

Virtual Mentor

American Medical Association Journal of Ethics

September 2002, Volume 4, Number 9: 251-282

Helping an Impaired Peer

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Virtual Mentor

American Medical Association Journal of Ethics
September 2002, Volume 4, Number 9: 253-255.

FROM THE EDITOR

Reflections and Rantings of a Crazy Uncle

Audiey Kao, MD, PhD

It is that time of year again.

Millions of birds from thousands of species such as the black-throated green warbler and the dark-eyed junco are beginning their southern migration. No two species follow exactly the same path from beginning to end, but the ultimate objective of each member of the migratory bird family is the same—embarking on an arduous journey to its winter home. What triggers birds to begin their journey? How can they travel and endure such long distances? How do they know where to go? These questions have mystified people from the earliest times as seen in the writings of Homer and Aristotle. And while we have a better understanding of bird migration, there remain mysteries about this journey that maybe only the birds will ever know.

That ringing, that constant ringing, I can't get this incessant noise out of my head. Wow!!!!!! There go 4 birds in migratory formation. Oddly enough, as I am scratching out this story, birds of an unnatural variety are jetting outside my high-rise office window. It is that time of year again. Jets are buzzing the Chicago skyline—flying advertisements for the 2002 Chicago Air and Water Show. Did you know that the Chicago Air and Water Show is the oldest and largest free admission air and water exhibition of its kind in the United States? More than 2 million "birdwatchers" come out each year to see civilian and military craft perform their acrobatics on water and in the air.

It is that time of year again.

Thousands of members of a rare species, the green-chested medical student, are taking their initial steps towards becoming physician healers. What continues to motivate confident, yet inexperienced "young" people to embark on such an endeavor? How will they endure and persevere during this long journey? When confronted with hard choices, will they know which is the right path? These questions challenge, in part, the personal character and social support of each student. But, more importantly, as each new member is welcomed into the professional family of physicians, the answers to these and other questions often lie with the clan "elders" who have taken this journey before them. If you are a member of this species, seek out an elder in your school, and you will be the better for it. *That incessant buzzing, I can't take it any more. Dang, today's young people*

show less respect for the experiential wisdom of their elders, and feel a greater sense of entitlement for everything. Oh get off your high horse, to get respect you have to show respect. Buzzzzzzzzzzzzzzzzzzzz.

"Did you see Uncle Aud (pronounced "odd") with his plaid sport coat and lime green pants? Oh god, not another family picture."

A family is not genuine unless there is something dysfunctional about it—we all have a "crazy" uncle (or aunt or some eccentric or offbeat member) in our families. The expectations, roles, rituals, and idiosyncrasies of a professional family of physicians are much the same as those in a family related by blood. In a blood family, parents should know what is in their children's best interest. In the family of physicians, teachers must be responsible for properly educating and mentoring students on what it takes to be a good doctor. In a biological family, the conduct of 1 member reflects on the whole. In a professional family, the conduct of 1 member reflects on the whole. A family's teenagers rebel. Our profession's students and residents are increasingly more rebellious about issues ranging from student debt to residency work hours. Parents in a family need to know when to let their children make their own decisions. Medical faculty and administrators need to be responsive to the issues raised by students and residents, but they also must realize that medicine is a profession, and not an occupation. Uncle Aud, what about children who are adopted? *Buzzzzzzzzzzzzzzzzzzzz, that incessant buzzing, I can't stand it anymore.* A family, related by blood or choice (adoption), doesn't hang out its dirty laundry for all to see. As a professional family, we, too, want the world to see only our good side. But in medicine, there are third parties—our patients—who can be harmed, and if we do not do an adequate job in self-regulation, then the public deserves to see our dirty linens. Remember young Skywalker, the action of 1 reflects on us all.

"Don't make me stop this car."

Remember those family trips you took as a kid. It is not hard to imagine what would happen when you combine 6 kids, 2 parents, 1 family station wagon during a long road excursion. When my parents took us on vacation, the calm and mature discourse in the family car—yeah, right—was a mix of Chinese and English. But nothing was said in the car that needed to be censored. *Oh that (bleep) buzzing, I can't stand that (bleep) buzzing.* As you start on your new and exciting road trip through medical school, remember to keep both arms inside the car, trust the driver, yell out when you need to stop for . . . anything, and be confident that you will eventually arrive at your destination.

I love you.

I don't know.

Are we there yet?

I hate you.

I am sorry.

I trust you.

Buzzzzzzzzzzzzzzzzzz.

Audiey Kao, MD, PhD is the editor in chief of *Virtual Mentor*.

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Virtual Mentor

American Medical Association Journal of Ethics
September 2002, Volume 4, Number 9: 256-259.

CASE AND COMMENTARY

An Impaired Resident, Commentary 1

Commentary by Erin Egan, MD, JD

Case

Steven and John are second-year residents in internal medicine at a major urban hospital. They have been friends since medical school and became closer while sharing long shifts during their intern year.

Over the past few weeks, John has not been himself. Steve thinks John has looked more sleep-deprived than the usual resident does, and that he might even appear tearful at times. John hasn't been joining the other residents for lunch and, when he has, Steve notices that he doesn't eat very much. Concerned, Steve realizes that John has been somewhat withdrawn for several months now. Previously, John, Steve, and Steve's wife Maria often went out to dinner or got together in the evenings, but John had declined the past few invitations. Steve has been passing off John's new behavior as the "winter blues" combined with the normal ups and downs of residency training. The R2s have been working as many hours as they did as interns, so Steve didn't make a big deal out of the fact that John didn't have time to hang out.

Last week, Steve saw the normally friendly and even-keeled John growl at a medical student and then yell at a nurse on the unit. Afterwards, he heard the nurses complain that John seemed distracted, hard to locate sometimes when they needed him, and had yelled at them about some missing lab results when it was he who had forgotten to order them in the first place. John had also been asking them for the correct dosages of commonly prescribed medications. In fact, John's behavior seemed so unpredictable and difficult of late that one nurse on the unit was asking for a transfer.

When Steve asked John whether everything was okay, John replied, "Yeah, fine." When Steve pressed a little about John's mood, John became defensive. "What, I'm supposed to be cheerful, too? Just because I'm not here 15 minutes before everyone else, and I ask some questions before charging ahead with treatment, suddenly the attending is all, "'You'd better shape up, Dr. Masterson.' Whatever."

Steve began thinking John must be depressed, or at least that John should talk to someone about his dissatisfaction with how things were going. Since he had been ignoring his friends, Steve wondered how willing John would be to accept help. Steve even found himself worrying about John's patients.

