Teaching of Professionalism

Objectives

- To ensure that students and residents know:
  - The definition of professionalism
  - The history and present status of professions, including medicine
  - The attitudes and behaviors that are characteristic of professionalism

- To inculcate these attitudes and behaviors in students and residents through formal teaching, role modeling, and use of other tools

- To provide the foundation for lifelong growth and development of professionalism
You have planned a social evening with your spouse tonight. Because of your hectic schedule on the IR service, you have seen very little of each other in the past several weeks, and are planning to meet for dinner at 6PM. You are ready to leave at 5:15 PM, when a nurse calls to speak with an IR doctor about Mr. Smith, who underwent a biliary drainage procedure earlier this afternoon. He is now hypotensive, diaphoretic, and complaining of severe RUQ pain. After a quick look around, you determine that no other IR team members are in the department.
A bedside ultrasound exam reveals a large hepatic subcapsular hematoma. You draw a blood sample for Hgb, Hct, and T&C, and page your attending. You catch the IR on-call nurse and technologist leaving for the day, and ask them to stay for a possible emergency add-on hepatic arteriogram and embolization. An hour and a half later, you and your attending are finishing the embolization of a pseudoaneurysm; a transfusion of 2U PRBCs is underway. Your attending tells you to leave, but you are reluctant.

Discuss your options at this time.
You had called your spouse earlier about the delay, but he/she is obviously unhappy. You arrive at the restaurant almost 2 hours late.

How would you explain your tardiness?
“Professionalism is the basis of medicine’s contract with society. It demands placing the interests of patients above those of the physician…”

Medical Professionalism in the New Millennium: A Physician Charter

Physician Charter

3 Fundamental Principles

- **Principle of primacy of patient welfare**
  - This is trust central to the physician
  - Must not be compromised for any reason

- **Principle of patient autonomy**
  - Physicians must be honest, and
  - Empower patients to make informed decisions

- **Principle of social justice**
  - Fair distribution of healthcare resources
  - Elimination of discrimination in healthcare
Which fundamental principle(s) of the Physician Charter is/are involved in this scenario?

- Principle of primacy of patient welfare
- Principle of patient autonomy
- Principle of social justice
You are still on the IR service. A patient with a fem-pop graft occlusion has been referred for thrombolytic therapy. Your attending decides this patient meets the selection criteria of the clinical trial of a new thrombolytic agent, for which she is the local PI. You observe the informed consent interview. To you, it seems unbalanced in favor of the new agent. Moreover, although your attending is a paid consultant and member of the scientific advisory board of the firm sponsoring the trial, she fails to disclose these facts in the informed consent interview.
Physician Charter
10 Professional Commitments

Commitment to...

...professional competence
...honesty with patients
...patient confidentiality
...maintaining appropriate relations with patients
...improving quality of care
...improving access to care
...a just distribution of finite resources
...scientific knowledge
...maintaining trust by managing conflicts of interest
...professional responsibilities
Which of the 10 commitments of the Physician Charter have been violated?

...professional competence
...honesty with patients
...patient confidentiality
...maintaining appropriate relations with patients
...improving quality of care
...improving access to care
...a just distribution of finite resources
...scientific knowledge
...maintaining trust by managing conflicts of interest
...professional responsibilities
In this scenario, which fundamental principle(s) of the Physician Charter has/have been violated?

- Principle of primacy of patient welfare
- Principle of patient autonomy
- Principle of social justice
Who is at risk (medical, legal, financial) in this scenario?

- Patient
- Physician-investigator
- Other patient-subjects enrolled in the same clinical trial
- Hospital
- Pharmaceutical company
- Society

What should you do?
You are close friends with a resident colleague, Steve, and often see him in social settings. You notice that Steve drinks excessively at these gatherings. He has admitted to you that he binges on weekends. You are very concerned and want to do something about it.

