
ADVANCING ASSESSMENT OF PROFESSIONALISM

in Continuing Certification

An ABMS and NBME Symposium

CHICAGO | September 22, 2019



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INTRODUCTION

On September 22, 2019, the American Board of Medical Specialties (ABMS) and National Board of Medical Examiners (NBME) convened internationally renowned experts in professionalism and assessment for a Symposium entitled *Advancing Assessment of Professionalism in Continuing Certification*.

Mark T. Keegan, MB, MRCPI, D.ABA, MSc, FCCM, a Professor of Anesthesiology at Mayo Clinic in Rochester, Minn. and full-time anesthesiologist and intensivist, served as moderator for the day-long Symposium. Dr. Keegan, who serves on the American Board of Anesthesiology's Board of Directors and chairs ABMS' Ethics and Professionalism Committee (EPCOM), started the day by framing the goals of the Symposium. They are as follows:

Understand the perspectives of various stakeholders regarding professionalism

Understand how experiences across the education and practice continuum inform next steps in assessing professionalism

Prioritize what should be assessed with respect to professionalism in continuing certification

Explore options to inform an initial plan for integrating assessment of professionalism into continuing certification



Dr. Mark Keegan served as moderator for the Symposium.



The Symposium serves as an ongoing dialogue between the presenters, panelists, and invited guests. This proceedings paper provides an overview of the Symposium, including the presentations, panel take-aways, highlights from the Question and Answer (Q&A) sections, take-aways from small group discussions, and reactor panel.

EXECUTIVE SUMMARY

Professionalism is a vital aspect of patient care. In fact, research suggests that the public believes board certified physicians are held accountable to higher standards. Additionally, studies have demonstrated that the competency of professionalism is associated with improved patient outcomes. The community of assessment professionals has an obligation to hold physicians accountable to a level of professionalism that warrants the high level of trust that the public has placed in board certified physicians.

To explore the natural evolution of professionalism and how that translates to assessment, ABMS and NBME convened internationally renowned experts in professionalism and assessment for a Symposium entitled *Advancing Assessment of Professionalism in Continuing Certification*. In addition to the ABMS Member Boards and NBME, other organizations represented were the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Medical Association, Council of Medical Specialty Societies, and Federation of State Medical Boards.

The Symposium sought to:

- Understand the perspectives of various stakeholders regarding professionalism
- Understand how experiences across the education and practice continuum inform next steps in assessing professionalism
- Prioritize what should be assessed with respect to professionalism in continuing certification
- Explore options to inform an initial plan for integrating assessment of professionalism into continuing certification

KEY FINDINGS

Regarding stakeholders' perspectives about the assessment of professionalism, the Symposium discussion focused on the following:

- The public believes that licensing and certifying boards test and assess health care professionals to ensure they are competent and up to date in all aspects of patient care, including professionalism.
- The assessment of professionalism in the undergraduate medical education (UME) and graduate medical education (GME) training environment is increasingly being driven by the learning communities' efforts to establish a belief system and less by sentinel events.
- Research suggests that unprofessional behavior in medical school and residency predicts subsequent disciplinary action by state medical boards.
- Organizational professionalism refers to the set of competencies and behaviors that organizations can use to define professionalism and is separate and distinct from those used to define professionalism for individuals.
- Research suggests that 50% of clinicians never receive an unsolicited patient complaint, while 4% of clinicians account for 35% of patient complaints. In comparison, 90% of clinicians never get a co-worker complaint while nearly 3% of clinicians account for almost half of staff complaints.

EXECUTIVE SUMMARY (Continued)

KEY FINDINGS

Assessing professionalism across the education and practice continuum serves as a guide to inform assessing professionalism in continuing certification. Along those lines, Symposium attendees noted the following:

- Assessment organizations must collaborate to promote and support a systems approach that addresses identity formation in medical school; learning environment measurement and modifications in UME/GME; measurement of individual and team performance at the practice level; and remediation that focuses on development, not punishment.
- Based on NBME's experience in assessing professional behaviors and the broader view of the stages of Miller's Pyramid of Clinical Competency, there may be opportunities to assess professionalism in terms of its knowledge, skills, and underlying attitudes that shape behaviors rather than focusing on behaviors, the latter of which has a negative connotation.
- Longitudinal assessment of professionalism in UME is more comprehensive than isolated assessments.
- Organizational professionalism may promote and support the assessment of board certified physicians' professional behaviors.
- The Federation of State Medical Boards' determination to clearly define the unprofessional conduct underlying disciplinary actions (DAs) and to enhance its transparency could help inform the Member Boards' efforts to move toward the consistent use of data from state medical boards.

In terms of prioritizing what should be assessed with respect to professionalism in continuing certification, the Symposium attendees suggested:

- Holding physicians accountable for unprofessional behavior, including responding to, and reporting it.
- Engaging in self-improvement by seeking/receiving feedback and making positive changes to address negative feedback.
- Maintaining competence throughout one's career.
- Respecting others from peers to patients.
- Engaging in prudent stewardship of health care resources.

When developing an initial plan for integrating assessment of professionalism into continuing certification, Symposium attendees recommended the following:

- Define professionalism in terms of an ethical value system with distinct knowledge, judgment, and skills that align with the standards and principles of the profession.
- Introduce professionalism standards as a constructive, rather than punitive, requirement and framed in the broader context of creating a health care system that supports professionalism and professional behaviors.
- Assess professionalism longitudinally throughout a physician's career.
- Consider egregious professionalism lapses (e.g., felony conviction, sexual misconduct) as a cause for revoking a diplomate's certification without an opportunity for remediation. The physician should be informed immediately and afforded due process to get his/her certification reinstated.

SESSION I

SETTING THE FOUNDATION: DEFINING PROFESSIONALISM AND UNDERSTANDING WHY IT MATTERS

Panel A: Professionalism Defined and the Importance of Assessing It

Panelists:

Richard E. Hawkins, MD
President and Chief Executive Officer;
ABMS

Peter Katsufraakis, MD, MBA
President and Chief Executive Officer;
NBME

TAKE-AWAYS

- *Defining professionalism as a belief system carries with it a three-part promise for physicians to acquire, maintain, and advance an ethical value system, knowledge and skills, and interpersonal skills to best serve the interests of their patients and the public above their own personal needs and interests.*
- *For purposes of assessment, the definition of professionalism should include a perspective beyond an individual's values and behaviors to that of group behaviors designed to develop, debate, and uphold the standards and principles that underlie the profession.*
- *Ultimately, assessment of professionalism will require a judgment of when a lapse is acceptable and remediable and when it is significant and requires further action.*



In his opening remarks, Dr. Hawkins shared his appreciation for NBME co-hosting the Symposium and helping to assemble a group of thought leaders with diverse and unique expertise, experiences, and perspectives to engage in the conversation about professionalism in continuing certification.

Dr. Hawkins noted that one of his proudest moments at ABMS was to help establish EPCOM in 2010 when he was Senior Vice President for Professional and Scientific Affairs. Among EPCOM's initial tasks was to define professionalism. EPCOM's definition states that:

“Medical Professionalism is a belief system about how best to organize and deliver health care, which calls on group members to jointly declare (“profess”) what the public and individual patients can expect regarding shared competency standards and ethical values, and to implement trustworthy means to ensure that all medical professionals live up to these promises.”

“*Medical professionalism pledges its members to a dynamic process of professional development, lifelong learning, and continued competence.*”

This definition was a departure from previous ones, which largely consisted of lists of values, principles, behaviors, or attitudes. Defining professionalism as a belief system carries with it some implications. This definition underscores the dual importance of technical competency standards and professionalism, but also shared ethical values. It highlights the shared accountability to develop legitimate and effective self-regulatory mechanisms. It points to the need for the profession to ensure trustworthiness of its members and delineate potential complications if trustworthiness is not obtained.

The definition is a three-part promise. Professionals need to acquire, maintain, and advance an ethical value system grounded in the conviction that the medical profession exists to serve patients' and the public's interest above their own needs and interests. They need to acquire, maintain, and advance the knowledge and skills necessary for good medical practice. Finally, they need to acquire, maintain, and advance the interpersonal skills necessary to work together with patients, eliciting goals and values to direct the proper use of the profession's specialized knowledge and skills. Medical professionalism therefore pledges its members to a dynamic process of professional development, lifelong learning, and continued competence.

Four EPCOM members, three of which were among the attendees, published a [paper on professionalism](#) in *Academic Medicine* in 2014. The authors stated that defining professionalism as a list of behaviors is essential for assessment because they are the standards that professionals must meet to gain the public's trust. However, a list is insufficient because it doesn't capture the social underpinnings and the foundational purpose of professionalism, the authors noted. It may be misconstrued that all individuals must do to be professional is check items off the list. It also doesn't anticipate behaviors that ultimately become important in professionalism as the health care system and physician practices evolve. Stewardship of scarce resources wasn't nearly as important 25 years ago as it is today. Moreover, the definition should include a perspective beyond the individual's values and behaviors to group behaviors designed to develop, debate, and uphold the standards and principles that underlie the profession, the authors suggested. It underscores the reason why organizations, such as NBME and ABMS, convene groups like this one to define the behaviors and standards that professionals must attain to gain the public's trust, Dr. Hawkins concluded.



“All these questions can be distilled into a simple one: Is this physician someone I would send my family to?”

Dr. Katsufakis addressed the importance of assessing professionalism. Typically, professionalism is assessed to determine whether an individual is qualified to begin practicing or continue to practice as part of the licensure or continuing certification process. It also may be assessed to guide an individual's learning and development. In addition, professionalism can be assessed to identify problems in the

routine course of professional activity or in response to specific events.

In documenting professionalism, ABMS incorporated professional standing into its continuing certification process. Professional standing is defined as having licensure by a governmental authority, behaving in a professional manner, and acting in the patient's best interest. However, this sets the bar fairly low, especially given that the requirements for licensure are not particularly demanding. Someone is presumed to be professional unless there is evidence to the contrary. A better way to document professionalism might be to accumulate evidence from valid assessments.

People carry mental models of what they think it means to be a professional. One perspective is that people are either a professional or they're not; it's an innate characteristic. Someone who has demonstrated unprofessional behavior is forevermore deemed unprofessional. Others view professionalism as somewhere in between, that is, some people may be more professional than others. Professionalism is sometimes considered a developmental continuum, so the process of establishing a professional identity also involves adopting the behaviors, values, and mores of the profession. Some people judge it in absolute terms, while others think of it in relative or contextual

terms, such as a specific clinical situation or professional role that influences whether or not one's behavior is professional. Another model uses a baseline (or threshold) of professional behavior, where individuals typically engage, but have occasional lapses.

In addition to critically analyzing these mental models, it's important to think about what questions will help assess professionalism. Asking about an individual's attitudes and beliefs may be useful from a developmental or formative standpoint, but it also may be more challenging because attitudes and beliefs can't be objectively probed and are dependent upon self-reporting. Asking about one's knowledge to resolve challenging ethical dilemmas emphasizes the knowledge base that underlies professional behavior. Asking about an individual's interpersonal skills can determine if the person has the necessary skills to demonstrate a high degree of professionalism. However, Dr. Katsufakis noted that all of these questions can be distilled into one simple one:

- *Is this physician someone I would send my family to?*

If the assessment is being used to make a high-stakes decision, then the information collected and tools used should be potentially defensible in a court of law. If it is being used to guide a physician's formative development, then the information should be rich enough that it provides

specific guidance to enable the individual to improve. Other considerations include when and how often professionalism should be assessed, the optimal setting, who should do the assessment, and what tool(s) should be used.

Tools that can be used to assess professionalism range from written tests, professional portfolios, and multi-source feedback to checklists, critical incident reports, and standardized patients/learners/teachers. Approaches to assessment could be systematic, routine, integrated, and comprehensive. Or they could be spontaneous and opportunistic, arising in response to a particular incident or focused on specific skills, attitudes, or behaviors of the physician.

