Contemporary Issues in Medical Professionalism

Challenges and Opportunities

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Physician organizations, academic institutions and accrediting bodies agree that professionalism is important to medicine. A number of them have created codes of conduct and competencies related to professionalism. Yet studies have shown that physicians face challenges as they seek to put the principles of professionalism into practice. This article examines four realities of medicine today—the potential for conflicts of interest, the advent of social media, the lack of professionalism education beyond medical school and residency, and the lack of support from organizations for which physicians work—that challenge medical professionalism.

In 2002, the American Board of Internal Medicine (ABIM) Foundation, the American College of Physicians and the European Federation of Internal Medicine published “Medical Professionalism in the New Millennium: A Physician Charter,” which identified three ethics principles and 10 professional responsibilities that comprise a modern definition of professionalism. To date, more than 130 professional organizations have endorsed the Charter. Professionalism is also central to the Liaison Committee for Medical Education’s standards for medical schools, the Accreditation Council for Graduate Medical Education’s core competencies for residents and fellows, and the American Board of Medical Specialties’ requirements for Maintenance of Certification. In addition, the Joint Commission requires health care organizations to have codes of conduct and processes for addressing unprofessional behavior in order to receive accreditation and certification.

Although there is broad agreement that physicians must consistently demonstrate professionalism throughout their careers, the medical community continues to struggle to sustain professionalism in the face of the complex and multifaceted challenges physicians face today. In this article, we review four realities in medicine that present challenges to professionalism: 1) the growing potential for conflicts of interest, 2) the advent of social media, 3) lack of professionalism education beyond medical school and residency, and 4) lack of support from the organizations for which physicians work. In addition, we propose strategies for addressing them.

The Growing Potential for Conflicts of Interest

On July 26, 2013, the Wall Street Journal ran the front-page story “Surgeons Eyed over Deals with Medical-Device Makers: Justice Department Investigation Shines Light on Federal Authorities’ Broader Scrutiny of Physician-Owned Distributor-ships.” The article recounted how one particular medical device manufacturer had set up a series of distributorships in which surgeons operated as distributors/owners, and thereby generated revenue for themselves above and beyond that which they received for implanting the devices. Although the article noted that such activities can be legal, it also cited concerns raised by the Department of Health and Human Services’ Office of Inspector General that such arrangements “pose dangers to patient safety” by motivating surgeons to undertake unnecessary surgeries and to favor their own devices over more “clinically appropriate” ones.

The story gets at one of the fundamental tenets of medical professionalism: the primacy of the patient’s welfare or medicine’s promise to place the well-being of patients...
ahead of its own interests. In this way, medicine promises to approach patient care more as a public service than as a business. Because physicians have special knowledge and skills and because patients are vulnerable, physicians have an obligation to place the welfare of their patients ahead of their own welfare. This concept is ubiquitous in medicine. For example, the AMA Code of Medical Ethics (Opinion 8.03) opens with the sentence: “Under no circumstances may physicians place their own financial interests above the welfare of their patients,” and closes with the following enjoiinder: “If a conflict develops between the physician’s financial interest and the physician’s responsibilities to the patient, the conflict must be resolved to the patient’s benefit.” At issue is the fundamental trustworthiness of medicine.

Although there always has been a potential for conflicts of interest, new concerns about the influence of “big industry” and “medical commercialism” began to surface in the late 1980s and early 1990s in response to the corporatization of medicine. Those concerns led some to believe that medicine had begun to lose its vaunted status as a trusted social institution. Arnold Relman’s 1980 New England Journal of Medicine commentary on the rise of a “medical industrial complex” is a classic expression of concern about the influence of industry over medicine and the potential for conflicts of interest in medical decision-making.9

Prior to this time, most physicians believed it was impossible for their decisions to be influenced by anything other than the patient’s interest. But as scientific data on physician decision-making and industry intentionally influencing medical practice and research began to emerge,10-12 physicians started to acknowledge that they might be subject to influences from industry.11,12 Today, with accumulating evidence of the presence of conflicts of interest,13 the prospect that physicians may hold divided loyalties or act as “dual agents”—and thus represent the interest of stakeholders other than patients—should continue to concern the public and the medical community.

Both the medical community and the public have taken steps to prevent conflicts of interest. For example, most academic medical centers, teaching hospitals, medical schools and health care systems now have fairly robust policies governing institutional and individual relations with industry.14 Nonetheless, questions regarding the effectiveness of these initiatives continue to mount.15

The Advent of Social Media

The advent of new Internet-based technologies such as social networks, blogs and micro blogs presents both opportunities and challenges for physicians. Use of social media is so pervasive today that the question is no longer whether physicians will participate but rather how they can best use social media to advance the health of the public.