You would:

1) Arrange to have a heart-to-heart talk with him
2) Inform the program director
3) Not get involved; it is none of your business
4) Discuss your concern with the chief resident
5) Choose another option
Several months later, one night when you and Steve are both on call, you notice alcohol on his breath.

What would you do at this time?
Which of the 10 commitments of the Physician Charter are at issue here?

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

- **Profess**: (v) to speak out publicly, declare

- **Profession**: (n) a group that speaks out together about its shared standards and values

- **Professional**: (n) an individual member of the group; (adj) acting in conformance with the shared standards and values of the group

- **Professionalism**: (n) a belief system holding that professional groups are uniquely well suited to organize and deliver certain social goods.

Matthew Wynia, MD, MPH. ABMS Sept 2012 Congress on Professionalism
Key Components of a Profession

- Philosophy: eg. eliminate suffering, prevent disease
- Body of knowledge
- Leaders who are role models in scholarly pursuit, writing, practice, service
- Qualifications for admission
- Requirements for CPD
- Code of professional behavior (oath, code of ethics)

ABR Foundation online modules on professionalism & ethics, 2011
Attributes of Professions & Professionals

- Skill based on theoretical knowledge
- Extensive period of education
- Specified practical experience acquired through institutional training
- Competence demonstrated by passing a prescribed examination as a criterion for membership
- Continuous upgrading of knowledge and skill
- Knowledge inaccessible to public (medicine, law)
- License to practice required (few exceptions)
Attributes of Professions & Professionals

- Public service and altruism
- Code of professional conduct; disciplinary procedures for violators
- Self-regulation by most highly qualified/senior members; independent of government; certification
- Work autonomy
- Judgment based on education, training, experience
- Lack of self-interest
Attributes of Professions & Professionals

- Dedication to service, institutions; primary orientation is to public, community
- Legitimacy: clear legal authority over some activities
- Power to exclude those not meeting requirements, expel incompetents; legal recognition, monopoly
- Mobility afforded by standardization
- High status in society
- Professional societies, associations
Examples of Professionals

Accountants
Actuaries
Advocates
Architects
Dentists
Engineers
Financial Analysts
Interpreters
Lawyers
Librarians
Nurses
Optometrists
Pilots
Pharmacists
Physicians
Professors
Social Workers
Teachers
Veterinarians
Development of a Profession

- Becoming a full-time occupation
- Establishment of 1st training school
- Establishment of 1st university school
- Establishment of 1st local association
- Establishment of 1st national association
- Establishment of state licensing laws
- Establishment of code of professional conduct
A capstone in the development of a profession is the introduction and adoption of a code of professional ethics

1st statement of moral conduct for the medical profession: Oath of Hippocrates (5th century BCE)

- Refrain from intentional harm
- Humility a core virtue

See Appendix B of ABRF module 1 for modern Oath of Hippocrates
By mid-1870s, med schools were replacing Oath of Hippocrates with Oath of Maimonides and others.

See Appendix A of ABRF module 1 for Oath of Maimonides.
Development of the Medical Profession

- Thomas Percival: English physician; 1\textsuperscript{st} modern code of medical ethics (1794), expanded 1803

  AMA Code of Ethics was taken directly from his work

- Coined terms “medical ethics” and “professional ethics”; invented clinical rounds, identified physicians’ “tacit compact with society”
AMA Principles of Medical Ethics

- In 1847 at 1\textsuperscript{st} meeting of AMA, code was adopted

- Explicit professional social compact
  - Obligations to patients, colleagues, community
  - Reciprocity: social/economic rewards in exchange for 1) putting patients first, 2) guaranteed competence of practitioners, 3) guarding public health

- Birth of professionalism
  - 1\textsuperscript{st} national code of ethics for any profession

- Most recent version of AMA Principles of Medical Ethics: 2001
Development of a Profession

- Others oaths and codes in use today
  - Declaration of Geneva as amended in 2006 (Appendix C of ABRF module 1)
  - Good Medical Practice: Duties of a Doctor Registered with the General Medical Council (UK) (Appendix D of ABRF module 1)
  - AMA Principles of Medical Ethics (Appendix E of ABRF module 1)
Modern medical practice beset by challenges

Increasing disparities - needs of patients and available resources to meet those needs

Increasing dependence on market forces to transform health care systems

Patients, consumer groups unclear about meaning of professionalism. Often view it negatively as set of guild-like privileges and entitlements focused entirely on the physician
Physicians feel bludgeoned by admonitions to behave professionally in systems that foster and reward unprofessional behavior.