Inherent challenges in assessing professionalism are subjectivity, observability, context, and ambiguity. Subjectivity creates opportunities for misunderstanding and defensiveness as it requires making a judgment. Regarding observability, sometimes the most important elements of professional behavior are not easily observed in a system of assessment. Context can be an important element that contributes to subjectivity. For all these reasons, the assessment of professionalism can be somewhat ambiguous. Although assessment of professionalism is going to be a challenging task, it is potentially a very rewarding one.

Drs. Hawkins and Katsufakis concluded by stating what they would like to achieve at the Symposium:

- *A good sense of what the most important behaviors and attributes ABMS and its Member Boards should assess as part of continuing certification.*
- *Whether ABMS should assess professionalism from the perspective of helping to develop and improve behavior or from the position of making decisions as to whether behavior is acceptable.*
- *A group consensus on which approach is most practical and feasible.*



HIGHLIGHTS FROM THE OPENING SESSION Q&A

Some attendees raised concerns about whether the assessment of professionalism would be legally defensible. Although Dr. Katsufakis deferred to attorney colleagues to address that, he noted that the concerns speak to the importance of ensuring that the information gathered for the assessment of professionalism is of appropriate rigor and sufficiently reproducible. Dr. Hawkins suggested that the focus shouldn't be on using the assessment to revoke certification, but rather on how to observe physician behavior, directly or indirectly, to provide feedback to improve that behavior.

One attendee compared the perspective of a physician either being professional or not to the medical profession's initial view of medical errors. Over time, the culture shifted from blaming the individual to creating a blame-free environment to the recognition that good clinicians find themselves in nuanced situations in which they make a mistake. He suggested that over time the discussion could move from "not being professional" to "unprofessional behavior." Everyone is susceptible to having moments of unprofessional behavior. It's only when persistent episodes of unprofessional behavior occur that may signify a serious problem.

In the end, assessment of professionalism will still require a judgment of when a lapse is acceptable and remediable and when it is significant and requires further action, Dr. Hawkins pointed out. How those judgments are made must be part of the conversation.

Another attendee encouraged the group to consider an approach to professionalism that addresses physicians who are not only in clinical practice, but those who are researchers, educators, and administrators.

Panel B: Assessing Professionalism from the Medical Profession Perspective

Panelists:

Helen Burstin, MD, MPH
Executive Vice President and Chief Executive Officer; Council of Medical Specialty Societies (CMSS)

Elliott Crigger, MD
Director of Ethics Policy and Secretary to the Council on Ethical and Judicial Affairs (CEJA), American Medical Association (AMA)

Warren Newton, MD, MPH
President and Chief Executive Officer, American Board of Family Medicine (ABFM)

TAKE-AWAYS

- *Data from state medical boards (SMBs) about non-professional behavior should be used consistently across the ABMS Member Boards.*
- *The standards for non-professional behavior should be universally applied across specialties and states.*
- *Assessment should be a standardized and fair process that includes a remediation component.*
- *Variability in the depth and quality of the records across SMBs poses a challenge to ensuring consistent decision-making.*
- *Physicians who move frequently remain a significant challenge for Member Boards to keep current with SMB actions against them.*



It's not a question of whether professionalism is important or whether it needs to be assessed, but rather "the devil's in the details," Dr. Burstin said. It's how it's done, who does it, and how it's used. She reviewed steps that CMSS has taken to ensure that professionalism remains at the core of its identity, beginning with its recent update to the Society's mission and priorities.

Additionally, most of CMSS' 45 specialty societies maintain codes of ethics and professionalism. These largely aspirational codes include statements of expectation that members will uphold principles of altruism, ethical behavior, and professionalism. Dr. Burstin shared the American Society of Clinical Oncology's definition of professionalism that she believes is particularly well done. It states that "Professionalism embodies an attitude of caring for both patients and colleagues, ethical and honest interactions, leadership abilities, respect for colleagues across disciplines and professions, excellent communication and listening skills and a commitment to continuously improving patient care."

The Physician Charter, written in 2002, is one of the earliest documents that discusses the key principles and responsibilities of professionalism and professional behavior. Many medical organizations, including CMSS, signed on to the Charter that remains remarkably on point nearly 20 years later. Dr. Burstin especially likes the opening statement that reads, "Professionalism is the basis of medicine's contract with society."

In 2010, CMSS adopted its Code for Interactions with Companies, which guides societies in the development of policies and procedures to ensure that they interact

in a highly professional manner with for-profit entities, such as pharmaceutical and medical device companies. To date, 62 societies have signed the voluntary Code. CMSS is considering a new common code of conduct and professionalism that could be adopted across all societies to ensure consistency among CMSS members.

Regarding the role of the ABMS Member Boards in assessing professionalism, first and foremost the boards should focus on monitoring for lapses in professionalism and consistently use data from SMBs about non-professional behavior. While collecting the data should remain a responsibility of the SMBs, there may be other potential issues, such as sexual harassment actions, the Member Boards can work on with them. The Member Boards may consider, for example, including sexual harassment as part of the assessment. The standards for non-professional behavior should be universally applied across specialties and states. There shouldn't be any variability from the patient's perspective in what's reported or used based on a physician's specialty or geography. Assessment should be limited to a standardized and fair process of responding to professionalism concerns reported to SMBs or other entities. When a lapse is detected, the Member Boards need to thoroughly address it, but have a fair process for remediation.

Physicians shouldn't have to prove their professionalism with burdensome documentation to the Member Boards. There

should be some presumption of professionalism based on the Accreditation Council for Graduate Medical Education (ACGME) milestone attestations at the completion of residency training. The evaluation of professionalism frequently requires direct observation at the local level, where physicians are already required to demonstrate professionalism in many ways, such as peer review and patient surveys. As former Director of Quality Measurement at Brigham and Women's Hospital, Dr. Burstin knows firsthand that these issues come forward at the local level, which is where it is preferable to address them.

The culture of medicine is rapidly changing, and along with those changes are a set of existential threats that drive the physician's identity, values, and behavior. There's a professional ecosystem that's rapidly evolving around rampant health system integration, a rise in the number of employed physicians, and impressive growth of private equity that often comes with very negative consequences. Professional expectations also are changing, with a drive toward value-based care, electronic health records, telehealth, artificial intelligence, and continuing certification. Lastly, personal anxiety continues to grow as reflected in issues around work-life balance, burnout, and student debt. These existential threats, which she views as the biggest threats to professionalism, should be recognized and addressed in the broader context of professionalism.



Dr. Crigger began his presentation explaining CEJA's primary responsibilities, which are to maintain and update the AMA Code of Medical Ethics and to promote adherence to the professional ethical standards set out in the Code. Adopted in 1847, the Code articulates the values to which all physicians commit themselves as members of the medical profession, regardless of specialty. It sets thresholds of conduct to promote public trust and safety, sustain professional accountability, and preserve the privilege of professional self-regulation. Regarding its legal status, the Code carries varied implications for physicians across the country, but it is referenced in some form in virtually every jurisdiction in the United States.

Once an SMB has taken action against a license belonging to a physician who is an AMA member, CEJA's role is to determine the physician's fitness for membership. CEJA offers the physician an opportunity for a hearing, where the physician can tell his/her version of events.

The council's decision-making process is based on written records obtained from SMBs and other investigative bodies, including the National Practitioner Data Bank (NPDB); supplementary materials provided by the physician; and physician testimony during the CEJA hearing. CEJA does not have the authority or resources to conduct an independent investigation. Information provided by SMBs can be incredibly detailed or a one-page order. If the physician provides supplementary materials at the state level, but the SMB doesn't include them in the record, CEJA will not have access to them. CEJA has the option of reporting its actions to the NPDB and usually does so for decisions that involve denial of membership or expulsion from AMA.

CEJA faces numerous challenges in its decision-making process. The variability in the depth and quality of the records across SMBs is its biggest concern. Next is ensuring

consistent decision-making. Another challenge is how to determine when it's appropriate to educate rather than punish.

Among the criteria CEJA uses in making decisions are the level of insight the physician shows for why the conduct was problematic and what steps the individual took to prevent it from happening again. Another is whether the conduct suggests there is an ongoing risk if this physician is allowed to continue practicing without supervision or restriction.

CEJA also tries to determine if the conduct involves a pattern of behavior or one-time event and whether the physician is remediable through counseling and/or education. CEJA members struggle with the Code's suggestion that a physician is either ethical or unethical. That is why CEJA refers to a physician as being "consistent with the Code"

or "not consistent with the Code."

A further criterion is the reputational risk to the profession. Is this physician's behavior so egregious as to undermine public trust in the profession or in the AMA's ability to hold physicians accountable? The latter is really the foundation of the Code and CEJA's work. Physicians don't always recognize that to the public they are doctors first and individuals second and will be held to a higher standard than others. Giving up a certain level of autonomy is just part of the commitment a physician makes when entering the profession.

Moving forward, CEJA would like to be able to use hearings as opportunities to educate rather than opportunities to discipline, Dr. Crigger concluded.



Dr. Newton focused on how a representative Member Board addresses the assessment of professionalism.

While ABFM does not conduct investigations regarding SMB actions taken against a physician's license, it does conduct peer review and due process, which offers substantial legal protection. Even these can be challenging as ABFM is working with 95,000 diplomates; nearly 83 different SMBs; 409 types of licenses; and well-intended, but Brownian, movement across the states.

A big challenge that Member Boards face is physicians who frequently move. An emerging problem is that SMBs, realizing the significance of removing a physician's certificate, will occasionally allow a physician to continue practicing, stating that there is no restriction to the license. But on closer look, however, there can be significant professionalism issues and restrictions. Specialty boards must have a formal process to review the information.

Losing one's board certification is very uncommon. Between 2013 and 2017, less than 1% of family physicians were reviewed, and of this only 10% lost their certification, and at least half of them had it restored later. Boundary issues,

substance abuse, and substandard controlled substance prescribing are the top reasons why family physicians lose their certification. ABFM encourages a physician's attorney to contact the board's legal counsel before negotiating a consent agreement to best protect board certification. Not understanding license limitations may result in a loss of certification.

According to Dr. Newton, professionalism lapses represent significant risks to the profession and specialty. In a national Harris Poll that tracks the prestige of various professions, physicians dropped 10% between 2000 and 2005. In the new health care world where nearly all physicians are employed, there is an increasingly common narrative that physicians are merely serving as agents of a larger system, and their sole purpose is to feed patients to subspecialty services and hospital beds.

To address this narrative, there should be coordinated ABMS action to identify positive professionalism and refocus on the social contract. He cited Sylvia R. Cruess, MD, and Richard L. Cruess, MD, thought leaders on professionalism and the role of the physician in the 21st Century, who defined professions as having a complex body of knowledge and skills that are used in the service of others and whose members are governed by codes of ethics and profess a commitment to competence, integrity, morality, altruism, and the promotion of the public good. All these characteristics are the basis of the profession's social contract with society. Through that, physicians have autonomy, self-regulation, and accountability.

But Dr. Newton is concerned that the social contract is beginning to fray significantly, citing the Bristol heart

scandal in the United Kingdom, which was responsible for the deaths of 35 children undergoing heart surgery at the Bristol Royal Infirmary, as an example. Similarly, there is the opiate scandal in the U.S. started by physicians who wanted to treat pain, but who ignored the deaths that were resulting. Because physicians didn't fulfill their part of the social contract, state governments are stepping in to dictate what physicians should do in the examination room, medication doses they can prescribe, and how they should document care. Unless the profession addresses costs and quality, physicians will lose more autonomy.

Because ABFM believes the issue of professionalism should be front and center in the dialogue about health care, it established the [Center for Professionalism and Value in Health Care](#) in Washington, DC. The premise is to begin to change conditions to make it easier to be professional by inviting all specialties and professions to participate, engaging employers and patients, and developing measures of quality care that better capture the core of what physicians do, Dr. Newton concluded.



HIGHLIGHTS FROM PANEL B Q&A

An attendee noted that the profession grapples with pinpointing the threshold for triggering a DA. Is it one incident? Does it matter if the incident is minor or significant? If it's a pattern, how many incidents define a pattern? Dr. Burstin likened instances of unprofessional behavior to near misses in patient safety. The more physicians are able to discuss them openly in the clinical context, the better the profession will become at identifying signals that could lead to unprofessional behavior.

