# NCC Pediatrics Continuity Clinic Curriculum:
# **Medical Professionalism**
## ***Faculty Version***

## Goals & Objectives:

1. Develop categories and identify elements of professional behavior in medicine.

2. Provide an explanation to the statement that "professionalism is a set of skills that develops over the course of time in medical practice."

## Pre-Meeting Preparation:

- Skim the AAP technical report "Professionalism in Pediatrics" (2007)
- Review some physician disciplinary actions to review. Click on the link: **VA**, **DC**, **CA**, **WV**
- Form categories of the types of unprofessional behavior cited.
- Prepare to discuss an incident in which you were challenged with a decision that involved professionalism in the care of patients.

## Conference Agenda:

- Have the most junior participant write their categories of professional behavior on the white-board. Using the real-life examples of citations, expand or modify the categories.
- Have each participant discuss a situation in which their professionalism was challenged.

## Extra-Credit:

Å **Professionalism** *(Pediatrics In Review, 2020)*

Å **Teaching and Assessing Professionalism** (*APPD, 2008* )

Å **Professionalism revisited during the pandemics of our time: COVID-19 and racism**
( *Perspectives in Medical Education, Feb 2021*)

Å **Opting in to Online Professionalism: Social Media and Pediatrics** (*Pediatrics, Oct 2013*)

Å **Tattoos, Beer, and Bow Ties** The Limits of Professionalism in Medicine (*JAMA Peds, June 2016*)

American Academy of Pediatrics
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TECHNICAL REPORT

# Professionalism in Pediatrics

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## ABSTRACT

The purpose of this report is to provide a concrete overview of the ideal standards of behavior and professional practice to which pediatricians should aspire and by which students and residents can be evaluated. Recognizing that the ideal is not always achievable in the practical sense, this document details the key components of professionalism in pediatric practice with an emphasis on core professional values for which pediatricians should strive and that will serve as a moral compass needed to provide quality care for children and their families.

## INTRODUCTION

Professionalism has been a central and defining feature in medicine since Hippocrates.[1] The concept of professionalism is now receiving renewed attention because of advances in technology, managed care and other business arrangements in health care, and a growing sense of the erosion of public trust in the medical profession.[2]

Pediatricians have a special status in society as privileged and trusted advocates for the well-being of children. Pediatricians have a responsibility to use their knowledge, skills, and influence to advocate for children and their interests in all domains of society, not just in health care. A child's health is broadly understood to include emotional, social, educational, psychological, and spiritual well-being.

As the pediatrician-child/family relationship has been threatened over time with the imposition of a business model, it has become more important than ever to adopt a standard of professionalism for pediatricians. The ability to promote professionalism across the continuum of medical education, from medical school curricula through continuing medical education for practicing pediatricians, depends on the ability to define and assess professionalism in the context of pediatrics.[3,4] Various professional groups have supported the need for a normative definition of professionalism, and there is considerable overlap in the definitions that they have formulated.[5–8] The American College of Physicians astutely noted in its recent iteration of their ethics manual that written guidelines are not a substitute for the experience and integrity of individual physicians but may serve as a reminder of the shared duties and obligations of the medical profession.[9] Allowing that the ideal may not be fully achievable in the practical sense, the purpose of this document is to provide a background on professionalism in pediatrics that serves a dual role: (1) to provide a concrete overview of the ideals for which pediatricians should strive and (2) to describe standards of professional behavior by which practicing pediatricians and trainees can be evaluated. This document begins with a general discussion of statements concerning professionalism in pediatrics and proceeds to the application of these statements in the central relationships in

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The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

**Key Words**
professionalism, pediatricians, physician-patient relations, medical student, resident

**Abbreviations**
ABP—American Board of Pediatrics
AAP—American Academy of Pediatrics
AMA—American Medical Association
HIPAA—Health Insurance Portability and Accountability Act

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pediatric practice—to patients and families, to students and residents, to other health professionals, to the profession, and to society in general.

## STATEMENTS OF PROFESSIONALISM IN PEDIATRICS

The American Board of Pediatrics (ABP) began its discussion of professionalism when it defined the optimal attitudes, knowledge, clinical judgment, technical skills, and interpersonal skills that applicants should possess in its 1974 publication *Foundations for Evaluating the Competency of Pediatricians*.[10] Since 1976, residency program directors have been asked to evaluate interpersonal skills, work habits, and personal qualities of residents, and beginning in 1982, the ABP requested that program directors also evaluate and attest to applicants' ethical and moral behavior as it affects their professional performance.