Several organizations collaboratively developed a charter to maintain fidelity of medicine’s social contract.

Charter embodies physicians’ commitment to welfare of patients and to improving the health system to benefit society.

Endorsed by hundreds of organizations, including:

ACGME
ABMS
ABR
RSNA

Since Charter was published in 2002, it has become clear that didactic teaching and role modeling are necessary but insufficient, and that several concepts about professionalism need updating.

A framework is needed for a behavioral and systems approach to professionalism.
<table>
<thead>
<tr>
<th></th>
<th>Old Assumptions about Professionalism</th>
<th>Contemporary View of Professionalism</th>
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</thead>
<tbody>
<tr>
<td><strong>Concept</strong></td>
<td>Attitudinal competence based on character</td>
<td>Multi-dimensional competency</td>
</tr>
<tr>
<td><strong>Lapses</strong></td>
<td>Physicians who lapse are unprofessional</td>
<td>Lapses occur in physicians who are good professionals; competency grows over time</td>
</tr>
<tr>
<td><strong>Challenges</strong></td>
<td>Infrequent</td>
<td>Common</td>
</tr>
<tr>
<td><strong>Response to lapse</strong></td>
<td>Punitive</td>
<td>Targeted coaching based on root cause analysis; sanctions reserved for those who fail to respond</td>
</tr>
<tr>
<td><strong>Health care system</strong></td>
<td>Setting in which lapses occur</td>
<td>Can increase / decrease likelihood of a lapse</td>
</tr>
<tr>
<td><strong>Training in professionalism</strong></td>
<td>Med school and residency are responsible</td>
<td>Health care leaders must support career-long professional development</td>
</tr>
</tbody>
</table>

Lesser CS, Lucey CR, Egener B et al. JAMA 2010; 304(24):2732-2737
<table>
<thead>
<tr>
<th>Values</th>
<th>Interaction with Patient/ Family</th>
<th>Team</th>
<th>Practice Setting</th>
<th>Professional Organizations</th>
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<tbody>
<tr>
<td>Compassionate Care</td>
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<tr>
<td>Integrity / Accountability</td>
<td>Maintain patient confidentiality</td>
<td>Report impaired colleagues</td>
<td>Support for med error disclosure</td>
<td>Strategies that foster culture of professionalism</td>
</tr>
<tr>
<td></td>
<td>Disclose medical errors</td>
<td>Participate in 360 evaluations</td>
<td>Stringent COI policies</td>
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<tr>
<td></td>
<td>Manage COIs</td>
<td>Standardize handoffs</td>
<td>Feedback to teams on performance</td>
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<tr>
<td>Pursuit of excellence</td>
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<tr>
<td>Fair and ethical use of</td>
<td></td>
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<tr>
<td>resources</td>
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An 80-year-old woman with shortness of breath is referred for US-guided thoracentesis. You, the junior resident on the service, perform the procedure under supervision, and all goes well. An hour later, the patient becomes acutely short of breath. CXR reveals a large pneumothorax. Your attending places a chest tube while you assist, and the patient is stabilized. Later, the patient’s son is angry and demands to know how many thoracenteseses you have done.

What is your response?

You feel badly after this encounter and want to discuss your dilemma further. Who do you choose?
Which of the 10 commitments of the Physician Charter are at issue here?