Another attendee asked who should be responsible for self-regulating the medical profession. Dr. Newton suggested that it should be a collaborative process with a role for SMBs with their investigative powers, credentialers at the local level where the incidents occur, and Member Boards that assess professionalism. He would like the focus to be on how best to intervene in a more positive and formative way before the physician is faced with a DA. Dr. Burstin said that is the responsibility of the Member Boards to work collaboratively with the societies and SMBs to establish those standards to ensure consistency across states. Dr. Crigger noted that historically the AMA's Code of Medical Ethics speaks to individual physicians about their behavior, but it doesn't address the behavior of the profession as a whole.

It also was asked whether professionalism is a moving target, citing social media and the increase of locum tenens as examples of societal changes that affect physician interactions. Although the profession will have to adapt to the changing work environment, such as new technologies and new care delivery systems, the basic construct of professionalism should not change, all three panelists agreed.

Panel C: Ensuring Professionalism from the Perspective of the Public and Regulatory Bodies

Panelists:

Thomas W. Hess, JD
Partner, Dinsmore & Shohl LLP,
ABMS Board of Directors

Robin Wagner, RN, MHSA
Senior Vice President of the Clinical
Learning Environment Review
(CLER) Program, ACGME

Patricia A. King, MD, PhD, FACP
Professor of Medicine, University of
Vermont Larner College of Medicine,
and Immediate Past Chair of the
Federation of State Medical Boards
(FSMB)

Rebecca Arnold LeBuhn (Becky), MA
Co-founder and Board Chair of the
Citizen Advocacy Center

TAKE-AWAYS

- *ACGME builds expectations for professionalism into its institutional requirements, common program requirements, and assessments for accreditation status.*
- *Professionalism and professional behaviors are a mixture of personal responsibility and manifestation of the organizational environment.*
- *There is a need to make decision-making about DAs more uniform across SMBs.*
- *FSMB is working to better define physician behavior underlying DAs and internally develop more transparent categories of those behaviors that could be adopted by SMBs.*
- *The public believes that licensing and certifying boards test and assess health care professionals to ensure they are competent and up to date in all aspects of patient care, including professionalism.*



Mr. Hess opened his presentation with a famous quote from Justice Potter Stewart who said, “I don’t know what pornography is, but I know it when I see it,” noting the same is true of professionalism. As an attorney who represents health care providers, the first question he asks is, “What is the standard that my client allegedly violated?”

Mr. Hess provided numerous examples of how the government has stepped in to regulate health care, beginning with the Medicare Act that became law on July 1, 1966. As written, the Medicare law prohibits the federal government from exercising any supervision or control over medical practice, how medical services are provided, who provides them, and how providers and medical institutions are run. Within three years, Congress stepped in to regulate it, once it saw the magnitude of Medicare’s size and amount of money being paid to health providers.

Among the laws created after Medicare were the Anti-Kickback Law, which prohibits exchange of remuneration for referral of services that are payable by a federal health care program, and the Physician Self-Referral Law (also known as the Stark Law), which prohibits physicians from referring patients for certain designated services paid for by Medicare or Medicaid to entities in which the physician or immediate family member has a financial interest unless a specific exemption applies.

Over time, increasingly more regulations were placed on physician-owned hospitals as concerns rose about physician motivation for sending patients to hospitals that they own when it was learned that unnecessary services were being provided. The Health Information Portability and Accountability Act (HIPAA) Privacy Rule, which established national standards for protecting individuals' medical records and other personal health information, requires physicians to protect their patient's health information. The Physician Payment Sunshine Act requires health care providers to disclose their financial relationships with pharmaceutical manufacturers. Congress passed all these federal laws to address physician conduct, whether it was to control costs, or prevent the over-utilization of services or corruption in the medical decision-making process.

When Mr. Hess began his career in 1976, he worked at the State Medical Board of Ohio as part of the attorney general's office. At that time, the SMB had 20 reasons for suspending, reprimanding, or terminating a physician's license. Today, it has 52 reasons.

Some reasons involve professionalism, such as the physician's failure to maintain minimal standards applicable to the selection or administration of drugs or employ acceptable scientific methods in the selection of drugs; willful betrayal of a professional confidence; use of a false, fraudulent, deceptive, or misleading statement in the solicitation or advertising for patients; departure from or failure to conform to minimal standards of care of similar practitioners; violation of any provision of either the AMA's or the American Osteopathic Association's Code of Ethics; impairment to practice because of habitual or excessive use or abuse of drugs, alcohol, or other substances; and termination from the Medicare and Medicaid programs.

In his experience, some SMBs, such as the State Medical Board of Ohio, do not presume a physician is innocent until proven guilty. The purpose of its administrative hearing is merely to discuss the penalty the board will impose on the physician for violating the law. Despite the presumption of guilt, he has agreed with some of the decisions the SMB has made, even some involving his clients.



A physician's specialty-based professional identity and understanding of professionalism is formed during their residency and fellowship years, Ms. Wagner noted. Given that, ACGME views itself as having a social contract with the public to ensure the safety and quality of the care patients receive from residents in training and when they enter practice after graduation. The social contract also calls for the provision of a humanistic, educational environment where residents are taught to manifest professionalism and effacement of self-interest to meet the needs of their patients. As a regulatory body, ACGME builds expectations for professionalism into its institutional requirements, common program requirements, and assessments for accreditation status.

In addition to accreditation status, ACGME has two evaluation components that provide formative assessments and insights to sponsoring institutions, programs, and residents and fellows—Milestones and the CLER Program.

The CLER Program, which she oversees, is a formative assessment designed to evaluate the interface between GME and the hospitals, medical centers, and ambulatory sites that host trainees and serve as their clinical learning environments. CLER assesses six focus areas across specialties: patient safety, health care quality (health disparities), supervision, transitions in care, well-being, and professionalism. CLER evaluates the clinical sites' infrastructure and expectations implemented to address these focus areas; how residents, fellows, and faculty connect to that infrastructure; and how the residents and fellows learn to contribute to systems-based solutions to address the focus areas.

The CLER Pathways to Excellence serves as a guidance document for the six focus areas. The professionalism focus area addresses education; attitudes, beliefs, and skills; faculty engagement in training, a culture of honesty in reporting; and clinical site monitoring. The document was formed with input from expert opinion and empiric data from several cycles' worth of site visits to the institutions that host residency and fellowship training programs.

Next, she shared data from the CLER National Report of Findings 2018 to demonstrate how professionalism manifests itself in the training environment. Regarding patient safety, half the residents/fellows who experienced an adverse event, near miss/close call, or unsafe condition, reported the incident through the clinical site's reporting

system. In follow-up conversations, residents/fellows who had not reported said that they relied on someone else to report or chose to resolve issues locally and not to report. Residents/fellows who explain that they solved the situation locally may be solving a problem for an individual patient, however, they are missing the connection to their professional responsibility to the system of care. This is an opportunity to educate residents/fellows that by reporting a patient safety event into the hospital's reporting system, they are helping the system identify patterns and trends, and take actions to prevent these events from happening to future patients.

Regarding supervision, the national report of findings noted 46.5% of residents/fellows reported that they have encountered an attending or consultant physician who made them feel uncomfortable when requesting assistance. This speaks to the professionalism of the physicians who are serving as role models and mentors for the trainees. The hesitancy of the residents/fellows to reach out for assistance has serious implications for patient safety.

In the focus area of well-being, 45.5% of residents/fellows reported they would "power through to handoff" despite being maximally fatigued. This could speak to the culture of the organization or to the residents/fellows missing the

connection to their professional responsibility to recognize how personal limitations may impact patient safety.

At nearly 90% of the clinical sites, residents/fellows reported observing some signs of burnout among faculty members and program directors. Among them were anger, cynicism, apathy, avoidance of clinical responsibilities, and decreased interest in teaching, all of which have important implications for trainees and patient safety. This example illustrates that unprofessional behavior is often a manifestation of the environment and factors in the environment. When speaking with health care leaders about burnout, there appears to be a focus on providing resources and resiliency training. Preliminary data indicates there is little focus, as of yet, on identifying the systems factors causing the stressors that result in these behaviors.

ACGME is learning that professionalism and professional behaviors are a mixture of personal responsibility and manifestation of the many layers of environment, Ms. Wagner concluded. Therefore, it's important to set expectations at all levels of the environment, implement systems and infrastructures that allow physicians to succeed and meet those expectations, and provide monitoring and feedback to create a better understanding of how to promote and support professionalism.



Every state or territory has an SMB composed of physicians, representatives from other regulated groups (commonly physician assistants [PAs]), and public members (the latter serve in all but three states), Dr. King explained. Some states have two licensing boards; an allopathic and osteopathic board. The Medical Practice Act gives these SMBs the authority to license physicians; receive, review, and investigate complaints against them; and adjudicate and potentially discipline physicians. FSMB represents all 70 state and territory medical boards and supports their mission for public protection.

The SMBs' functions complement professional self-regulation by protecting the public and strengthening the public trust and social contract between society and the

medical profession. The public believes that physicians who are licensed have received the appropriate education and training and have been assessed, tested, and found to be competent in all ways, including professionalism. The ability to file a complaint with an SMB offers patients' recourse for a negative interaction with a physician and builds public trust. Because many individuals who serve on SMBs are physicians, the boards support the notion of professional self-regulation. This privilege, however, could be revoked if the profession doesn't do it responsibly. And while this is a complaint-driven system, some states are working to be more proactive.

A model Medical Practice Act published by FSMB lists approximately 60 examples of unprofessional conduct, a number consistent with those in Acts across the country. Among them are misrepresentation on a licensing application, inappropriate prescribing, sexual misconduct, disruptive behavior, substandard care, fraudulent practice, and cheating on a licensing examination.

In 2018, approximately 80,000 complaints were submitted to SMBs, according to data gathered by FSMB from the boards across the country. Reporting of complaints, however, requires that the public understand the

recourse they have through SMBs. There were 8,500 DAs taken. Approximately 4,000 physicians were disciplined, representing 0.4% of the 985,000 licensed physicians in the U.S. Several physicians had more than one DA. In total and over time, only 4% of the physician population in the U.S. has been disciplined, so it's a small but important number.

The complaint data is rich in terms of understanding the public's concerns. Given that 70,000-plus complaints don't result in a DA, knowing the type of complaint can serve as a formative opportunity for SMBs. Vermont's medical board, on which Dr. King served, tries to take advantage of those opportunities by providing formative feedback. At times, this feedback is positive because it involves a physician who the board believes acted appropriately.

Understanding the underlying complaint of an SMB's DA can be difficult because the legal documents vary in quality and transparency. FSMB attempted to categorize the 8,500 complaints by the board actions' Conclusions of Law to find that 33% involved quality of care, 29% were deemed miscellaneous, 23% were classified as general, and 16%

were related to professionalism. The miscellaneous and general categories were too vague to determine what the actual complaint was about. The professionalism category didn't indicate what type of unprofessional behavior the physician engaged in. This lack of transparency is problematic for the public because it could result in patients not being sufficiently warned about a physician's unprofessional conduct. FSMB is trying to determine how to better define the actual physician behavior underlying DAs and internally develop more transparent categories that could be shared by SMBs.

SMBs are composed of individuals who are dedicated to public protection but are not experts in professionalism, Dr. King concluded. They review a wide range of physician misconduct from the very egregious to minor lapses, one-time incidents to repeating patterns. They are charged with deciding on remediation or DA, working with the state's attorneys general and respecting due process. Developing a definition(s) of professionalism would be most helpful.



Ms. LeBuhn addressed professionalism from the patient perspective based on her decades of work with consumer advocates, and public members on SMBs and voluntary certifying bodies. Consumers encounter physician professionalism in two dimensions – through personal encounters in the clinical setting and in relation to the larger professional culture.

On the personal level, patients want safe, competent, quality care, and, on the professional culture level, they believe that physicians know which colleagues do not meet that standard. So, reporting physicians who provide substandard care to an authority empowered to remediate or, if necessary, remove them from practice is an important component of professionalism. She gave an example of a Missouri urologist who performed unusually long surgeries, with adverse, and sometimes life-threatening, consequences. Although some individuals within the hospital had concerns,

these were not made public. The physician moved to another state to practice in a veteran's administration facility that reportedly did not query the NPDB about this physician. Now six years after the original incidents, Missouri's SMB is investigating the complaints.