On the other hand, Steve thought that he might be making too much of what was just a bad mood. And he worried about the potential harm he could do to John's career by mentioning the situation to the residency director. Steve had heard that state medical boards require psychiatrists to turn over records of doctors whom they saw as patients. He also thought about the negative image many in the hospital had of mental illness (or any weakness in general) among residents. He didn't want to paint John as deficient just because he had a bad week.

Finally, Steve brought up the topic with Chris, another resident, and a mutual friend of his and John's. Chris said, "Oh, man, I wouldn't touch that with a ten-foot pole"

"If he was drinking or doing drugs, would you do something?" Steve asked.

"Yeah, but there's a difference."

"What's the difference?" asked Steve. "He's actin' weird. He's making mistakes. You want to wait til someone gets hurt? What if John gets hurt?"

"Yeah, but if you label him as a psych case, he'll never get a job. Hell, he may not get a license."

"And if he screws up and causes harm to somebody?"

Chris did not respond. Great. Steve was more confused than before.

Commentary 1

Residency is a time of physical, emotional, financial, and intellectual stress. Each resident reacts differently, but all experience times when their reactions to the stress affect their behavior. The emotional and cognitive behavior disturbances that occur in residency have been well documented. Residents report mood swings, appetite disturbances, depression, and increasing cynicism.¹ They frequently report feeling burned out and admit that this emotional state affects the patient care they provide.² Sleep deprivation is increasingly recognized as a cause of impairment and error.³ All of this indicates that residents (and almost everyone else) are regularly expected to perform their clinical duties with some degree of impairment at least some of the time. It is hard to say when an individual resident has crossed the line from the normal reaction to residency training to being dangerously impaired.

Physicians have a duty to report impaired or incompetent physicians. This duty is reflected in professional codes of ethics and is reinforced in medical ethics training.^{4,5} However, beyond impairment due to substance abuse, there is little guidance as to what constitutes impairment or incompetence. Deciding when another resident is dangerously impaired is a difficult call, largely left to the judgment and conscience of each physician. Residents already have anxiety about their clinical decision making skills and responsibility, and making this type of

judgment about a colleague can be overwhelming. On the other hand, it is essential that residents be willing to take proper ethical action when the behavior of a colleague becomes alarming. Because residents work together and depend upon one another, they will be the first to notice problems in other residents' clinical performance. Residents are therefore the first warning mechanism when patient safety is threatened by a resident's impairment.

Patient safety is the crucial issue. Issues of professionalism are extremely important, and if a resident is behaving inappropriately toward other providers or ancillary staff some action must be taken. But when patient safety is at issue the problem takes on a special urgency.

The first step in determining what to do in this month's clinical case requires that Steve decide whether he believes John's behavior is a threat to patient care. If so, then Steve has no choice but to go to the program director immediately. The fact that Steve is aware of specific instances of errors and omissions probably means that there are many instances that he is not aware of. As painful as it is, and regardless of the possible effect of John's career, if patients are even possibly at risk, there is no excuse for any delay.

If patient safety is not immediately threatened, Steve has time to look at a few other options. Getting feedback from others is helpful. It may help Steve feel more comfortable that he is doing the right thing, and it may open up options that Steve had not previously considered. There may be resident support services at the hospital, or a counselor that John can talk to. Chief residents are also a resource for this type of conflict.

One concern that Steve has is that John's career may be affected. There are 2 perspectives on this that may help. First of all, John's career may be enhanced if he needs help and gets it now. Certainly John will have better career options if he is not seen as difficult to work with and unprofessional. In addition it is unlikely that John's career would be affected by alerting the program director to the problem. Most programs understand that residents are under a huge amount of stress, and that other aspects of a resident's life may make that stress temporarily unbearable. Program directors have avenues to deal with these kinds of problems that have no long term effect on a resident's career. If Steve waits until others report John's behavior, early interventions may no longer be available. Steve may best protect John's career by alerting the people who are in a position to help John.

Residency training is a difficult time. Every resident will experience some degree of impairment due to stress or sleep deprivation. Other residents are an important support system when stress becomes overwhelming. Sometimes problems are severe enough that additional action must be taken. When those situations arise, residents must act to protect patients' welfare. Ultimately the decision to intervene is matter of conscience and personal integrity. These problems are present at all levels of medical practice and they do not become any easier to address. The ethical

duty to report impaired colleagues is part of the price of being a professional, and the duty is to patients, not colleagues or friends.

References

1. Collier VU, McCue JD, Markus A. Stress in medical residency: status quo after a decade of reform? *Obstet Gynecol Surv.* 2002;57(8):496-497.
2. Shanafelt TD, Bradley KA, Wipf JE. Burnout and self reported patient care in an internal medicine residency program. *Ann Intern Med.* 2002;136(5):358-367.
3. Weinger MB, Ancoli-Israel S. Sleep deprivation and clinical performance. *JAMA.* 2002;287(8):955-957.
4. Opinion 9.031 Reporting Impaired, Incompetent, or Unethical Colleagues. American Medical Association. *Code of Medical Ethics 2008-2009 Edition.* Chicago, IL: American Medical Association; 2008:300-302.
5. Synder L, Morin K, eds. *Ethics Manual.* 4th Ed. Philadelphia: American College of Physicians; 2000.

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Virtual Mentor

American Medical Association Journal of Ethics
September 2002, Volume 4, Number 9: 260-263.

CASE AND COMMENTARY

An Impaired Resident, Commentary 2

Commentary by DeWitt C. Baldwin, Jr, MD

Case

Steven and John are second-year residents in internal medicine at a major urban hospital. They have been friends since medical school and became closer while sharing long shifts during their intern year.

Over the past few weeks, John has not been himself. Steve thinks John has looked more sleep-deprived than the usual resident does, and that he might even appear tearful at times. John hasn't been joining the other residents for lunch and, when he has, Steve notices that he doesn't eat very much. Concerned, Steve realizes that John has been somewhat withdrawn for several months now. Previously, John, Steve, and Steve's wife Maria often went out to dinner or got together in the evenings, but John had declined the past few invitations. Steve has been passing off John's new behavior as the "winter blues" combined with the normal ups and downs of residency training. The R2s have been working as many hours as they did as interns, so Steve didn't make a big deal out of the fact that John didn't have time to hang out.

Last week, Steve saw the normally friendly and even-keeled John growl at a medical student and then yell at a nurse on the unit. Afterwards, he heard the nurses complain that John seemed distracted, hard to locate sometimes when they needed him, and had yelled at them about some missing lab results when it was he who had forgotten to order them in the first place. John had also been asking them for the correct dosages of commonly prescribed medications. In fact, John's behavior seemed so unpredictable and difficult of late that one nurse on the unit was asking for a transfer.

