient care, medical knowledge, practice-based learning, interpersonal and communication skills, and systems-based practice) also reflects a lack of professional commitment.
- *Commitment to honesty with patients.* Honesty with patients and their families requires not only truthfully informing them about their condition (or their child’s condition) and the treatment you recommend, but also informing them about potential adverse reactions to treatments and about medical errors, whether or not those errors result in actual harm.
- *Commitment to patient confidentiality.* Trust and confidence of patients and families depend upon their knowledge that the physician will safeguard patient information. In some situations, adolescent sexual health care for example, confidentiality can be maintained even if the patient is a minor. The physician must be aware of the laws regarding physician-patient confidentiality in their practice area. The electronic health record presents unique challenges to the maintenance of confidentiality, and protocols must be followed to keep access secure. Although confidentiality must sometimes yield to overriding considerations of public welfare (e.g., when harm may come to the patient or others), the patient and/or family should be informed of the intention to divulge clinical findings to appropriate authorities.
- *Commitment to maintaining appropriate relations with patients.* Patients and families are dependent upon the knowledge and decision-making of the physician. Their vulnerability and dependence should not be exploited. Appropriate emotional, physical and financial boundaries should be maintained between the physician and his or her patients and their families.
- *Commitment to improving quality of care.* Continuous improvement of care involves not only ongoing, informed review of the medical literature and maintenance of clinical competence, but also working with colleagues, health care systems, and other professionals to improve patient safety and provide high value care, reduce medical errors, improve accessibility and efficiency of care, minimize overutilization and underutilization of medical resources, and improve health outcomes.

The Pediatric Competencies that are most relevant to this area of professionalism are:

- Patient Care
 - Organize and prioritize responsibilities to provide patient care that is safe, effective and efficient
 - Interview patients/families about the particulars of the medical condition for which they seek care, with specific attention to behavioral, psychosocial, environmental, and family-unit correlates of disease
 - Counsel patients and families
- Practice-Based Learning and Improvement
 - Identify strengths, deficiencies and limits in one's own knowledge and expertise
 - Identify and perform appropriate learning activities to guide personal and professional development
 - Participate in the education of patients, families, students, residents, and other health professionals
- Interpersonal and Communication Skills
 - Demonstrate the insight and understanding into emotion and human response to emotion that allows one to appropriately develop and manage human interactions
- Professionalism
 - Professionalization
 - Professional Conduct
 - Humanism
 - Cultural Competence
- Systems-Based Practice and Improvement
 - Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate
 - Advocate for quality patient care and patient care systems
- Personal and Professional Development
 - Develop the ability to use self-awareness of knowledge, skills, and emotional limitations to engage in appropriate help-seeking behaviors
 - Manage conflict between personal and professional responsibilities
 - Demonstrate trustworthiness that makes colleagues feel secure when one is responsible for the care of patients
 - Demonstrate self-confidence that puts patients, families, and members of the health care team at ease

BEHAVIORAL STATEMENTS

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

Examples of Exemplary Professional Conduct

1. Demonstrates accountability, responsibility, and respect for patients and families, including appropriate verbal and nonverbal communication
2. Optimizes comfort and privacy of patients when performing a history and physical exam or a procedure
3. Maintains comprehensive, timely, medical records and correspondence and protects patient confidentiality
4. Communicates collaboratively with colleagues, health care providers, patients, and families to provide safe and effective care
5. Provides culturally competent care for all patients
6. Recognizes limitations of training and experience and seeks help appropriately
7. Accesses available information to support clinical decision-making
8. Responds to constructive feedback and demonstrates commitment to ongoing professional development
9. Acknowledges errors in medical care; discloses them to colleagues, affected (or potentially affected) patients, and responsible authorities; and takes steps to prevent future errors
10. Demonstrates appropriate boundaries for patient relationships

Examples of Lapses in Professional Conduct

1. Provides unsupervised care of an infant, child, or adolescent without previous experience or training in the appropriate skills
2. Excludes parents or other caretakers from involvement in management of their child's illness when there is no valid reason for doing so
3. Provides treatment that is inconsistent with best practice or evidence without justification
4. Documents information that does not accurately describe the patient's condition or the care provided
5. Willfully misrepresents clinical data in communication with other health care providers
6. Fails to consult a supervisor or a clinician who is more experienced in caring for the problems being confronted
7. Provides preferential treatment to certain patients or families to the detriment of others, based upon considerations other than clinical need and available treatment
8. Fails to recognize and apologize for discourtesy or errors in treatment or judgment
9. Fails or inappropriately delays to respond to a request by a family or other professionals (nurse, social worker, physician colleague) to provide care for a patient for whom he/she is responsible
10. Participates in physical or verbal abuse toward colleagues, staff, patients, or family members

TEACHING PROFESSIONALISM

Learning Objectives for Trainees

- Identify instances when personal circumstances can be at odds with professional values
- Describe professional responsibilities in regards to patients, families, and colleagues
- Describe how one's behavior can serve as a model for colleagues
- Demonstrate that professionalism involves a wide array of responsibilities to the individual; their colleagues, patients, institution; and society
- Demonstrate understanding that a commitment to professional behaviors, and development as professionals, occurs throughout the entirety of one's career

Reflective Exercises

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

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

Note: Considering the different competencies and Milestones for professionalism, discuss the vignettes from the point of view of different training levels across the continuum (students, junior resident, senior resident, attending physician). What would be the expected behaviors of different levels of professional in these vignettes?

CHAPTER 2 VIGNETTES – PROFESSIONALISM IN PATIENT CARE

The vignettes that follow were developed for use in a small group setting to help stimulate discussions about issues regarding professionalism. Medical educators are encouraged to expand upon these to reflect local issues and experiences.

Vignette 1 – Trustworthiness

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

Points to consider during discussion:

- What would you do if you were the supervising resident?
- What should the medical student have done?
- What are the potential consequences of ignoring the student's actions?
- What is the downside of pointing out the student's behavior on rounds?

Vignette 2 – Tardy Parent

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

Points to consider during discussion:

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

Vignette 3 – Error Disclosure

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

Points to consider during discussion:

- Describe what you know about your institution's policy for error disclosure to patients and families.
- How does one balance responsibilities to patients/parents with colleagues/departments/ institutions?
- If endotracheal tubes in the right main bronchus during surgery became a chronic occurrence in patients, what action would you take?
- To whom would you raise your concerns?
- What if you believe that the problem with the endotracheal tube and the nosocomial RSV infection had nothing to do with the infant's ultimate death?

Vignette 4 – Elevator Chats

You are on your hospital's elevator and you overhear another physician discussing the behavior of a parent of one of her patients.

Points to consider during discussion:

- Whose responsibility is it to remind that physician about confidentiality?
- What would you do in response to hearing this?
- What if the physician is from another department?
- What if the physician is a department chair?
- What if the person speaking on the elevator was a student?

Vignette 5 – Work/Life Integration

As a trainee, you care for a 15-year-old boy with a malignancy. You develop a close relationship with him during your residency. Later in your training, he is terminal, and he has begun to talk openly with you about dying. You have assured him that you will be there as a support for him whenever needed. He is admitted to the hospital conscious but close to death, and he asks one of the other residents to call you at home and ask you to come in. You are not on call, and you are on your way out the door to your 3-year-old daughter's dance recital.

Points to consider during discussion:

- How appropriate is it for physicians to make promises to patients?
- In your opinion, is work-life integration a component of professionalism? Why or why not?
- How will you decide in what circumstances a patient's needs might take precedence over family obligations?
- When it is said: "Professionalism demands placing the interests of patients above those of the physician (self interest).", What does that mean to you? What is "self-interest"? How is it different than "self-sacrifice?"

Vignette 6 – Firing a Patient

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

Points to consider during discussion:

- What if the trainee and the mother of the patient are of different races?
- What if the trainee and the patient's family are of different religious groups?
- What is the mechanism to end care with a patient and transfer their care to another physician?

Vignette 7 – Too Much or Too Little Information?

You are a trainee participating in continuity clinic in a community pediatrician's office. The pediatrician prescribes levetiracetam for migraine headaches to one of the patients, but he does not sufficiently review the risks and benefits related to hypersensitivity reactions. You ask, "Shouldn't you mention the need to stop the medication if the patient gets a rash." The pediatrician replies, "If I did that, they would never take the medication."

Points to consider during discussion:

- How would you discuss this with the pediatrician in the clinic, if at all?
- What do you perceive as your responsibility to this family?
- How would your actions change if you knew the pediatrician was responsible for an important performance evaluation on you?

ASSESSMENT TOOLS

An assessment of professional behavior is an essential aspect of the pediatric milestones. However, many other tools are also well suited for assessing professionalism in patient care. This includes direct observation assessments of the trainees' behavior with actual or simulated patients. Among the most widely used tools are the Mini-CEX, the Professional Mini-Evaluation Exercise (P-MEX), and the Standardized Direct Observation Assessment Tool. The available tools vary widely in their being subject to validity measures. This is well covered in a systematic review.¹¹

Multisource evaluation tools, which receive input from all members of the healthcare team and patients and their families, are also useful. Ad hoc evaluations are an effective method to document and assess critical incidents both for positive behaviors and when there are opportunities for improvement.

When assessing something as complex as professional behavior, it is important to remember that no one instrument can capture all dimensions. Furthermore, accurate assessment of professionalism requires a longitudinal perspective. While there are certainly unprofessional behaviors that require immediate attention and possibly action, it would not be appropriate to base a trainee's entire professional assessment on one single event.

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Chapter 3: Professionalism with Physician Colleagues and Other Health Professionals

The professional development of physicians involves experience and reflection; experience increases knowledge and skills, whereas reflection on that experience improves self-knowledge and insight. Providing learners with role models who use and promote the use of reflection in their daily work will create the kind of environment that embodies professionalism as a core value. Thus, the culture of the work environment has enormous potential to contribute in a positive way to the formation of physicians during residency. Central to this concept is the ability of trainees to embrace the concept of the multidisciplinary team and a culture of patient safety and continuous quality improvement. These attributes are inherent to the triple aim to produce improved outcomes for our patients, better health for populations and cost effective care. This paradigm for care places a premium on team based care with coordinated services and appropriate stewardship of resources.

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

- *Commitment to improve quality of care*
Quality improvement requires that physicians “work collaboratively as a member of the health care team to increase patient safety and reduce error.”¹ To accomplish this, physicians need to value interdisciplinary teamwork and contribute effectively to team function to ensure optimal care to patients. Equally important is the team’s responsibility to examine its system of care on a continuous basis, accept responsibility for shortcomings and failures, and work together to improve the system. Part of this responsibility includes being acutely aware of patient safety in clinical practice and being willing to report events that might lead to preventable harm. In addition, this must embrace a culture of searching for opportunities to improve on the system of care provided on a continual basis. These qualities are extolled in the CLER Pathways to Excellence document from the ACGME (Jan 2014).
- *Commitment to professional responsibilities*
As a member of a team, the physician must contribute to the overall functioning of the team by performing his or her share of the work in a way that builds on the contributions of other team members. Underlying this functional responsibility is a culture that values and embraces a genuine respect and appreciation of the skills of all team members. Such a culture can help to create a safe patient care environment in which conflicting opinions can be openly expressed and discussed in order to provide continuous improvement of care for patients. Healthcare is delivered by multidisciplinary teams and quality issues need to be addressed within the team structure supporting a culture of continuous process improvement.

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

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

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

Physicians are also accountable to other members of the profession. Assisting colleagues with daily work, completing tasks on time, providing coverage in emergencies, and seeking help when the care required is beyond one’s scope are some examples of how this aspect of professionalism can be demonstrated. Furthermore, physicians need to demonstrate respect for all health care providers, across all disciplines. Negative comments made about others diminish the professionalism of all physicians and perpetuate problems. It also gives a life to stereotypes and teaches all trainees unprofessional behavior.

Finally, physicians are accountable to each other. Professional responsibility does not stop with one’s own practice. With the opportunity to self-regulate comes the responsibility of taking the behavior of our colleagues seriously. When we witness unprofessional behavior, we have a duty to address this behavior so that it does not continue and if remediation is warranted, it can be implemented. When working as part of a team, trainees may witness unprofessional behavior on the part of peers or colleagues. Whenever possible this should be addressed with the individual. There should be a safe process for reporting unprofessional behaviors of more senior colleagues so as not to put trainees in the uncomfortable position of addressing these issues directly.

The Pediatric Competencies that are most relevant to this area of professionalism are:

- Systems-Based Practice
 - Work in inter-professional teams to enhance patient safety and improve patient care quality.
- Personal and Professional Development
 - Provide leadership that enhances team functioning, the learning environment and/or health care system/environment with the ultimate intent of improving care of patients.
- Professionalism
 - Professionalization
 - Professional Conduct

BEHAVIORAL STATEMENTS

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

Examples of Expected Professional Conduct

- Follows policies and procedures
- Demonstrates self-awareness and the ability to be self-critical in reflecting on practice
- Accepts feedback from others and develops goals for practice improvement
- Participates in hospital patient safety training around issues of preventable harm and reports events that could potentially result in patient harm
- Works collaboratively and cooperatively as a member of a health care team
- Leads with respect and fair treatment of colleagues and provides appropriate guidance to team members
- Accepts responsibility for negotiating conflict and bringing about conflict resolution at the appropriate time and in the appropriate setting
- Ensures the safety of patients by not allowing oneself and/or team members to go beyond their limits of knowledge and skill in delivering care
- Accepts the responsibility of teaching colleagues by developing the knowledge base, skills, and attitudes necessary to be a competent teacher
- Gives appropriate feedback to peers regarding improvements in behavior that will enhance professionalism and is willing to report lapses through the proper institutional channels
- Arrives on time for scheduled activities and appointments and in the event of an emergency arranges appropriate coverage

Examples of Lapses in Professional Conduct

- Fails to engage in self-reflection and disregards feedback from others that would be helpful in practice improvement
- Fails to notify supervisors of inability to work in a timely manner and does not take responsibility for ensuring proper coverage
- Fails to ask for or address patient input (to the extent possible based on individual patient needs and clinical circumstances) in making decisions
- Does not demonstrate the required leadership when running a team to create a supportive learning environment or a culture of safety and balancing workload by neglecting to define the roles of each team member
- Avoids responsibility to negotiate conflict among team members and/or report lapses in professionalism
- Ignores the opportunity to acknowledge and incorporate the expertise of other team members in enhancing patient care
- Does not expend the effort to acquire the knowledge, skills, and attitudes that are necessary to be an effective educator of trainees and families
- Fails to take part in patient safety training, shirks the responsibility to report patient safety concerns and does not embrace quality improvement efforts to improve patient care
- Does not demonstrate respect for all team members at all times

TEACHING PROFESSIONALISM

Learning Objectives for Trainees

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

Reflective Exercises

These reflective exercises can be used for individual reflection on professionalism issues or can be modified and discussed as a part of a larger group meeting. Where applicable, related competencies/milestones are indicated. After holding a discussion about professional responsibilities of physicians, ask learners to describe, in one page or less, an incident in which they were challenged with a decision that involved professionalism in relationships with other physicians or health care personnel.

- Using any of the vignettes below, ask learners to describe a similar real-life situation. Ask them to identify the conflicting values and what they learned from the situation.