This case raises important questions about how physicians slip through the cracks and the culture that enables them to do so. The failure of colleagues to report this urologist is a breach of professionalism, just as is the failure of colleagues to report Dr. Nasser and multiple other violators of sexual boundaries since exposed in investigative reports. Whether or not state practice acts require it, a culture of professionalism should embrace mandatory reporting as part of the profession's "contract with society." Ms. LeBuhn suggested that SMBs and other authorities investigating a medical error or unprofessional conduct, could assess professionalism by determining who was in a position to witness the incident and whether they reported it.

Ohio Governor Mike DeWine expressed the same thought after Richard Strauss, MD, went undisciplined despite multiple instances of sexual misconduct during his 20 years as a sports physician at Ohio State University. The governor instructed the SMB to review closed cases of sexual misconduct and determine whether witnesses to those instances reported them to the board. According to Governor DeWine, Dr. Strauss escaped discipline because

of “a failure of people to do what is right.” Ms. LeBuhn believes this is a model for other states and should apply to more than just sexual misconduct cases.

Professionalism also entails staying current with trends in health care delivery, such as expanding scopes of practice for non-physician health care practitioners. Increasingly, patients are seen first by PAs or nurse practitioners and see a doctor only when necessary. Studies show that in states where advanced practice nurses and PAs are authorized to practice independently, they provide quality care. Some in the medical community argue that physicians possess more knowledge and skill by virtue of longer years of education. That argument misses the point because non-physician practitioners aren’t trying to be doctors, they simply want to practice to the extent of their education and skills. Professionalism involves recognizing and respecting the

qualifications of all members of the health care team.

Most opinion surveys, including a recent one by ABMS, show that consumers believe licensing and certifying boards ensure that health care professionals are competent and up to date. The implication is that consumers believe these authorities also enforce codes of professionalism.

About the goal of establishing greater consistency and predictability in the way Member Boards respond to licensing board’s DAs, Ms. LeBuhn called for caution. Already subject to criticism for being too lenient, SMBs shouldn’t be tempted to tailor DAs so as to protect a physician’s certification status. Consumers expect boards to act on the facts regardless of the implications for a physician’s certification status.



HIGHLIGHTS FROM PANEL C Q&A

One attendee asked if there were any efforts underway to make decision-making more uniform across the SMBs. FSMB is working internally to identify language used to describe board actions that the states could adopt, Dr. King responded. Another goal is to build best practices for DAs and remediation that could be shared across the states. In response to the public's concerns about physicians whose unprofessional conduct goes unnoticed because they move, FSMB is working to improve how information is shared between hospitals and SMBs to enhance transparency.

Mr. Hess reinforced the need for consistency for how SMBs address decision-making with an example of a physician he represented. The physician, who lived in Pennsylvania, had a license to practice there, West Virginia, and Ohio. The physician, whose employer upcoded, was charged with the crime. The federal judge stated that the physician signed the upcoded documents and fined him. The employer paid the fine. The West Virginia board deferred to the Pennsylvania board, which made the physician take a continuing medical education (CME) course on coding. The Ohio board suspended his license for two years.

Sometimes physicians don't report other physicians because of the significant professional and financial toll it takes on both parties, noted an attendee. He saw firsthand how two physicians were consumed by lawsuits and legal costs to defend themselves. One was a neurosurgeon who complained about a physician in the community and was sued for defamation; the other was the chair of the medical staff who was sued by a vascular surgeon investigated by the medical staff. Previously, concerns of physician misconduct were typically investigated at the local level, the attendee added. But in today's changing health care environment, physician employees don't attend medical staff meetings anymore. That leaves the hospital administrators running the peer review process, which may not be viewed as fair a process for the physicians.



Larry Green, MD, ABMS Chair-Elect and Professor and Epperson Zorn Chair for Innovation in Family Medicine and Primary Care at the University of Colorado School of Medicine, served as moderator for a discussion session during which he asked attendees to respond to three questions:

1. How has the culture of medicine changed, particularly with respect to professionalism?
2. How can continuing certification promote professionalism?
3. What are the areas of professionalism that matter the most and do they differ by specialty?

Regarding how the culture of medicine has changed with respect to professionalism, the following themes emerged:

- A growing expectation of stewardship of health care resources.
- The need to balance the individual patient's needs with societal and larger population health needs.
- The quest for work/life balance that pits a physician's duty to his/her patient against his/her duty to self-care.
- Lack of civility due to the anonymity of evaluation systems.
- The growth of private equity and introduction of for-profit medicine and their impact on the erosion of a positive image of physicians.
- The institutionalization of medicine resulting in the decline of solo practice.
- Lack of role models of professional behavior due to growing demands on faculty.

With respect to how continuing certification can promote professionalism, the following themes emerged:

- Evaluating professionalism by asking questions as a means to change behavior.
- Using the formative aspects of continuing certification to help physicians understand that professionalism permeates everything they do.
- Having a mechanism to assess professional behavior will promote professionalism; follow-up with communicating its importance.

Regarding the areas of professionalism that matter most and whether they differ by specialty, the following themes emerged:

- Utilization and health care costs, which can be specialty specific, but should be addressed by all the Member Boards.
- Learning and improvement are the principal components of professionalism; they are at the core of the relationship between the physician and patient, and radiate outward across the health care team and system.
- Self-assessment and reflection are professional qualities that span across all specialties and are even promoted in the UME/GME arenas.
- Although professionalism may be expressed differently across the specialties, the underlying behaviors, attitudes, beliefs are the same.

SESSION 2

LEVERAGING THE PAST: ASSESSING PROFESSIONALISM IN EDUCATION, TRAINING, AND PRACTICE

Panel A: Assessment Strategies and Lessons Learned in Undergraduate Medical Education and Graduate Medical Education

Panelists:

Michael A. Barone, MD, MPH
Vice President for Licensure
Programs, NBME

Alison Whelan, MD
Chief Medical Education Officer, American
Association of Medical Colleges (AAMC)

Barry Egner, MD
Asante Health

TAKE-AWAYS

- *The assessment of professionalism in the UME and GME training environment is increasingly being driven by the learning communities' efforts to establish a belief system and less by sentinel events.*
- *Assessment organizations must collaborate to promote and support a systems approach addressing identity formation; learning environment measurement and modifications; measurement of individual and team performance in context; and remediation that focuses on development, not punishment.*
- *While there has been a lot of growth regarding assessment of professionalism in UME/GME, there is also room for improvement and consistency as the schools are using numerous different measurements with varying levels of validity.*
- *A professional health care organization defines the culture it's trying to achieve, creates the structures to support that, provides the people who work there with the tools and the education they need to create that culture, and offers remediation to those who are struggling.*
- *The American Board of Otolaryngology - Head and Neck Surgery (ABOHN) is in the process of validating a professionalism assessment tool to better identify candidates who will perform well during residency.*



The assessment of professionalism in the UME and GME training environment is increasingly being driven by the learning communities' efforts to establish a belief system—indoctrinating and enculturating students about what it means to be a professional—and less by sentinel events, Dr. Barone stated. When thinking about professionalism or competency development, and assessment in an educational setting, it's helpful to rely on frameworks that are “tried and true.” As an example, Miller's Pyramid of Clinical Competency can help tie competence to assessment methods at each level of the pyramid.

Commonly used assessments in UME/GME include clinical evaluation “rating” forms. While some of these use aspects of validated rating scales with behavioral anchors, home-grown instruments which often have little in the way of reliability and validity are quite common. Qualitative descriptive feedback from peers or faculty is used to complement the evaluation forms. Theoretically, these tools could measure everything along the competency schema in Miller's Pyramid (i.e., knows, knows how, shows, and does), but these tools are often not meeting expectations.

Other commonly used assessment strategies in UME/GME are reflection exercises, direct observation, and self- and peer-evaluations. Reflection exercises can be interspersed

along a trainee's professionalization journey. Outside the clinical environment, as part of the early curriculum, for example, direct observation could take place during anatomy lab or team-based learning sessions. Structured clinical examinations can be used anywhere across the medical education continuum. In New York City, for example, all rheumatology fellows are tested annually in a clinical skills setting using an observed structured clinical examination (OSCE). Other instruments include the Professionalism Mini-Evaluation Exercise, or P-MEX, which evaluates trainees on 24 different directly observable items of medical professionalism. Regarding self-evaluations, students tend to rate themselves higher on professional attributes than their peers, opening the door to a multi-source feedback (MSF) approach. Today, MSF instruments are commonly used as part of the formative/summative assessment of professional behaviors.

Recent discussions have focused on "harmonizing" many of the ACGME milestones across the specialties. The professionalism milestones could, regardless of field of practice, evaluate professional behavior and ethical principles, accountability/conscientiousness, and self-awareness and help-seeking behaviors. There are also emerging discussions about possibly using online reviews, such as looking at a trainee's social media profile. While it's tempting to think about using many sources of information to assess one's professional behavior, it's important to look to the literature for approaches and tools that have already been validated.

Two challenges of assessing professionalism that must be considered are local culture and incentives. Research suggests that faculty essentially often serve as "a silent

witness" to professionalism lapses because they are concerned about the ramifications to a student's professional career and how the punishment may outweigh the lapse. [A paper](#) he cited provided a medical student's perspective arguing that rating scales may undermine professionalism by sapping internal motivation and converting conversations about professionalism into "grades" or as a means to obtain a good residency.

The conversation, however, is changing from measuring professionalism in settings where the expectations may be unclear to focusing on professional identity formation. Going back to the 1950s, Columbia University sociologist Robert Merton stated that the purpose of medical education was to get somebody to "think, act, and feel like a physician." Fast forward to 2016, Drs. Sylvia and Richard Cruess suggested adding a fifth level to Miller's Pyramid to reflect the embodiment of a professional identity. This is more in tune with ABMS' definition of a belief system.

Dr. Barone believes that the assessment of professionalism is only going to be successful if it's bookended, as part of a system, with meaningful work in the learning environment and support for the trainee's professionalization, and then linked to processes that can course correct performance. Furthermore, assessment organizations must collaborate to promote and support a systems approach addressing:

- Identity formation
- Learning environment measurement and modifications
- Measurement of individual and team performance in context
- Remediation that focuses on development, not punishment



Dr. Whelan highlighted three constructs of professionalism. The centuries-old model of professionalism associates a physician's personal character with virtues, ethics, and humanism. In the 1990s, a new model focused on competency, with behaviors to be demonstrated and assessed. This behavioral model emerged because of the perceived failure of the virtues model to translate

ethical instruction into ethical action. In the past decade, the professional identity formation model was created. Developed because of concerns about the reductionist behavioral model, this model described the progressive incorporation of the values and aspirations of the profession into an individual's identity.

The construct used would determine what type of assessment and remediation is appropriate. In other words, professionalism lapses would be dealt with differently depending on whether they are an inability to apply ethical principles, an instance of inappropriate behavior, or a lack of insight into one's own professional identity.

While UME emphasizes professional identity formation, it also recognizes that trainees need a very clear roadmap to get there. The roadmap is all about the professional

behaviors. Assessment toggles between the two. Whatever construct is ultimately chosen, it must be transparent for the learners, assessors, and the public.

Dr. Whelan discussed the current state of assessment strategies for professionalism in UME. For pre-admissions, the Situational Judgment Test, which was developed by AAMC, presents a hypothetical dilemma, asks examinees to rate the effectiveness of various approaches, and provides a score that complements their academic scores. This tool, which has been shown to be valid and reliable, predicts a medical student's performance in those areas that link back to pre-professional behavior. The Situational Judgment Test is currently being piloted with promising results.

Regarding accreditation, the Liaison Committee on Medical Education standards require all schools to establish a learning environment that promotes the ongoing development of explicit and appropriate professional and ethical behaviors in medical students, faculty, residents, and other health care professionals at all training locations. The Liaison Committee on Medical Education expects that these behaviors are clearly articulated in measurable terms, are taught and modeled by those supervising students, and are clearly assessed in students throughout their medical education program.