...professional competence
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...maintaining appropriate relations with patients
...improving quality of care
...improving access to care
...a just distribution of finite resources
...scientific knowledge
...maintaining trust by managing conflicts of interest
...professional responsibilities
A true story as told on KevinMD, Feb 1, 2012

Patients will understand an honest mistake if the doctor tells the truth

by Neil Baum, MD | in Physician | 3 responses

It was 1976 and I was a junior resident in urology at Baylor College of Medicine in Houston, Texas. I was assigned to a rotation in pathology where my job was to process specimens taken at surgery, dictate a gross description of the specimen and then place the specimens into the cassettes that would be used to make the permanent sections. I was transferring a prostate biopsy, approximately 0.5mm x 10mm, and it slipped from the forceps and was washed down the drain of the sink. I searched for the tiny sliver of tissue and even took the drain trap apart but could not locate it. I felt terrible and told the director of the pathology lab who recommended that I call the urologic surgeon, Dr. Seybold, and report what had happened with the biopsy.

Simple lesson?

Survey of 1891 U.S. Physicians (64% resp.)*

- 1/3: disagree with disclosing errors
- 1/5: say it is acceptable at times to tell patients something untrue
- 2/5: do not agree completely with disclosure of financial relationships with drug and device firms

You are on a crowded hospital elevator. In a loud voice, one internal medicine resident is joking about an obese patient, as he explains to his colleague that the patient’s I.V. placement had turned into a protracted affair. Multiple attempts had caused extreme discomfort to the patient, frustration on the part of the resident, and ultimately, failure to access a vein. According to the resident, the patient had yelped and squealed “like a stuck pig”, until he had snapped at her, “Well, if you weren’t so damned fat!”
Questions to consider:

- Whose responsibility is it to remind this resident about patient confidentiality and respect for others?
- What would you do in response to hearing this conversation on the elevator?
- What if it were not a resident making these remarks, but an attending or department chair?

_Vignettes and role playing, combined with feedback, are powerful formative tools that can shape professional behaviors. Role modeling is also one of the most powerful._
Which of the 10 commitments of the Physician Charter are at issue here?

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...a just distribution of finite resources
...scientific knowledge
...maintaining trust by managing conflicts of interest
...professional responsibilities
Training, Board Certification, and Professionalism

- Contract with society
- Boards assure public that profession is self-regulating
- Duty is competent members of the profession:
  - Medical Knowledge
  - Patient Care
  - Communication and Interpersonal Skills
  - Professionalism
  - Practice-based Learning and Improvement
  - Systems-based Practice
Training, Board Certification, and Professionalism

- Assurance of competency offered to public is based upon:
  - Accredited residency training: supervised full-time training experience during which the 6 competencies are developed
  - Secure certifying examination
  - Post-training: in practice, competencies maintained through a program of CPD (MOC)
Training, Board Certification, and Professionalism

- **RRC Requirement:** Program faculty evaluated on professionalism; must ensure a culture of professionalism in their programs.

- **RRC Requirement:** All residents and faculty members must “demonstrate responsiveness to patient needs that supersedes self interest….”

- **ABR Requirement:** PDs attest for each resident before oral exam: he/she “will have achieved adequate professional qualifications…” (ie, all 6 competencies)
Innovative approach to accredited training:

- Committee: RRC, ABR, PDs, resident
- Milestones based on 6 competencies
- Professionalism included; knowledge, attitudes, and behaviors spelled out
Diagnostic Radiology Milestones

Professional Attitudes & Behaviors

- Recognizes importance and priority of patient care
- Advocates for patient interests
- Fulfills work-related responsibilities
- Is truthful
- Recognizes personal limitations; seeks help when needed
- Recognizes personal impairment; seeks help when needed
- Responds appropriately to constructive criticism
Diagnostic Radiology Milestones

Professional Attitudes & Behaviors

- Places needs of patient before self
- Maintains appropriate boundaries with patients, colleagues, others
- Exhibits tolerance and acceptance of diverse individuals and groups
- Maintains patient confidentiality
- Fulfills institutional/program requirements concerning professionalism and ethics
- Attends required conferences
Formative Assessment Tools for Professionalism