When Steve asked John whether everything was okay, John replied, "Yeah, fine." When Steve pressed a little about John's mood, John became defensive. "What, I'm supposed to be cheerful, too? Just because I'm not here 15 minutes before everyone else, and I ask some questions before charging ahead with treatment, suddenly the attending is all, "'You'd better shape up, Dr. Masterson.' Whatever."

Steve began thinking John must be depressed, or at least that John should talk to someone about his dissatisfaction with how things were going. Since he had been ignoring his friends, Steve wondered how willing John would be to accept help. Steve even found himself worrying about John's patients.

On the other hand, Steve thought that he might be making too much of what was just a bad mood. And he worried about the potential harm he could do to John's career by mentioning the situation to the residency director. Steve had heard that state medical boards require psychiatrists to turn over records of doctors whom they saw as patients. He also thought about the negative image many in the hospital had of mental illness (or any weakness in general) among residents. He didn't want to paint John as deficient just because he had a bad week.

Finally, Steve brought up the topic with Chris, another resident, and a mutual friend of his and John's. Chris said, "Oh, man, I wouldn't touch that with a ten-foot pole"

"If he was drinking or doing drugs, would you do something?" Steve asked.

"Yeah, but there's a difference."

"What's the difference?" asked Steve. "He's actin' weird. He's making mistakes. You want to wait til someone gets hurt? What if John gets hurt?"

"Yeah, but if you label him as a psych case, he'll never get a job. Hell, he may not get a license."

"And if he screws up and causes harm to somebody?"

Chris did not respond. Great. Steve was more confused than before.

Commentary 2

There are four basic questions here.

1. What is going on with John?
2. What is causing it?
3. How aberrant is it?
4. What can/should Steve (or others) do about it?

Is John behaving in an impaired manner? Of course he is! His friends and fellow residents, Steve and Chris, as well as the nurses and medical students have all noted and even commented on it. And it will probably not be long before his attendings become aware of it, if they are not already. Is it unusual? From what we are told, it seems to be unusual for him. He simply is not behaving the way he usually does both at work and away from work.

Is such impaired behavior unusual among sleep-deprived and overworked residents? Not at all! Over half of the PGY1 and PGY2 residents in a recent national survey reported that they had worked at least once during the past year while in an "impaired condition", ascribing it largely to sleep loss and overwork.¹

Should we be concerned about his behavior? Absolutely! If he continues to do the things he is doing, the care of his patients is going to suffer and the chances of a medical mistake appear likely. Steve's concern for his friend and colleague is well founded. And even Chris knows that John is heading for trouble, but is fearful of the traditional "marine corps" mentality of medicine that admits of no "weakness or failure."

But is this all that's going on? No! He is also clinically depressed. In addition to showing some of the types of impaired behavior that many residents may show under conditions of sleep deprivation and stress, he also exhibits some classical symptoms of depression: social withdrawal, loss of appetite, mood disturbances, mental distraction, sleep loss, cognitive impairment, and emotional outbursts that are not typical of him.

Is this unusual? Again, not at all! Many studies have described the serious physical, psychological, and emotional consequences of prolonged sleep deprivation, fatigue, and stress during residency.¹ In one report, more than 30 percent of residents were found to be clinically depressed during their PGY1 year.² In the past, many such residents simply "toughed it out" or self-medicated.

What should/can Steve (or others) do? Since the situation appears to be deteriorating and clinical depression is eminently treatable, it would seem to be a friendly and collegial act to assist John to get some relief from the symptoms that must surely be disturbing to him as well. Indeed, not reporting behavior of a colleague that could potentially result in harm to a patient is unethical, since it violates the fundamental fiduciary responsibility of physicians to their patients. Allowing John to continue to "screw up" clinically also is unfair to him as well as to his colleagues and patients.

While Chris may feel concerned about the possible negative professional consequences of getting help for John, most residency directors today have been sensitized to the effects of prolonged sleep deprivation and fatigue during residency, and confidential systems for referral and treatment are nearly always available without prejudice. Talking to a sympathetic and trusted faculty member, or to the program director, or even the director of medical education in the hospital, is probably the best way to start the process if John cannot accept the fact of his impaired and potentially harmful behavior and seek help himself.

As far as stigmatizing John with a psychiatric diagnosis, his depression, while clinically real, seems fairly recent and largely situationally determined. As such, it can probably be treated as well by an experienced internist or generalist as by a psychiatrist. Since medication for depression may take a few weeks to become fully effective, a brief medical leave may be considered. However, recognition and acceptance of the problem, together with good medical treatment and collegial support, should make such a disruption unnecessary. As for Chris' concerns about how this could affect John's future licensure, since depression is frequently treated

by other than psychiatrists and is such a common problem among residents, I believe there is little substance to his worries about John's having a psychiatric record that would be of concern to a State Medical Board.

References

1. Shanafelt TD, Bradley KA, Wipf JE, Back AL. Burnout and self-reported patient care in an internal medicine residency program. *Ann Intern Med.* 2002;136(5):358-367.
2. Valko RJ, Clayton PJ. Depression in the internship. *Dis Nervous Sys.* 1975;36(1):26-29.

DeWitt C. Baldwin, Jr, MD trained in pediatrics, psychiatry, and family medicine and has held professorial rank at 9 medical schools, 2 of which he helped to start. He currently serves as scholar-in-residence at the Accreditation Council for Graduate Medical Education (ACGME), where he continues to research and write about the working and learning environment of medical students and residents.

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Virtual Mentor

American Medical Association Journal of Ethics
September 2002, Volume 4, Number 9: 264-267.

CASE AND COMMENTARY

Conflicting Views of Medical Necessity: The Moran Case

Commentary by Ben Berkman

Ann Smith participates in an HMO through her husband's employer. Suffering from pain, numbness, and loss of strength in her right shoulder and arm, she decides to visit her primary care physician (PCP), who diagnoses her with carpal tunnel syndrome and recommends a conservative course of physical therapy. Ann completes the physical therapy, but does not see any improvement in her condition. In fact, her condition has worsened to the point that she can barely use her right arm.

Fearing that she was misdiagnosed, Ann researches other possible medical explanations for her condition. She finds an out-of-network specialist and self-pays for the consultation. The specialist believes that Ann has thoracic outlet syndrome, a condition where a bone compresses nerves in the neck, slowly damaging the nerve. There is an inexpensive treatment to relieve pressure on the nerve, but this method only provides temporary relief. The specialist has developed an unconventional treatment called "microneurolysis" where, in addition to relieving the pressure, the surgeon repairs the patient's injured nerve. Based on the likelihood that microneurolysis would provide a more permanent solution with a better chance of preventing irreversible nerve damage, the specialist recommends the \$98,000 microneurolysis surgery to Ann.