Medical schools now have a framework for assessing professionalism; observation by clinical faculty is the most common method being used. While there has been a lot of growth regarding assessment, there is also room for improvement as the schools are using numerous different measurements with varying levels of validity.

Most clerkship evaluation forms now include professionalism concerns. Additionally, many schools have adapted general professionalism concern forms (not tied to a clerkship) that students, peers, faculty, and other health care professionals may complete. Communication is such an important skill

that it is typically treated as a separate competency with its own set of measurements.

In 2014, AAMC convened a Medical Student Performance Evaluation (MSPE) task force to standardize, to the extent possible, information in the MSPE across schools, and present it clearly and concisely, and in a way that allows information to be easily located. Related to professionalism, AAMC provided a new template in which it asks the school to describe how it defines professionalism and what it assesses in students as well as the individual applicant's areas of strength and weakness. While schools vary in how fully they have adopted this recommendation, a [2018 survey of 147 schools](#)' MSPEs published in the *Journal of Graduate Medical Education* found that 81% of schools included formal information on professionalism, up from only 12% in 2015. Work to improve the MSPE continues with two AAMC working groups: the Group on Educational Affairs/ Group on Student Affairs MSPE Narratives Project and the MSPE Effective Practices Working Group.

For residency applicants, AAMC developed a Standardized Video Interview tool that focuses on two ACGME competencies: knowledge of professional behaviors and interpersonal and communication skills. The tool was found to be valid and reliable but has not progressed beyond the pilot stage.

Although competency-based medical education is just starting to enter the UME/GME arena, Dr. Whelan believes it will drive a better assessment of professionalism because competency-based medical education reframes how entrustable professional activities (EPAs) are viewed. Readiness for entrustment is based on one's ability or level of ability, reliability, integrity, and humility. "It's the ability to know what you don't know and to ask for help," she said. This new framing of entrustment ties directly to professionalism.



Dr. Egner offered insights on professionalism from the perspective of health care organizations. Aside from the significant impact that health care organizations have on

the expression of professionalism by individuals within them, organizations themselves may act professionally or they may not. A set of competencies and behaviors define professionalism for organizations similar to, but distinct from, the set that defines professionalism for individuals. Professionalism is contextual, however, so the norms may vary among different cultures or there may be conflicts between professionalism values, such as self-care and care of the patient, that may be resolved differently based on the culture.

The limited impact of the health care that physicians deliver, which determines only 15% to 20% of health outcomes, is

an illustration of why “organizational professionalism” is a new and important perspective. The more impactful social determinants of health are not under the purview of health care organizations, the government, or communities, but rather a combination of all of those. That means professional health care organizations must seek strategic partnerships with other health care organizations, the public, and government to improve health. A professional health care organization defines the culture it’s trying to achieve, creates the structures to support that, provides the people who work there with the tools and the education they need to create that culture, and offers remediation to those who are struggling. This culture applies to all individuals working there, not just medical professionals.

In the August 2017 issue of *Academic Medicine*, Dr. Egner and his colleagues [published an article](#) about the Charter on Professionalism for Health Care Organizations, which is primarily aimed at leadership. Four domains are outlined in the Charter (e.g., relationships with patients, relationships with community, organizational culture, and operations and business practices), and each domain has a list of organizational competencies.

Dr. Egner and his peers are in the process of trying to determine what health care organizations are currently doing to assess their professionalism. The goal is to develop a set of metrics describing organizational professionalism. Next, they will identify best practices and design interventions to help organizations move toward a higher level of professionalism.

He identified two dilemmas for assessing individual professionalism in the context of organizational professionalism. One is who is responsible for the professionalism of the entire organization. While leaders have a special responsibility, individuals also have a responsibility. The second dilemma regards responsibility for actions undertaken by a group, such as a division or the hospital board.

Dr. Egner provided examples of how individuals can be assessed within each of the organizational professionalism domains. For example, professional behavior regarding patient relationships includes advocating for policies that give patients access to records, inviting family members to participate on rounds, or expanding hours in the intensive care unit. Refusing to care for or respect preferences of patients belonging to certain ethnic or religious groups would be considered unprofessional because doing so compromises the organization’s commitment to respect and diversity.

In terms of relationships with communities, individuals volunteering in free clinics, becoming a board member of a community organization or advocating for community representation on a hospital board are examples of professional behavior. Refusing to participate in emergency room calls is unprofessional because it disregards a duty to community health.

Regarding organizational culture, professional actions include supporting colleagues suffering from adverse events (e.g., a malpractice suit or poor medical outcome). It could even be taking action in real-time when a physician yells at a nurse or, at the organizational level, undertaking the creation of a peer support network to address such issues. An example of unprofessional behavior is disparaging the hospital administration to patients rather than advocating for change within designated structures.

In terms of operations and business practices, pointing out financial conflicts of interest, such as screenings that identify potential referrals to specialists but are not recommended by standard setting bodies, falls under professional behavior. Unprofessional behavior would be refusing to accept patients without commercial insurance and engaging in “surprise billing.”



HIGHLIGHTS FROM PANEL A Q&A

Dr. Burstin asked if anyone knows how much an individual's sense of professionalism changes from UME to GME to practice and whether someone with a fixed sense of his/her own professionalism is influenced by the external environment. Dr. Egner responded that the hope is physicians internalize professionalism regardless of the environment they encounter, but he acknowledged that some individuals do benefit from external pressures to behave in certain ways.

Another attendee questioned how organizational professionalism can be maintained as increasingly more hospitals are being bought out by health systems and medical staffs are atrophying in favor of the more powerful hospital administration. Dr. Egner suggested to create agreements, such as the Charter, that can serve as a belief statement to which physicians hold each other accountable. And while the medical staff and/or administration are responsible, so too is the individual. Exactly how these principles will play out in these new settings remains to be seen as this is uncharted territory, he added.

Another attendee, whose institution was embroiled in a recent scandal regarding a faculty member who is a sexual predator, wondered what kind of system would allow this type of person to move from one organization to another without being discovered. Dr. Barone pointed out that many faculty members say they are not incentivized to report such activities. But if people can't see the incentive to report such egregious behavior, then he believes the profession has lost its way in this regard.

Brian Nussenbaum, MD, MHCM, FACS, ABOHNS Executive Director, shared the board's five-year journey, thus far, to develop a professionalism assessment tool after realizing that exam scores and other metrics about medical school performance did not necessarily translate to how well someone will perform during residency. Based on program director feedback, ABOHNS developed a structured interview, pilot tested it, and is now starting to collect outcomes to validate the instrument that assesses such non-cognitive skills as teamwork and communication. If validated, this tool will allow Otolaryngology – Head and Neck Surgery to get the best possible residents into the specialty and provide program directors a way to assess residents' areas of strength and weakness upon entry into residency. The residents can be then remediated early on in residency. Dr. Barone noted that more of this type of work, which does take a lot of time and effort, needs to be done and linked to the learning environments and remediation.

Dr. King questioned whether there is a way to assess risk through the continuum because while it may not have an impact in the UME setting, for example, that risk could have significant adverse impact on patients and the physician in practice. Dr. Barone noted that program directors may have more opportunity to assess risk because of the extended time they have with residents. In contrast, medical students spend only a limited time with their UME educators. Dr. Egner suggested that identifying risk as part of the Member Boards' continuing certification programs may be beneficial as well.

Panel B: Assessment Strategies and Lessons Learned from the Efforts of Health Care Institutions and Regulatory Bodies

Panelists:

Gerald Hickson, MD

Senior Vice President of Quality, Safety and Risk Prevention and Joseph C. Ross Chair of Medical Education and Administration at Vanderbilt University Medical Center

Carrie L. Bradford, MHA, RHIA, CPCS, CPMSM

Senior Director for Professional Staff and Credentialing at NorthShore University HealthSystem

David Henderson, JD

Chief Executive Officer of the North Carolina Medical Board (NCMB)

Kathy Chappell, PhD, RN, FNAP, FAAN

Senior Vice President of Accreditation, Certification, Measurement, and the Institute for Credentialing Research and Quality Management at the American Nurses Credentialing Center (ANCC)

TAKE-AWAYS

- *Research suggests that 50% of clinicians never receive an unsolicited patient complaint, while 4% of clinicians account for 35% of patient complaints. In comparison, 90% of clinicians never get a co-worker complaint while nearly 3% of clinicians account for almost half of staff complaints.*
- *Recent trends in assessing professionalism that reflect changes in the work environment and culture are low-volume physicians and a more significant focus on clinician well-being during the reappointment process.*
- *Often, not disclosing past disciplinary problems related to unprofessional conduct is a bigger concern for institutions than the underlying conduct itself as the attempt to cover it up raises questions about the applicant's character.*
- *Tools such as the 360° feedback and the Interprofessional Professionalism Collaborative's assessment instrument promote the assessment of professionalism cross professions.*
- *The growing problem of the "geographic solution" must be addressed.*



Dr. Hickson highlighted the work of Vanderbilt University's Center for Patient & Professional Advocacy (CPPA), established in 2002 in response to a tragic event involving a medical error, patient harm, and a clinician modeling disrespectful behavior. "Everyone recognized the risk, but no one acted effectively," Dr. Hickson said. CPPA's research, service, and training focuses on identifying, measuring and addressing unprofessional behaviors. Today, 200-plus health systems take advantage of CPPA's programs to support the pursuit of professional accountability. Patients, family members, and medical team members are uniquely positioned to see faulty systems of care and team members behaving unprofessionally. Their observations can be captured to identify clinicians whose behavior needs to be addressed. CPPA faculty train and support peer messengers and leaders to promote self-reflection and change with these clinicians.

Behaviors that adversely impact a team's ability to achieve intended outcomes are unprofessional and should be addressed early and often. A clinician who does not wash his/her hands is acting unprofessionally because that behavior threatens patients and other team members. Respect for others and established best practices is core to being professional.

In early studies, Dr. Hickson and colleagues found that 50% of clinicians never receive an unsolicited patient complaint, while 4% of clinicians accounted for 35% of them. Furthermore, patient complaints are proxy measures of malpractice claims experience. Coworkers also experience disrespect. Staff complaint distribution, however, is even more skewed; 90% of clinicians never get a co-worker complaint while nearly 3% account for almost half of them.

Participating sites submit patient and staff stories to CPPA's Patient Advocacy Reporting System® (PARS®) and Co-worker Observation Reporting SystemSM (CORSSMSM). Complaints are coded to identify clinicians at risk for malpractice claims and avoidable medical outcomes. "And we know that high risk today predicts high risk tomorrow unless peers are willing to share," Dr. Hickson said.

CPPA also is committed to developing an infrastructure (i.e., people, processes, and systems) to support the work. One key element is leaders who will not blink when the physician modeling unprofessional behavior is perceived to have special value. Strong leaders also support a standard and predictable approach, such as the Vanderbilt Professionalism Pyramid, to sharing concerns as soon as they are collected. The pyramid defines a tiered intervention approach beginning with an informal cup of coffee for a single report escalating to a peer-delivered

"awareness" intervention (supported by local and national peer comparisons data) for those who appear to model a pattern to a "guided interventions by authority," which includes a written corrective action plan. The small number of clinicians who do not respond to these interventions are subject to DA as defined by the organization's policies.

As a work in progress, CPPA is tracking the performance of 74,000-plus physicians. In 10 years, slightly more than half are associated with an event that warrants coffee. Most physicians respond professionally and less than 3% show evidence of pattern development. Less than 1% of physicians go on to require a formal written plan, which in most cases directs a mental and physical screening exam. Few physicians (>0.2%) have been unable or unwilling to respond, including those who demonstrate evidence of early cognitive dysfunction. A troubling finding, however, is that slightly more than 0.2%, depart unimproved and are identified at a second site participating in the CPPA programs. Professionalism is about demonstrating technical and cognitive competence, modeling respect, and promoting teamwork. It's also about a willingness to sit down and have face-to-face conversations with colleagues, which is something nobody likes to do, but it can have a profound impact on peers and the patients they serve.