- Teaching and Assessing Professionalism: A Program Director’s Guide – ABP, APPD
  - Critical Incidents
  - Peer Assessments
  - Professionalism Mini-Evaluation Exercise
  - Multi-Source Assessments (360 eval)
  - Direct observation and feedback
  - End-of-rotation global assessments
  - Conference attendance logs
  - Timelines in completing institutional/program requirements
ABR Examinations

- **Present Exams**
  - No blueprint requirement for Professionalism content in “written” exams
  - May occur in oral exams, not explicit

- **Future Exams**
  - Explicit inclusion of professionalism content: Certifying Exam, Non-interpretive Skills Module

- **Attestations/Agreements**
  - ABR requires direct evidence of Professionalism in residency: individual resident agreement to abide by ABR’s Exam Security Policy
Once in practice post-training...

- Absence of accredited training (second pillar)
- Continuous Professional Development takes its place
- Why needed?
  - Skills decline with years in practice
  - Patients receive only ~1/2 of indicated care
  - 10 commitments: some physicians falter
  - Proportion of physicians disciplined increases with each decade after first licensure
- MOC is the solution!
Relationship Between Training, Time & Competence

Increasing years in practice:

- > 50% of studies decline
- 1/62 studies improved
- 2 studies initially improve followed by decrease

Half of Recommended Care Is Delivered

Adults received 55% of care that is recommended

Children received 46% of the care that is recommended


Physician Performance Problems

- Physicians disciplined by State Medical Boards in 2002
  - 1739 licenses revoked / 1218 restricted
- Underlying causes:
  - Mental/behavioral problems
  - Impairment due to substance abuse
  - Physical illness – cognitive impairment
  - Failure to acquire/maintain knowledge and skills
- 1/3 physicians – impaired ability to practice medicine safely at some time

Leape & Fromson, Annals of Internal Medicine, 2006;144:107-115
# Physician Performance Problems

**Discipline by a State Medical Board**

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<tbody>
<tr>
<td>Quality / competence / negligence</td>
<td>34%</td>
<td>38%</td>
<td>50%</td>
</tr>
<tr>
<td>Unprofessional conduct</td>
<td>30%</td>
<td>46%</td>
<td>43%</td>
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<tr>
<td>Impairment</td>
<td>14%</td>
<td>16%</td>
<td>4%</td>
</tr>
<tr>
<td>Miscellaneous / other</td>
<td>32%</td>
<td>2%</td>
<td>40%</td>
</tr>
<tr>
<td>Sample size</td>
<td>375</td>
<td>890</td>
<td>396</td>
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Communication ➔ frequent complaint to state medical boards
News Release

FOR IMMEDIATE RELEASE
February 28, 2012

Dallas Doctor Arrested for Alleged Role in Nearly $375 Million Health Care Fraud Scheme
Office Manager for Doctor and Five Owners of Dallas-Area Home Health Agencies Also Arrested

WASHINGTON - A physician and the office manager of his medical practice, along with five owners of home health agencies, were arrested today on charges related to their alleged participation in a nearly $375 million health care fraud scheme involving fraudulent claims for home health services.

The arrests and charges were announced today by Deputy Attorney General James Cole and Health and Human Services (HHS) Deputy Secretary Bill Corr, along with Assistant Attorney General Lanny A. Breuer of the Justice Department’s Criminal Division; U.S. Attorney Sarah R. Saldaña of the Northern District of Texas; HHS Inspector General Daniel R. Levinson; Special Agent in Charge Robert E. Casey Jr. of the FBI’s Dallas Field Office; Dr. Peter Budetti, Deputy Administrator for Program Integrity for the Centers for Medicare and Medicaid Services (CMS); and the Texas Attorney General’s Medicaid Fraud Control Unit (MFCU).