If used appropriately, social media has the potential to significantly extend the influence of medicine within society.16 Specifically, it can facilitate information-sharing between physicians and the public and help connect physicians with patients in underserved areas.17 Social media also may be useful in medical education, as it could enable instructors to reach learners across geographic boundaries and allow for more flexibility for both teachers and students. Surveys suggest that physicians are receptive to the idea of learning through social media and related technologies.18

Unfortunately, research also demonstrates that physicians and medical trainees exhibit unprofessional behavior online.19,20 The type of behaviors most frequently reported to state medical boards include inappropriate communication with patients, misrepresentation of credentials, use of the Internet for inappropriate practice, breaches of patient confidentiality, failure to reveal conflicts of interest, depiction of intoxication and use of discriminatory language.21 Such behaviors may result in serious consequences including termination of employment and disciplinary actions from state medical boards.21 Medical students should also be aware that program directors increasingly use online content when selecting residents and fellows.22

The American College of Physicians (ACP) and the Federation of State Medical Boards (FSMB) recently published guidelines to help physicians make wise decisions about online behavior.23 They state that all students, residents, fellows and practicing physicians must understand that professional codes of conduct applicable in medical schools, hospitals and clinics extend online.24 The role of health professions schools to enforce codes of conduct online was recently upheld by the Minnesota Supreme Court, when it ruled on June 20 of this year that the University of Minnesota did not violate a mortuary student’s free speech rights by punishing her for posting on Facebook comments about a cadaver she was working on.25 Physicians are encouraged to “apply ethical principles for preserving the relationships, confidentiality, privacy and respect for persons” to all online activities.22 The ACP and FSMB guidelines also suggest physicians should separate their online professional and social activities,21 although this is difficult as patients are increasingly reaching out to their physicians online.

One tactic we have found helpful in coaching medical trainees about online behavior is derived from Jostens’ “Pause Before You Post” public service campaign.26 Before communicating online, pause to reflect on the following questions: 1) Who will be able to see what I post? 2) Will anyone be embarrassed or hurt by it (including me)? 3) Am I proud of what I’m posting? 4) Is this consistent with my professional values as a physician or medical student?

Lack of Professionalism Education Beyond Medical School and Residency

Professionalism is a core competency for physicians. Behaving in a professional manner is associated with a physician being perceived as knowledgeable, skilled
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and conscientious. In contrast, unprofessional behavior is associated with reduced staff productivity, lower morale, increased staff turnover, poor communication, reduced efficiency, a higher risk for errors, and decreased satisfaction and increased burnout among learners. Students and residents exposed to unprofessional behaviors among physicians may, in turn, learn and manifest those behaviors themselves.

Although we would all like to assume that physicians know how to manifest professional behaviors, it’s not always the case. For example, a survey of practicing physicians showed that although most embraced the Charter’s ethics principles and responsibilities, their self-reported behaviors sometimes conflicted with those principles and responsibilities (eg, being aware of an impaired colleague but not reporting the individual to authorities). Vitalsmarts “Silence Kills” study showed that, although a majority of physicians had concerns about a colleague’s competence, fewer than 10% were willing to discuss their concerns with that individual. In another survey of physician executives, most reported regularly encountering physicians exhibiting unprofessional behaviors such as delivering insults, yelling, showing disrespect and refusing to complete duties.

Most of the literature about professionalism education is focused on medical students and residents. To presume such education should end at residency is wrong. It needs to continue through the course of a physician’s career. There are multiple reasons why. First, patients expect their physicians to demonstrate professional behaviors. Second, professionalism is associated with improved medical outcomes such as increased patient adherence with treatment programs.

Practicing physicians should be taught the elements of professionalism (eg, communication skills, ethics, humanism, excellence, altruism and accountability) using Arnold and Stern’s framework. Providing physician education on professionalism is important because doing so conveys a strong message about its importance as a competency.

For professionalism to flourish, it must be assessed as well as taught, as assessment drives learning, improves skills and promotes professional behaviors. Because there’s no single measure for assessing professionalism in practicing physicians, multiple measures must be used. These include 360-degree reviews (by colleagues, allied health staff and learners), self-assessments, patient assessments and patient complaint reviews—all of which can be combined in a “professionalism portfolio.” The Division of General Internal Medicine at Mayo Clinic-Rochester has begun doing this as part of the annual review process. The process provides opportunity to give feedback, promote reflection, reward exemplars, evaluate professionalism training programs and generate research hypotheses. Physicians who repeatedly manifest unprofessional behaviors must be confronted and undergo corrective action.

Lack of Organizational Support

If an organization’s culture does not support professionalism, it is unfair to expect it from the people who work for the institution. Health care organizations need to support and encourage a culture of professionalism. This is especially relevant today as more and more physicians are joining larger groups or going to work for large health care organizations, where they do not enjoy the autonomy they may have once had.