Ms. Bradford offered her perspective of professionalism as a credentialing professional with 30 years of experience. Among the host of characteristics used to define an individual's level of professionalism are a neat appearance, proper demeanor, reliable, competent, ethical, etc. The best gauge for her, however, is how the physicians treat her staff when going through the application process. Those who treat her staff poorly are usually gone in two years. They just don't have the ability to "play well with others," she added.

When reviewing physicians' credentials, Ms. Bradford is responsible for verifying their medical school education, residency, and fellowship with primary sources. She wants to know if they are board certified, have ever been

reported in the NPDB, and status of their licensure. The NPDB will reveal any malpractice issues as well as revoked privileges and/or licensure concerns. Additional information is garnered from the physicians' curricula vitae, work history, and malpractice history. Ms. Bradford is looking for consistency in these documents with what the physician wrote in the application. She establishes a timeline to get this information to determine the physician's accountability. If the physician can't meet a simple 30-day window to produce information, how is he/she going to treat a patient?

Working in a Joint Commission-accredited organization, Ms. Bradford is required to obtain peer references, which must address the six ACGME/ABMS core competencies. Hospital policy dictates who is allowed to complete peer reviews, who is the best person to complete them, and when further information is required, among other specifications. For example, a program director is required to fill out the peer review for new graduates. Despite having a policy, she still routinely receives a lot of questions about filling out peer references. The biggest issue is with low-volume physicians who don't come into the hospital often, so there may not be many physicians on staff who know them well enough to write a peer reference. Many individuals are apprehensive to indicate they don't know

the physician in question, but Ms. Bradford encourages them to do so to ensure accuracy of the information. Some physicians prefer doing this over the phone, so she always gives them that option. Ms. Bradford believes that some individuals may have concerns about litigation if they put this information in writing.

Once all the information is pulled together, she sends it to the Division Head and Chief who do a comprehensive review. They are looking for time gaps, red flags, and any information that is lacking. Time gaps, for example, determine if the physician has been working consistently, which is important when trying to determine one's competence. Ms. Bradford recommends that they call the physician directly because sometimes meeting face-to-face with a person can "tell you a whole lot," she said. Once they sign off that this physician has the necessary clinical training, the information is passed to the Credentials Committee for review.

The reappointment process is repeated every two years, per Joint Commission requirements. It is less intense than the application process because it's more about updating existing information, Ms. Bradford noted. NorthShore University HealthSystem, which does participate in the PARS and CORS programs, evaluates quality and performance closely.

Ms. Bradford shared two recent trends in assessing professionalism that reflect changes in the work environment and culture. The first is that it's getting increasingly more difficult to assess because physicians don't interact the same way they used to. They don't come to the hospital and "hang out" in the lounge, so they don't really get to know their colleagues. Secondly, the reappointment process focuses more on a personal level from a wellness standpoint than it has in the past. More physicians are seeking assistance from the institution's wellness resources because they are experiencing burnout.



Using NCMB as an example, Mr. Henderson provided a glimpse into how SMBs view professionalism. The statute authorizes NCMB to deny a license or take disciplinary action against a physician based on approximately 25 reasons, one of which is unprofessional conduct. The statute highlights the physician's character and competence, which he believes are equally important, in its description of unprofessional conduct. It defines the expectation of ethics, honesty, justice, and good morals of all licensees. The statute does not distinguish between unprofessional conduct occurring within the practice or outside it, in North Carolina or elsewhere. A professional has the obligation to conduct himself/herself at all times in a manner that's consistent with the ethics of the profession.

NCMB attempts to detect character issues before a physician applies for licensure, after they receive their license, and when matters are brought to its attention.

During the license application, there are "red flag questions" that ask the applicant to disclose any problems he/she has had in the past. Oftentimes, the underlying conduct is not near as serious as the attempt to cover it up because the

latter raises questions about the applicant's character. NCMB does a criminal background check and verifies the applicant's medical school/residency training. In addition to determining whether the applicant has successfully completed the program, NCMB inquires whether he/she has been disciplined for unprofessional conduct or behavioral reasons, and if so, what kind of action was taken. The applicant provides two physician references from individuals he/she chooses. Sometimes these individuals provide "nuanced information" about the applicant's character that NCMB follows up on. Finally, test score annotations are reviewed.

After the physicians are licensed, NCMB uses many vehicles to inform licensees about its expectations. The goal is to be proactive and help physicians stay out of trouble. NCMB's newsletter, *The Forum*, publishes relevant articles and board actions. While most physicians go straight to the back of the issue to see the board actions first, it is a great way to let licensees know the potential consequences for inappropriate conduct. NCMB has approximately 40 position statements, including ones that address behavioral, ethical, and professionalism issues. As part of its outreach efforts, staff present at state and local professional organizations on related topics.

Despite these efforts, NCMB continues to receive reports related to bad behavior, quality of care issues, and substance abuse and mental health issues. This information comes from private vendor and public records, patients, health care providers, hospital change in staff privilege reports, FSMB Data Bank, NPDB, and the licensee as part of the annual renewal process.

Many cases are closed without any action due to a lack of

evidence. In other cases, unless the unprofessional conduct is repeated or egregious, NCMB usually resolves it through some type of private remediation. The physician may be asked to speak with the North Carolina Professionals Health Program to rule out substance use disorder or mental health issues. Oftentimes, when the underlying substance use disorder or mental health issues are addressed, other issues get resolved as well. NCMB has utilized various assessment treatment programs that address disruptive behavior, professional sexual misconduct, ethics, etc. These can be found in the [FSMB Directory of Physician Assessment and Remedial Education Programs](#).

NCMB has a good success rate because it works with proven remediation programs, and because there is a lot at stake and physicians are highly motivated to cooperate.

When remediation doesn't work or is inappropriate due to the seriousness of the misconduct and/or prior history, NCMB must take disciplinary action. The latter can be a hybrid action such as a consent order that includes discipline and remediation. Underlying untreated mental health and substance use disorders can be a big impediment to successful remediation.

In closing, Mr. Henderson noted that it's important to define professionalism expectations for physicians and regularly communicate and educate them about those expectations. Furthermore, as mentioned in the [Continuing Board Certification: Vision for the Future Commission report](#), DAs should not automatically impact certification—especially non-disciplinary/remedial actions involving mental health or substance use disorders.



Taking an interprofessional focus, Dr. Chappell noted that there are differences in the conversations regarding professionalism across medicine and nursing. These differences could be related to how members are enculturated into medicine, varying levels of independence and influence, and pressure to succeed with zero tolerance for failure, or that nursing is just using different terms to describe similar concerns such as bullying behavior and horizontal violence. [A study](#) citing that nurses cause the most disruptive behavior for interns speaks to the need to have a broader conversation.

Dr. Chappell reviewed how nursing addresses professionalism in the context of certification. Approximately 246,000 nurses are board certified by ANCC. There are four million nurses practicing in this country. ANCC is the largest nursing certifier in the United States. It has 18 active board certifications, maintains 32 retired board certifications, and develops all its board certification examinations in-house. The American Nurses Association publishes a Code of Ethics as well as a Nursing Scope and Standards of Practice. It uses a professional self-regulatory model consistent with medicine's model. However, most of the conversation about professionalism in

nursing focuses on nurse-to-nurse bullying or inappropriate behavior. More recently, there has been an increase in abuse toward nurses by patients and nurses being the victims of violence at the hands of patients and their families.

From a certification exam standpoint, all ANCC's certification exams test some domain of professional behaviors and ethical practice. Most nurses renew through continuing professional development. Those in specialty practice must attest to their continuing professional development requirements and ANCC does do audits to validate renewal requirements. For advanced practice registered nurses who have a regulatory component to their certification, ANCC does primary source verification for eligibility. ANCC works with the respective state licensing boards to address any complaints. In recent years, ANCC has had to implement increased rigor for exam security due to cheating. It has invested significantly in web patrolling and data forensics. One recent incident involved an individual who, after taking the APRN certification exam, went on YouTube to share what was on the exam.

Dr. Chappell concluded her presentation by calling for more interprofessional collaboration. Pointing to [a paper](#) in *Academic Medicine* that defined professionalism from the perspective of patients, physicians, and nurses, she noted the gaps between the patients' and nurses' viewpoint compared with that of the physicians. For example, keeping the patient and family members up to date and exploring the patient's needs were very important to nurses and patients, but perceived as less important by physicians. Dr. Chappell noted how 360° feedback, which incorporates more than just physician feedback, has been shown to improve the skills of everyone on

the health care team. The [Interprofessional Professionalism Collaborative](#) developed a valid and reliable assessment instrument to be used across multiple health professions and in various practice sites. The instrument is posted on its website along with other educational tools and

resources that promote the assessment of interprofessional professionalism. All these examples demonstrate the importance of using a similar frame of reference across the medical professions when defining professionalism.

HIGHLIGHTS FROM PANEL B Q&A

Dr. Egner questioned how to address the growing problem of the “geographic solution,” which is driven by economics and the need to fill positions. Is this a matter of professionalism, either at the individual or organizational level, or law? There has been a lot of discussion about information that is nuanced or sugar-coated and physicians’ willingness to discuss things verbally, but not write them down. Sometimes lawyers prevail upon hospitals to sign non-disclosure deals on the condition of a settlement. This problem is exacerbated by some recipient institutions that don’t want to know about a physician’s past unprofessional behavior. Dr. King said that she pushes leaders to fill out peer references accurately and honestly as they have a responsibility to do so. For those physicians who have had a lapse, it’s not about being perfect, but being honest.

John Moorhead, MD, MS, Immediate Past Chair of the ABMS Board of Directors, raised another growing problem of medical expert testimony, and how to address when physicians admit to lying in previous testimony or testify about the standard of care outside their scope of practice. This behavior is not only unethical, it’s unprofessional. But it’s unclear who is accountable. He believes that the SMB should be notified, but people are afraid of getting sued. Dr. Henderson responded that this is not only a matter of public protection, but of protecting the integrity of the profession. NCMB does offer statutory immunity for people who report concerns unless they are made in bad faith. If the person does get sued, at least he/she will have a good defense.

Dr. Whelan led participants in tabletop conversations about lessons learned from the assessment of professionalism in UME, GME, and in practice; what is working well; and what challenges lie ahead. A number of themes emerged from the discussions.

Regarding lessons learned:

- There may be a disconnect between what is assessed and what is communicated across the continuum. There is significant variability in what is attempted to be measured.
- Despite the definitions of professionalism being aspirational, they do map well to what is being assessed or could be assessed.
- There are core behaviors that demonstrate professionalism across the specialties, however, many may manifest differently depending on the specialty. There are differences between disrespect for patients and colleagues.
- More work needs to be done to assess professionalism across the continuum, including getting representation from training and education centers and incorporating the learners' voice.
- It's easier to implement best practices for assessing professionalism in the UME and GME settings than it is in practice.
- Given that assessment is predictive of future behavior, better tools to assess professionalism are needed.

Among the things that are being done well are:

- Promoting professional identity development.
- Recognizing that individual behavior makes a difference and aspects of emotional intelligence behaviors are teachable.
- Renewing the focus on physician wellness and its impact on professionalism across the continuum.
- Identifying that there are problems with how professionalism is currently assessed.
- Starting to engage in dialogue across the continuum to address the assessment of professionalism.
- Conducting new research and ongoing development of new tools (and range of tools) to assess professionalism.

Among the challenges are:

- Identifying expectations of professional behaviors, including definitions, action types, and division of responsibilities, across the continuum.
- Assessing professionalism of physicians in practice at the Member Board level consistently across the specialties.
- Holding physicians accountable for unprofessional behavior.
- Integrating multiple data sources to make a determination of unprofessional behavior.
- Creating a formative environment that encourages open and honest sharing about professional issues.
- Defining what is formative and summative and how to use data for both purposes in addressing and remediating issues with professionalism.
- Recognizing and rewarding positive exemplars and not just penalizing lapses in professionalism.
- Addressing competing/conflicting values and pressures, such as litigation risk and financial considerations.