The ABP continued its pediatric-specific efforts to clarify ethics and professionalism issues in practice with the pioneering 1987 publication "Teaching and Evaluation of Interpersonal Skills and Ethical Decision Making in Pediatrics."[11] Admittedly, the content area in ethics is not straightforward. To assist residents and pediatricians in practice with difficult ethical decisions, the American Academy of Pediatrics (AAP) Committee on Bioethics has been publishing guidelines on key ethical issues since 1983 (available at http://aappolicy.aappublications.org). Most recently, the ABP added more specific guidelines for the teaching and evaluation of professionalism as part of the core curriculum for residency training in pediatrics. The following 8 components of professionalism have been endorsed by the ABP as the most appropriate for teaching and evaluation[12]:

- Honesty and integrity—embody the principles of fairness, the ability to meet commitments and keep one's word, and the duty to be intellectually honest and straightforward in interactions with patients and peers and in all professional communication.
- Reliability and responsibility—represent accountability to children, families, other physicians, medical staff, community, and ultimately society. They require acceptance of responsibility for errors made, including the willingness to acknowledge and discuss errors, consequences, and alternatives with the family and with peers.
- Respect for others—involves treating all persons with respect and regard for individual worth and dignity, including sensitivity to gender, race, and cultural differences as well as maintenance of patient confidentiality when appropriate.
- Compassion/empathy—the ability to understand children's and family members' reactions to pain, discomfort, and anxiety from their point of view, not that of the physician.
- Self-improvement—involves a commitment to lifelong learning and education.
- Self-awareness/knowledge of limits—the maturity to recognize when a problem involves knowledge or technical skills beyond the experience of the provider and to ask for consultation or assistance in those situations.
- Communication and collaboration—involve the recognition that patients' families and the health care team must work cooperatively with each other and communicate effectively to provide the best patient care and social activism.
- Altruism and advocacy—refer to the unselfish regard or devotion to the welfare of others. Patient well-being should be the primary motivating factor in patient care, ahead of physicians' own interests and needs.

## PEDIATRICIANS' RESPONSIBILITIES TO PATIENTS, FAMILIES, AND COMMUNITIES

The connotation of "good doctor" historically brings to mind a physician who embodies both the art and science of medicine. The concept is epitomized in the pediatrician who can give advice without being patronizing, who is concerned about how an illness and its consequences (financial, emotional, psychological) will affect the family, and who strives to help the child and/or parent understand a disease process and its natural history (compassion/empathy). This doctor is thorough and technically skillful and continually incorporates new knowledge into his or her practice (self-improvement).[13] To other physicians, a "good pediatrician" is a colleague with whom they would entrust the care of their own child.[14]

To be effective, the relationship between a pediatrician, his or her patient, other medical professionals, and the parent or surrogate (hereafter, "parent") of that child must be collaborative. The role of the parents is to take an interest in and responsibility for their child's health care, seek attention for medical problems in a timely manner, and communicate and work effectively with their child's pediatrician to create an acceptable treatment plan. In return, the pediatrician's obligation is to provide appropriate information regarding the child's health care, including the benefits, risks, and costs of all reasonable treatment alternatives (communication and collaboration). Parents should have their questions answered, feel free to seek second opinions, and be advised of the pediatrician's potential conflicts of interest (honesty and integrity). Pediatricians should communicate to parents any errors in patient care, including any consequences that have resulted or may result because of the error (honesty and integrity; reliability and responsibility).

Children, as patients, should be afforded continuous

access to care. On-call pediatricians should be responsive in a timely manner, coverage should be available during absences, and notice of closing a practice or changing participation in insurance plans is expected (curtailing access). Except in cases of emergency or in which state law allows otherwise, the permission of a parent will be necessary before a pediatrician can offer medical treatment to a child. Parents may accept or refuse a recommended medical treatment on behalf of their child. Pediatricians and pediatric medical subspecialists have a duty to respect the wishes of the child and family when these wishes are intended to do good (beneficence) and avoid harm (nonmaleficence). A child's parent usually is the most appropriate person to determine what actions will be in the best interest of the child (communication and collaboration; altruism and advocacy). Children and adolescents who desire to participate should be included in the decision-making process (patient assent) when their neurologic status, development, and level of maturity allow, although state laws that affect the minor's ability to consent to (provide legally binding authorization for) medical care are complex.[15]

### Resolving Conflicting Goals of Care

Conflicts may occur when the parent, child, and physician fail to agree on what would be optimal care under a given set of circumstances. When pediatricians and parents disagree, the pediatrician should explain the basis for the disagreement, educate the parent, and attempt to meet the child's needs within the constraints that exist. In these cases, the physician must seek to understand the reason for the disagreement and determine if the child would be put at significant risk of serious harm by following the wishes of the child and/or parent. In cases in which serious harm to a child is likely if the parent's wishes are followed, the pediatrician must get a second opinion and act to protect the best interests of the child. Institutional ethics committees should be consulted for guidance, education, and advice regarding unusual or complicated ethical problems that involve the care and treatment of children.[16]

If a physician or other health care professional is unwilling to honor a family's refusal of intervention in a situation in which the family has chosen an established alternative, he or she should withdraw from the case and must provide reasonable assistance to the parent in making alternative arrangements for care. A physician may not discontinue care of a child as long as additional treatment is medically indicated or until another physician has assumed care.