The indictment, filed in the Northern District of Texas and unsealed today, charges Jacques Roy, M.D., 54, of Rockwall, Texas; Cynthia Stiger, 49, of Dallas; Wilbert James Veasey Jr., 60, of Dallas; Cyprian Akamnonu, 63, of Cedar Hill, Texas; Patricia Akamnonu, RN, 48, of Cedar Hill; Teri Sivils, 44, of Midlothian, Texas; and Charity Eleda, RN, 51, of Rowlett, Texas, each with one count of conspiracy to commit health care fraud. Roy also is charged with nine counts of substantive health care fraud, and Veasey, Patricia Akamnonu and Eleda are each charged with three counts of health care fraud. Eleda also is charged with three counts of making false statements related to a Medicare claim. All the defendants are expected to make their initial appearances at 2:00 p.m. CST today in federal court in Dallas.

In addition to the indictment, CMS announced the suspension of an additional 78 home health agencies (HHA) associated with Roy based on credible allegations of fraud against them.

Today’s enforcement actions are the result of the Medicare Fraud Strike Force operations, which are part of the Health Care Fraud Prevention & Enforcement Action Team (HEAT). HEAT is a joint initiative announced in May 2009 between the Department of Justice and HHS to focus their efforts to prevent and deter fraud and enforce anti-fraud laws around the country.
News Release

December 5, 2010

Doctor Faces Suits Over Cardiac Stents

By GARDINER HARRIS

Word quickly reached top executives at Abbott Laboratories that a Baltimore cardiologist, Dr. Mark Midei, had inserted 30 of the company’s cardiac stents in a single day in August 2008, “which is the biggest day I remember hearing about,” an executive wrote in a celebratory e-mail.

Two days later, an Abbott sales representative spent $2,159 to buy a whole, slow-smoked pig, peach cobbler and other fixings for a barbecue dinner at Dr. Midei’s home, according to a report being released Monday by the Senate. The dinner was just a small part of the millions in salary and perks showered on Dr. Midei for putting more stents in more patients than almost any other cardiologist in Baltimore.

The Senate Finance Committee, which oversees Medicare, started investigating Dr. Midei in February after a series of articles in The Baltimore Sun said that Dr. Midei at St. Joseph Medical Center, in Towson, Md., had inserted stents in patients who did not need them, reaping high reimbursements from Medicare and private insurance.

The senators solicited 10,000 documents from Abbott and St. Joseph. Their report, provided in advance to The New York Times, concludes that Dr. Midei “may have implanted 585 stents which were medically unnecessary” from 2007 to 2009. Medicare paid $3.8 million of the $6.6 million charged for those procedures.

The report also describes the close relationship between Dr. Midei and Abbott Labs, which paid consulting fees to the cardiologist after he left the hospital. “The serious allegations lodged against Dr. Midei regarding the medically unnecessary implantation of cardiac stents did not appear to deter Abbott’s interest in assisting him,” the report states.
January 20, 2012

Who Else Is Paying Your Doctor?

It took longer than expected, but the Obama administration is finally poised to enact badly needed regulations requiring that the manufacturers of drugs, medical devices and medical supplies disclose all payments they make to doctors or teaching hospitals. The information, which would be posted on a government Web site, will allow patients to decide whether they need to worry about any possible conflicts of interest.

Such payments can be for legitimate research and consulting. But there is also a lot of cash being spread around to pay for doctors’ travel and entertainment or for gifts or modest meals for a prescribing doctor’s staff.

As Robert Pear reported in The Times this week, some prominent doctors and researchers receive hundreds of thousands or even millions of dollars a year in exchange for providing advice to a company or giving lectures on its behalf. About a quarter of all doctors take some cash payments from drug or device makers and nearly two-thirds accept meals or food gifts. Analysts contend that even seemingly trivial gifts can influence doctors to prescribe expensive drugs that may not be best for a patient’s health or pocketbook.