After extensive review of Ann's medical record and the neurosurgeon's procedure and results, Ann's PCP is convinced that the microneurolysis procedure will provide the best remedy for Ann's disorder. The HMO medical staff decision makers do not concur that the surgery is medically necessary and authorize only the cheaper surgery provided by an in-network physician. Ann challenges the ruling, but after an internal appeal her claim is still denied.

Questions for Discussion

1. As the PCP, how do you balance your responsibilities to the patient with your obligations as an HMO employee? If you believe that the HMO decision is incorrect, how can you best advocate for your patient?
2. Is "the best remedy" synonymous with "medical necessity?" Who should answer that question, the patient's physician; or the organization that is paying the bills?
3. When the treatment plan entails financial and perhaps legal decision making, what is the physician's role?

Subsequent Legal Proceedings

This scenario is based on the facts of *Moran v Rush Prudential HMO*, on which the Supreme Court recently rendered a decision.¹ After her HMO refused to pay for the most effective treatment, Debra Moran demanded an independent review of the HMO's decision, a right granted by Illinois law.² The HMO refused to comply with her request for an independent review of its decision, citing the Employee Retirement Income Security Act (ERISA), a federal law that preempts state laws concerning certain employee benefits.^{1, 3}

The case spent many years in court. While it was pending, Ms Moran decided to have the microneurolysis operation. She borrowed \$94,000 to pay for the treatment, and amended her complaint to include a demand for reimbursement.¹

The 7th Circuit Court of Appeals eventually ruled in favor of Ms Moran, ordering the HMO to submit to an independent review regarding the medical necessity of the microneurolysis surgery. Based on the specifics of Ms Moran's medical condition, the independent third-party reviewer decided that microneurolysis surgery was medically necessary. The Court of Appeals subsequently ordered the HMO to reimburse Ms Moran for the surgery.⁴

The HMO then appealed to the Supreme Court. Previously, federal circuit courts had demonstrated a regional split on the issue of independent review, so the Supreme Court accepted the case as a means to clarify the state law – ERISA controversy.^{1, 5, 6} In June 2002, the Supreme Court, in a 5-4 split, affirmed the 7th Circuit Court's decision.¹

Legal Analysis

The federal law, ERISA, was enacted in 1974 with the intent of protecting pension plans from fraud and mismanagement. Although 38 states currently have laws requiring HMOs to submit to an independent third-party review to resolve disagreements about the medical necessity of a procedure,⁵ HMOs have avoided complying with these laws by arguing that ERISA preempts them from state laws that allow third-party reviews.⁷ ERISA set forth minimum standards for administration of employee benefits, particularly pension plans, but it also included the statement that ERISA "shall supersede any and all State laws insofar as they may now or hereafter **relate to any employee benefit plan...**" (emphasis added).⁸ Adding to the ambiguity of the law, the preemption was limited by an exception that preserved state power to regulate insurance, banking, or securities businesses.⁹

The broad language, "any employee benefit," has led to much debate and controversy about the intended scope of the ERISA preemption.⁷ Congress allowed ERISA to preempt state laws out of a desire to create a national standard for the administration of employee pension plans, which is exactly what ERISA provided. ERISA's main objective was not to regulate health benefits.

HMOs argued that ERISA exempted them from complying with state laws, a view supported by a series of court decisions.⁷ This exemption from state legislation and the absence of federal laws created a void in the regulation of HMOs.

Moran represents a move away from this judicial trend. In *Moran*, the Supreme Court held that a state law requiring HMOs to submit to an independent third-party review was not preempted by ERISA. The Court argued that a third-party independent review law was exactly the kind of state power that ERISA preserves by allowing states to regulate the insurance business.

The *Moran* decision allows each state to decide how to regulate the independent review procedure. This poses a problem for HMOs because it requires them to comply with a complex assortment of regulations across states, adding layers of management and possibly raising costs. It is possible that this decision will prompt Congress to pass a federal law to set a national standard for independent review laws, overruling this decision.^{5, 7}

Ethically, the *Moran* decision also allows doctors to act as stronger advocates for their patients. If a doctor truly believes that a certain treatment is the best course of action for a patient, he or she can now act with the knowledge that the HMO does not have final decision making power. In at least 38 states, patients and physicians can be secure in the knowledge that disagreements between physician treatment recommendations and HMO decisions can be taken to an objective, third-party review board.

References

1. *Rush Prudential HMO, Inc. v Debra C. Moran et al.* 122 S. Ct. 2151 (2002). US Lexis 4644.
2. 215 Ill. Comp. Stat., ch. 125, sec 4-10 et seq.
3. AMA Litigation Center Memo. July 16, 2002. Subject: *Moran v Rush Prudential HMO*. Leonard Nelson.
4. *Debra C. Moran v Rush Prudential HMO, Inc.* 230 F.3d 959 (2000).
5. Kaiser Family Foundation. *Daily Health Policy Report*. Available at: www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=8911. Accessed June 26, 2002.
6. *Corporate Health Insurance, Inc. v Texas Dept. of Ins.* 215 F.3d 526 (2000).
7. Furrow BA, Greaney TL, Johnson SH, Jost TS, Schwartz RL, eds. *Health Law: Cases, Materials, and Problems*. 3rd ed. St. Paul, Minn: West Group: 1997:808-815.
8. Employee Retirement Income Security Act (ERISA). 29 U.S.C sec 1144(a).
9. ERISA. 29 U.S.C sec 1144(b)(2).

Ben Berkman is a second-year student at the University of Michigan Law School. He was a 2002 summer extern in the Ethics Standards Group at the American Medical Association headquarters in Chicago.

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American Medical Association Journal of Ethics
September 2002, Volume 4, Number 9: 268-270.

MEDICAL EDUCATION

Haircuts, Neckties, Boy Scouts, and "Mama Said": What is Professionalism?

Sam Huber

What does it mean to be professional? Is it the way you dress for clinic? How you obey your manners? If you are a "good person," does that mean you know all that you need to know to be a "good doctor?" If your mother raised you well, are you all set? The Accreditation Council on Graduate Medical Education says that residents need to be competent in professionalism, and the Liaison Council on Medical Education recommendations for medical schools won't be far behind the residency programs. "A scout is trustworthy, loyal, helpful, friendly, courteous, kind, obedient, cheerful, thrifty, brave, clean, and reverent." Does professionalism mean to say the same of a doctor? If not, then *what is professionalism?*

After a year as a fellow in the American Medical Association's Institute for Ethics, I am still a beginner in the field of medical professionalism. To attempt a complete definition at this point would be both daunting and redundant. Several authors have explored different aspects of professionalism, and some useful references are listed at the end of this article. Instead, I will provide a beginner's guide to professionalism and include some of my own thoughts along the way.