### Nondiscrimination, Societal Obligations, and Continuity of Care

The AAP believes that the medical care of infants, children, and adolescents should be delivered or directed by well-trained pediatricians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care.[17] A pediatrician has broad authority to enter into or decline a medical relationship with a family except in emergency situations. Once a relationship is established, however, the pediatrician should assume responsibility for the medical care of the child and also recognize when the child needs to be referred to a pediatric medical subspecialist, pediatric surgical specialist, or other physician or qualified clinician for diagnosis or treatment of a condition or symptom complex outside of the physician's scope of practice (self-awareness/knowledge of limits).[18]

Pediatricians or pediatric subspecialists who offer their services to the public should not refuse to accept children into their practice because of race, color, religion, national origin, disability, sexual orientation, or any other basis that would constitute discrimination (respect for others). Pediatricians should not refuse to care for acutely ill children on the basis of the ability of the family to pay for services rendered. However, practice overhead expenses preclude the provision of comprehensive health services for every child whose family requests routine or preventive health services unless there is some means of compensation. The AAP believes that the medical care of infants, children, and adolescents should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, culturally effective, and provided according to the medical home concept.[17] Pediatricians have a special obligation to work together to help secure access to health care for all children, including those who are uninsured or underinsured.[19]

Pediatricians have an obligation to refrain from providing nonbeneficial interventions and should also be good stewards of health care resources by using the most efficient means to diagnose a condition, using resources of optimal quality wisely, and helping to ensure that resources are available equitably.[5] A pediatrician may not refuse to treat a child whose condition is within the physician's current realm of competence solely because the child has a communicable disease. A pediatrician should honor requests for second opinions and should be available to provide guidance to the parents and child after they have obtained opinions from other physicians. Pediatricians and subspecialists to whom they refer their patients should make every effort to communicate effectively and in a timely manner with each other about their assessments of the patient and coordinate their treatment plans (reliability and responsibility).

### Boundaries in Patient Care

Compassionate and empathetic care for the child historically has been balanced with the need to remain objective and avoid becoming overinvolved. Boundary violations can pose a serious threat to professional judgment.[20] An increase in trust and change in bound-

aries is likely to occur as a child/family-pediatrician relationship evolves. Boundary transgressions might include abusive behaviors, sexual behavior between the physician and the patient or members of the patient's family, a physician who treats family members, and gift-giving between a family and the physician.[21–23] The development of strong empathetic and nonromantic, nonsexual feelings of affection for a patient or family do not constitute boundary violations and are deeply valued by patients and families, and it provides an opportunity for personal growth for the pediatrician.

The pediatrician may wish to continue providing care for a patient who is an adolescent or a young adult (eg, during high school and college matriculation or for older children with special health care needs) to minimize fragmentation of care. The pediatrician, the family, and the patient should discuss whether, for any reason, the patient might instead wish to change physicians. Mature patients should be encouraged to take increasing responsibility for their personal health care by communicating directly with the pediatrician and making their own appointments while informing parents of these appointments. As the new patient-physician relationship evolves, it may be appropriate to develop an option under which the adolescent can obtain confidential care if needed.[24,25]

One of the most common and difficult boundary issues occurs when a pediatrician treats his or her own family members. Because the close relationship carries a potential for the pediatrician to lose objectivity or fail to explore sensitive issues and areas with the patient, family members should be encouraged to seek another pediatrician. Exceptions include underserved areas in which there may be only 1 pediatrician, which would make this impractical, or in the case of an emergency. Regarding nonurgent care rendered to minor patients, the American Medical Association (AMA) has stated, "In particular, minor children will generally not feel free to refuse care from their parents."[19] This same concern may carry over to medical care that is provided to minors by other relatives.

Occasionally, a pediatrician may receive a gift from a patient or the parents of a patient. Small gifts given in gratitude may sometimes be accepted if they do not affect professional clinical judgment. Repeated attempts at gift-giving or the offer of expensive gifts may represent an attempt by the family to consciously or unconsciously control the patient-physician interaction. Larger or more expensive gifts are clear and serious boundary transgressions unless they are given as a charitable donation to a nonprofit institution.[26] There is also a potential conflict of interest when patients who make large contributions to medical institutions receive preferential treatment (eg, they are seen immediately, moved to the top of the operating room schedule, etc).

### Privacy and Access to Health Information

Respecting the privacy of patients and their families, including protecting the confidentiality of patient information, is a central feature of professionalism in pediatric practice. The importance of privacy has been underscored by federal regulation, known as the Privacy Rule, issued pursuant to the Health Insurance Portability and Accountability Act (HIPAA).[27,28] HIPAA was intended to create national standards to protect individual personal health information and give patients or their surrogates increased access to their medical charts.

Under the HIPAA Privacy Rule, parents have new rights to control and have access to the health information about their minor children, with limited exceptions. When a minor has the right to consent to care or a parent has agreed that the minor may receive confidential care, the minor may exercise his or her own rights to access and control protected health information. However, state or other applicable law governs if it has explicitly addressed disclosure of a minor's health information or medical charts to a parent. If state or other law does not define the parent's ability to access the child's health information, a licensed health care professional is allowed to exercise discretion to grant or deny such access.