CHAPTER 3 VIGNETTES – PROFESSIONALISM WITH PHYSICIAN COLLEAGUES AND OTHER HEALTH PROFESSIONALS

The vignettes that follow were developed for use with an individual, or in a small group or noon conference setting to help stimulate discussion about issues of professionalism. Program and clerkship directors are encouraged to expand upon these to reflect local issues and experiences. Where applicable, related competencies/milestones are indicated.

Vignette 1 – Sick Call

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

Points to consider during discussion:

- Assume that you are the chief resident. How would you respond to this resident? What if the resident were male? What if this is the first time? What if this is a chronic problem?
- If you decide that efforts to get this resident to come in at this point in time are futile, what do you say to the next resident that you call to come in when they ask why the sick call resident is unavailable?
- Issues with a double standard (such as having a child versus not) come up frequently. What strategies can one use to even the playing field?

Vignette 2 – What's the Prescription?

A respected and well-liked division chief approaches one of your peers for a prescription for meperidine for his headaches. He explains that he has been too busy to get to his own physician for a new prescription and today his headaches are particularly bad. When the resident sheepishly says that she would rather not write the prescription, the faculty member nervously withdraws the request and apologizes.

Points to consider during discussion:

- Imagine that your peer comes to you for advice about what she should do. Do you get involved or steer clear of the situation?
- If you feel it is part of your professional responsibility to become involved, how would you proceed?

Vignette 3 – Covering for a colleague

You are assigned to a subspecialty team with four junior residents who rotate call and cover each other's patients every fourth night. The morning after one specific colleague takes call is always chaotic and stressful. He says the night is too busy for him to follow up on labs, imaging studies, etc. You and the other two trainees have been coming in earlier and earlier to compensate so that rounds still go smoothly. You are halfway through the rotation and decide it is easier to continue to cover for the other resident than raise concerns.

Points to consider during discussion:

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

Vignette 4 – Angry Eval

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

Points to consider during discussion:

- What is your definition of professionalism?
- Do the incomplete assignments constitute a lapse of professionalism? If so, how would you respond to your colleague?
- How do you as current residents make time for these types of activities?

Vignette 5 – Seeking Advice

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

Points to consider during discussion:

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

Vignette 6 – Yes, Nurse?

You have been called by a nurse about a patient care issue. This nurse has a history of calling you quite a bit for what you deem are non-emergent issues. You are concerned about this as it disrupts your other duties.

Points to consider during discussion:

- What are your next steps?
- Who should you involve in the discussion?
- Have you done all you can to satisfy your professional responsibilities in this circumstance?

Vignette 7 – Hostility from Nursing Staff

You have noticed there are issues between the nursing staff and the residents. Residents feel they are disrespected by the nurses on a daily basis and feel it is a hostile work environment and definitely not the best for patient safety.

Points to consider during discussion:

- How would you address this issue?
- What resources would be needed to help improve this situation?
- Who would you involve to help solve this issue?
- How does it affect patient safety?

Vignette 8 – Exceeding Capacity

As an intern on your night ward rotation, there have been several nights where the acuity on the service as well as the number of new admissions has exceeded the capacity of yourself and the supervising resident to continue to provide safe care for the patients on the team. On each occasion you have persevered until the final night, after which you send an extensive communication to the chief resident describing several potential patient safety concerns.

Points to consider during discussion:

- Is it a breach of professionalism to not report through hospital channels the patient safety concerns?
- Is it a breach of professionalism to have not prospectively called for help (eg, from the attending)?
- How should the chief handle this circumstance and counsel the intern?
- Who else should be involved in the conversation?

Vignette 9 – Second Guessing

You and a colleague are rotating in the intensive care unit on a team with two second-year pediatric residents, a 4th year medical student, an intensive care fellow and attending. It has become a regular occurrence on rounds to second guess and outwardly criticize patient care decisions made by the more junior members of the team. In particular, the 4th year student has been frequently handled in this manner; on a few occasions bringing her to tears after rounds. The ICU fellow has been the main culprit with the attending mostly in the background. You have spoken with the fellow on more than one occasion to not be so hard on the student who you feel is doing a nice job and would someday be a good resident in the program. You fear the student is having a negative experience that will impact her willingness to train further in the program. The fellow, when you have spoken, just shrugs his shoulders and says “this is how you learn.”

Points to consider during discussion:

- Is this type behavior ever acceptable within the construct of the care team?
- What do you think of the attending’s behavior in this circumstance?
- Having been rebuffed by the fellow and put off by the attending’s apparent indifference about the fellow’s behavior, how would you proceed?
- What should be the outcome in this circumstance?

ASSESSMENT TOOLS

“A true evaluation of professionalism must focus on the reasons for a behavior, rather than just the behavior itself. Professional behavior assessment tools must take into consideration the contexts in which unprofessional behaviors occur, the conflicts that lead to lapses in behavior, and the reasons choices were made.”² This approach clearly cannot rely on one tool and/or one source of input. Input needs to be provided by faculty, peers, nurses, families and other ancillary personnel. Other options also include multidisciplinary simulations or use of standardized patients. Some examples of available tools include:

- The 360-degree assessment instrument for PM&R residency programs³
- The professionalism mini-evaluation exercise⁴

These tools do not specifically assess a trainee's role as a team leader or ability to work within the team, nor do they assess their role in creating a culture of patient safety and continuous process improvement. Most current assessments of teamwork focus on high acuity rather than low acuity situations. It would seem that items could be added to existing tools to specifically address leadership and performance within the multidisciplinary team structure or could be inferred from comments on global or specific professionalism assessment tools. As for the quality improvement/patient safety piece, one could consider using a curriculum checklist as suggested by Nagy et al⁵.

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Chapter 4: Wellness and Its Impact on Professionalism

The specific goals of this chapter are to highlight the importance of managing one's own wellness and reducing unhealthy stress responses to situations that may arise during training. Another aim is to raise awareness and promote understanding about the impact of stress on professional behavior in individuals and teams. Pediatric training can be a time of great growth and a time of increased stress due to a number of factors. Studies report that the prevalence of burnout among pediatric residents ranges from 55–76%.^{1,2} Professional behavior is particularly vulnerable during times of extreme stress, anxiety and burnout. Stress may be caused by a combination of factors including sleep deprivation, the pressures of the work environment, the vulnerabilities (relative lack of experience and knowledge) of residents inherent in the training process and the acuity and complexity of patients. Learning how to utilize healthy coping mechanisms to respond to stress is of utmost importance.³

When wellness has been compromised and stress prevails, individuals may manifest unprofessional behaviors they would be unlikely to exhibit under normal circumstances. Maladaptive coping of stress, or lack of wellness, can influence professionalism in a number of ways. These include a state of detachment in providing clinical care that is prominent during burnout, a lack of insight or inability to recognize when one is practicing in an impaired state, an imposed lack of commitment or depletion of prior commitment to one's professional responsibilities. Additionally, poor coping with stress can result in a state of tension in attempting to balance one's personal and professional life. Many of these behavioral characteristics overlap with characteristics of burnout.⁴ In addition to the impact stress and/or lack of wellness has on the individual; stress within a patient care team can have a substantial impact on team members and function. Strategies to combat lapses in professionalism in this area are available to trainees and programs. Fostering healthy, adaptive, and mindful responses to the inevitable stress of training should be of great priority in programs. Consistently responding to stressors with healthy responses is the goal of mindful, competent physicians. This is especially important to trainees as they are in the midst of formation of their own professional identity and development of life-long strategies. Explicit discussions about ways to cope and respond to stress need to occur.^{3,5}

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

Principle of Primacy of Patient Welfare

One of the fundamental principles of the charter is that physicians are expected to be dedicated to serving the interests of the patient, not allowing market forces, societal pressures, or administrative exigencies to compromise this principle. Implied is the importance of striving to not allow one's personal life to adversely impact the primacy of patient welfare, but if that is not feasible, then identifying an alternative colleague who can serve this role.

Commitment to Professional Responsibilities

This responsibility includes the obligation to participate in the process of self-regulation, including remediation and discipline of physicians who have failed to meet professional standards. Maintaining high standards for professional behavior even under times of stress is a responsibility that we share for ourselves and our colleagues. Recognizing and reporting lapses in professional conduct through appropriate channels is an element of this commitment.

The Pediatric Milestones that are most relevant to this area of professionalism are:

Personal and Professional Development

- Develop the ability to use self-awareness of one's own knowledge, skills, and emotional limitations that leads to appropriate help-seeking behaviors
- Use healthy coping mechanisms to respond to stress
- Manage conflict between personal and professional responsibilities
- Practice flexibility and maturity in adjusting to change with the capacity to alter behavior

Professionalism

- Professional Conduct

BEHAVIORAL STATEMENTS

The components of professionalism and the importance of wellness and management of stress listed above provide general goals. It may be helpful to identify specific behaviors or practices that would exemplify the spectrum of behaviors in these domains and would predict stages from least desirable to most desirable way of being.

Examples of Exemplary Professional Conduct

- Demonstrates a commitment to professional responsibilities, even during periods of stress, by making a personal commitment to a respectful workplace
- Chooses altruism
- Works collaboratively with other members of the team, engaging in reflective self-assessment and accepting external scrutiny to improve professional standards
- Recognizes limitations and demonstrates appropriate help-seeking behaviors and models this behavior to others
- Shows advanced coping mechanisms and healthy responses to stress
- Proactively plans how to personally respond to anticipated stressor and helps other to anticipate stressors as well
- Adapts easily to almost any situation and embraces change and challenging situations as a positive experience
- Demonstrates flexibility and resilience
- Acknowledges stress responses in colleagues and provides them with support and strategies to seek assistance

Examples of Lapses in Professional Conduct

- Expresses concern that limitations may be seen as a weakness and doesn't seek help
- Easily frustrated with stress and rigid about accepting change
- Demonstrates potentially disruptive behavior in the workplace: abrupt and dismissive comments, angeriness and/or gestures or body language that convey significant frustration and anger
- Practices though impaired
- Responds to stress by complaining about the "system," engendering discontent in colleagues
- Disregards and/or ignores a colleague's obvious distress or impairment

TEACHING PROFESSIONALISM

Learning Objectives for the Trainees

- Identify and appreciate the impact of wellness and stress on professionalism as it relates to one's professional responsibilities and the ability to function effectively.
- Identify signs of impairment (in one's self and/or other professionals) and utilize effective help-seeking behaviors.
- Recognize and respond to personal stress with healthy coping mechanisms that assist in maintaining excellent professional and humanistic attitudes and behaviors.
- Recognize the importance of wellness in balancing one's personal and professional time/life.

Reflective Exercises

- These reflective exercises can be used for individual reflection on professionalism issues or can be modified and discussed as a part of a larger group meeting. Where applicable, related competencies/milestones are indicated. (Additional reflective exercises⁶)
- After holding a discussion about professional responsibilities of physicians, ask trainees to describe, in one page or less, an incident in which they were challenged with a decision that involved professionalism in stressful situations.

- Ask trainees to reflect and describe (either in group or individually journaling) strategies that they use to cope with stress and maintain wellness.
- Discuss as a group, what wellness means to the trainees. Consider using the AAP Resilience curriculum materials⁷ and develop an Individualized wellness plan.
- Using any of the vignettes below, ask residents to describe a similar real-life situation. Ask them to identify the conflicting values and what they learned from the situation.

CHAPTER 4 – WELLNESS AND ITS IMPACT ON PROFESSIONALISM

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

Vignette 1 – Moody Senior Resident

A senior resident becomes irritated with a nurse who has paged her that the new admission – a child with a rash and high fever – has arrived to the ward. The resident complains to her medical student that she should not even be on call today because she has one more call this month than the other senior resident. Later she feels badly that she was abrupt with the nurse and sad she complained, but she just feels so out of control sometimes. The nurse pages again about 10 minutes later to let the senior know that the family speaks only Spanish and will need an interpreter. This news sends the resident into a “tailspin” of moodiness, frustration and worry. She again feels disturbed with her inability to cope but does not think to apologize to the medical student or nurse.

Points to consider during discussion:

- What concerning behaviors is the senior resident displaying?
- Have you ever had times where you feel this overwhelmed and/or stressed? What strategies do you use to cope with these situations in the moment?
- What strategies could be used to prevent this kind of behavior? What has happened to this resident?

Vignette 2 – Drunk Med Student

A fourth-year medical student is completing a rotation as a sub-intern in the PICU. Her performance has been outstanding, and the senior resident on the service has already submitted an excellent evaluation about her. It is the last day of the rotation, and the student arrives at work obviously intoxicated and unable to care for her patients appropriately. The senior resident, without knowledge of the attending, sends her home to “sleep it off” with no further feedback. She receives honors for the course. Approximately five months later, at the resident selection committee meeting, two resident members describe the incident and recommend that she be excluded from the list of potential candidates for the residency program.

Points to consider during discussion:

- What other courses of action could the senior resident in the PICU have taken five months previously?
- What should the program director do?
- Should this incident affect her ranking in the program?
- What actions would be appropriate for the medical student to take after the incident?

Vignette 3 – Remark from Senior Resident

Dr. Z is the senior resident on the ward team. Although his first preference had been to complete a nephrology fellowship at his current hospital, he recently matched to an outside program and is preparing to move out of the area. During resident work rounds, he makes a glib remark about the nephrology service attending: “He is such a compulsive idiot. It is not necessary to follow the electrolytes so frequently. It is obvious the patient is improving.” The medical student and intern on the team appear uncomfortable with his remark.

Points to consider during discussion:

- If you were the intern on the service and wanted to convey your discomfort to the senior resident, how would you approach that conversation?
- What do you think contributed to the senior resident's behavior and how could these underlying factors be prevented or curtailed?
- What does respectful workplace mean to you? Does your institution have expectations about these concepts?

Vignette 4 – Is Everything Okay?

One of your senior resident colleagues arrives late each morning for morning report and does not check in with the night team as she is supposed to do in her role as ward supervisor. In addition, you notice that she seems withdrawn and anxious. She shares with you the fact that she is really questioning her choice of being a doctor. She is not making personal connections with her patients like she used to either. She admits that she is not sleeping well and feels tired all the time.

Points to consider during discussion:

What are the behaviors that make one worry about burnout, anxiety and/or depression?

How would you approach the senior resident? How could you help her?

Are there any programs that exist or could be started to assist residents who are having difficulty?

Are there ways to help decrease the risk of this situation in the first place from a program standpoint?

Vignette 5 – Not Home for the Holidays

The holiday schedule was just posted in the residency program office and you have been scheduled to work during the Christmas holiday for a second year in a row. Your significant other was upset last year because you were on-call Christmas eve, and it was a particularly busy night. You are not looking forward to informing him/her about this year's schedule.

Points to consider during discussion:

- Assume that you are the resident and are conflicted about what to do. What would you do?
- Would you approach the Chief resident about the schedule? Why or why not?
- Would you just accept the schedule and not make a big deal out of it?

Vignette 6 – Worrysome Nurse

You have been called by a nurse about a patient care issue. This nurse has a history of calling you quite a bit for what you deem are non-emergent issues. You are concerned about this as it disrupts your other duties.

Points to consider during discussion:

- What actions would you consider as your next steps?
- Who should you involve in your discussion(s)?
- What action(s) will satisfy your professional responsibilities in this circumstance?

ASSESSMENT TOOLS

Burnout inventory (Maslach)⁸

Individualized Learning plan for wellness⁷, scoring rubric from Lockspeiser et al.⁹

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Chapter 5: Society and Professionalism

Pediatricians have been committed to public health and welfare since the founding of our specialty. This concept of advocacy has been defined as the application of learned skills, information, resources, and action to speak out in favor of causes, ideas or policies to preserve and improve quality of life often for those who cannot effectively speak out for themselves.¹ In order to maintain and improve children's health, pediatricians must have a deep understanding of and commitment to the broader community in which the children they care for are raised and nurtured.