Three Domains of Professionalism and How They are Related

Although there has been an explosion of literature on medical professionalism in the past 10 years, it would be a mistake to think that this is a new concept. Paul Starr's *Social Transformation of American Medicine* has influenced thinking since the mid 1980s. Eliot Freidson has been writing on the sociology of medicine since the 1970s, and George Engel published on the "care and feeding of the medical student [as] the foundation for professional competence" in a 1971 *Journal of the American Medical Association* article. Different fields and diverse opinions have been brought to bear on professionalism, expanding the term to cover a broad set of ideas. The results of these varied analyses can be categorized into three domains: habits of practice, habits of group maintenance, and habits of mind.

Habits of practice or activity include matters of dress, address, decorum, and etiquette. They are the ways in which physicians behave toward patients and toward each other. A breakdown in the latter during an epidemic at the Manchester Infirmary's Fever Hospital lead Thomas Percival to write one of the original codes of ethical conduct, *Medical Jurisprudence* in 1792, which set up a system of rounding and attending physicians that is maintained today in many hospitals. Habits of practice involve "behaving like a doctor," and can be taught by example.

The Aristotelian "teach virtue by being virtuous" applies here, mainly because an internalization of reasons and justifications is unnecessary. Proper dress, white coat, "Good morning Mrs. Jones, what brings you in today" are justifiable behaviors, but both their performance and their effect may occur without regard to the actor's mindset. This does not diminish their importance.

Habits of group maintenance are activities and values that work toward maintaining the socially granted power of the medical profession. These powers are informed by an elusive and tacit social contract between physicians and the general public, and include self-regulation, exclusivity of practice (non-competition), financial compensation, and control over physician supply. Many of the social responsibilities of the physician either derive from the social contract, or serve to maintain it. Charity care, public health and hygiene, health education, and political action are examples of habits of group maintenance. The rise of organized medicine on the national, local, subspecialty, and hospital levels has allowed responsibility for some of these habits to become institutionalized or spread over a collective group of physicians. Maintaining the social power of the profession is a high-stakes and non-trivial endeavor. Social prestige, financial reward, physician autonomy, and public legitimacy are not easily regained once lost. Recruitment of new students and the future quality of medicine depend on the current professional behavior of physicians and the socialization of trainees.

Beyond these two sets of habits is a third domain of discourse on professionalism that I think addresses the foundations of professional action. Habits of mind are the reflective, cognitive, and philosophical schemata that inform medical practice and medical behavior. They are characteristic patterns of thinking that help physicians move from clinical information to clinical decision making and allow others to distinguish a professional from a quack. They may be explicit or tacit and "informal," and within medicine, some habits are better than others. Habits of mind—cultivating clinical mindfulness; reflection in daily practice and education; the model of medicine (biomedical, biopsychosocial, relationship-centered, or others) that we teach and practice; emotional intelligence—are what lead to habits of action whether we are aware of them or not. In both ethics and professionalism (different branches of medical behavior), it is not enough to intuit one's way to a course of action. The traditional standards, values, and goals of the profession must be taken into account. They are applied by the physician not in a cookbook manner, but more like the style of a gourmet chef; the ingredients and techniques of a school are known and the outcome is recognizable, but each dish is distinct.

Habits of mind can be taught only by practice. The student may not be able to recognize the habits of mind used by an exemplary practitioner because they may be subtly employed or seamlessly integrated into the physician's behavior. The role of a mentor is to make explicit the reflective components of his or her medical practice, and to encourage students to practice and learn their own habits of mind. John Dewey's pedagogy of study + experience + reflection = education seems appropriate to this mode of teaching and learning.

Where and When?

Ethics can be described as an activity, not purely a set of rules. In this light, ethics are not timeless. The values of the profession are relatively unchanging, but the process and activity of using those values to meet today's challenges is a necessarily dynamic process. Seeking a reflective equilibrium between principles and dynamic action makes professionalism an activity as well. Moving beyond rules of social conduct, professionalism becomes living, vibrant, and a daily part of medical practice.

Some make an appeal to personal virtue in the area of medical professionalism. They cite the noble and ancient history of the profession, and its link to other "helping professions" such as law, education, and ministry. Contemporary professionalism in a culturally diverse society moved beyond personal virtue when Percival appealed to a collective commitment to patients, the public, and their health as the *raison d'être* for his code of ethics and behavior in 1792. He saw that conflicts of personal morality and individual virtues end in a quagmire in the clinic. An appeal to nobility is the end, not the beginning, of hope for the future of the profession.

Contemporary professionalism is a group activity, one practiced in the company of others. It is more about everyday behavior than the actions one takes when no one else is looking, or how one holds up in a rare or distinct crisis. It has little to do with whether or not you run red lights late at night. It is about demonstrating the values of the profession. If we claim to support certain traditional values, then we should embody them in daily and public practice. An emphasis on what goes on in the solitude of the individual practitioner's heart leads to a pessimistic professionalism, and there is no room for that in today's medicine.

So, professionalism includes practice, education, reflective and applied ethics and demonstrating the values of the profession in all of our health care relationships. Sure, your necktie and white coat and what your mother taught you are in there, but there is a lot more to professionalism and a lot more at stake.

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Virtual Mentor

American Medical Association Journal of Ethics
September 2002, Volume 4, Number 9: 271-274.

HISTORY OF MEDICINE

Old Tactics, New Threat: What Is Today's Risk of Smallpox?

Susanna Smith

Bioterrorism is not some new, inventive way of attacking the enemy nor is it a 21st century form of warfare.

It is in fact a historically documented, primitive form of attack dating back as far as the sixth century BCE when the Assyrians poisoned their enemies by contaminating wells with rye ergot, a fungus blight which causes delusions, cardiovascular problems, and death.^{1, 2}

Although there was little understanding of germs and the spread of disease in the 14th century, the Tartan army hurled the corpses of dead comrades infected with the plague over the walls of the city of Caffa. Residents of the city fled to Italy, taking the plague with them adding to the second major outbreak of the "Black Death" in Europe.¹

Some speculate the 15th century Spanish conquistador Francisco Pizarro first introduced smallpox as a biological weapon by offering the Incas gifts of cloth possibly laden with smallpox during his conquest of Peru. Whether the introduction of smallpox was intentional or not, Pizarro was aided in his subjugation of the Incas by the epidemic that raged through the native population.¹

The first well-documented use of smallpox as a biological weapon was by British troops in the French and Indian Wars.⁴ In 1763 Captain Ecuyer of the Royal Americans presented 2 blankets and a handkerchief laced with smallpox to the Native Americans as gifts.¹ Four years later the British general, Sir Jeffrey Amherst, gave more contaminated blankets to Native Americans loyal to the French, killing as many as half of the population of the infected tribes.^{1, 2}

Smallpox became a less effective biological weapon with the advent of a vaccine in 1796 by Edward Jenner, who demonstrated that inoculation with cowpox protected against smallpox infection.³ Yet there are accounts during the Civil War of the future governor of Kentucky, Dr. Luke Blackburn, selling smallpox contaminated clothing to Union officers.