The HIPAA Privacy Rule also dictates the need for privacy regarding patient identification that extends to inpatient rounds, patient charts, and telephone and casual conversations that formerly might have been conducted in public places such as elevators and hall corridors. Teaching conferences, computerized presentations, and radiographic exhibits all must avoid the use of patient identifiers and preferentially take place in areas where strict confidentiality can be preserved. Physicians are expected to take a leadership role in safeguarding the patient's privacy in contracts and organizational policies and procedures.[27]

### Advocacy

At the very heart of professionalism is the pediatrician's commitment to put the interests of children and their families above his or her own. Altruism may be the defining feature of professionalism and the one that is most at risk with the corporate transformation of American health care. In particular, managed care arrangements can intensify the inherent conflict between the health care interests of children and the pediatricians' financial interests.[29]

Financial incentives to reduce or limit access to care are viewed by many as particularly problematic[29,30] and are a source of growing distrust of both pediatricians and managed care organizations. Pediatricians must not allow financial considerations to affect clinical judgment about a child's health and welfare. Managed care, with its emphasis on primary and preventive care, has the potential to increase access to a full range of pediatric

clinicians and services but can also result in underutilization of appropriate services.[30]

Pediatricians must be advocates for their patients. They should facilitate access to appropriate and effective pediatric services and challenge treatment-authorization policies that delay or deny needed treatments, including mental health services, social work services, developmental evaluations, occupational and physical therapy, child life interventions, dental services, and vision, hearing, and speech and language services. It is permissible and even desirable for pediatricians to discuss their concerns about specific insurance policies with parents and to ask parents to help by bringing these concerns to the attention of their insurance companies to effect a resolution.

Pediatricians should exercise due diligence in contracting with payers to avoid assuming legal or financial obligations that would put them in conflict with the health and well-being of their patients.[31] Physicians are legally responsible for the claims submitted for their professional services and for the accuracy and completeness of information in the medical chart. Pediatricians should ensure that coding and billing appropriately reflect the level of services provided to the patient.[32] To do so, some pediatricians choose to implement compliance programs in accordance with the guidance from the Office of Inspector General.[33,34] If an insurance company is perceived to be conducting business unethically, it should be reported to the relevant state board of insurance.

As advocates, pediatricians play a necessary role in quality assurance. This may include the need to provide feedback to referring physicians. A pediatrician should make every effort to determine all of the facts in a specific case before making a judgment about the quality of care that was rendered by another physician, particularly if opinions are being sought by the parents. Generally, feedback can and should ultimately be provided in an educational and noncritical manner to both provider and parent. The pediatrician receiving feedback should recognize this is an opportunity for learning. Qualifying feedback as a source of continuing education rather than criticism will help pediatricians care for future patients. Pediatricians, pediatric medical subspecialists, and pediatric surgical specialists should all respect one another as critical partners in the optimal delivery of care.

### Information and Education

Pediatricians should inform and educate patients and parents and help them understand clinical recommendations and make informed choices among all reasonable care options and referrals. "Gag orders" or insurance policy clauses that prohibit the primary care physician from full disclosure of medical options and/or specialty referrals are never appropriate. Pediatricians are obligated to disclose the full range of medically, scientifically, legally, ethically, and practically acceptable treatment options, even those that are not included in the family's insurance coverage and those with which the pediatrician may philosophically disagree. Health plans must disclose all relevant information about benefits, including any restrictions in coverage and financial incentives that might negatively affect a child's access to care.[35,36] Descriptions should be clear, simply written, and easy for any family to understand. It remains the obligation of parents to understand their children's insurance benefits. Pediatricians cannot and should not be expected to counsel parents on the details of their insurance plans. Parents bear the ultimate responsibility to understand who and what is covered or not covered. In the inpatient setting, social workers and case managers often can assist with these issues.

### Appeals Processes

Patients and families should have access to fair appeals processes, and pediatricians should be child advocates within that system. However, health plans are not obligated to pay for treatments that are not justifiable on clinical or scientific grounds even if some patients might desire them. Pediatricians should take an active role in the development of practice guidelines and familiarize themselves with the attributes/recommendations that will enable them to distinguish medical management guidelines that are based solely on cost/utilization data from those that are based on scientific evidence.[37]

## MEDICAL SCHOOL TEACHING FACULTY RESPONSIBILITIES TO RESIDENTS AND STUDENTS

The obligations of medical school academic and clinical faculty to residents and students should include:

- Instructional development of academic competency—adequate, up-to-date academic preparation of residents and students to be competent and ethically responsible pediatricians.
- Modeling appropriate behaviors—using systems or standards that nurture professionalism, interdisciplinary collaboration, respect, and partnership with child and family, including a humane working environment.
- A caring and compassionate environment for learning—active involvement in bedside teaching, with fostering of an appropriate learning environment, including faculty treatment of residents and students.
- Fair assessment processes—fair assessment of professionalism, including remedial education, and one-on-one direct oversight with interim evaluations if there are problems.