In addition to these traditional components of advocacy, the pediatrician's contract with society extends more broadly. The Physician Charter states that "professionalism is the basis of medicine's contract with society" and the following components of the Charter relate to this broader professional mandate:

- Commitment to improving access to care
 - All patient care decisions must be made without regard to personal views about a patient's lifestyle, cultural beliefs, race, ethnicity, gender, sexuality, disability, age, or socioeconomic status. Decisions about medical care must be based only on clinical judgment, patient needs, available evidence, patient's values and the likelihood of effectiveness. Pediatricians must work with patients and families individually and at the community level to ensure that access to quality pediatric health care is available to all. In addition, pediatricians should be able to assess and address barriers to access to care, including barriers based on geography, language, cultural differences, economic forces, legal restrictions, and educational differences. To optimize access to care, pediatricians should deliver culturally sensitive care that meets the specific needs of the patient and family.
- Commitment to a just distribution of finite resources
 - Pediatricians must work within their health care organizations to ensure a just distribution of resources. A commitment to following evidence based guidelines will help to ensure that finite resources are not misused or overused. Pediatricians should continuously examine resource utilization as part of their routine practice and work to distribute limited resources fairly.
- Commitment to scientific knowledge
 - Pediatricians are expected to support the appropriate use and development of new scientific knowledge. Even if the individual pediatrician is not personally creating new knowledge, the recognition and responsible use of new knowledge must be part of his/her practice. Pediatricians must be able to assess and use organized evidence in everyday decision making and those who are engaged in research must ensure full disclosure, obtain informed consent, and ensure confidentiality.
- Commitment to maintaining trust by managing conflicts of interest
 - The opportunities for conflicts of interest in the patient-physician relationship are ever-present and continuously changing. Pediatricians and pediatric organizations must not compromise the trust placed in them by their patients and by society at large. Pediatricians must be cautious in interactions with for-profit medical industries such as pharmaceutical companies, equipment manufacturers, and nutritional firms. There is a special risk of conflict of interest for those in positions of leadership or those recognized as an expert in their area of research or practice. When pediatricians develop relationships with medical industries, those relationships should be disclosed when enrolling patients in studies, interpreting research results, assessing others' research, expressing editorial opinions, creating health care guidelines or standards for care, or serving as editors or reviewers of scientific journals.

The Pediatric Competencies that are most relevant to this area of professionalism are (numbers in parenthesis indicate charter statements linked to):

- Patient Care
 - Interview patients/families about the particulars of the medical conditions for which they seek care with specific attention to behavior, psychological, environmental, and family-unit correlates of disease (1)
 - Make informed diagnostic and therapeutic decisions that result in optimal clinical judgment (3)
 - Counsel patients and families (1)
 - Provide effective health maintenance and anticipatory guidance (2,3)

- Medical Knowledge
 - Demonstrate sufficient knowledge of the basic and clinically supportive sciences appropriate to pediatrics (3)
- Professionalism
 - Professionalization (1)
 - Professional Conduct (4)
 - Humanism (1)
 - Cultural Competence (1)
- Systems-based Practice
 - Coordinate patient care within the health system relevant to their clinical specialty (1)
 - Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate (1,2)
- Practice-based Learning and Improvement
 - Identify strengths, deficiencies, and limits in one's knowledge and expertise (3)
 - Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems (2,3)
 - Use information technology to optimize learning and care delivery (1,2,3)
 - Participate in the education of patients, families, students, residents, and other health professionals (1)
 - Take primary responsibility for lifelong learning (3)
- Interpersonal and Communication Skills
 - Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds (1)
 - Demonstrate the insight and understanding into emotion and human response to emotion that allow one to appropriately develop and manage human interactions (1)
- Personal and Professional Development
 - Manage conflict between personal and professional responsibilities (4)
 - Recognize that ambiguity is part of clinical medicine and respond by utilizing appropriate resources in dealing with uncertainty

The specific goals of this chapter are to describe the professional responsibilities of pediatricians with respect to our contract with society, to provide examples of professional behavior and of lapses in professional conduct, and to suggest some exercises that can be used in discussions with learners regarding this topic.

BEHAVIORAL STATEMENTS

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

Examples of Exemplary Professional Conduct

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

Examples of Lapses in Professional Conduct

- Demonstrates prejudicial behavior based on race, ethnicity, religion, disability, gender, age, socioeconomic status, or lifestyle
- Overtly demonstrates cultural insensitivity, especially if with conscious intent and without remorse
- Intentionally distorts or misrepresents medical evidence in the development of practice guidelines or medical policies
- Fails to take all reasonable steps to protect confidentiality of patients in clinical care or research
- Accepts gifts from industry
- Accepts gifts from patients/families that carry an implied or explicit intention of impacting patient care
- Fails to participate in advocacy for the legitimate needs of patients
- Fails to disclose conflicts of interest to the public or in the course of patient care, when those conflicts of interest affect that care
- Falsifies research data in any public presentation or publication of that research
- Fails to obtain IRB approval or consent for research
- Coerces any patient participation as a subject in research in any way such as misrepresenting benefit or possible harm to that patient
- Fails or refuses to participate in the legal process designed to protect the welfare of children and their families
- Fails as an opinion leader to disclose relationships to industry

TEACHING PROFESSIONALISM

Learning Objectives for the Trainees

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

Reflective Exercises

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

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

CHAPTER 5 VIGNETTES – SOCIETY AND PROFESSIONALISM

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

Vignette 1 – Unprepared Parent

One of your continuity clinic patients, a 3-year-old boy, is brought by his mother to a clinic visit. Upon entering the examination room you are introduced to a 6-year-old-girl, the stepsister of your patient. The mother explains that

this child has just come to live with them, having spent the first years of her life with her grandmother. It is two days before school is to begin and the child needs immunizations before she can enroll in school. She is not yet registered on the mother's Medicaid policy. The mother asks that you immunize her daughter using the brother's Medicaid number.

Points to consider during discussion:

- Is following the mother's request a valid way to improve access to care?
- How does not following the mother's request affect access to care?
- What are your alternatives?
- Are there any possible ramifications for the boy's immunization status if you record her vaccines under his Medicaid number?

Vignette 2 – Teen's Trust

You are a senior resident supervising an intern's encounter with a 15-year-old girl in the Emergency Department. The intern has done a very nice job of gaining the teenager's trust, and the adolescent has disclosed to the intern that she may be pregnant. After confirming an early pregnancy, the intern comes to you for guidance in referring the patient for prenatal care. You ask whether the patient has considered abortion. The intern states that as a Catholic she is not willing to present abortion as an option to the patient.

Points to consider during discussion:

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

Vignette 3 – Alternative Therapy?

A patient presents to the Emergency Department with increased seizure activity. He was recently started on phenobarbital; however, the level at the time of evaluation is found to be zero. The mother explains that she is not giving the phenobarbital and produces a bottle of liquid that she is using as an alternative therapy for the child's seizures. She reports that she was told at the alternative medicine store to not give the phenobarbital and to give the herbal liquid instead.

Points to consider during discussion:

- How could you try to reach a compromise with this family?
- What is the role for child protective services?
- How would you address the situation if the child started to seize while in the ED?

Vignette 4 – Problem Prescription

A physician colleague that you work closely with requests that you write her a prescription for antibiotics. She states that she has had a cold for the past week and is concerned she may be developing sinusitis or pneumonia. She does not have a primary care provider.

Points to consider during discussion:

- What are the laws regarding prescribing for people who are not under your care as a provider?
- What may be the consequences for the physician who writes such a prescription?
- What may be the consequences for the individual who requested the prescription?
- Are there other ways to assist the individual rather than just writing the prescription?

Vignette 5 – Headaches

A fourteen year old girl is brought to your clinic for an acute appointment. The father states that she has been having headaches approximately every two weeks for the last four months since school started. The headaches only occur on weekdays. She states that headaches are accompanied by nausea and seeing “bright spots”. The pain is pulsatile, left sided and lasts for 4–8 hours. She denies any confusion, difficulty walking or other symptoms. The exam is completely normal. You reassure the parent that she most likely is experiencing migraine headaches. He insists on a CT or MRI of her brain and lab work to make sure she does not have a tumor.

Points to consider during discussion:

- How can you incorporate high value care principles into your discussion with the parent and child, such as the American College of Radiology “Choosing Wisely” recommendation to not do head imaging for uncomplicated headaches?
- What are the downsides to ordering head imaging for this patient? Would you feel differently if the request was for simple lab work only?

Vignette 6 – Informed Consent

A provider fails to obtain proper informed consent (i.e., not explained at all, explained improperly, not witnessed or without a proper interpreter present) from the parent of a child who is to undergo a lumbar puncture with sedation. The procedure is complicated by respiratory depression which requires bag/mask/valve ventilation and administration of an intravenous reversal agent. The parent was present during the procedure and demands to know what is occurring with her child.

Points to consider during discussion:

- Regarding the lack of informed consent, does it matter if this was intentional or just an oversight?
- Are the consequences of the lack of informed consent different depending on whether the resident was intentional about it?
- If the provider who obtained the consent was a trainee what would be a good response to the learner?
- What are the provider’s options in addressing the parental concerns over the procedure and resultant complications?

Vignette 7 – Free Ticket

A patient’s family offers you tickets to an event as gratitude for your recent care of their child during a hospitalization.

Points to consider during discussion:

- What are the possible responses?
- Under what circumstances would it be appropriate to accept them?
- Under what circumstances would it be inappropriate?

Vignette 8 – Pharma Perks

A pharmaceutical company has given you financial support as a principal investigator in a drug trial.

Points to consider during discussion:

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

Vignette 9 – Note Needed

You are the primary care provider for a 7-year-old girl with mild intellectual disability and cerebral palsy, most likely related to prematurity. The girl is enrolled in a special school program and is transported to and from school by a van each weekday from 8 a.m. to 4 p.m. The mother requests that you write a letter attesting to the fact that she cannot work because of her daughter's medical condition.

Points to consider during discussion:

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

Vignette 10 – No Insurance or Parent

A Spanish-speaking patient presents to the ED with nausea, vomiting, altered mental status and decreased urine output. Lab evaluation reveals renal failure and workup fails to find an etiology. Patient reports being eighteen years of age but you suspect he is much younger. No parent or guardian is identified and he has no insurance. You discover he is in the U.S. as an undocumented citizen. His renal function does not improve and he requires chronic dialysis. Due to lack of insurance and citizenship, he cannot be placed in an outpatient dialysis unit.

Points to consider during discussion:

- What responsibility does your health care system assume for patients without insurance and citizenship?
- Do you alert the authorities that patient is in the US?
- What resources can be made available to this patient if he remains in the US?
- How might the care of the child be affected if he is returned to his home country that has limited medical resources?

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Chapter 6: Professionalism After Training

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

Two of the professional responsibilities in the Physician Charter related to clinical care are:

- Commitment to professional competence
 - Achieving and maintaining competence involves a commitment to maintain the medical knowledge, clinical abilities and team skills necessary for the provision of quality care.
- Commitment to improve quality of care
 - Continuous improvement of care involves not only ongoing, informed review of the medical literature and maintenance of clinical competence, but also working with colleagues, health care systems, and other professionals to improve patient safety, reduce medical errors, improve accessibility and efficiency of care, minimize overutilization and underutilization of medical resources, and improve health outcomes.

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

- How will you know that you are doing a good job?
 - Physicians should always continue to question whether or not they are doing a good job. This process of self-reflection and self-assessment is the critical step in maintaining professionalism. As physicians move from medical school, through residency or fellowship training, to an independent practice position, they will move from a situation where others reflect on their professionalism to an environment in which they are responsible for their own assessments and actions. These are hard questions: Am I doing a good job? How do I know? In an academic setting, there may be some system of performance evaluation and in a group practice, there should be efforts among colleagues to assess quality. Is the care being delivered up to date? Is work being benchmarked? Are patients leaving care? How is the practice regarded in the community? There may be external benchmarks, but there must also be a system of internal measures. It is appropriate to ask your colleagues for feedback and help in identifying specific areas in which improvement is needed. In addition, many hospitals and practices have the capability to obtain specific information about your performance that can help guide improvement. Since patients and their families are the ultimate measure of effectiveness, physicians in practice can solicit their opinions as well. Distributing anonymous questionnaires to families can provide valuable information. Although it is a bit daunting to ask, their answers will likely be reassuring and may give some suggestions as to how to make your performance or that of the practice even better.
- How can you find support for your professionalism?
 - There are many ways to find help with professionalism efforts. One way is to remain active with a local, regional, or national professional organization. Membership in the American Medical Association (AMA), Academic Pediatric Association (APA), American Academy of Pediatrics (AAP), subspecialty organizations and local pediatric societies are good ways to find peer support. It is also important for physicians to identify a mentor either in the community or from past professional contacts. This individual could be a former attending physician or program director. Discussing issues, problems, and positive and adverse events with a mentor is helpful in monitoring professionalism even without having daily contact. A few

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

- How do you maintain work-life balance?
 - As a trainee, duty hours are regulated by requirements set forth by the Accreditation Council for Graduate Medical Education (ACGME). In practice, there are usually no such restrictions and it falls on the physician to monitor his/her time. Fatigue from sleep deprivation impairs performance and can compromise patient care. Excessive work hours can also have a detrimental effect on family relationships and cause added stress. One should also not ignore the importance of maintaining good physical health through regular exercise and appropriate nutrition. These strategies can help the physician cope with stress. For those physicians having difficulty finding a good work-life balance, the advice of mentors and senior colleagues can be obtained and may be very helpful.
- What if you change careers or enter a new type of practice?
 - Changing careers or reentering pediatrics after a significant break is a likely scenario for many pediatricians. This is a time when there must be an extra emphasis on professionalism. New roles require a retooling, not only in knowledge base and communication styles, but also in performance expectations. Again, the role of a mentor or advisor is critical. A senior colleague or a peer can be made aware of the need for feedback. Also, physicians should set aside time for self-reflection or even engage in keeping a journal that describes the transition and the difficulties that might be faced.
- How does professionalism change as you become a more senior physician?
 - As previously noted, professionalism is a developmental process that continues throughout the life of a physician. Lifelong learning and keeping "current" is a professional responsibility that may be more of a challenge for those in private practice. Nonetheless, with added experience, the physician will have gained skills to better cope with stressful situations, more effectively utilize self-reflection to improve care and have developed efficient systems to communicate with other providers. As a senior physician, he/she can serve as a role model for junior colleagues, helping them to understand the need for self-assessment and lifelong learning and serving as a resource for issues that arise.

MAINTENANCE OF CERTIFICATION (MOC)

The medical profession must work to ensure that all of its members are competent and exhibit professional behavior. The mission of the American Board of Pediatrics (ABP) is to assure the public that pediatricians have the knowledge and skills necessary to provide quality care and that they maintain these skills over a lifetime of practice. At the time of completion of pediatric residency and fellowship training, program directors are asked to attest to the clinical competence and professionalism of their learners. Once the trainee passes his/her initial General Pediatrics Certifying Examination (and for those who pursue fellowship, their Subspecialty Certifying Examination), there are mechanisms to ensure that he/she continues to act in professional ways worthy of the public's trust.