The last documented case of smallpox in the US occurred in 1949. In 1967 the World Health Organization (WHO) took on the project of eradicating smallpox, which was accomplished in 1977.³ Routine vaccination for smallpox in the United

States stopped in 1972, while worldwide vaccination ceased in 1980. The two labs currently permitted to house stocks of the virus are the Centers for Disease Control (CDC) in Atlanta, Georgia, and the Institute of Virus Preparation in Moscow, Russia.³

Today we face a known threat of biological warfare, our expectations primed by the anthrax scare last fall. The news is filled with fear-provoking headlines about the estimated high susceptibility of the US population to smallpox due to the halt in vaccine distribution 30 years ago, and the uncertainty of how long a vaccine is effective. Some estimates put the antibodies' lifespan at just 10 years.³ Without vaccination, smallpox has a "case-fatality rate of 30 percent or more among unvaccinated persons in the absence of specific therapy."³

In November 2001, the Bush administration made a \$428 million deal to increase the stockpile of smallpox vaccine to 286 million doses by the end of 2002. With the "threat of an aerosol release of smallpox deemed 'real'"³ and with potentially catastrophic consequences, a debate has arisen over various vaccination strategies: vaccinating those exposed after a terrorist attack (the "ring vaccination" that is the current government strategy); offering mass vaccinations after an attack; vaccinating doctors and emergency responders now; or optional vaccination for the public at large now.

Recent studies suggest that the current government-endorsed policy of ring vaccination, recommended in June 2002 by the Advisory Committee on Immunization Practices (ACIP)⁴ and now under consideration by CDC and Department of Health and Human Services (DHHS), would be less effective than mass vaccination in the event of a bioterrorist attack with smallpox.⁵ These studies suggest that making the vaccine available to the general population before an attack would save more lives.⁵

An irresponsible editorial printed in *The Wall Street Journal*⁶ on July 10, 2002 takes a stance in favor of mass vaccination but makes no mention of the estimated 1 in 300,000 people⁹ who could have serious or fatal reactions to the smallpox vaccine. Nor does this editorial take into account other risks associated with the smallpox vaccine such as the danger posed by the unvaccinated contracting the virus from those who are vaccinated; "the live smallpox (vaccinia) vaccine virus can be transmitted from person to person. In addition to sometimes causing adverse reactions in vaccinated persons, the vaccine virus can cause adverse reactions in the contacts of vaccinated persons."⁴ A later editorial in *The New York Times*⁸ continues to advocate for mass vaccination while recognizing the risks. *The Washington Post*⁹ is a more cautious proponent of mass vaccination but suggests that when mass vaccinations are made available, "adult Americans should be trusted as far as consistent with public health to make decisions for themselves and their families."

Whether to make smallpox vaccine available to a select few or the public at large is not an easy decision. The concern over the adverse reactions to the vaccine is warranted. If vaccines were made available to a select group, perhaps doctors and emergency workers, or even to the population at large as so many are pressing for, how should a person go about determining whether he or she should be vaccinated? As assessed by the ACIP and listed on the CDC website, "the risk for smallpox occurring as a result of a deliberate release by terrorists is considered low, and the population at risk for such an exposure cannot be determined."⁴

But why, in a world where medical decisions are based on empirical evidence, is "low" not quantified with numerical percentages of risk? Risk analysts spend their professional lives analyzing financial risk, the likelihood of natural disaster, and the occurrence of human error. That is why teenage boys pay more for car insurance than middle-aged men, why people living along the San Andreas fault line are charged more for house insurance than homeowners in Ohio. The CDC's assessment of the risk of smallpox exposure in the US as "low" is not satisfactory. Does a doctor working in the emergency room of a hospital in a major city have the same risk of smallpox exposure as a farmer living in the middle of Kansas? Proponents of mass vaccination are suggesting the choice be left to the individual, but how, without this missing piece of the puzzle, can a person weigh the cost of getting the vaccine against the likelihood of actually needing it? Until the government releases data assessing the likelihood of a smallpox attack no person will be making an informed decision on the vaccination question.

References

1. History of bioterrorism. The Biological Terrorism Response Manual. Available at: <http://www.bioterry.com/>. Accessed August 21, 2002.
2. NOVA: History of biowarfare. Public Broadcasting Service: NOVA online. Available at: <http://www.pbs.org/wgbh/nova/bioterror/history.html>. Accessed August 21, 2002.
3. Henderson DA, Inglesby TV, Bartlett JG, et al. Smallpox as a biological weapon, medical and public health management. *JAMA*. 1999;281(22):127-137.
4. Draft supplemental recommendation of the ACIP: use of smallpox (vaccinia) vaccine, June 2002. Centers for Disease Control. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5010a1.htm>. Accessed August 21, 2002.
5. Kaplan EH, Craft DL, Wein LM. Emergency response to a smallpox attack: the case for mass vaccination. *Proc Natl Acad Sci USA*. 2002;99(16):10935-10940.
6. Smallpox scenarios. *Wall Street Journal*. July 10, 2002:14A.
7. O'Toole T, Inglesby T, Larsen R, DeMier M. Dark winter: bioterrorism exercise Andrews Air Force Base, June 22-23 2001. John Hopkins Center for Civilian Biodefense. http://www.upmc-biosecurity.org/website/events/2001_darkwinter/dark_winter.pdf. Accessed August 21, 2002.

8. The expanding smallpox plan. *The New York Times*. July 13, 2002:A10.
9. Defending against smallpox. *The Washington Post*. July 15, 2002:A16.

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Virtual Mentor

American Medical Association Journal of Ethics
September 2002, Volume 4, Number 9: 275-276.