### Communication

Pediatric training should focus on providing a core foundation of knowledge, attributes, skills, and competencies to all pediatric residents regardless of their future career paths. Communication is a key element of medical practice. Clinicians should be capable of effective, respectful, and compassionate 2-way communication with patients, parents, and other members of the health care team. Health care communication must be formally taught, learned, and evaluated. Students and residents should be taught the principles of cultural effectiveness to enhance their understanding of the child and family in the context of the medical home.

### Modeling Appropriate Behavior

Within pediatric training programs, residency program directors and pediatric faculty members must model the professional behavior they seek to instill in their trainees. Recently, both informal and formal residency curricula have become more challenging as a consequence of the 80-hour workweek limitation on house officers. Opportunities to model behavior can occur in the clinic, at the bedside, on the telephone, or in the patient's chart. Being able to communicate clearly in the medical chart and document medical care concisely and correctly are equally important as verbal communication with families, patients, physicians, and other health care professionals. Medical liability risk managers have described this as an area of professionalism that is in need of improvement and recommend use of the acronym OLFACTORY to help physicians improve their documentation skills: O = original, L = legible, F = factual, A = accurate, C = consistent, T = timely, O = objective, R = rational, and Y = yours.[38]

Clinical teachers must teach by example and be capable of demonstrating how to manage difficulties that occur in relationships with patients, medical staff, or colleagues; effectively and compassionately communicate with patients, families, colleagues, and members of the interdisciplinary team; gracefully and honestly acknowledge errors; confront poor practice in a colleague or trainee; and explain to children and parents when things have "gone wrong." Mentors of pediatric house officers and medical students should be aware of the process of socialization that exists and the various ways that trainees learn and internalize professional and humanistic values, attitudes, and behaviors. Students and residents may be more influenced by what is known as the "hidden curriculum" (what is taught by observing the daily behavior of health care professionals, both good and bad) than by formal training in ethics, although formal curricula in both ethics and professionalism are still valuable.[39] When pediatricians behave in ways that are contrary to ethical standards taught in formal courses, they reinforce the view that medicine is a profession that lacks integrity.[40] Perhaps more importantly, when pediatricians keep silent in the face of inappropriate behavior, the implication is that the status quo is acceptable, and the opportunity to discuss the professional behavior in the clinical context is lost. Currently, unprofessional and unethical physician behavior is often tolerated when it should not be. Students and residents should be encouraged and advised to evaluate faculty members as teachers of ethics, knowledge, and attitude, and faculty members should be encouraged to evaluate each other on the basis of professionalism as well as academic productivity.

### Caring and Compassion

Caring and compassion are central to the effective practice of pediatrics. Students and residents must be taught to attend to the emotional, spiritual, and practical realities of illness and its effects on children and families as well as themselves.[41] Historically, medicine has defined its mission in terms of "curing" disease while overlooking illness (ie, the patient's experience of disease). Patients and families require a caring physician who is empathetic and strives to understand the illness experience of each child and affected family. How does one teach or remediate sensitivity and caring? Personal reflection, small-group discussions,[42,43] participation in family conferences, and longitudinal experiences with families who are living with chronic illness[44] are all examples of key strategies that may be used in nurturing professionalism among trainees. More focused methods include role modeling, one-on-one discussion, closer supervision, observation of resident interactions with families under stressful situations, and feedback sessions in which the resident specifically asks for guidance about how they could or should have handled difficult interactions with parents or patients.[45] Exposure to parent panels, former patients, and siblings of patients through small-group discussion; support group attendance; grand-rounds formats; use of standardized patients in teaching venues; and supervised role-playing are other ways.[46]

Because students and residents develop their professional identities over time, professionalism should be viewed as a developmental process across all stages of a medical career.[47,48] More emphasis on stress management is essential, and incoming residents might benefit from improved orientation regarding the demands of residency and ways of coping. In addition to learning how to care for others, young physicians also must learn to care for themselves.[49] Those who have their personal needs met are, in turn, more supportive of their patients' and families' needs,[50] and this self-nurturing will promote the ability to show compassion and empathy for others.[45] Those who create pediatric training programs need to be mindful of the ways that students and residents are treated. It is more likely that pediatricians in training will become caring and compassionate toward

their patients if they feel that they are treated in a caring and compassionate manner.

### Fair Assessment Processes

Students and residents are expected to treat patients, families, medical staff, and colleagues fairly. In return, they must be treated fairly in the educational system. This will require developing clear expectations for performance, providing adequate opportunities to learn expected competencies and receive clear and frequent feedback, and providing remediation when necessary.[3,51–53] There should be a safe mechanism for students and residents to appeal evaluations with which they disagree, including those related to professionalism.

Documentation of deficiencies, mentoring, and personal counseling sessions are critical in the process. The principles and practice of professionalism that are being taught must be in place continually during the process of counseling and remediation. It is inappropriate for training directors and medical school faculty members to allow residents who have failed to develop appropriate professional skills despite counseling and remediation to complete the training program and qualify for the ABP examination process.