In order to maintain certification by the ABP, a pediatrician must demonstrate that he or she has a valid, unrestricted medical license (this is Part 1 of MOC). If a license is restricted in any way by a State Licensing Board due to a disciplinary action taken against the license holder, the ABP certificate is subject to revocation. Certificates have been revoked by the ABP on the basis of disciplinary actions, the majority of these revocations falling into three categories: impairment due to chemical or substance abuse; incompetence/negligence; and sexual misconduct and violations of appropriate physician/patient boundaries. Other, less frequent, causes of disciplinary action include conviction of a crime, inappropriate prescribing, Medicaid/Medicare fraud or other fraudulent misrepresentations.

MOC also involves an assessment of two of the professional behaviors related to patient care: a commitment to competency and a commitment to improve quality of care. The MOC process involves measures of knowledge building to assess the physician's commitment to lifelong learning (Part 2), and measures of quality improvement to evaluate performance in practice (Part 4). MOC also includes a measure of cognitive expertise, that is, completion a recertifying examination (Part 3).

PROFESSIONAL BEHAVIOR AND PRACTICE REQUIREMENTS

There are several other places where professionalism is included in the assessment of physicians. If there are serious lapses in professionalism, the physician may be prohibited from obtaining the approval needed to work as a general pediatrician or subspecialist. These areas include:

- *State Licensing*
 - In the United States, all states and the District of Columbia have the authority to issue medical licenses. The states set the requirements for licensure, the penalties for practicing without proper authorization and the criteria for suspending or revoking a license. The Federation of State Medical Boards of the United States (FSMB), an organization comprised of the individual state medical boards has an electronic notification system that alerts state boards when one of their physicians has received disciplinary action in another state. Through this, the ABP is quickly informed about any license suspension or revocation.
- *Hospital Credentials*
 - Every hospital is required to establish bylaws that codify qualifications for staff membership and areas of practice. A graduating trainee will need to apply for staff privileges at every hospital in which he/she provides patient care. The application usually includes questions about any unprofessional behavior, and character references are also routinely sought. As specified in their bylaws, hospitals have the right to revoke staff privileges.
- *Liability (Malpractice) Insurance*
 - When seeking liability or malpractice insurance, insurers will also assess a pediatrician's professional conduct through a series of questions in the application. Insurance may be declined due to past episodes of unprofessional behavior. Insurers and hospitals must report adverse information to the National Practitioner Data Bank (NPDB). In addition to other information, the NPDB collects reports of liability payments made on behalf of health care professionals regardless of whether the payment was the result of a verdict or a settlement. In addition, some states require reporting of settlements to their medical boards.
- *Third-Party Payers*
 - Most practicing pediatricians and pediatric subspecialists will need to contract with third-party payers. As a part of the process, the third-party payers will ask program directors and training institutions to verify the resident or fellow's completion of training as well as identify any past episodes of unprofessional behavior, lapses in training, instances of program modification, or special oversight that was required.

The Pediatric Competencies that are most relevant to this area of professionalism are:

- Interpersonal and Communication Skills
 - Communicate effectively with physicians, other health professionals, and health-related agencies
- Professionalism
 - Professionalization
 - Professional Conduct
 - Humanism
- Personal and Professional Development
 - Use healthy coping mechanisms to respond to stress
 - Manage conflict between personal and professional responsibilities
- Systems-based Practice
 - Work in inter-professional teams to enhance patient safety and improve patient care quality
 - Participate in identifying system errors and implementing potential systems solutions

BEHAVIORAL STATEMENTS

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

Examples of Exemplary Professional Conduct

- Participates actively in maintenance of certification
- Constructs and participates in a lifelong learning plan
- Surveys peers and patients about the quality of care being delivered
- Participates in hospital-based, commercial, or organizational continuing medical education activities
- Maintains hospital staff privileges
- Participates in community-based child advocacy activities
- Completes clinical documentation and communication in a timely fashion
- Continually strives to improve care

Examples of Lapses in Professional Conduct

- Engages in unethical or illegal practices
- Promotes the business of medicine above duty to patients
- Engages in discriminatory hiring practices
- Conducts practice without regard to monitoring quality or safety

TEACHING PROFESSIONALISM

Learning Objectives for the Trainees

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

Reflective Exercises

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

- After holding a discussion about professional responsibilities of physicians, ask trainees to describe, in one page or less, how they will monitor their professionalism in the future.
- Using any of the vignettes below, ask trainees to describe a similar real-life situation. Ask them to identify the conflicting values and what they learned from the situation.
- Hold a teaching session to review the state licensing regulations and obtain, review, and discuss a list of reasons for license revocations. The American Medical Association publishes these in State Medical Licensure Requirements and Statistics, and each state has license revocation information on its Web site.
- Hold a meeting with trainees to discuss what form of professional misconduct requires the program director to report unprofessional behavior to the ABP. What is a minimum threshold?
- Perform a confidential written exercise that requires trainees to describe an unprofessional behavior they have seen in an attending and indicate what they would have done in a similar situation.
- Gather a group of senior faculty for a discussion about the professionalism challenges they face in an effort to serve as role models for trainees.
- Observe physician-patient interactions from movies or television and discuss the issues of professionalism that are raised.

CHAPTER 6 VIGNETTES – PROFESSIONALISM AFTER TRAINING

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

Vignette 1

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

Points to consider during discussion:

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

Vignette 2

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

Points to consider during discussion:

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

Vignette 3

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

Points to consider during discussion:

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

Vignette 4

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

Points to consider during discussion:

- How will you deal with this?
- Is this a quality of care issue?
- Is this a possible variation in style?
- Should you mind your own business?
- How can you handle this situation as a group practice?

Vignette 5

You notice that one of your colleagues in your Pediatric Critical Care group has been showing up late to work, calling in sick not infrequently and seeming much more on edge lately. This is very unlike her. You notice that when she comes in to work sometimes she is slurring her speech a bit and seeming a bit confused. You are concerned that she might have developed a drug/alcohol problem.

Points to consider during discussion:

- Is this any of your business?
- Do you discuss this initially with your colleague? Your Division Chief? The Hospital Medical Staff? The local Board of Medicine?
- What is your responsibility to the patients in your unit?
- What kinds of support might exist that you can suggest to your colleague?

Vignette 6

It is your 35th birthday and you have plans to go out for a really nice dinner with your husband after clinic. Since having children, you haven't been out for a really special dinner in a long time. During the day, one of your Oncology patients gets transferred to the PICU in respiratory failure. You run off to the unit immediately after clinic finishes to speak with her family. At this point, it is 5 p.m. and the family wishes to speak with you about whether they should redirect care. You look at your watch, realizing that your dinner reservations are for 6:30 p.m.

Points to consider during discussion:

- How do you explain this situation to your husband?
- Are you obligated to stay?
- Could this situation have been avoided?
- What other resources can you call upon in this situation?

Vignette 7

You are now two years out from your Pediatric Gastroenterology fellowship and have joined a private practice of six individuals in your hometown. You enjoy your practice group very much but realize that you actually miss the tradition of sitting down twice a year with your program director to review your evaluations. You think that you are doing a good job, but honestly realize that you have no idea how you are doing both personally and as a practice.

Points to consider during discussion:

- How can you get feedback on your performance?
- Who would be helpful to get this feedback from?
- How can you improve your own performance and that of your entire practice?

Vignette 8

You have just joined your new practice and are very excited. You are somewhat surprised by the long hours seeing patients and doing patient follow-up. You find yourself getting in earlier and earlier and staying later each day to catch up. After a few months, your spouse comments that you are not sleeping much, you seem grumpy most of the time. You feel like you are starting to make some “silly mistakes” in terms of your patient care. It dawns upon you that you actually miss the days of “duty hours” in residency where you were limited in how much you could work.

Points to consider during discussion:

- How can you better adjust to your new role as an attending?
- What resources are there to help you?
- Are there things that you can do during residency/fellowship to help you prepare for your life as an attending?

CHAPTER 6 CASES – PROFESSIONALISM AFTER TRAINING

Case 1: A Patient Lost

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

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

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

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

Guiding Questions:

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

Case 2: Professionalism After Training

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

Dr. White typically sees twenty patients per morning session and last week noted after a single morning session that three patients seen that morning had been referred to Dr. Johnson, the new chief of pediatric gastroenterology at the

children's hospital. Dr. White notes that each of the three patients seen by Dr. Johnson had undergone some sort of endoscopic procedure with biopsies. He only knows this because the pathology reports of normal biopsies are in the record. He has not received any follow-up letters from Dr. Johnson. Ironically, as Dr. White was reflecting upon these facts, Mrs. Reyes called to thank Dr. White for the timely referral of her daughter Selma to Dr. Johnson.

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

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

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

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

Guiding Questions:

1. What is your duty to know the practice of the physicians to whom you refer?
2. After receiving multiple normal biopsy reports, what options, if any, should you pursue? Internal chart audit? Call the referring doctor? Call the department chair?
3. What if you learn that the numbers of endoscopic procedures exceeds the standard of care?
4. Should Dr. White be concerned about the lack of follow-up correspondence?
5. What if you perceive that the pattern of endoscopies correlates with patient insurance?

Case 3: Lifelong Learning

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

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

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

Guiding Questions:

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

Chapter 7: Electronic Professionalism

Advances in technology have revolutionized medical education and expanded the reach of communication both within and outside of the medical community. While these advances have led to numerous benefits in medicine, they have also created new challenges in professional behavior for medical trainees and faculty. The use of email, text messaging, smart phones, social networking sites and mobile applications have accelerated communication among health care providers, but also have the potential to create conflicts not previously encountered. Most hospitals, medical schools and graduate medical education programs now have social media guidelines. Despite the presence of these institutional standards, both medical educators and trainees believe that they frequently view inappropriate posts, created by their colleagues, on commonly utilized social networking sites.^{1,2}

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

- Commitment to patient confidentiality
 - New electronic communication technologies, including social networking sites, have transformed the way people communicate and share information. While these technologies can aid in the care of patients (e.g., sharing a photo of a rash with a dermatologist), physicians must protect this information as they would any other confidential documents. It goes without saying that it is never appropriate to share patient-identifiable information on any unsecured social networking sites. For other types of professional communication, there are HIPAA compliant technologies available and physicians, with the assistance of IT specialists within the institution, should utilize those technologies in order to assure patient confidentiality.
- Commitment to maintaining appropriate relations with patients
 - The rise of social networking sites has blurred traditional patient-physician boundaries. As physicians, we are taught to keep an appropriate separation with our patients. Becoming “friends” with patients can result in a sharing of many, more private, aspects of our lives with our patients. Almost all guidelines relating to electronic professionalism discourage physicians from “friending” patients or families on social networking sites.^{3,5} In contrast, physician practices have developed social media presences to share information and enhance access for patients and their families. Patients “friending” professional social media sources does not interfere with maintaining appropriate relations.
- Commitment to professional responsibilities
 - The loosening of social inhibitions in the online environment often allows people to behave differently than they would in person, a phenomenon known as the online disinhibition effect.⁶ Negative comments written on social networking sites by physicians, even when posted anonymously, can damage the doctor-patient relationship. Physicians need to avoid online disinhibition by respecting social media guidelines and participating in the processes of self-regulation.

Medical professionalism underpins the trust the public has in physicians. Electronic communication and social media may facilitate the ability of physicians to meet their professional responsibilities to society by ensuring effective communication with the public at large. However, physicians must be cognizant of the “three P’s” of electronic professionalism: public, permanent and powerful.⁷

- Public
 - While social networking sites contain purposefully public communications, “private” email and text messages may inadvertently become public as well. Copies of emails and text messages are kept by email service providers and telecommunication companies and are discoverable in a lawsuit. There have been numerous instances in which confidential information and unprofessional behavior became public in this fashion.
- Permanent
 - An inappropriate statement or photograph can exist forever in an electronic medium (be it an email, text message, or social networking site posting) and eventually make its way into the public realm, leading to embarrassing disclosures of unprofessional behavior.

- Powerful
 - The permanence of electronic media and the potential for public disclosure make these communications quite powerful. For example, sending identifying patient information electronically without the use hospital-approved encryption can jeopardize patient confidentiality and privacy. Additionally, inappropriate use of technologies poses a threat to workplace professionalism, especially within the inequitable relationships common in medical education (e.g., resident-medical student, or faculty resident).

The Pediatric Competencies that are most relevant to this area of professionalism are:

- Patient Care
 - Provide effective health maintenance and anticipatory guidance
- Practice-based Learning and Improvement
 - Use information technology to optimize learning and care delivery
 - Develop the necessary skills to be an effective teacher
- Interpersonal and Communication Skills
 - Communicates effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds
- Professionalism
 - Professionalization
 - Professional Conduct
 - Cultural Competence
- Systems-based Practice
 - Know how to advocate for the promotion of health and the prevention of disease and injury in populations

BEHAVIORAL STATEMENTS

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

Examples of Exemplary Professional Conduct

- Separates professional and personal content online
- Maintains a professional decorum in personal content
- Does not use publicly accessible social media to discuss individual patients or their care
- Treats colleagues fairly and with respect in all forms of interaction and communication
- When posting material online, declares any conflicts of interest transparently
- Maintains appropriate physician-patient boundaries
- Notifies a colleague if his or her electronic communications appear inappropriate

Examples of Lapses in Professional Conduct

- Consistently uses electronic media during educational activities for unrelated purposes
- Sends communications to colleagues that are harassing or intimidating in nature or include disrespectful language or tone
- Does not obtain consent for patient photographs
- Uses non-encrypted technology when sending confidential patient information
- Violates institutional human resource policies or federal privacy laws
- Displays social media content that discriminates against an individual or group on the basis of culture, beliefs, race, gender, sexual orientation or religion
- Routinely uses the internet or social networking sites to gather personal information about patients

TEACHING PROFESSIONALISM

Learning Objectives for the Trainees

- Describe how electronic communication technologies have effected medical practice and professionalism
- List examples of information that are inappropriate to post online
- Describe the risks and potential consequences of sending unencrypted emails or text messages that contain protected health information
- Discuss the impact of social networking on the professional boundaries between physicians and patients
- Identify situations when the use of electronic communication may become a disruption in a hospital or doctor's office
- Discuss the impact of social networking on the inequitable relationships inherent to a teaching hospital or medical education environment
- Ascertain that multiple perspectives and opinions exist regarding social networking site content
- Rate the risks and benefits of commonly used modes of interpersonal communication within the hospital
- Discern when it is acceptable to use the internet or social media to gather information about a patient
- Teaching Methods

Reflective Exercises

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

- Have trainees review your hospital's social media policies. Following the review, ask the trainees to discuss examples of social media content they have encountered that has violated these guidelines. In addition, ask the trainees to describe what next steps they take after viewing inappropriate content.
- Many trainees believe that electronic professionalism guidelines impede individualism. Have a group of residents discuss this perception. What are the best ways to balance personal and professional content online? Following initial discussion, ask trainees to identify examples of physician generated social media content that is professional and allows for individual expression.
- Have trainees brainstorm ways that physicians can professionally use social media to help meet their responsibilities to patients and society.
- After holding a focused discussion on the disruptions encountered by use of electronic communication during educational forums or patient encounters, ask trainees to discuss an incident in which they found the use of electronic communication distracting either to themselves or to others. Ask how each handled the situation. Discuss if silence promotes, condones and improves disruptive behaviors.
- Discuss how electronic health records affect the doctor-patient relationship.