VIEWPOINT

The Secret Ingredient

Colleen Danz

The federal government is currently considering legislation which calls for the clarification of food labels, requiring that the 8 main food allergens be identified by their common names and the food allergens in additives be disclosed.¹

- Approximately 7 million Americans suffer from food allergies; 30,000 people receive emergency treatment due to ingestion of a food allergen and an estimated 150 people die each year from anaphylactic shock.²
- Ninety percent of all allergic reactions are caused by 8 major foods—milk, egg, fish, crustaceans, tree nuts, wheat, peanuts, and soybeans.²
- An FDA study has shown that fewer than 1 in 10 parents restricting milk from their allergic child's diet were able to correctly recognize milk on the label. Milk can be labeled as whey, casein, and lactoglobulin.³
- Albumin, semolina, and vegetable protein concentrate are terms used for eggs, wheat, and soy, respectively.
- Hidden sources of the top food allergens:
 - Some brands of canned tuna fish contain casein, a milk protein.
 - Influenza vaccines are grown on egg embryos and may consist of a small amount of egg protein.
 - Steak sauces and Worcestershire sauce contain anchovies.
 - Tree nuts are found in many foods including barbecue sauce, cereals, crackers, and ice cream.
 - At least one brand of hot dogs and one brand of ice cream also contain wheat.
 - Several baked goods, canned tuna, cereal, crackers, and soups consist of soybeans.
- There is no regulatory definition for the term "dairy-free," which means that products marked "dairy-free" may contain milk proteins that are hazardous for people with a milk allergy. FDA regulations allow the use of caseinates (casein is one of the major milk allergens) in "non-dairy" products.⁴
- In 2000 the number of food recalls because of unlabeled food allergens rose to 121 from about 35 a decade earlier.²
- An FDA study found that one-quarter of all food manufacturers do not list ingredients that cause potentially fatal allergic reactions.³
- Forty-seven percent of manufacturers do not check their products to ensure that all ingredients are accurately portrayed on labels.³

The Senate bill S. 2499, the Food Allergen Consumer Protection Act, was introduced into the Senate on May 9, 2002 and is still being revised. To support this bill [contact](#) your representatives and let them know the importance food label clarification for American consumers. Please be specific and tell them about your experiences with and opinions on today's food labeling standards.

References

1. User-friendly food labels. *The New York Times*. July 16, 2002:A16.
2. S 2499 Food Allergen Consumer Protection Act. Thomas Legislative Information on the Internet. Available at: <http://thomas.loc.gov/>. August 16, 2002.
3. Food labels identify allergens more clearly. US Food and Drug Administration. http://www.fda.gov/fdac/features/2006/206_foodlabels.html. January 30, 2009.
4. Hahn M, Taylor S. Dairy-free and non-dairy: what do these terms mean for milk-allergic consumers? Food Allergy Research & Resource Program Information Library. Available at: <http://www.farrp.org/articles/dairyfree.htm>. Accessed August 9, 2002.

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Virtual Mentor

American Medical Association Journal of Ethics
September 2002, Volume 4, Number 9: 277-279.

VIEWPOINT

A-B-C, 1-2-3, H-I-V: Sesame Street Tackles AIDS

Michelle Lim

On September 30, the South African version of *Sesame Street*, *Takalani Sesame*, will introduce a character with HIV to the cast, joining the ranks of Zikwe (Cookie Monster), Moshe (Big Bird), and Neno (Elmo). The new Muppet will be the first children's show character to bring HIV and AIDS issues directly to the attention of preschool children. The Muppet's name, shape, and color will be unveiled later this month.

Harsh realities of the AIDS epidemic in South Africa prompted the Muppet's introduction. A UNAIDS 2002 report estimated that 250,000 South African children under the age of 15 years are infected with HIV, and another 70,000 to 100,000 babies are born HIV-positive each year.¹ These children often face isolation, rejection, and the grief of losing one or both parents while having to deal with the debilitating symptoms of the disease. The new Muppet will be a 5 year-old orphan girl with "high self-esteem" to encourage positive self-image among children. As a lively and integral member of the community, she will be respected and appreciated by her fellow Muppets and will be a role model for children with HIV, particularly young South African girls. Unequal gender relations, sexual customs, and socioeconomic factors combine to make women in South Africa especially vulnerable to both HIV infections and the stigma and discrimination associated with having the virus.

Takalani Sesame will teach kids, by example, how to interact with a playmate who has the human immunosuppressive virus, stressing that the individual is a member of the family community. The character will help instill positive attitudes toward people who are infected with HIV, according to Yvonne Kgame of SABC, the network that airs the show in South Africa.²

The story lines, written for children ages 3 to 7, will not mention common ways of viral transmission, such as drug abuse and sexual contact. Instead the show offers coping mechanisms for children faced with loss and isolation caused by the epidemic. In one episode, the new Muppet is sad because she misses her mother. In another, children treat her as an outcast because she is HIV-positive, but then the Muppets console her, replacing the lesson of exclusion with lessons of compassion and inclusion.³ *Takalani Sesame* will also instruct children in public health precautions. As Joel Schneider, vice president and senior adviser to Sesame Workshop explains, "We will be very careful to fashion our messages so they are

appropriate to the age group. 'What do I do when I cut my finger? What do I do when you cut your finger?' That sort of thing."²

Takalani Sesame is intended as a prompt for initiating family discussions about HIV/AIDS. The show endeavors to dispel the widespread denial of and ignorance about the disease by creating an environment where people affected by HIV/AIDS can openly talk about their concerns. Print resources containing educational materials and suggestions on how to discuss the issues with children will be available for parents.

Takalani Sesame debuted in July 2000 as part of the South African Department of Education's Early Childhood Development effort to provide basic literacy and mathematical skills for preschool children. The program is co-produced by Kwasukasukela and Sesame Workshop with funding provided by USAID and the South African Broadcasting Corporation (SABC), among others.⁵ The show has a unique African flavor with original characters, themes, and story lines that reflect and celebrate the rich diversity of South African cultures. With the introduction of the new Muppet, the South African government takes a major step in the education of children about HIV/AIDS and the impact of the epidemic in the country.

Takalani Sesame's innovative approach to raising HIV/AIDS awareness among children is daring and commendable. Rampant in South Africa and other developing countries, AIDS remains a health issue of global concern affecting an increasingly greater scope of children each year. Introducing the show to other countries might help more children who are affected directly and indirectly by HIV/AIDS. However, some members of the US House Energy and Commerce Committee, which oversees PBS funding, have expressed the opinion that bringing the character with HIV to America's *Sesame Street* audience would be inappropriate. Although Sesame Workshop has no plans for introducing such a character in the US, its producers answer the Congressional objection by explaining that they have carefully developed age-appropriate content for the show. *Sesame Street* has a sound record of success in treating matters of diversity and prejudice in ways that are appropriate and accessible to preschoolers. It might be said without exaggeration that *Sesame Street's* frog-like Muppet, Kermit, with his complaint that, "It's not easy being green," has contributed to the colorblind congeniality among children of various ethnicities in daycare centers and kindergartens around the US today.

More than 10,000 children in the United States are HIV-positive. The array of aggressive treatments that prolong their lives are outward signs and harsh reminders of their illness. Fears of losing friends and respect from their community are common. As 6 year-old Tanya expressed in a recent *TIME* article, "It feels terrible to have AIDS . . . because if my friends found out, they wouldn't play with me anymore."⁶ Children, like Tanya, with HIV seek relief from the physical and emotional stress of their illness. *Takalani Sesame* offers coping mechanisms for dealing with the stress, while informing them about preventive health measures and

tackling social issues of stigma and discrimination. The show presents important age-appropriate health education that may prevent new infections.