Having an environment that encourages professionalism is especially important in organizations charged with teaching medical and other students. Learners are heavily influenced by attending faculty and will often readily adopt their behaviors, good or bad.

Professional behavior benefits the organization as well. It generates trust and promotes the reputation of individuals and the organization; it encourages staff engagement, greater productivity, and favorable recruitment and retention rates; and it encourages communication and speaking up in situations where it is critical to patient safety and the quality of care. Disruptive behavior, the antithesis of professional behavior, is all too common in hierarchical organizations such as hospitals. Such behavior can lead to dysfunctional teams, safety and quality lapses, and depression and burnout.

Organizations can do a number of things to promote professionalism. They can select, train and monitor their teaching faculty, who can promote a culture built on professional values and behaviors. They can emphasize the importance of proper dress and decorum, let employees know they can speak up without fear of retaliation and teach them to work as teams. Lucey and Souba proposed that organizations address lapses in professionalism similar to the way they address lapses in safety (eg, skills training). They can redesign or develop curriculum on professionalism that includes narratives collected from within the organization. Such changes have led to desirable results in a number of organizations. The ABIM Foundation has published an analysis of these and other organizational approaches to advancing professionalism.

Summary

The potential for conflicts of interest, the rise of social media, the lack of professionalism education beyond medical school and residency, and the lack of organizational support challenge professionalism in medicine. Avoiding conflicts of interest and optimally using social media require individual physicians to monitor their own behaviors. Organizations should commit to providing physicians with education on professionalism throughout their careers. In addition, they need to reward professional behavior and see that examples are set from the top down. Future initiatives should explore ways to support and enhance professionalism at both the individual and organizational level.

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Conflict of Interest: Dr. Mueller is a member of the Boston Scientific Patient Safety Advisory Board and Associate Editor of the NEJM Journal Watch General Medicine.
REFERENCES

ICD-10 is Coming
An Update on Medical Diagnosis and Inpatient Procedure Coding

By Burke Kealey, M.D., and April Howie, CPC, CPMA

In October 2014, the United States will switch from using the ICD-9 coding system to ICD-10. This change will allow for greater specificity in describing medical conditions and the addition of new codes as medical knowledge and technology evolve. The change will be a big one for hospitals and clinics. This article describes what physicians need to know about the new system and what the organizations they work for need to consider when preparing for the change.

Since 1979, the United States has been using the ninth revision of the International Classification of Diseases (ICD-9). The ICD is used to classify diseases and other health problems on death certificates, in health records, and for national morbidity and mortality statistics. It is also used to monitor the incidence and prevalence of disease and is essential for resource allocation and reimbursement. ICD-10 was endorsed by the World Health Assembly in May 1990 and came into use in 1994. Most other countries now use ICD-10. The 11th revision will be available in 2015.

The Health Insurance Portability and Accountability Act requires hospitals and health systems to switch from ICD-9 to ICD-10 by October 1, 2014. ICD-10 differs from ICD-9 in that it allows for greater specificity in describing a patient’s condition; it also allows for new codes to be added as medical knowledge and technology change. That greater specificity will allow for better quality measurement and better analysis of disease patterns. It also will aid researchers, as it captures the severity of illness, which is currently not possible with ICD-9. In addition, ICD-10 will result in more accurate bills being submitted for reimbursement, theoretically reducing waste in the medical system.

With ICD-10, the number of diagnosis codes (-CM codes) will expand from 14,000 to 68,000 and the number of procedure codes (-PCS codes) will increase from 4,000 to 87,000. No physician will need to learn all of these codes. And many of them will be embedded in the drop-down menus of electronic health record (EHR) systems. All physicians, however, will need to know something about the changes headed their way, as they do affect the way they will need to document patient care.

Physicians and ICD-10
The fundamental point for physicians to understand is that because ICD-10 allows for more specificity, the supporting documentation in the medical record will need to be more specific as well. Physicians will need to note the primary diagnosis as they currently do with ICD-9, but with ICD-10 they also will need to attend to the following new sub-classification criteria: laterality, stages of care, specific diagnosis, specific anatomy, associated/related conditions, cause of injury, additional signs/symptoms/conditions, dominant vs. nondominant side, external cause(s) and/or places of occurrence, cause and effect relationship, and recurrent vs. initial. For example, the documentation for a patient with asthma would need to encompass the specific diagnosis, severity, whether it is intermittent or persistent, the level of exacerbation, cause and effect, the history of tobacco use, and exposure to environmental smoke (even prenatal exposure) (Table). In the case of a neoplasm, the supporting documentation would still need to include notations about site (the ovary) and behavior. It also would need to include information about such details as laterality; whether the malignancy is on the left or right side; whether the malignant neoplasm is of the isthmus uteri, endometrium, myometrium, fundus uteri or overlapping sites of the corpus uteri or whether it is unspecified; the disease stage; and the