## PEDIATRICIANS' RESPONSIBILITIES TO OTHER HEALTH CARE PROFESSIONALS: TEAM RESPECT AND COMMUNICATION

Pediatricians must treat each other and all other health care professionals with integrity, honesty, and respect in their daily interactions, because effective patient care depends on effective team functioning.[54] All health care professionals share a primary bond in their mutual ethical concern for patients. Respectful treatment includes being truthful and responsible, following through on commitments, honoring the expertise of other health care professionals, being open to learn from others, and being collaborative in patient care. Pediatricians should raise concerns about trainees, colleagues, and individual health care professionals directly with the relevant parties instead of verbalizing issues in front of patients, families, and/or staff. There should be no tolerance of verbal or physical abuse on the part of either physician or staff members, because it undermines credibility and effectiveness with patients and other health care professionals.

Pediatricians also have obligations to provide appropriate supervision and referral. The AAP acknowledges the crucial role that nonphysician health care professionals play in pediatric care and stresses the importance of working collaboratively with nurses, social workers, chaplains, nurse practitioners, physician assistants, and others.[55,56] Pediatricians should respect the contributions of other health care professionals but also acknowledge the appropriate limitations and roles of these professionals. The AAP states that the relationship among pediatric professionals is one of interdependence.[56] Incorporation of the input of these colleagues into the plan of care instead of treating it as separate and unrelated ensures effective, coordinated care.

Sexual harassment in the workplace and in educational settings creates an environment that demeans people and has a negative effect on individual performance and effectiveness as well as organizational productivity and unit morale. It is incumbent on employers, organizations, and institutions to represent all their constituents, male and female, and provide education and guidance that discourages this destructive behavior. In particular, medical schools and training programs must be aware of the prevalence of the problem and have action plans available.[57]

## PEDIATRICIANS' RESPONSIBILITIES TO THE PROFESSION

### Peer Review

Professional self-regulation is a privilege, not a right, and has to be earned continuously to sustain public confidence in the profession.[58] Work toward a system of medical regulation that combines professional, organizational, and patients' perspectives should be aimed at making the medical profession accountable for its performance.

The use of explicit standards (such as clinical practice guidelines that are based on evidence evaluation), the adoption of collective and personal responsibility for observing standards of practice, effective local medical regulation that is based on quality reviews, a systematic process for ensuring continuing medical education, and swift and effective strategies for dealing with physician misconduct are integral to maintaining a professional practice.

Ironically, science and technology have provided the medical profession with powerful tools that empower and enable physicians to extend and improve quality of life while exposing patients to the potential for iatrogenic harm.[13] Although members of the public appreciate what medical technology can achieve, they also have heightened awareness of the risk of medical errors[59] and the historic reluctance of the medical profession to admit to these errors. Professionalism demands that each health care professional know and accept his or her own limits. It is our responsibility to be open about risks and variations in performance, to communicate effectively, to act promptly to protect pediatric patients from poor practice, and to admit to the errors that are an expected and everyday occurrence in judgment-based clinical decision-making.[13,60]

There is a general reluctance of doctors to report colleagues whose performance falls below a minimum standard because of a lack of absolute clinical guidelines, the question of what constitutes an acceptable degree of variation in practice and outcome, the influence of case mix on outcomes, and other variables. Poor performance

or substandard performance can have protean causes including stress, burnout, the effects of physical or mental illness, death of a loved one, chronic fatigue, communication or systems-of-care failure, and others. Examples include lack of attention to detail, failure to return telephone calls or pages in a timely fashion when on call, or failure to follow-up with families regarding test results when promised. Addressing these issues requires active intervention tempered by concern, compassion, and understanding, because the primary professional obligation of patient safety is at stake.

Clear evidence of what constitutes poor or unsafe practice is more certain and widely recognized. Examples include practicing medicine under the influence of drugs or alcohol or with untreated mental health disorders, falsifying medical information, or intellectual dishonesty with colleagues or patients.[19] Physicians have an ethical obligation to report such behavior in accordance with the legal requirements in each state, and the profession should show its determination to confront poor practice. Alcohol or drug impairment should be reported to the hospital's in-house impairment program, the chief of pediatrics, or the chief of the hospital staff. Some medical societies or state licensing boards have external impaired-physician programs to which individuals can be referred. Issues of incompetence and remediation should be addressed by the appropriate clinical authority. The hospital peer-review body should be notified when appropriate, and sentinel events should be discussed thoroughly and reported to the Joint Commission. A sentinel event is defined by the Joint Commission as an unexpected occurrence that involves death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Incompetence that poses an immediate threat to the health of children should be reported directly to the state licensing board. Physicians who are under investigation or have been charged should be protected from destructive gossip and rumors, and communication should be governed by the rules of confidentiality until such charges are proven or the physician is exonerated.