TAKE-AWAYS FROM SMALL GROUP DISCUSSIONS (CONTINUED)

- Focusing on how patients are impacted by unprofessional behaviors.
- Developing and/or implementing effective assessment tools.
- Communicating among and between credentialing boards and SMBs.
- Breaking down silos and communicating the importance of professionalism across the continuum to reach the practicing physician.
- Providing faculty development training about how to assess professionalism.
- Being transparent in reporting actions taken.
- Sharing information among bodies collectively responsible for professional self-regulation.
- Balancing the tyranny of metrics versus the power of metrics.
- Maintaining the ability to self-regulate as trust in the medical profession erodes.



PLENARY SESSION

ASSESSMENT OF PROFESSIONALISM AS AN OBLIGATION FOR SELF-REGULATION

Panelists:

Maxine Papadakis, MD
Professor of Medicine Emeritus at the
University of California, San Francisco (UCSF)

TAKE-AWAYS

- *Research suggests that unprofessional behavior in medical school predicts subsequent DA by SMBs.*
- *Given that one in five students have lapses in professionalism during medical school, which Dr. Papadakis believes is part of professional identity formation, she recommended to normalize minor lapses in professional behavior and calibrate responses based on the severity of the lapse.*
- *Studies have shown that lapses of professionalism during internal medicine residency are associated with a higher risk of subsequent DAs and board certification in internal medicine is associated with fewer DAs.*
- *Isolated assessments often fail to identify inadequate or marginal performance and do not provide the best opportunity for remediation whereas longitudinal assessment for professionalism is a more comprehensive measure.*
- *Distinguishing between lapses and patterns of unprofessional behavior is essential because a lapse has a beginning and end and is likely remedial whereas a pattern is usually more difficult to remediate and may pertain to one's character.*



Dr. Papadakis started the plenary session by offering a definition of professionalism given by Louis Brandeis, who, at the time, was the youngest Supreme Court nominee. Although he cited his definition more than 100 years ago, it resonates with her today. Paraphrasing the Brandeis definition, professionalism is:

- A body of knowledge that is owned by the profession and distinguished from a skill
- An occupation pursued largely for others, for which the financial return is not the accepted measure of success
- An obligation for self-regulation

As a former dean of students, list-based definitions of professionalism were useful to Dr. Papadakis, but they had limitations. Just putting behaviors on a list didn't help students understand what should be on the list and why. Additionally, by focusing on behaviors, medical educators may overlook or neglect their responsibility to assess and transform the environments in which students learn and to do the same with systems problems. A more abbreviated definition of professionalism that Dr. Papadakis carries around with her is that "a professional is someone you can trust to do the right thing even when no one is looking."

Increasingly concerned that medical education professed

that professionalism was a fundamental competence, but systems were not consistently in place to support that tenet, in 1995 Dr. Papadakis and her colleagues established the UCSF Professionalism Evaluation System, which created a process to make professionalism a “core” competence. A key component of the process is the “Physicianship Evaluation Form” that site or clerkship directors use to evaluate students’ professionalism lapses. If a student receives a Physicianship Evaluation Form (only one form can be submitted per one rotation), it documents that the student did not meet the objective(s) of professionalism. An example of not meeting the objective(s) of professionalism is a student who frequently arrives late to clinic or does not notify the appropriate individual if he or she will be absent from an in-patient team meeting. Since the goal of the system is remediation, Dr. Papadakis met with the students who received a Physicianship Evaluation Form to hear their perspectives and to provide feedback about their professionalism lapses.

The Physicianship Evaluation process had performance measures built into it. Information would be transmitted in the MSPE if students received two or more Physicianship Evaluation Forms in the third or fourth year of medical school. Similar to the performance threshold where students who did not pass two clerkships or rotations, based on inadequate performance in the core competencies of fund of knowledge or clinical skills, might not graduate from medical school, students could potentially be considered for dismissal based on their pattern of lapses in the core competence of professionalism.

The need for outcome data spurred Dr. Papadakis and her colleagues to research whether unprofessional behavior in medical school predicted subsequent DA by SMBs when the medical students became practicing physicians. [In a case control study](#), the medical school graduates from UCSF, University of Michigan, and Jefferson Medical College who were disciplined by any SMB between 1990 and 2003 were matched to controls from their medical school, graduation year, and specialty. The study of 732 physicians (1/3 cases, 2/3 controls) showed that physicians had been disciplined across 40 SMBs in the United States. There was a 26% attributable risk associated with unprofessional behavior in medical school and subsequent DA. Individuals who were irresponsible were nearly nine times more likely to have a subsequent DA; those who demonstrated poor self-improvement were three times more likely to face DA. In comparison, lower scores on the Medical College Admission Test had an attributable risk of 1% for the association of unprofessional behavior in medical school and subsequent DA and there was no association for NBME/United States Medical Licensing Examination® Step 1 scores. Students in years one and two who did not pass a course on the

first attempt had a 7% attributable risk; there was no such association in years three and four.

Dr. Papadakis believes that a conservative estimate is that one in five students has lapses in professionalism during medical school and that lapses in professionalism are part of professional identity formation. As such, she recommended normalizing minor lapses in professional behavior and calibrating responses based on the severity of the lapse.

Dr. Papadakis then discussed whether the association of lapses of professionalism during residency is associated with subsequent DAs. Working in collaboration with the American Board of Internal Medicine (ABIM) and FSMB, Dr. Papadakis and her colleagues looked at residents in U.S. categorical or primary care internal medicine residency programs between 1990 and 2000 who became ABIM diplomates. Performance measures used were the program director ratings of six components, one of which is professionalism, and the Certification Exam Score. Of the 66,171 residents [in the study](#), 1% received a DA; the most common reason for DA was failure to meet CME requirements. Other reasons included fraudulent billing, inappropriately prescribing controlled substances, substances abuse, and professional conduct. Those who scored low on the program directors’ ratings of professionalism were twice as likely to have a subsequent DA. Similarly, residents who scored lower on the Certification Exam were two times as likely to have a subsequent DA. Consequently, this study documents that ratings on professionalism during training do bare on the subsequent care of patients. Also, the data support the inclusion of professionalism as a competency in the AAMC Physician Competencies Reference Set.

The data in these two studies, however, do not support the dismissal of trainees for fear of subsequent DA; the odds ratio is low and there is poor sensitivity and specificity for the individual, Dr. Papadakis warned. Advancement of residents should be based on demonstration of the ACGME competencies.

[Another study](#) she presented focused on practice characteristics of physicians who were in an internal medicine residency between 1995 and 2004. Unlike the previous study in which all subjects had received ABIM board certification and diplomate status, this study was of residents in categorical and primary care medicine residencies whether or not they had received ABIM board certification. Of the 66,881 residents in the study, 95% became ABIM diplomates (half generalists, half subspecialists). Of the remaining 5%, 1.6% became board certified in another specialty and 3.4% never became board certified. Nearly three-quarters of the non-board certified physicians were practicing medicine, mostly internal medicine. The disciplinary rate for the ABIM cohort was

1.2%. For those who went into another specialty, it was 2.4%. For those who never certified, the disciplinary rate was 6%; five times that of the ABIM cohort.

While some argue that students should have a fresh start at the beginning of each course or clerkship, and keeping in mind the data that Dr. Papadakis had reviewed, she is a proponent of assessing students longitudinally on professionalism because the behaviors associated with professionalism are longitudinal and cumulative. She maintains that isolated assessments not only often fail to identify inadequate or marginal performance but do not provide the best opportunity for remediation. Longitudinal assessment also serves as a more comprehensive measure for students because they can show improvement over time.

It is challenging to identify residency applicants who are most likely to be professional. The personal interview has a limited ability to assess non-cognitive domains and the application essay is not predictive of performance. Dr. Papadakis supports the use of instruments, such as the Multiple-Mini Interview, which has been found to be an excellent predictor of pre-clerkship and clerkship performance of professionalism. It includes scenarios that require the applicant to explain how they would handle, for example, a medical student with alcohol on his/her breath or inadvertently giving the wrong drug.

Regarding remediation of marked professionalism lapses and unprofessional behavior during UME, there is a dearth of data looking at long-term outcomes. She wondered whether all medical students are truly remediated or are some being taught “just to stay under the radar.”

Dr. Papadakis believes in focusing on problems in the educational environment, and not just the learner, when addressing professionalism lapses. She mentioned a conference hosted by the Josiah Macy Jr. Foundation and chaired by David M. Irby, PhD, in April 2018, that addressed

this topic particularly well. The conference proceedings can be found in a monograph entitled [Improving Environments for Learning in the Health Professions](#). Because creating a culture of professionalism requires addressing unprofessional behavior by faculty, at UCSF, an evaluation of “respectful” treatment by medical students of residents and faculty was created. Medical students were asked two questions about their residents and faculty:

1. Did Dr. X treat me with respect?
2. Did you observe Dr. X treating others (residents, patients, nurses, staff) with respect?

Behaviors that students identified as showing a lack of respect toward them included belittling or humiliating a person and speaking sarcastically or insulting. It was critical the medical students knew that information from the “respect” questions were taken seriously, transmitted to the departments, and reviewed by a dean; data from the respect questions could even influence faculty promotion.

In conclusion, Dr. Papadakis emphasized that professionalism is a core academic competence, and not just a disciplinary one. Addressing professionalism lapses is intrinsic to self-regulation. Professionalism includes the educational environment, systems issues, diversity, and inclusion. However, it's important to be mindful not to erode the fundamental characteristics of the profession while attempting to create a culture of professionalism. As the Department Chair in Medicine at UCSF, Robert Wachter, MD, wrote a few years ago in *The New York Times*, “Our businesslike efforts to measure and improve quality are now blocking the altruism, indeed the love, that motivates people to enter the helping professions. While we're figuring out how to get better, we need to tread more lightly in assessing the work of the professionals who practice in our most human and sacred fields.”

“*A professional is someone you can trust to do the right thing even when no one is looking.*”

HIGHLIGHTS FROM THE PLENARY SESSION Q&A

One attendee questioned whether recently published studies linking board certification in internal medicine, anesthesia, and surgery to fewer DAs are really showing a relationship between the two or just measuring how buttoned-up a person is. Moreover, is it possible to assess how responsible a person is prior to entering medical school to select people who are less likely to be unprofessional. Dr. Papadakis responded that the associations remain consistent in numerous studies and conducting a study of cause-and-effect would take decades to complete. Regarding responsibility, she said it speaks to only one component of professionalism.

It seems clear that the data showing the impact of training and assessing professionalism at the UME level on professional behavior later in one's career is much stronger than the data on anything else being taught in medical school, another attendee pointed out. Dr. Papadakis agreed, but noted that the data focus on short-term outcomes because that's what can be measured. Because knowledge taught in medical school will change over time, it's more important to teach critical thinking, she added.

Dr. Papadakis also stressed the importance of distinguishing between lapses and patterns of unprofessional behavior. A lapse has a beginning and end, and it is likely the most remedial. Lapses are a part of professional identity formation. A pattern, however, is usually more difficult to remediate and may pertain to one's character.

While UCSF's Physicianship Evaluation Form and respect questions capture some unprofessional behavior, they do not capture all of it; individuals may be afraid to put their concerns in writing for various reasons, including fear of retribution or even litigation. However, Dr. Papadakis asked that the conversation be turned around to put the patients' voice at the forefront: What would they want the institutions to do?

Clinical psychologist Betsy White Williams, PhD, MPH, emphasized that any individual who observes unprofessional behavior and does nothing about it is complicit in the behavior and is only reinforcing it. That makes it more difficult for someone like her who tries to remediate problematic behavior. People are often remediable, but it's imperative to understand the contributory factors that are causing those behaviors to occur. These may include biopsychosocial issues, such as health and mental health conditions, external life stressors, and system issues. Taking a different perspective, Dr. Papadakis noted that the institution must decide how far it will go to remediate physicians. While an institution has an obligation to create the best learning environment that it reasonably can, it is not the institution's obligation to get the student "to step over the finish line," she said, adding, "And that's the push-pull here."