CHAPTER 7 VIGNETTES – ELECTRONIC PROFESSIONALISM

Using any of the vignettes below, ask trainees to describe a similar real-life situation. Ask them to identify the conflicting values and what they learned from the situation.

Vignette 1 – Facebook Crowd Sourcing

Points to consider during discussion:

- Identify any potential patient privacy concerns.
- What would you do after reading this message?



Vignette 2 – Fax or Text?

You are on call overnight and obtain an ECG on a child who presented with syncope. You think the ECG is abnormal and call the on-call cardiologist. Instead of faxing the ECG, she asks you to text a photograph because she will receive it faster and the ECG will be easier to read.

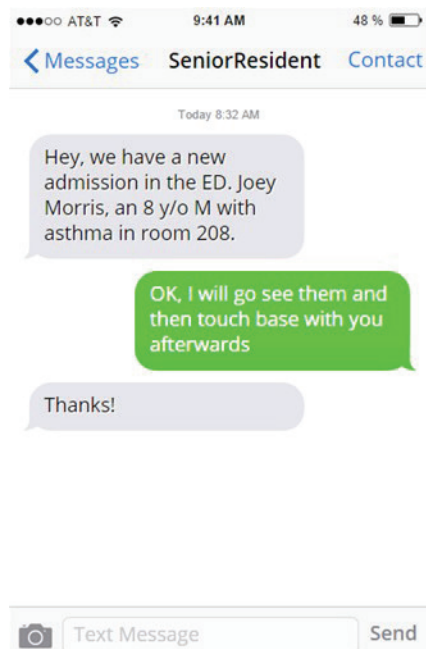
Points to consider during discussion:

- Identify any potential patient privacy concerns.
- What would you do next?
- If protected health information is not included, is consent needed to send the ECG?
- What can you do to ensure that this communication is more secure?

Vignette 3 – Personal Info via Text

Points to consider during discussion:

- Identify any potential patient privacy concerns.
- Does it matter if it's a work phone or your private phone?
- What medical information is OK to text on an unsecured network?
- What can you do to ensure that this communication is more secure?



Vignette 4 – YouTube Post

One of your colleagues places your intern “class video” on YouTube. The video is a humorous depiction of the intern class’ first year of training. It contains no protected health information.

Points to consider during discussion:

- Does placing this video on YouTube create any professionalism issues?
- How might your opinion of the video change if you were a hospital administrator or the parent of a patient?

Vignette 5 – Tweeting Complaints

Points to consider during discussion:

- What professionalism issues are highlighted in this vignette?
- What would you do after reading this message?



Co-Trainee
@AmR423



 Follow

Sometimes I really hate this job, can't wait for this ED shift to be over in an hour...

 Reply  Retweet  Favorite  More

11:03 PM - 19 Jan 14 · Embed this Tweet

Vignette 6 – Tweeting about Personal Opinions

Points to consider during discussion:

- Many people will disagree with this post, but does it create any professionalism issues?
- Is there a difference between sending this message using an anonymous versus identifiable account?
- What would you do after reading this message, knowing it came from a colleague?



Co-Trainee
@AmR34



 Follow

Same-sex marriage is legal now??? Not according to me...

 Reply  Retweet  Favorite  More

3:41 PM - 26 Jun 15 · Embed this Tweet

Vignette 7 – Neophyte Doc

A well respected, older physician, an expert in his field, tells you he is proud that he has never used Twitter, Facebook or any other social networking site. He isn't even sure if information about him can be found online.


Points to consider during discussion:

- What are the downsides to ignoring social media and electronic communication technologies?
- How can web 2.0 technologies be used to advance a physician's role as a professional?
- Is this doctor correct in believing that he doesn't have an online footprint?

Vignette 8 – Message Board Post

Points to consider during discussion:

- Does commenting in this situation violate any electronic professionalism guidelines? Is commenting beneficial?
- When giving medical advice online, should you state that you are a physician (or a medical student)? Is it better to use your real name or post anonymously? Should you mention the name of the hospital (or medical school) where you work?



Anonymous

Open Question[Show me another »](#)


Should I Give My Newborn the Hep B Vaccine?

I am so torn on vaccines... I need your help deciding what to do. I know it's important to vaccinate against harmful diseases like polio, but I want to eliminate the unimportant ones. I've been reading about the Hep B vaccine and there's a lot about it that doesn't make sense to me. I'm giving birth in a month and I'm Hep B negative. Isn't my child's risk pretty low? Is the vaccine worth the risks? Anyone else struggling with this?

19 hours ago - 1 week left to answer.

[Report Abuse](#)

[Answer Question](#)



Your Reply

Best Answer - Chosen by Voters




I'm a pediatric resident at [Your Hospital] and I really think it's important to vaccinate your child against Hep B. First of all, it's one of the safest and most studied vaccines that we have. There are no known long term side effects. In addition, we know it works best when given to newborns, so why wait?

19 hours ago - 1 week left to answer.

[Report Abuse](#)

22% 14 Votes

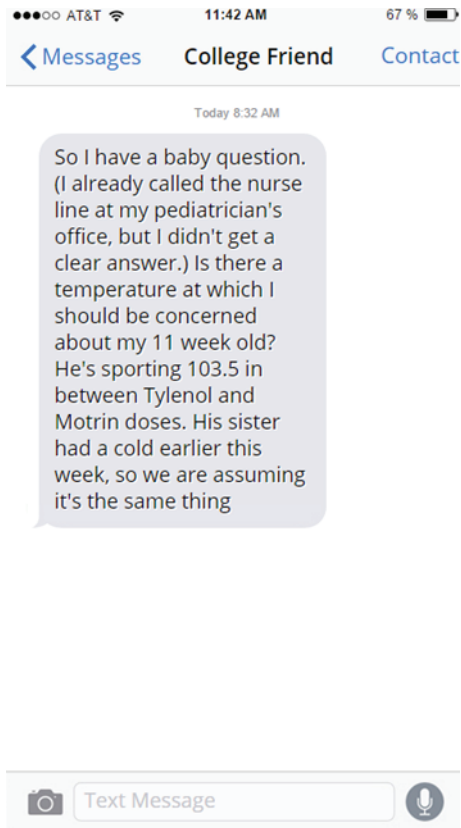
43 people rated this as good

11  Interesting!  Email  Save

Vignette 9 – Advice for a Friend

Points to consider during discussion:

- Who should you give medical advice to?
- What conflicts exist in this situation?
- What medical-legal issues should be considered?
- Does giving advice electronically instead of face-to-face change any of these issues?



Vignette 10 – Searching for Info

The day before your continuity clinic, you always search for information about your adolescent patients on Google and Facebook to identify any risk taking behaviors that you want to discuss with them.

Points to consider during discussion:

- How can the internet affect the doctor-patient relationship?
- What professionalism issues are highlighted in this vignette?
- Is it OK to routinely use the internet or social networking sites to gather information about your patients or only in certain circumstances?
- Is there a difference between searching social media sites about patients and searching about residency or fellowship applicants?

Vignette 11 – Broadcasting Complaints

Points to consider during discussion:

- What professionalism issues are highlighted in this vignette?
- How would you give feedback to your colleague?
- What are potential solutions to help resolve the problem between your colleague and the senior resident?



Vignette 12 – Inappropriate Posts

While in the ED one evening, a teenager arrives after being stabbed in the abdomen. The knife is still protruding from the abdomen. The PEM fellow wishes to get a picture of the wound/knife for teaching purposes, but he has forgotten his camera. After obtaining patient/parent consent, he asks you to take a picture using your cell phone and email it to him, which you do. Later that week, while looking at a different colleague's Facebook profile, you see that she posted the image with the caption, "You never know what will walk in off the streets." Several residents have left comments about the image on her Facebook page.

Points to consider during discussion:

- Under what circumstances is it appropriate to take educational medical photographs?
- Is it appropriate to use an internet-connected cell phone to take such images?
- What are the risks of transmitting medical images electronically?
- Who has behaved unprofessionally here? You? The PEM fellow? The resident who posted the image on Facebook?
- What medical legal issues should be considered?

Vignette 13 – Embarrassing Post

Points to consider during discussion:

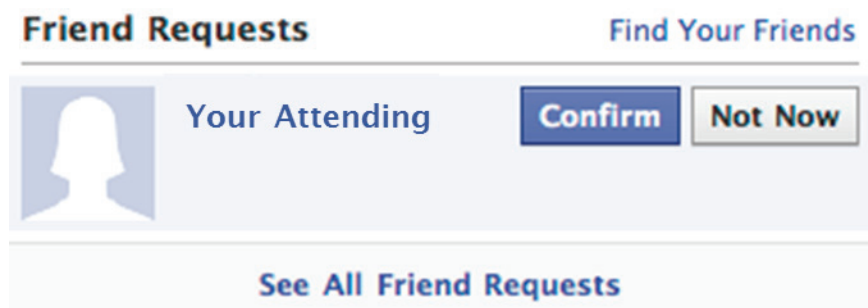
- Does this post create any professionalism issues?
- What would you do after seeing this post about yourself?



Vignette 14 – To Friend or Not to Friend?

Points to consider during discussion:

- Inequitable relationships are inherent to teaching hospitals and the medical education environment (e.g., resident-medical student, or faculty resident). How can social media affect these dynamics?
- Does this request create any professionalism issues?
- Would you “confirm” this request? What if it was your Senior Resident? Chief Resident? Program Director?



Vignette 15 – Talking About Tests

Points to consider during discussion:

- Does this message create any professionalism issues?
- Does this message constitute irregular exam behavior that can be investigated and have action taken?



Co-Trainee
@AmR57



 Follow

Abscess grows *Serratia marcescens*,
nitroblue tetrazolium test shows no color
change. Does that mean the answer was
CGD? #HopeIPassed #Step2WasHARD

 Reply  Retweet  Favorite  More

2:31 PM - 10 Jul 15 · Embed this Tweet

ASSESSMENT TOOLS

There are no published tools to assess a trainee's electronic professionalism.

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ACKNOWLEDGEMENTS

We would like to acknowledge the following colleagues for their contributions to the development of some of the concepts included in this chapter: Paul S. Matz, MD, Katherine Gargiulo, MD, Robert McGregor, MD, Matthew McDonald, MD and Leonard Levine, MD.

Chapter 8: Humanism Within Pediatrics

The concept of humanism has been a cornerstone of medicine throughout history. Beginning from the time of Hippocrates and the development of the Hippocratic oath, doctors have been dedicated to the physician's duty to benefit the sick and protect them from injustice.¹ In 1902, Sir William Osler's commitment to humanism was exemplified by his famous quote, "It is much more important to know what sort of person has a disease, than know what sort of disease a person has."² In 1927 Dr. Frances Peabody wrote an article on "the Care of the Patient" that emphasizes the importance of both the science and the art of medicine.³

While humanism has been defined in multiple ways, two definitions stand out. One definition by physician and ethicist Edward Pellegrino includes "a set of deep-seated personal convictions about one's obligations to others, especially those in need; encompassing a spirit of sincere concern for the centrality of human values in every aspect of professional activity."⁴ Similarly, Dr. William S. Branch defines humanism as "The physician's attitudes and actions that demonstrate interest in and respect for the patient that addresses the patient's concerns and values. This generally relates to patients' psychological, social and spiritual domains."⁵

While some contend that humanism and professionalism are similar, Dr. Jordan Cohen has distinguished the two as separate concepts. He defines professionalism as the way of acting, observable behaviors that meet the expectations of patients. Some examples include competency, confidentiality, and fulfilling responsibilities. In contrast, humanism is a way of being, including a set of deep seated convictions of others, especially those in need. Examples include altruism, compassion and respect for others. In summary, Dr. Cohen states that "Humanism is the passion that animates professionalism."⁶

Humanism has many components that are central to the Professionalism Charter. These include the principles of primacy of patient welfare that embrace altruism and trust, core concepts to the relationship between pediatricians and patients. The pediatrician's role in social justice, such as eliminating discrimination within pediatric care is also key to humanism. And the commitment to honesty with patients and enhancing the communication with patients is critical in our role as healers.

The Pediatric Competencies that are most relevant to the concept of humanism include:

- Patient Care
 - Interview patients/families about the particulars of the medical condition for which they seek care, with specific attention to behavioral, psychosocial, environmental, and family-unit correlates of disease
 - Counsel patients and families
- Practice-based Learning and Improvement
 - Participate in the education of patients, families, students, residents, and other health professionals
- Interpersonal and Communication Skills
 - Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds
 - Demonstrate the insight and understanding into emotion and human response to emotion that allow one to appropriately develop and manage human interactions
- Professionalism
 - Humanism: Humanism, compassion, integrity and respect for others based on the characteristics of an empathetic practitioner
 - Professionalization: A sense of duty and accountability to patients, society and the profession
 - Professional Conduct: High standards of ethical behavior which includes maintaining appropriate professional boundaries
 - Self-awareness of one's own knowledge, skill and emotional limitations that leads to appropriate help seeking behaviors
- Personal and Professional Development
 - Develop the ability to use self-awareness of one's own knowledge, skills, and emotional limitations that leads to appropriate help-seeking behaviors
 - Use healthy coping mechanisms to respond to stress

- Practice flexibility and maturity in adjusting to change with the capacity to alter behavior
- Trustworthiness that makes colleagues feel secure when one is responsible for the care of patients

BEHAVIORAL STATEMENTS

The components of humanistic practice by physician colleagues and other health professionals listed above provide general goals. It is important to identify specific behaviors or practices that indicate exemplary behavior and those that represent lapses in humanism.

Examples of Exemplary Humanism

- Makes humanism into a habit by consistently embracing humanistic practices and values
- Demonstrates altruism by choosing to prioritize patient needs above his or her own
- Expresses genuine compassion and empathy during interactions with patients and their families
- Serves as a role model of integrity and honesty in everyday practice
- Recognizes and celebrates ways in which each patient is unique, whether due to race, ethnicity, culture, or values
- Respects the individual needs, preferences, and goals of each patient and family
- Identifies and validates the perspectives of others in any group dynamic or conflict
- Accepts his or her own limitations or flaws, viewing them as opportunities for reflection and ongoing improvement
- Utilizes healthy coping mechanisms to avoid burnout and depression
- Chooses optimal personal wellness techniques in order to maintain a healthy balance of mind, body, and spirit and to bolster resilience

Examples of Lapses in Humanism

- Prioritizes his or her own needs above those of patients
- Does not offer therapeutic messages or other expressions of empathy or sympathy when the opportunity arises
- Misses opportunities to provide optimal care/service to patients (e.g. leaving work undone; not following through on new issues; failure to communicate details when transferring care; omissions in documentation)
- Does not explicitly acknowledge or address important unique aspects of patients, such as race, ethnicity, culture, or values
- Avoids or poorly manages conflict
- Makes assumptions, sometimes incorrectly, about the individual needs, preferences, and goals of each patient and family based on previous experiences, stereotypes or other bias (conscious or not)
- Avoids or does not prioritize reflection such that opportunities for self-improvement are missed
- Emotionally distances self from patients and their families as evidenced by becoming less responsive to patient and family needs and requests even if continuing to manage some aspects of the patient adequately
- Treats patients, families or colleagues in a disrespectful, judgemental, inattentive or non-inclusive manner
- Demonstrates a lapse in forming a therapeutic relationship with a patient or family
- Does not demonstrate behaviors that sustain personal wellness
- Demonstrates signs and symptoms consistent with burnout including emotional exhaustion, physical exhaustion and/or depersonalization
- Demonstrates signs of medical or mental health illness
- Demonstrates signs and symptoms consistent with depression

TEACHING HUMANISM

The teaching of humanism in medicine is a multi-faceted endeavor. During medical practice, a trainee engages in human-to-human interactions with a myriad of groups including patients, parents, other family members, physician colleagues, and inter-professional colleagues, to name a few. Training in humanism enhances the quality of each of these relationships. Deliberate integration of humanistic principles into the training experience will allow trainees

to bring integrity, empathy, altruism, and respect to these interactions. Ultimately, the trainee's perspective on him or herself is among the most crucial. Training in humanism must explicitly address a physician's self-image to ensure that physicians, in training and beyond, learn to care for themselves as human beings even as they work humanistically with patients and team members.