The new rules were championed by Senator Charles Grassley, a Republican, and Senator Herb Kohl, a Democrat, and incorporated into the health care reforms enacted in 2010. The reform law required the Department of Health and Human Services to establish reporting procedures by Oct. 1, 2011, and required manufacturers to start collecting the relevant data by Jan. 1, 2012. The proposed rules were finally issued on Dec. 14 and are subject to comment until Feb. 17, after which they will be revised and issued in final form.

The Centers for Medicare and Medicaid Services will publish the disclosure data on a public Web site that the law says must be searchable and understandable so that patients and advocacy groups can see which doctors are being paid and how much. Manufacturers could be fined up to $150,000 a year for failing to report payments and up to $1 million a year for “knowingly” failing to report.
State Disciplinary Actions by Year

Annual Rate of Serious Disciplinary Actions by State Medical Boards: 2000-2011

18% decrease since 2004

MOC: a Comprehensive Approach to Physician Accountability

- Integrates the patient’s voice
- Holds peers accountable for self-regulation
- Supports transparency to the public
- Addresses patient safety
- Addresses communication skills and professionalism
- Includes assessment of knowledge and cognitive skills
- Incorporates quality improvement
Component 1: Professional Standing

- **Licensure Requirement**
  - State Medical Licensure - DANS
  - ABR received ~1200 reports since 10/05
  - 60 certificates have been suspended or revoked
  - ~50 on probation; some reinstated

- **Future ABMS Requirements**
  - Patient and Peer Surveys – Communications, Professionalism
  - 360 degree evaluations = feedback
Component 1: Professional Standing

- Papadakis et al (J Med Lic & Discipl, ‘04, ‘06)
  - Disciplinary action by a medical board was strongly associated with prior unprofessional behavior in medical school

- Strongest unprofessional behavior predictors:
  - Irresponsibility (unreliable attendance at clinic, lack of follow-up related to patient care)
  - Diminished capacity for self-improvement (failure to accept constructive criticism, argumentativeness)
Component 2: LLL & SA

- 34 “Non-Interpretive Skills” SAMs:
  - 14 in ethics and professionalism
  - 4 in systems-based learning and QI
  - 1 in communications
  - Remainder in safety
ABRF Ethics and Professionalism Modules

1) Attributes of Professions and Professionals
2) Physician-Physician and Physician-Patient Interactions
3) Ethics of Personal Behavior, Peer Review, and Contract Negotiations with the Employers
4) Conflict of Interest
5) Ethics in Research
6) Ethical Issues in Human Subjects Research
7) Research Involving Vertebrate Animals
8) Relationships with Vendors
9) Publication Ethics
10) Ethics in Graduate and Resident Education

www.abrfoundation.org
MOC Component 3: Cognitive Expertise (Exam)

- Practice-profiled, computer-based, q 10 yrs
  - Required module: Non-Interpretive Skills (NIS) - includes Professionalism content
    - Content must be based on expert consensus for validity
    - Domain must be well-defined for reliability
    - Higher-level judgments and vignette-like item types lead to fidelity
  - Clinical areas (4 elective modules) - include content assessing other competencies
  - Feedback to examinees
MOC Component 4: Performance in Practice

- Practice Quality Improvement Projects
  - Incorporate competencies such as:
    - practice-based learning and improvement,
    - systems-based practice,
    - communication and interpersonal skills
  - Demonstrate that the diplomate *does*, rather than only *knows*
  - Provide the hard evidence of maintaining competency and professional responsibility
Summary

- Professionalism not a character trait, but a belief system involving lifelong learning and development; board certification and MOC are integral.

- Medical professionalism based on social contract.

- Physician Charter Principles: 1) primacy of patient welfare, 2) patient autonomy, 3) social justice.

- 10 commitments of the Charter embody attitudes, behaviors of medical professionals.

- Lapses are challenges in complex situations.

- Health care system shapes the culture to support professionalism.