Entertaining, age-appropriate health education is an essential part of the global fight against HIV/AIDS. Caring for children with HIV is not merely about treating opportunistic infections; it also means replacing their despair with hope by teaching others to accept and support them.

References

1. Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections: South Africa. UNAIDS and WHO: 2002 Update. Available at: <http://www.unaids.org/en/knowledgeCenter/HIVData/default.asp>. Accessed July 31, 2002.
2. Muppets to introduce HIV-positive character. *The Atlantic Journal-Constitution*. July 12, 2002.
3. S. Africa 'Sesame St.' to add HIV-positive Muppet. *CNN*. July 12, 2002.
4. Woodall, B. Sesame Street to introduce HIV-positive Muppet. *Reuters News Service*. July 12, 2002.
5. Taking Takalani Sesame to the children. *Science in Africa: MERCK*. September 2000. Available at: <http://www.scienceinafrica.co.za/2001/september/takalani.htm>. Accessed July 31, 2002.
6. Stodghill, R. Time of their lives. *Time*. August 12, 2002;160:49.

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Virtual Mentor

American Medical Association Journal of Ethics
September 2002, Volume 4, Number 9: 280-282.

PERSONAL NARRATIVE

Through the Student's Eyes: Some Promises Can't Be Kept

Erin Talati

Medical malpractice policies have become so prohibitively expensive, and threats of malpractice suits so numerous, that physicians are being driven out of practice.¹ Attempts at widespread tort reform have been unsuccessful. The National Board of Medical Examiners (NBME) and Federation of State Medical Boards (FSMB) are approaching the problem from a different perspective. They want to limit malpractice litigation and, therefore, liability premiums by eliminating potentially problematic physicians before they've had a chance to practice. For several years, the NBME and FSMB have considered adding a clinical skills exam to the United States Medical Licensing Examination (USMLE) as a means of rooting out unqualified physicians-to-be. This year they announced their decision to move forward with the proposal.

The clinical skills exam will be administered to US medical students concurrent with Step 2 of the USMLE, usually taken between the third and fourth years or during the fourth year of medical school. The clinical skills exam is designed to test medical students' performance in tasks that make up the typical physician's day. In 10 to 12 thirty-minute encounters with standardized patients, students will be required to take a history, complete a physical exam, make diagnoses, counsel patients, and share their impressions on a case. Trained physician reviewers will evaluate the students' performance. To pass, students must demonstrate satisfactory clinical and communication skills. Exam administrators expect that 5-7 percent of students will be unable to pass the exam on first-attempt. One to 2 percent of students will fail even after repeated attempts. The NBME and FSMB believe that eliminating this cohort of students before they become practicing physicians will at least reduce the number of physicians that will subsequently come before state medical boards for consideration of malpractice.

A number of groups have voiced concerns about the addition of the clinical skills exam to the USMLE. The majority of these concerns have concentrated on the financial burden that the additional exam would place on the already strained budgets of medical students. The potential costs associated with the exam are enormous and merit some attention here. While an examination fee has not yet been determined, administrative costs alone are estimated at \$950 per exam. Furthermore, testing centers are being established in only 6 or 7 cities nationwide, necessitating indirect expenses for travel and accommodations. Perhaps most disturbing is that the 250-500 students annually who are not expected to pass the

exam after repeated attempts will still face an average educational loan debt of \$100,000² and not have a license to practice medicine. These financial concerns are indeed valid, and certainly require attention. A larger question to consider, however, is whether the exam can actually accomplish what it hopes to accomplish.

The NBME and FSMB are motivated by a desire to improve overall patient-physician communication by recognizing and removing candidates who lack these skills. In the midst of what many are calling a malpractice crisis, this is an admirable goal. Insufficient evidence exists, however, to support the claim that the exam can accomplish this goal. One consideration is whether the test itself can detect the kind of skills that patients feel are lacking when they decide to sue. Errors happen in medicine, independent of a physician's excellent clinical skills. While preventing mistakes is beneficial, studies suggest that what physicians lack is the knowledge of how to handle the situation after the error has occurred. Physicians need to know how to deal with patients when something unexpected happens such that neither physician nor patient can predict how the situation will play out. A scenario in which students roleplay doctors with standardized patients who are acting cannot possibly capture the very real, spontaneous emotions and responses that accompany learning about an adverse outcome. When something goes wrong, patients, in general, want 3 things from their physician: (1) an explanation, (2) an acknowledgement or apology, and (3) reassurance that corrective measures are being taken.³ These communication skills are not assessed in the patient-physician encounters that are being simulated in this exam.

Another potentially troubling aspect of this exam is the message that it might be sending to those who pass. A few years ago, I was good enough at multivariable calculus to pass an exam. Today, I wouldn't even know where to start. The point is that the practice of medicine is more complex than riding a bike: without repeatedly using and refining the skills required to successfully interact with patients, these skills will be lost. To send the message that passing a clinical skills exam means that a student has sufficient communication skills to deal with patients before the student has completed undergraduate medical training denies the importance of emphasizing these skills throughout graduate medical training and beyond. One could argue that a physician is more strongly influenced by the way he or she sees situations handled during residency and fellowship than in undergraduate training. In fact, the recognition that certain specialties have unique communication concerns supports the idea that what students learn post-medical school is critical in determining how they deal with patients.⁴ Setting a standard where students who ultimately fail this exam are denied the opportunity to improve their skills throughout graduate training and students who pass may be satisfied that they don't need further improvement seems counterproductive to the maximization of patient-physician communication.

The clinical skills exam assigns equal weight to assessing the clinical and communications skills of students. If medical students, who pay constantly increasing tuition in medical education and leave medical schools with an average

\$100,000 in debt, are graduating without the skills to conduct a history and physical and generate a differential diagnosis, then stricter standards should be developed for accreditation of medical schools. Arguably, these skills should also be assessed in some way before a student graduates. The art of doctoring, however, means more than going through these motions. It is something that must be continuously learned—the promise of producing better physicians by standardized elimination of the weakest is simply a promise that cannot be kept.

References

1. Crane M. Doctors' insurance affecting patients. *The Columbus Dispatch*. July 8, 2002.
2. Santana S. Paying the price to become a doctor: the impact of medical school debt. AAMC Reporter. January 2002. Available at: <https://www.aamc.org/newsroom/reporter/jan02/medschooldebt.htm>. Accessed July 2002.
3. Marcus LJ, Dorn BC. Mediation before malpractice suits? *Newsweek*. March 27, 2000:84.
4. Ambady N, LaPlante D, Nguyen T, Rosenthal R, Chaumeton N, Levinson W. Surgeons' tone of voice: a clue to malpractice history. *Surgery*. 2002;132(1):5-9.

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