We are in the midst of a professional evolution in which the language of professional quality review and improvement is replacing professional solidarity. Medical societies' ethics committees, hospital credentials and utilization committees, morbidity and mortality reviews, and other forms of peer review have long been established by organized medicine to scrutinize physicians' professional conduct. Pediatricians in both academic and private practice should welcome and support these methods of ensuring good medical practice. They balance the pediatricians' right to exercise medical judgment freely with the obligation to do so wisely, compassionately, objectively, and temperately.[19] They also demand acceptance of the tenet that mistakes happen, can affect any system and, thus, involve any doctor, have to be discussed openly, and provide critical opportunities for learning and creating systematic improvement. In states where peer review is considered "discoverable" by state law, which allows physicians who are engaged in good-faith peer-review activities to be sued after case review, the peer-review process is undermined by the lack of confidentiality, and the effectiveness of peer review is limited.

### Medical Testimony

Pediatricians are often called to court to testify on behalf of children in cases of suspected abuse and/or neglect. Whether as expert witnesses or witnesses of fact, pediatricians have ethical obligations to give honest, objective, and accurate information and should not accept a commitment as an expert witness outside their defined area of expertise. When medical malpractice is an issue, an expert witness is key to ensuring a fair hearing for the physician in question as well as for the patient and family. The AAP has articulated recommendations for pediatricians who provide expert witness testimony in medical malpractice cases.[61] It is unethical for expert witnesses to base their fees for testifying contingent on the outcome of the case.[62,63] Reliable, objective, and accurate expert witness testimony and a truthful analysis of the standard of care are extremely important in pediatric cases in which juries can be manipulated out of compassion for injured children and their families.[61]

A witness of fact who, in the case of medical malpractice, is the treating physician, whether as the defendant or the previous or subsequent treating physician, has an ethical obligation to be adequately prepared and to testify honestly and truthfully to the best of his or her medical knowledge. A witness of fact is not to be an advocate or a partisan in the legal proceeding.

## PHARMACEUTICAL AND OTHER INDUSTRIES AND POTENTIAL CONFLICTS OF INTEREST

Issues of professionalism and the integrity of the profession as a whole are raised when pediatricians are the recipients of special marketing incentives such as gifts and other perquisites from representatives of the health care industry. Such behavior challenges the physician's clinical objectivity[64,65] and poses a conflict of interest between the patient's welfare and the physician's financial interests. Also, issues of justice are raised as the increased costs of marketing are passed on to children and their families. Despite these concerns, the AMA acknowledges the fact that gift-giving has been a customary practice in medicine with a beneficial educational and service function to physicians and patients. The AMA recently launched an initiative to educate physicians and members of the health care industry

about the AMA guidelines on appropriate gifts from industry. The AAP has endorsed the AMA guidelines regarding gifts to physicians from industry. The AMA guidelines do not prohibit gifts outright but offer 7 basic guidelines for their appropriateness[66]:

- Any gifts should primarily entail a benefit to patients (eg, education to improve patient care) and should not be of substantial value.
- Individual gifts of minimal value should be related to the physician's work (eg, pens, notepads).
- Meetings should be primarily dedicated, in both time and effort, to promoting scientific and educational activities and discourse.
- Subsidies for meetings should be accepted by the conference's sponsor, not individual participants.
- Subsidies should not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences, including compensation for the physician's time.
- Scholarship funds are permissible as long as the selection of students is made by the academic or training institution.
- No gifts should be accepted if there are "strings attached."

The American College of Physicians took a slightly different approach in its ethics manual,[50] and strongly discouraged the acceptance of all types of individual gifts, hospitality, trips, and subsidies from the health care industry. The American Medical Student Association took the toughest policy stand on gifts from the health care industry and advocated for outright prohibition. Their recently initiated PharmFree Campaign urges medical students to take a pledge to accept no money, gifts, or hospitality from the pharmaceutical industry; to seek unbiased sources of information; and to avoid conflicts of interest in their medical education and practice.[67]

The Compliance Program for Pharmaceutical Manufacturers of the Office of Inspector General provides clear examples of the expectations regarding the manufacturers' conduct and relationships with purchasers, research funding for educational programs, and potential conflicts of interest.[68] It is advisable for physicians to heed this guidance as it pertains to the professional relationship between physicians and representatives of pharmaceutical manufacturers.

## SUMMARY

The provision of health care in contemporary society is increasingly complex. Pediatricians are being asked to care for more patients with more complicated medical and social histories, using more technology, and often with less time and compensation for the care of each patient. The degree of bureaucratic oversight is growing exponentially. In the practical sense, this leaves pediatricians at risk of losing sight of what called them into the health profession in the first place—a desire to care for children and their families. This report outlines the key components of professionalism in pediatric practice in the belief that an emphasis on core professional values will serve as a moral compass in these turbulent times and will invigorate pediatric practitioners with the enthusiasm to strive to provide the quality care to which they committed and for which they trained and sacrificed when they began their medical careers.