Several strategies for teaching humanism have been developed and we present two here. Drs. Steve Miller and Hillary Schmidt, suggest that humanism can be taught. In their article, "The Habit of Humanism," they propose that humanism can be learned and become a reflex or habit.⁷ They clarify the importance of three steps:

1. Identify multiple perspectives, those of the patient, the patient's loved ones, and those of the health care provider
2. Reflect on whether these perspectives converge or conflict
3. Choose to act altruistically, a choice we have every day

This framework can serve as a road map to enhance pediatricians' humanism through deliberate reflection on the perspectives of all the stakeholders in an encounter.

A second model was proposed by Dr. William Branch and his colleagues.⁸ They emphasize three specific teaching methods to enhance humanism:

1. Focus on addressing seminal events
2. Effective and deliberate role modeling by faculty members
3. Use of active learning methods⁵

Utilizing a seminal event as a teaching strategy ensures recognition of the event and provides opportunity for debriefing. Debriefing was first developed by the military after soldiers returned from battle. This allows a forum to discuss the components of the event; review of the decisions that were made while also addressing the emotional response that the event may have triggered. (Debriefing may be a helpful strategy for Case D below, for example.) Role modeling is a key concept within humanism. A quote by Daniel Tosteson best exemplifies this concept: "When I ask an educated person ... 'What is the most significant experience in your education?' I almost never get back an idea, but almost always a person."⁸

Dr. Branch and colleagues also recommend infusing humanism into the overall learning environment by using active learning methods. He and his colleagues address the importance of establishing a climate of humanism by helping teams and units to develop a group mission statement, gain skills in communicating bad news, and continue focus on recognizing the patient and his/her perspectives and that of their loved ones. The recognition of perspectives is consonant with Miller and Schmidt's work.⁷ The humanistic learning climate ensures that all are treated with respect, work within an atmosphere of trust, and confirms the needs of patients, learners and other disciplines are being met. The modeling of these behaviors is key to reinforcing the importance of these values and empowering others to emulate them.⁵

Learning Objectives for the Trainees

- Trainees will be able to identify the key elements of humanistic doctoring and describe how humanism relates to professionalism
- Trainees will articulate the relationship between personal wellness and humanism and will develop strategies to maintain and augment their own wellness during training and beyond
- Trainees will be able to identify challenges to humanism that arise in the training environment and will develop mechanisms for addressing these challenges.
- Trainees will develop an individualized wellness plan that will promote resilience in their everyday practice of pediatrics

CHAPTER 8 VIGNETTES – HUMANISM WITHIN PEDIATRICS

Reflecting on humanism as it applies to our interactions with colleagues, as distinct from patient care endeavors, is also an essential component of training. Our duties to our team members are summarized well by the quotation “We have an obligation as educators to share with [colleagues] how we have coped with feelings of anger, anguish, shame or uncertainty in caring for patients.”⁹ In the natural ebb and flow of one’s career in medicine, each of us will undoubtedly encounter low periods in which we lose hold of the meaning and purpose in our work. Such situations can lead to burnout or even depression so we must all develop skills in reaching out to colleagues in need or who are suffering. Below are several cases that can trigger reflection and discussion about our duties to one another.

Vignette 1 – Granny Knows Best?

You’re in the midst of your weekly primary care clinic session. Your next patient is Alex, a 4-year-old boy with spastic quadriplegia who has struggled with a long series of pneumonias. A recent feeding evaluation indicated a high risk of aspiration with any kind of oral feeding. Upon entering the exam room, you see Alex’s grandmother feeding him pudding. You tactfully bring up the results of the feeding evaluation to assess the family’s comprehension of the results. “We understand why the doctors say he’s not supposed to eat,” his grandmother says. “But Alex loves his food and it makes us happy to feed him.” As you again explain the risks of feeding Alex by mouth, his grandmother interrupts you and says “Feeding a child is never wrong.”

Questions for discussion:

- What might be motivating the different people in this case? What are the goals of the mother? Grandmother? Trainee?
- How do these goals come into conflict and how do they complement each other?
- What, if any, role does culture play in this case?

Vignette 2 – Untruthful Subintern

As the attending of record on the inpatient service you decide to observe the evening sign out. The subintern is handing over one of your patients to the resident on call. The resident asks about the drug level sent earlier in the day as the student neglects to pass on those results and they may be important in managing the patient overnight. The student pauses and then says they were normal. You happened to check for that drug level yourself just a few minutes earlier so you could discuss plans for the evening with the team but were told by the lab tech it would not be ready for another half hour.

Questions for discussion:

- What factors could be driving the medical student’s behavior? While this behavior is not acceptable, might there be underlying causes that would influence the team’s reaction to the behavior?
- How would you approach the medical student?
- Can you identify characteristics of the training environment that could put strain on a student such that integrity may be compromised?
- How can we, as supervisors and role models, help students to make the right choices when faced with these dilemmas? Is simply instructing them to “be honest” going to be sufficient?

Vignette 3 – Privileged Intern

Robert is a PGY-1 intern with whom you are working in continuity clinic. He was born and raised in a very homogenous, suburban community, which consisted of primarily higher income, white families. He is now working in a continuity clinic which provides service to mostly low income, minority patients. Robert frequently will leave the exam room to precept with you, and states that he doesn’t understand why the parent can’t do a better job, whether it is adherence with medications, or being on time for appointments.

Questions for discussion:

- What might be an explanation behind Robert's behavior? How do his life experiences seem to influence his doctoring?
- How can you help Robert to have insight into how his attitude is perceived by others?

Vignette 4 – Angry Intern

It's Monday morning, although you arrived well-rested and refreshed this morning, by the end of rounds your to-do list for the day seems insurmountable, your pager has been incessant, and the familiar feeling of exhaustion returns. Late that afternoon, you admit a 3-year-old ex-preemie with chronic lung disease who presents with wheezing. As you take the history, he is screaming and ripping off his oxygen mask, causing his O2 saturation to drop to the high 80's. When you approach him, he pushes you away and you are unable to do much of an exam. You feel absolute fury towards this child. You truly wish he would shut-up and cooperate so that you wouldn't have to deal with him. You also want to yell at the mother to get out of her chair and restrain her son. Instead, you exit the room as your pager is beeping once again.

Questions for discussion:

- How should we respond to patients/families who bring out negative reactions or emotions within us? What emotions might this trainee be experiencing?
- How might negative emotions influence our doctoring? How do we maintain our ability to doctor as we know we should?
- Why do our relationships with some patients become difficult?

Vignette 5 – Depressed Doctor

It is February and you are post-call. Overnight you had a few admissions and transferred one patient to the ICU. It was not so busy that dinner was impossible, but when other residents invited you to meet them in the cafeteria, you declined. You were not hungry or interested in being around others. Rounds are done and you are finishing up your work so that you can go home and sleep. Your team and attending seem to think you have done a good job overnight, but you think that you could have done better and that your performance was generally mediocre. This constant sense of mediocrity creates a feeling of sadness in you. Sometimes you are tearful, especially when sleep-deprived. Even at home, sleep is difficult, and sometimes you've been using Ambien that a fellow resident prescribed for you.

Questions for discussion:

- Is the trainee in this vignette experiencing depression, burnout, or just the normal stress of training?
- If this was a trainee in your program, how could you support him or her best?
- How can this trainee regain a sense of wellness?

Either of the cases above could also be used to stimulate discussion about how we view ourselves as physicians. Sulmasy writes "All health care professionals are wounded healers. They cannot escape suffering themselves. Moments of pain, loneliness, fatigue and sacrifice are intrinsic to the human condition. The physician or nurse's own suffering can become the source of compassion in the healer's art. (Sulmasy)¹⁰ Trainees are so often worried about whether they are performing optimally. Am I as smart as the others? As efficient? As caring? Do I really have what it takes to be here? Am I managing my patients well? Did I make the right decision the other night on call? This pattern of self-doubt affects many of our most talented trainees and may lurk below a veneer of confidence.

When trainees are alone, tired, and stressed their negative self-image may dominate unless they are given opportunities to reflect on these emotions and identify skills with which to cope. Education in humanism can be utilized to develop strategies to preserve a sense of self-efficacy, to help trainees give themselves a break and recognize their good work as doctors. Sessions dedicated to the trainee as human being allow trainees to realize

that their colleagues, whom they deeply respect, are experiencing similar feelings. This realization can be extremely therapeutic. In addition, through discussion of case vignettes, strategies for confronting self-doubt can be articulated as a group exercise. This additional vignette can also be used to stimulate similar discussion.

Vignette 6 – Dealing with an Error

You are beginning your oncology rotation and assuming care for Jordan, a 12-year-old boy status post renal transplant, complicated by chronic rejection and post-transplant lymphoproliferative disease (PTLD). His course has been complicated and, sadly, he is not expected to live much longer. He was admitted with febrile neutropenia and has been on ceftazidime. Today he will be discharged but his antibiotic course must continue at home. On the day of discharge, you assemble the patient's discharge paperwork and prescriptions, including the ceftazidime order, before going to clinic. Your co-resident agrees to discharge Jordan in the afternoon. A few days later you hear that Jordan was readmitted to the ICU with renal failure and encephalopathy. It was discovered that his antibiotic was not "renally-dosed." Jordan required a couple of needless days in the ICU during his end-of-life period, which was very distressing and frustrating for his family.

Questions for discussion:

- How does the clinician integrate this experience? What strategies might be helpful to "forgive" oneself and to learn from this experience?
- What factors may contribute to errors beyond the individual trainee? In the face of an error, should we focus more on "systems issues" or on individual accountability?
- What is the cumulative effect of medical errors on our doctoring?

Vignette 7 – Complaining colleague

Finally, we present a case that demonstrates an example of how a trainee may be perceived in a certain environment to have strong professionalism attributes, but in other venues may demonstrate depleted humanism.

It is April and you are serving as a co-supervisory resident with a colleague on the general pediatric inpatient team. Your colleague is always well dressed, poised, leads rounds effectively and is a role model for communication with patients. However, in the work room, in the presence of medical students, interns and other residents, she publicly complains. She ventilates her frustration about patients, their parents, their inability to understand instructions, and tends to make assumptions about parents while stating derogatory stereotypical comments. Her behavior makes you uncomfortable and you also worry about the impact on the interns, medical students and team morale.

Questions for discussion:

- Do you feel it is your responsibility to address this issue? If you believe so, why?
- How would you approach the discussion with your co-supervisory resident?
- What circumstances might contribute to your colleague reacting in this manner?

STRATEGIES TO MAINTAIN WELLNESS

To maintain a humanistic attitude and demonstrate humanistic behaviors, clinicians across the educational continuum must remain nurtured and resilient. Teaching humanism, therefore, should entail explicit teaching of wellness strategies for practitioners. Wellness includes a healthy balance of mind, body and spirit that results in an overall feeling of thriving. Components of wellness include physical, intellectual, emotional, relationship enhancing and spiritual components.

While rewarding, a career in pediatrics can be stressful. Pediatricians confront emotionally challenging situations such as medical errors, sudden patient decompensation, medical uncertainty and patient death. Over time, the cumulative effect of these stressors take their toll on pediatricians. The rates for depression and burnout are higher in physicians than the general population and the onset often occurs early in training, even as early as

medical school.^{11, 12} The rates for depressive symptoms for pediatric residents have been noted to be as high as 20% of residents, while rates of burn out, based on the Maslach scale, range from 25–75%.^{13, 14, 15} The components of burnout which include emotional exhaustion, depersonalization and decreased feelings of personal accomplishment¹⁶ can develop due to fatigue, long hours, timing in training, perceived loss of control and other personal factors. Burnout is a critical problem because it affects both pediatric health care providers themselves and the patients for whom they provide care. Burnout can dramatically affect relationships with patients by resulting in a loss of empathy and distancing from patients. This distancing can lead to a vicious cycle: patients experience a sense of abandonment and dissatisfaction with the health care provider's care juxtaposed with the health care provider feeling a sense of failure by not making the connections with patients which had been one of the most rewarding benefits of their profession. As a result, burnout can lead to career dissatisfaction, social isolation and eventual departure from the career. Those who are burned out may have heightened levels of self-blame from negative outcomes and experience inadequate attention to their personal medical and mental health needs, depression and substance abuse, and most concerning suicide.^{17, 19, 20}

Negative drivers of humanism may prevent the development or maintenance of humanistic behaviors. These include, but are not limited to, poor communication skills, fatigue and exhaustion, inattention or neglect by colleagues or supervisors, a personal sense of isolation, practice in a toxic environment, guilt, repetitive exposure to grief responses, and lack of control over one's personal or professional life.

To maintain humanistic behaviors and values, the focus must be on the positive drivers of humanism. These include a deliberate attention and curriculum to enhance communication skills, creation of a nurturing environment that supports colleagues, positive role modeling by colleagues, opportunities for debriefing following sentinel events, time for self reflection and creating a community of caring.

To achieve wellness, identification and implementation of resilience strategies must be deliberate. Resilience, as noted by Epstein, is to respond to stress in a healthy way, achieving desired professional goals at minimal psychological costs. Enhancement of resilience empowers individuals to rebound quickly and grow stronger in their approach to emotionally challenging situations.⁴ This entails a personal and individual journey where one size does not fit all. A strategy that may work for one individual may not work for someone else. Trainees should be encouraged to develop an individualized wellness learning plan, a deliberate strategy to commit to wellness strategies that are important to them. These can be developed and implemented in a similar way to their individualized learning plans.

The following table summarizes both short term or "in the moment" strategies along with long term resilience strategies to maintain wellness. Short term strategies include those that can be implemented immediately when faced with a challenging or frustrating encounter and one is striving to maintain humanistic behaviors. The development of strong personal insight in understanding your own reactions and ways to adapt to the situation quickly are paramount. Strategies to help you think on your feet and de-escalate situations allows you to remain present during the encounter or know when it is prudent to excuse yourself. (See Table 1)

Table 1: Short-term and long-term strategies to preserve trainee wellness

SHORT-TERM STRATEGIES	LONG-TERM STRATEGIES
<ul style="list-style-type: none"> • Take deep breaths and refocus • Remain present and listen well • De-escalate the situation • Excuse yourself, step away from the situation • Splash water on your face • Share the experience with a trusted friend or colleague • Gather opinions of others about how to respond to the stressor • Get fresh air • Listen to music • Mindfulness meditation 	<ul style="list-style-type: none"> • Occupational <ul style="list-style-type: none"> ○ Develop self-awareness of how you respond to strong emotions ○ Maintain healthy professional boundaries ○ Cultivate the ability to say “no” ○ Reflect on the meaning of one’s work and continually seek out reminders of that meaning ○ Ask reflective questions like “What surprised you today? What inspired you today?” ○ Celebrate the successes in work ○ Maintain a sense of humor ○ Create rituals to release the tension of the day (eg: listening to music on the way home, taking a shower after work, exercise) • Emotional/Cognitive Strategies <ul style="list-style-type: none"> ○ Take time to grieve losses ○ Allow emotional “process” time using mediation, journaling, debriefing ○ Regularly self-assess for signs of stress or frustration ○ Mindfulness meditation • Relationships with Others <ul style="list-style-type: none"> ○ Develop a family within the workplace ○ Acknowledge that colleagues may be suffering ○ Have your “go to” person to share experiences ○ Work towards a community of caring • Spiritual Strategies <ul style="list-style-type: none"> ○ Religious beliefs and faith may provide comfort for some ○ Take solace in the medical field as an endeavor greater or more important than any one individual • Attention to Self-Care <ul style="list-style-type: none"> ○ See a physician to attend to medical needs ○ Ensure access to mental health professionals as needed ○ Encourage sleep hygiene, nutrition, exercise ○ Take time for vacation/spend time in nature ○ Pursue hobbies, activities outside of work to clear the mind

We suggest that learners across the educational continuum take an active role in developing their individualized wellness learning plan. This is relevant whether you are just starting out in your training in medical school or have practiced for decades. By identifying your individual resilience strategies you can make a deliberate effort to adapt them and thrive within your career.

ASSESSMENT TOOLS

Another way to focus on humanism during the training experience is to include humanism during trainee assessment. The Pediatric Milestone Project, to emphasize humanism, created a Professionalism sub-competency labeled “Humanism, compassion, integrity, and respect for others.”²² As a trainee matures into an independent practitioner, he or she develops from the novice stage, characterized by “[Seeing] the patients in a ‘we versus they’ framework... detached and not sensitive to the human needs of the patient and family” to more advanced performance which includes altruistically going “beyond responding to expressed needs of patients and families” and engaging in advocacy.²² Values and characteristics inherent to humanistic practice may also be assessed using a variety of established and published scales (Table 2). Educators interested in including these scales into their program’s system of assessment should do so with formative intent. None of these instruments are intended for high-stakes evaluation. They can, on the other hand, be valuable sources of data to identify trainees in need of additional support, whose demonstration of humanistic behavior is challenging for them.

Table 2: Examples of Established Instruments Measuring Component of Humanism

INSTRUMENT NAME	DEFINITION
Maslach Burnout Inventory	The most widely used research measure in the burnout field. Burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment which can include negative, cynical attitudes and dehumanized perception of others. A short version of the scale, including seven items, was published in 2005. ²³
Resilience Scale	The Resilience Scale is a self report measure of an individual’s ability to respond to adversity. The 26 item version reflects five core characteristics of resilience: perseverance, equanimity, meaningfulness, self reliance and existential aloneness. ²⁴
Jefferson Scale of Physician Empathy	A 20-item self-assessment with well-established psychometric properties. The scale has demonstrated reliability and validity and all items are relevant to the measure of empathy, a key component of humanism. An alternate version exists for patients to complete about their provider. ^{25,26}
Tolerance of Ambiguity Scale	Ambiguity can derive from novelty, complexity, and confronting problems which are difficult to solve. The construct speaks to an individual’s ability to cope with uncertainty and risk. Individuals vary in their tolerance for ambiguity which may influence both cognitive and emotional functioning. Numerous scales exist to measure tolerance of ambiguity. ²⁷
Patient-Practitioner Orientation Scale	An 18-item scale that distinguishes physicians focused primarily on the provider’s needs and the medical problem or condition at hand from those focused on the patient and cultivating a relationship in which the patient shares in decision-making. ²⁸

SUMMARY

Cultivating humanism is an inherent part of our profession and an integral aspect of pediatric residency training. The Pediatric Milestone Project has highlighted sub-competencies relevant to humanism. While included under the umbrella of professionalism, humanism encompasses some distinct concepts such as a focus on altruism, compassion and respect for others. Strategies for teaching and enhancing humanism exist and programmatic adoption is key along with supporting trainee reflection on experiences. Creation by trainees of an individualized wellness plan allows them to identify and prioritize the wellness strategies most valuable to their personal and professional lives. Validated measures of humanism exist and can be implemented in a formative way into training programs.

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Chapter 9: When a Learner Is Not Meeting Expectations Relating to Professionalism

The majority of learners will have no issues with passage through the developmental stages of professional competency. They will move from being medical students, whose course of learning and behavior were guided by others, to a mode of learning and professional behavior that is self-directed as graduate medical education trainees. Occasionally, there will be a learner who needs extra guidance and perhaps even external control. Rarely, one may encounter an individual who is not suited for a professional career in pediatrics and who has escaped the normal processes in place to protect patients and the public at large. These are the most challenging situations for a program director. They are fraught with interpersonal stress, institutional and program upheaval, and occasionally legal entanglements. When unprofessional behavior occurs, it is the responsibility of the program director to determine the weight of the infraction and to chart a course of action. What follows in this chapter are some suggested guidelines for addressing remediation in professionalism.

It is critically important to identify deficiencies in training and to immediately embark on a remediation action plan. Lapses in professionalism can be in different categories and include behavioral, performance, attitude or accountability issues.¹ It is imperative for the program director to have accurate and extensive documentation related to professionalism issues. The program director must document the assessments that identified the professionalism deficiency, and all conversations, meetings, and actions involved in the development of a plan. This documentation should be placed in a separate and non-discoverable file. If further action is needed by the program, institution or outside agencies, the program director will need to have this record in place. There may be future inquiries regarding whether the learner ever had a break in training or any unusual monitoring. These questions often appear on credentialing and licensing forms. The proper answer to these questions depends on the severity of the professional lapse. A single lapse could be considered part of a learners' developmental process, but learners should be aware that serious professional problems will require a notation on future credentialing forms. Program directors are encouraged to meet with a trainee who is having trouble in the presence of a third party, such as a chief resident/fellow, assistant program director or other faculty member to provide a witness about what was communicated.

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

DEVELOPING A REMEDIATION PLAN

When a program director determines that a learner requires remediation for a lapse in professionalism, a careful plan for remediation and follow-up must be developed. In general, a program director must decide whether to pursue broad remediation with activities directed towards professionalism issues in general. Or, one may choose to focus on the specific behaviors in which the learner has demonstrated lapses. This decision will help guide the remediation plan.

It is challenging to find literature on best practices for remediation of graduate medical education trainees with respect to deficiencies in professionalism. Authors have noted that the assessment methods used by program directors for identifying deficiencies in competence and the strategies used to remediate these challenges are not standardized.² The Alpha Omega Alpha Medical Honor Society has developed a publication on Best Practices in Medical Professionalism that program directors may find extremely useful. In this document, a format for developing a remediation plan is proposed that includes the following:³

1. Assessment/Diagnosis of the problem
2. Development of an individualized learning plan
3. Perform instruction and remediation activities
4. Follow-up and reassessment with the learner/certification of competence

The first step in the remediation plan includes identification of the deficiency through the assessment process utilized by the training program. Ideally, multiple reliable and valid assessment tools are utilized to uncover the deficiency as it may cross domains of competence. The second step involves having an organized approach to the learner's lapse in professionalism and the creation of a specific plan tailored to the deficiency of the individual. Once the lapse is confirmed, it is critical to understand the context in which it occurred and communicate a clear action plan to the learner. This written document articulating the action plan should include characterization of the professionalism lapse, the clear requirements for remediation including specific behavioral change goals, the plan for monitoring and reassessment, guided self-reflection and/or deliberate mentored practice, if recommended, feedback during the remediation process, expectation for what is acceptable performance and a clear outline of the consequences. Guidance and mentorship is critical in the implementation and successful completion of a remediation plan. The third step involves the provision of the remediation activities and consideration of services the learner may need both personally and professionally. Behavioral approaches may need to be considered when dealing with breaches of professionalism. The final component of the plan includes reassessment to ensure that the learner has achieved an acceptable level of performance. It should be noted that depending on the guidelines of the institution, other supervisors such as the Department Chair, Vice Chair of Education, the Designated Institutional Office or others, may need to be notified of such trainee issues.

A number of institutions have developed formal remediation programs to work with trainees and physicians with professionalism lapses. These include the Vanderbilt model, the Center for Professionalism and Peer Support at Brigham and Women's Hospital and the University of Colorado School of Medicine Remediation Program. Each of these programs differ in their focus and intensity. The Vanderbilt model is tiered, with interventions dependent on the degree of the infractions.⁴ Similarly, the Brigham and Women's Hospital program is a multi-step process with an emphasis on changing the unwanted behavior.⁵ Finally, the University of Colorado School of Medicine program works with trainees both with medical knowledge and clinical reasoning deficits as well as professionalism issues.⁶ Through the development of a Success Team, this program develops a comprehensive remediation program.⁶

Whether your institution has a formal remediation program, such as is described above, or you need to create one independently, it is critical to follow the four steps noted above. Enlist the aid of those at your institution with experience in the remediation process and document your process all along the way. In most instances, the program director and the learner should establish a contractual remediation plan. Such a plan would specify tasks or criteria that the learner must fulfill before returning to a position of good standing within the program.

Leave of Absence

At times it may be necessary to recommend or, even require, a leave of absence for an individual learner. When behaviors fall to a level that may be harmful to the trainee or potentially to a patient in the trainee's care, a leave should be required. There should be program and institutional guidelines in place that give the program director authority to take this action. This will ensure that the trainee seeks the kind of help that he/she needs in order to return safely to work.

What Constitutes Egregious Action

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

Consideration of Context and Pattern of Behavior

It may be appropriate to consider the context in which unprofessional behavior occurs and whether the lapse is a single event or a pattern of behavior. There is clearly a gradation in the seriousness of offenses. Consideration can be given to the meaning of an episode for the individual learner and the program but the program must articulate what constitutes acceptable and clearly unacceptable behaviors.

When Context Does Not Matter

There will be some instances in which legal and ethical standards have been breached requiring that action be taken regardless of context or pattern of behavior. Such acts might include physical assault, sexual misconduct, and wanton harm of patients or their families.

Specific Tools Available to Help with Breaches of Legal/Ethical Standards

- Consultation
 - In these difficult situations, the program director should request consultation from departmental and hospital administrative staff. In many cases, the hospital attorney will need to be informed and consulted. Hospitals may have ethics boards, graduate medical education committees or other constituents of a due process procedure.
- Documentation
 - In more egregious cases of professional misconduct that may result in criminal or civil litigation, an even higher standard of documentation is required. The graduate medical education office at your institution can help you define what is necessary.
- Physician Impairment Program
 - In many states, there are specific physician impairment programs, particularly for cases of substance abuse. These programs are very helpful in providing sufficiently rigorous surveillance and specific referral resources to avoid loss of license and/or board certification.
- Involvement of Law Enforcement
 - In some cases, the hospital may choose to notify law enforcement officials about specific violations of criminal law such as assault, robbery, or drug sales.
- Notification of the American Board of Pediatrics
 - A program director has the responsibility to notify the ABP if a lack of professionalism has been identified during training that warrants further evaluation and observation, or an extension of training. Although reporting may occur at any time, the ABP requires program directors to evaluate the clinical competence and professionalism of trainees at the end of each year of training on the tracking roster. The critical elements for a program director to understand include:
 - » If an unsatisfactory evaluation is given for professionalism, the resident must repeat the year of training or, at the discretion of the ABP and recommendation by the program director, complete a period of observation. Until the unsatisfactory evaluation is remediated, the Board will withhold permission to take the certifying examination.
 - » A resident or fellow who receives an unsatisfactory evaluation for professionalism receives no credit for that year of training, unless the program director provides evidence as to why a period of observation would be more appropriate than a repeat year of training.
 - » If a period of observation is acceptable and the resident is at the end of his/her training period, this observation will extend into a subsequent training period, such as during a subspecialty fellowship or during a physician's initial period in practice.
 - » A plan for remediation must be developed and submitted to the ABP for approval. Observation plans for lapses in professionalism are developed on a case-by-case basis. The observer must provide an assessment of clinical competence with particular attention to professional attitude and behavior at the end of the agreed upon period of observation.

- » Less than satisfactory performance in professionalism will be grounds for continued denial of credit for training and result in a disapproval to take the certifying examination. Additional information can be obtained by contacting the ABP.
- ABP Monitoring Plan Requirements (for period of observation for lapses in professionalism)
 - If the learner is still in training, the remediation plan is at the discretion of the program director and does not require official review from the ABP.
 - If the learner has been evaluated as unsatisfactory in professionalism, but has been determined to be otherwise clinically competent at the end of training, a remediation plan must be developed in conjunction with the ABP. Development of such a plan must include four critical elements. Initially, the plan must describe clearly the lapses which lead to the unsatisfactory performance in professionalism. Secondly, the trainee must describe significantly how this behavior has affected others. The third section should detail the monitoring plan and specifically how multi-source feedback will be used. Lastly, any additional interventions that are required should be described. Forms required can be referenced in the toolkit provided by the ABP. This toolkit will be sent when the program director documents an unsatisfactory professionalism performance and observation is recommended at the end of training. The ABP will approve the plan for observation.
 - Monitoring phase: A designated observer will be required to provide quarterly reports to the ABP for review by the ABP's Credentials Committee.

KEY POINTS

- It is challenging to identify and remediate lapses in professionalism but it is essential to the development of a learner and a key responsibility of a program director. A program director needs to be familiar with strategies and tools that are available both internal and external to one's department and institution.
- Programs should have a policy that addresses lapses in professionalism and the basics of remediation that may be applied to a learner.
- An organized approach to the creation of a remediation plan is recommended to aid in the achievement of successful correction of a professionalism deficiency.
- Knowledge of the ABP requirements and actions for unsatisfactory professionalism evaluations are important.

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Chapter 10 – Identity Formation and Trustworthiness: Foundations of Professionalism

Trust is a foundational component of the doctor-patient relationship and physicians' professional contract with society. Kennedy et al define trustworthiness as a multidimensional construct that includes the following: clinical knowledge and skills, recognition of one's own limitations, conscientiousness, and honesty.¹ As medical educators, one of our major goals is to develop trainees into independently practicing physicians who embody the attributes listed above¹ and can establish effective, healing relationships with their patients and families. Patients and families must be able to not only trust individual clinicians' competence, but also their moral character, in addition to the profession as a whole.² In our complex medical environment, in which technological, political, legal, and changing market forces can all influence the practice of medicine, optimal patient care cannot be provided unless our patients and families trust us to do what is right.^{2,3} The American Board of Internal Medicine (ABIM) Foundation's *Physician Charter*³ makes explicit the profession's commitment to serving the best interests of the patient regardless of external forces, respecting patient autonomy, and promoting social justice within healthcare as fundamental, guiding principles for the practice of medicine. These principles are grounded in the concept of trustworthiness, making this virtue the foundation of medical professionalism.

While *The Physician Charter*³ provides a comprehensive list of professional responsibilities, the few listed below are key to physicians' establishing and maintaining a trusting relationship with patients and society.