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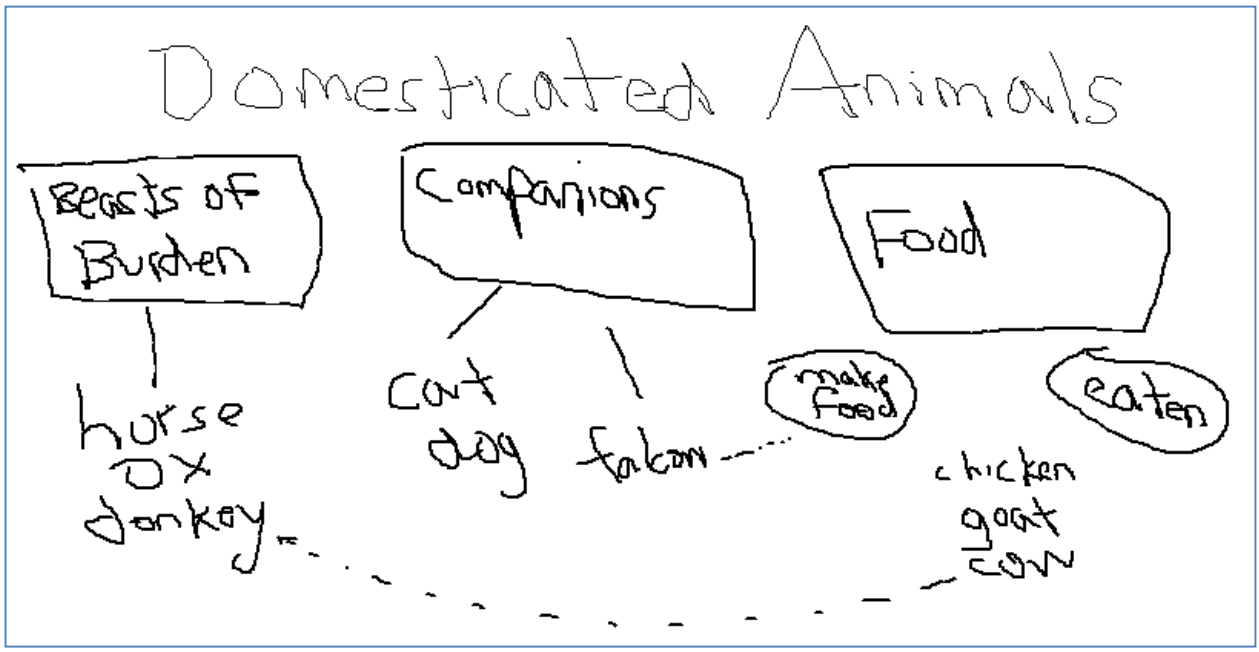
Outline categories of professional behavior here. As an example, this outline of categories of a wholly unrelated topic is provided.



| *Category* | *Examples* | *Example from State Medical Boards* |
|---|---|---|
| professional competence | continued education<br>reading<br>practicing sound clinical decision making | |
| professional responsibilities | being available and competent for assigned duties, avoiding substance abuse, not drinking while on duty, seeking appropriate medical and mental health when incapacitated, keeping superiors, subordinates, and other providers informed, following institutional policies, maintaining licensure, privileges, and certification | |
| honesty with patients | giving patients an honest assessment of their condition<br>fully disclosing adverse effects of medications | |
| patient confidentiality | not disclosing sexual activity by a teenager<br>careful use of voicemail when calling with results<br>keeping patient identifiable papers out of the open | |
| maintaining appropriate relations with patients | not prescribing medications for family members, sexual relations with parents or patients | |
| improving quality of care | participating in performance improvement, keeping up to date on clinical matters, seeking and acting on constructive feedback | |
| primacy of patient welfare | going home when sick and at risk of transmitting disease to patients, assuring adequate and competent follow-up and coverage of patients when you have a personal life commitment, preventing administrative forces from compromising patient welfare | |
| scientific knowledge | not falsifying research data, reading and keeping up to date | |
| improving just distribution of resources | practicing evidence-based medicine, avoiding ordering expensive, unproven diagnostic studies or therapies | |
| improving access to care | addressing educational, cultural, and socioeconomic class barriers to care | |
| maintaining trust by managing conflicts of interest | disclosing conflicts of interest when treating patients or conducting research | |

Discussion Prompts:

- What challenges do social media and "the business of medicine" bring to professionalism?
- Three important conflict areas that contribute to distrust of our profession are lack of access to care, research scandals, and the replacement of professional standards of conduct with "business" standards of conduct. (paraphrased form the *PIR* 2020 article). Do you agree or disagree? Can you think of any other conflict areas?
- Also from the article, "The promotion of wellness is the promotion of professionalism." What does this mean? Is wellness the same thing as professionalism? Is wellness a necessary but insufficient component of professionalism?
- How do competence and humanism each contribute to the ability to provide safe, effective, and ethical care?

If residents are at a loss for their own real-life examples when their professionalism was challenged, consider looking at the vignettes that start on page 13 of the APPD "Teaching and Assessing Professionalism" document or doing the quiz and the end of the *Pediatrics in Review* article.