- *Commitment to honesty with patients.* Honesty with patients encompasses informed consent for treatment, procedures, and/or clinical research that is complete and truthful regarding the benefits, as well as the potential adverse consequences; and our responsibility to fully disclose medical errors. Honesty is an important and necessary attribute in establishing and maintaining trust. Therefore, lapses in this principle can undeniably compromise trust between physicians and their patients.
- *Commitment to patient confidentiality.* Patients' sharing of personal information with their physician is essential to the practice of medicine. In order for patients to comfortably disclose the details of their life and illness to physicians, they must have full confidence in their ability to keep this information confidential and protected against inappropriate disclosure.
- *Commitment to maintain appropriate relations with patients.* Physicians have a professional responsibility to maintain appropriate boundaries in their relationships with patients. They should never exploit their relationships with patients for personal gain (e.g., sexual, financial). and recognize that patients often experience a state of dependency which enhances their vulnerability when ill.
- *Commitment to managing conflicts of interest.* Conflicts of interest are a reality in medicine. Physicians have a duty to appropriately manage these conflicts of interest, which includes disclosing them to the general public. Transparency in disclosing conflicts of interest aids in maintaining physicians' trust with society.
- *Commitment to professional competence.* Our patients and families trust us to provide high quality care. To do so, physicians must have a commitment to life-long learning to maintain their medical knowledge and clinical skills. A patient's trust is linked to our competence and abilities as a professional.
- *Commitment to improving quality of care.* Human error and less than optimal systems exist in medicine; and our patients and families experience the effect on a day-to-day basis. Earning and maintaining trust in this environment requires physicians to demonstrate their commitment to the continuous quality improvement of health care (e.g., consistently working to reduce medical errors, eliminating inefficiency and waste and rebuilding unsafe systems. The need for the development of better quality measures and their subsequent application to care delivery must also be addressed.

Recognizing trust as the core of medical professionalism provides us with a foundation upon which we can begin to teach the essential knowledge, skills and attitudes of medical professionals. Our trainees' learning is dependent upon their participation in patient care activities that allow them to make critical decisions with increasing levels of autonomy.⁴ In order for this process to occur successfully, supervising physicians must be able to trust their trainees. Specifically, supervising physicians have to decide when to trust a trainee to perform a certain task or drive care decisions based on their level of competence.⁴ Trainees earn said trust by not only demonstrating clinical competence under direct supervision, but also exhibiting specific professional traits that may provide insight

into their future behaviors as practicing clinicians.⁴ For example, Kennedy et al demonstrated that supervising physicians' assessment of trustworthiness went far beyond clinical skills and extended into other dimensions — discernment (awareness of limits in regards to skill and knowledge), conscientiousness (thoroughness and dependability), and truthfulness (absence of deceit).¹ Through double-checking trainees' clinical findings against their own clinical assessments and/or other documented, factual information and listening to language cues during clinical presentations, supervising physicians assessed trainees' through this multidimensional framework of trustworthiness to determine their competence and ability to perform independent patient care.¹

Medical educators have a responsibility to not only develop competent physicians who are dedicated to life-long learning, but also, physicians of character who hold the values of the profession as their own.^{2,5} According to Forsythe,⁵ the public and those who prepare professionals for service understand that “who we are” can influence “how we practice.” Thus, the goal is for our trainees to develop their own internal compass rooted in the standards of medical professionalism that will guide them to make principled decisions, even during times of stress.⁵ In other words, we must support trainees in developing their professional identity, a sense of who they are as physicians.⁵

The Pediatric competencies most relevant to professional identity formation and trustworthiness are:

- Patient Care
 - Gather essential and accurate information about the patient
 - Perform complete and accurate physical examinations
 - Carry out management plans to completion
- Medical Knowledge
 - Demonstrate a commitment to gaining sufficient knowledge of basic and clinically supportive sciences appropriate to pediatrics
- Practice-based Learning and Improvement
 - Identify strengths, deficiencies, and limits in one's knowledge and expertise
 - Identify goals and perform appropriate learning activities to guide personal and professional development
 - Incorporate formative evaluation feedback into daily practice
 - Take primary responsibility for lifelong learning to improve knowledge, skills, and practice performance
- Professionalism
 - Professionalization: A sense of duty and accountability to patients, society, and the profession.
 - Professional conduct: High standards of ethical behavior, including maintaining appropriate professional boundaries
 - Self-awareness of one's own knowledge, skill, and emotional limitations that leads to appropriate help-seeking behaviors
 - Trustworthiness that makes colleagues feel secure when one is responsible for the care of patients

BEHAVIORAL STATEMENTS

Examples of professionalism that relate to professional identity formation and trustworthiness that are listed above provide general goals. In discussions with trainees, it may be helpful to identify specific behaviors or practices that exemplify professionalism in this domain, and others that would represent lapses of professionalism.

Examples of Exemplary Professional Conduct

- Identifies personal and professional strengths, as well as areas needing improvement, through reflective self-assessment
- Recognizes one's own limitations and can develop a plan with appropriate mentorship to improve any deficiencies
- Actively seeks out and incorporates feedback to further personal and professional growth

- Adopts the ethical standards of the profession as their own and works to develop a sense of who they are as physicians, demonstrating an awareness of and a commitment to professional identity formation
- Practices medicine with a commitment to their professional responsibilities, including honesty and integrity, even during times of stress
- Forms therapeutic and trusting relationships with patients through effective communication
- Maintains appropriate professional boundaries with patients and their families
- Appropriately safeguards patient information and maintains patient confidentiality
- Appropriately discloses medical errors with honesty and empathy
- Demonstrates appreciation of multiple perspectives of a multidisciplinary team
- Manages conflict in a professional and productive manner
- Serves as a positive role model for trainees and fellow colleagues
- Manages medical ambiguity

Examples of Lapses in Professional Conduct

- Avoids opportunities to engage in reflective assessment, specifically regarding one's own areas needing improvement
- Avoids receiving feedback and/or fails to incorporate feedback into their practice
- Fails to develop one's own internal compass based on the ethical standards of the profession
- Practices medicine with a lack of integrity
- Treats patients with disrespect and/or lack of empathy, failing to establish a trusting doctor-patient relationship
- Fails to maintain appropriate professional boundaries with patient and families
- Demonstrates a lapse in patient confidentiality
- Fails to disclose medical errors
- Fails to disclose and/or manage conflicts of interest
- Fails to appreciate the multiple perspectives of a multidisciplinary team
- Avoids or poorly manages conflict
- Models negative, and/or unprofessional behaviors in the workplace
- Acts dogmatically in the face of medical ambiguity

TEACHING PROFESSIONALISM

The transition from medical student to adept pediatrician is an evolutionary process in which knowledge and skills are acquired and professional values are incorporated into a clinician's sense of self.^{5,6} This personal adoption of professional values is an essential component of professional identity formation⁵ and the development of a competent, trustworthy physician. The process requires time and experience and is influenced by trainees' self-awareness, attitudes, and habits of life-long learning,⁴ all of which can be molded with the appropriate guidance. Thus, teaching professionalism requires us to understand and mentor trainees through the process of professional identity formation.

Robert Kegan^{7,8} explored the process of how individuals undergo the evolution in their understanding of their relationships with other individuals and groups throughout most of their life. Forsythe⁵ expanded on this concept and uses three of the six stages originally described by Kegan, specifically stages 2, 3, and 4, to explain individuals' relationships with their profession.⁷ The following are the stages most relevant to professional identity formation. Stage 2 encompasses an individual's ability to appreciate the perspective of another person, but only in the context of how that person's views impact him or her personally.^{5,9} In stage 3, a learner views the world through multiple perspectives, and those perspectives can have an impact on their own personal identity.^{5,9} Here learners begin to identify with the profession by learning the implicit and explicit rules. They start to model the behaviors they witness, highlighting the importance of the hidden curriculum. In this stage, it is of utmost importance for senior physicians to demonstrate the professional behaviors they want their junior trainees to emulate. However, stage 4 is the critical transition in which individuals' actions are led by their own expectations, not the expectations of others, and the values of the profession become integrated in their own personal and professional beliefs.^{5,9} In this stage,

individuals understand “who they are” as professionals;⁵ and this new found identity allows them to appropriately reconcile and resolve conflicts that emerge between personal and professional expectations with honesty and integrity.

All of the stages, but specifically stage 4, are critical to professional identity formation and thus, to the development of a physician who is trusted by the public and his or her colleagues. Medical educators can modify and positively influence this developmental process in the following ways: 1) providing trainees with content-specific curricular experiences to enhance their development and explicit role modeling (i.e. pointing out what behavior they are modeling and why) 2) intentional skill-building in the areas of giving and receiving feedback, self-care, and conflict resolution, and 3) by setting appropriate, stage-specific, expectations for professionalism competencies of learners using a developmental approach.^{6, 10}

Learning Objectives for Trainees

1. Trainees will explain the concept of professional identity formation and its impact on their individual professional development as a clinician throughout the entirety of their career
2. Trainees will describe the core elements of trustworthiness
3. Trainees will discuss how professional identity formation is linked to the concept of trustworthiness
4. Trainees will articulate those professional responsibilities most important to establishing and maintaining a trusting relationship with patients and society
5. Trainees will identify lapses in professionalism and the implications of those lapses on the trust-based doctor-patient relationship and society’s trust in the profession as a whole
6. Trainees will learn to self-regulate their own professionalism through continual self-assessment and address any deficiencies or lapses as a part of their life-long commitment to professional development

Reflective Exercises

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

- After holding a discussion about the professional responsibilities of physicians, ask your trainees to reflect and write, in one page or less, about their own professional identity formation, where they think they are in the process, and how this affects their relationships with colleagues, patients and families, and the profession.
- Ask your trainees to reflect on their own personal ideals and how they align with the professional responsibilities of physicians.
- Ask your trainees to describe a time in which they observed exemplary professional conduct that led to an effective, trusting encounter between a physician and his or her patient.

CHAPTER 10 VIGNETTES – IDENTITY FORMATION AND TRUSTWORTHINESS: A FOUNDATION OF PROFESSIONALISM

Using any of the vignettes below, ask your trainees to describe a similar real-life situation. Ask them to identify the conflicting values and what they learned from the situation.

The vignettes that follow were developed for use in a small group setting to help stimulate discussions about issues regarding professionalism. Medical educators are encouraged to expand upon these to reflect local issues and experiences.

Vignette 1 – Appropriate Escalation of Care

An intern is working overnight on a general pediatrics unit and becomes clinically concerned about a newly admitted patient. The intern is unsure of the next steps to take and discusses the patient’s condition with a fellow intern; and together, they decide to continue to monitor the patient without any acute intervention. They do not alert the supervising senior resident or the attending of their concerns. An hour later, the patient clinically deteriorates and has to go to the intensive care unit.

Points to consider during discussion:

- What is your initial reaction to this scenario?
- What would you do if you were the supervising resident or the attending?
- How should the intern's failure to escalate his or her concerns be addressed?
- How do the actions of the intern potentially affect how he or she will be supervised in the future?
- What are possible reasons that the intern chose not to escalate care?
- Should anything be discussed with the patient and their family?

Vignette 2 – Honesty in Patient Care

The medical team is rounding and your fellow co-resident is presenting. When he or she reports the exam findings, he or she states the exam was normal and reassuring. However, you know that your co-resident arrived late this morning and was unable to examine his or her patients prior to the start of rounds.

Points to consider during discussion:

- Do you have a responsibility to say something to your fellow colleague? Supervising resident? Attending?
- How should the behavior of your fellow co-resident be addressed?
- When is the appropriate time to address your fellow co-resident's behavior?
- How do you think the actions of your fellow co-resident potentially affect how he or she will be supervised in the future?
- What are the potential consequences of not addressing the behavior?

Vignette 3 – Missing Opportunities for Improvement

A medical student gives long presentations on rounds that do not focus on the pertinent negatives and positives. As the supervising resident, you decide to provide one-on-one feedback to the medical student to help him improve his presentation skills. However, the medical student is dismissive. When you discuss the medical student with your fellow interns, you find out that they tried to give him similar feedback and he was dismissive of their comments as well.

Points to consider during discussion:

- Is the dismissive nature of the medical student considered unprofessional? Why or why not?
- Considering the prior attempts at feedback, what should the supervising resident do?
- What are possible barriers preventing the medical student from receiving feedback?
- What guidance should be provided to the medical student to facilitate his continued professional development?

Vignette 4 – Informed Consent

A febrile neonate receives a lumbar puncture as a part of his or her medical work-up in the Emergency Department. It was a difficult lumbar puncture requiring multiple attempts by two Emergency Medicine attendings, which leads to the development of a hematoma at the LP site. When the patient is admitted, the mother expresses to the admitting resident that she is upset because no one explained the complications associated with a lumbar puncture.

Points to consider during discussion:

- What is your reaction to this scenario?
- What is a physician's responsibility when providing informed consent?
- Do you think the mother's relationship with the medical system and/or individual clinicians has changed due to this incident? And if so, how?
- How would you address the mother's concerns?
- Do you discuss the case with the Emergency Medicine attendings?

Vignette 5 – Patient Confidentiality

The daughter of a well-known celebrity is a patient in your hospital. Your colleague is a true fan of the celebrity and has been to all of the celebrity's concerts. Your colleague disclosed to you that he or she looked up the patient in the electronic medical record and found out the patient is located on the 4th floor and he or she is simply going to walk around on that floor to see if he or she can run into the celebrity for a quick autograph. Your colleague is not providing any medical care to this patient.

Points to consider during discussion:

- Would you say anything to your colleague in response to this plan?
- What is considered a breach in patient confidentiality?
- Whose responsibility is it to safeguard the privacy of the patient and his family?
- If your colleague were to run into the celebrity, how do you think this would affect the family's trust in the medical institution and/or their physicians?

Vignette 6 – Disclosure of Medical Errors

A patient is admitted in the PICU for bacteremia and sepsis. IV antibiotics are ordered and a higher than typical dose of Vancomycin is ordered and given to the patient before it can be corrected. There is no resultant harm to the patient.

Points to consider during discussion:

- Considering there was no harm to the patient, do you think the medical error should or should not be disclosed and why?
- Whose responsibility is it to disclose medical errors?
- Is there an appropriate time to disclose the medical error?
- How do you think the disclosure of the medical error will affect the relationship between the patient's family and the medical team and/or the institution?
- What would be your course of action if you notice that the dose of IV Vancomycin continues to be improperly ordered?

Vignette 7 – Hidden Curriculum

There is a hospital-wide quality improvement initiative to decrease the rate of central line related blood-stream infections. As a part of the hospital-wide initiative, the medical teams are being asked to discuss central line care on rounds when relevant to the patient. When you bring this to the attention of your attending physician, he or she reports a lack of belief in the quality improvement process and would prefer not to participate. He or she prefers to leave the care in the hands of nursing.

Points to consider during the discussion:

- What is your initial reaction to your attending's response?
- Describe the hidden curriculum. Is the hidden curriculum present in this situation? If so, how may it affect the trainees?
- How does a physician balance their day-to-day responsibilities with their professional responsibilities to improving the overall quality of care?
- Whose responsibility is it to address the attending's behavior?

SUMMARY

Professionalism is built upon the concept of trustworthiness. In essence, a trustworthy physician is a physician who has embodied the key elements of clinical competence, discernment, conscientiousness, and honesty while demonstrating a strong commitment to their professional responsibilities. As medical educators, we have a responsibility to cultivate these professional traits in our trainees. The goal of becoming a trusted professional (i.e., one who can safely and effectively practice without supervision) is a true developmental process that requires a focus on professional identity formation, the utilization of appropriate teaching methods, including targeted reflection, role modeling, and skill building, as well as setting clear expectations for accountability that aligns with the developmental level of the trainee.

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