SESSION 3

MOVING INTO THE FUTURE: ASSESSING PROFESSIONALISM IN THE CONTEXT OF CONTINUING CERTIFICATION

Panel A: Assessing Professionalism for Continuing Certification: Perceived Challenges and Potential Solutions

Panelists:

George Mejicano, MD, MS
Professor of Medicine at Oregon Health & Science University

Craig Campbell, MD, FRCPC, FSACME
Associate Professor of Medicine at the University of Ottawa and Principal Senior Advisor of Competency-based Continuing Professional Development in the Office of Specialty Education at the Royal College of Physicians and Surgeons of Canada

Betsy White Williams, PhD, MPH
Clinical Director of the Professional Renewal Center and Associate Professor in the Department of Psychiatry and Behavioral Sciences, School of Medicine University of Kansas

TAKE-AWAYS

- *Perceived challenges to assessing professionalism in continuing certification are the debate of whether professionalism is learned or attributable to a person's character, the myopic focus on bad behavior, the "tip of the iceberg phenomenon," and the focus on individuals versus the overall system.*
- *Other challenges are determining the best model of assessment to use (i.e., virtues, behavioral, or identify formation); defining strategies to promote learning and assessment that incorporate various perspectives; and integrating multiple data sources to generate a consequential decision.*
- *The Royal College of Physicians and Surgeons of Canada is working with the Medical Council of Canada on what will likely become a national MSF process that includes both qualitative and quantitative data, and engages a trained facilitator who coaches physicians on how to use the data and feedback.*
- *From a remediation perspective, challenges to assessing professionalism include that it is a culturally bound concept and cultural norms are dynamic, multiple definitions of professionalism exist, and various stakeholders operationalize professionalism differently.*



Dr. Mejjicano highlighted four perceived challenges and potential solutions to assessing professionalism in continuing certification. The first challenge is the debate of whether professionalism is learned or whether it is attributable to a person's character. The second challenge is the myopic focus on "bad behavior," especially with the advent of reporting systems that focus on critical incidents. The third is the "tip of the iceberg phenomenon." Simply put, "we do not know what we do not know," he said. The fourth challenge is the focus on individuals versus the overall system. Dr. Mejjicano believes that the system should be the bigger focus, recognizing that the broader health care system sends mixed signals to learners and practitioners about what is tolerated and what is valued.

The problem with focusing on behavior is that it does not get to one's intent, values, or inner thought processes. "It's not what do you do when no one's looking, it's what are you thinking when no one's looking," he said. Further, it's unclear how many lapses actually occur, in part because of confidential processes used by Human Resources professionals.

Regarding solutions, Dr. Mejjicano suggested embracing a growth mindset instead of debating nature versus nurture. This mindset is based on the concept that individuals can improve their performance, moving from novice to expert. But decay sets in over time, so people need to be

continually monitored and boosted up, when necessary. The key is learning the signs of decay in order to know when to intercede.

Dr. Mejjicano proposed celebrating positive behavior instead of focusing on bad behavior. Institutions should be seeking examples of exemplary behavior and not just those of unprofessional behavior. Instead of perpetuating the iceberg phenomenon, he recommended incorporating the perspectives of other individuals and systems to help eliminate existing "blind spots." Those other voices could be gathered through, for example, MSF or peer and/or patient input. Other options for gathering multiple voices include crowdsourcing and workplace-based assessments. Data, which is now being gathered in real-time, can serve as the basis of group decision-making. Dr. Mejjicano's fourth solution is to shift the focus from the individual versus the system to relentless culture change.

Regarding assessment, the type of approach that is used matters. For a behavioral approach, a portfolio or e-portfolio are a good fit. He believes a values approach that incorporates reflective exercises might be better. Dr. Mejjicano's definition of reflection has a rubric that can determine whether an individual has gained insight as a result of an unprofessional incident. The third is the trust approach. Some have characterized trust by linking professional values to specific behaviors. For example, individuals who display maturity accept blame for failure, don't make inappropriate demands, and are not abusive and critical during times of stress. Another view of trust is not just whether individuals have knowledge and skills, but do they have discernment, truthfulness, and conscientiousness. At the UME level, these attributes are being measured and may provide a path forward for assessing professionalism in other settings, including ones for practicing physicians.



Dr. Campbell identified three challenges to assessing professionalism in continuing certification. Because professionalism is such a complex construct, decisions about curriculum and assessment require a conceptual foundation.

Defining strategies to promote learning and assessment must incorporate generational, specialty-specific, and professional practice perspectives. Finally, he believes that assessing professionalism requires the integration of multiple data sources to generate a consequential decision.

Elaborating on the complexity of professionalism, Dr. Campbell mentioned the three models: virtues, behavioral, and identity formation. The key question is whether professionalism is a set of virtues, such as altruism, humility, and integrity; a set of competencies that can be demonstrated; or an adaptive developmental process that involves adopting the values, habits, or behaviours of a community of practice.

The Royal College of Physicians and Surgeons of Canada has embraced the Canadian Medical Association's view of professionalism exemplified by its recently revised Code of Ethics and Professionalism. The Code underlies the values of the profession as demonstrated by practicing medicine competently, safely, and with integrity; avoiding any influence that could undermine professional integrity; and developing and advancing professional knowledge, skills, and competencies through lifelong learning. Dr. Campbell posits that if lifelong learning is an ethical imperative of physicians, then physicians demonstrate their professionalism through participation in the Royal College's Maintenance of Certification (MOC) program.

In 2015, the Canadian Medical Association redefined its "Professional Role" to state that as professionals, physicians are committed to the health and well-being of individual patients and society. The definition includes a set of competencies in four key areas. The physicians' commitment to patients involves applying best practices and adhering to high ethical standards. Their commitment to society entails recognizing and responding to societal expectations in health care, such as patient safety. Their commitment to the profession includes adhering to professional and ethical standards and participating in physician-led regulations. Their commitment to personal health/well-being emphasizes the importance of maintaining it. "I would argue that professionalism is expressed through all these dimensions," he said.

In its MOC program, the Royal College assesses professionalism primarily through assessing knowledge and using MSF. Professional Role milestones are integrated across multiple EPAs. An example includes working within interprofessional teams.

At the UME level, professionalism is being assessed through 12 national EPAs in the curriculum. For residency

training, the Royal College created and maintains a case-based curriculum on bioethics. The cases were designed to illustrate key ethical principles to support teaching and assessment of bioethics at residency programs. Each case is organized around questions and includes an analysis with conclusions constructed by the authors and references for future learning.

The curriculum served as a foundation for developing interactive self-assessment programs designed for physicians who can receive MOC credit for completion. The modules pose questions, provide immediate feedback, and give a quiz to consolidate knowledge. As an example, a 50-second video on disruptive behavior can be seen through the lens of the patient, resident, trainee, or physician. Ninety days after launching the self-assessment program, nearly 655 participants, primarily specialists and some residents, completed the disruptive behavior module. The feedback has been encouraging, with many participants reporting that it helped them identify ways to promote a just culture.

The Royal College is working with the Medical Council of Canada on what Dr. Campbell expects will become a national MSF process involving feedback from colleagues, non-physician co-workers, and patients. What sets this MSF process apart from others is the inclusion of both qualitative and quantitative data. It is linked with a trained facilitator who coaches physicians on how to use the data and feedback to build an action plan. "It's intended to be developmental, not punitive," he said. More than 80% of pilot participants reported making practice changes based on patient feedback.

Using multiple types of data sources and numerous observers synthesized over time will likely help construct a more accurate "picture of professionalism" for diplomates, Dr. Campbell concluded.



According to Dr. Williams, a clinical psychologist who assesses and treats trainees/physicians in difficulty, the assessment of whether a physician is "professional" is a

difficult task that cannot be accomplished through the use of a single psychological test. She discussed the many challenges in assessing professionalism, including that it's a culturally bound concept, cultural norms are dynamic, multiple definitions of professionalism exist, and various stakeholders operationalize professionalism differently. Often the demonstration of "unprofessional" behavior occurs in response to a system issue. Physicians working in multiple locations may demonstrate behavioral problems in one location, suggesting that they responded poorly to a system failure at that location. Those demonstrating behavioral issues across locations likely have additional contributory factors.

Important considerations in assessing these physicians include the reason for the referral, types of data available, and how will the data be used (e.g., to make a diagnosis or to determine remediability, a treatment/remediation plan, or progress).

In many cases, unprofessional behavior occurs intermittently so it is important to get a sense of the behavior over time. Looking for patterns is helpful including understanding onset, pervasiveness, and chronicity of the behavior. Other important data include whether the physician received feedback, prior treatment/remediation, and the success and/or failure of treatment/remediation.

It is necessary to understand the potential contributory factors as such understanding informs the treatment/remediation effort. Dr. Williams uses a biopsychosocial approach that assesses whether there are medical or psychiatric conditions, personality characteristics, and/or past/ongoing psychosocial stressors that could be contributory. When interpreting the data, it is important to evaluate quantitative and qualitative aspects of performance. Absolute level of performance and how the physician approached the task can provide useful insights into what contributory factors might be and how best to approach treatment/remediation. It is important to utilize appropriate norms, particularly when interpreting neuropsychological

test data. Her data suggest that there are many contributing factors in the biopsychosocial sphere and reinforce that understanding the contributing factors is critical to treatment/remediation efforts. Many individuals who Dr. Williams assesses/treats/remediates are diagnosed with medical conditions, such as sleep apnea, that were previously undetected. Her data also suggest there may be risk factors and predisposing factors that can be used to identify people who are more vulnerable to having these kinds of difficulties earlier on. Many, but not all, people are remediable, Dr. Williams said. Some physicians who are remediated become change agents in their organizations, helping to re-shift the culture.

The assessment of professionalism should be considered in the context of potential pathways forward and using the data to support treatment/remediation. She discussed the importance of providing in-the-moment feedback in response to unprofessional behavior and ways to do that. Other considerations Dr. Williams raised are: What are the mechanisms of acquiring and improving professionalism? How is professionalism maintained over time? What types of data will best support growth and ongoing professional development? How is a positive growth mindset fostered? What level of system support is needed?



HIGHLIGHTS FROM PANEL A Q&A

One attendee asked Dr. Williams if the changing health care employment environment is making it more difficult to remediate physicians because it's easier to terminate their employment contract. In her experience, Human Resources tends to be less tolerant of outlier behaviors, affording the individual opportunity for remediation, but having little tolerance for ongoing behavioral issues, she said. In contrast, medical staffs can be a little more forgiving and accepting of the notion that remediation is a process that could take some time.

The changing nature of the structure of health care organizations is an opportunity to ensure that they are providing feedback early and often as well as investing in the right resources for individuals who need additional assistance, Dr. Hickson noted. Recruiting physicians is an incredibly expensive process and sometimes organizations do not always provide the full story about the physicians in question. While this speaks to the professionalism of the organization, it is incumbent on the profession to have intentional discussions to decide what approach should be used when individuals are unable to be remediated. Because they are all culpable, all organizations should invest in these resources, he said.

Dr. Mejicano agreed and called for using discernment, conscientiousness, and truthfulness as lead indicators to help figure out when individuals need an intervention, whether it's talking over a cup of coffee or more resource intensive remediation for a more egregious behavior. "That's why I think focusing on lapses is the wrong approach," he said. "We have to look at exemplary behavior and determine what pieces of information will give us early indicators." The professional mindset that labels asking for help as a bad quality must change as well, Dr. Mejicano added. When medical students, residents, and even physicians in practice, don't ask for help when they are in trouble, problems are hidden.

Another attendee asked Dr. Williams whether she is given the necessary data she needs to help remediate physicians. Some organizations send all the collateral data they have, while others are very particular about what they send, she said. As part of the participation agreement, that is part of receiving services at her program, the doctor waives his/her right to look at any of the data. Despite informing the organization that this information will not be disclosed, there are still instances where we might not receive all the data.

Individuals also have a difficult time providing feedback, Dr. Williams said. To combat that, she developed the mnemonic "CURT®." The conversation would go like this:

- I am Concerned about your behavior.
- It makes me Uncomfortable or if you would rather it is Unprofessional.
- Please Refrain from doing that because we don't behave like that here.
- Thank you.

"The most powerful feedback is when it is tied to the problematic behavioral event," she said. "If you give people feedback in the moment, you are doing them a favor."

Dr. Moorhead noted the importance of mentors, which are lacking once physicians complete their residency and enter into practice. Dr. Campbell elaborated on the MSF process that is linked to a facilitator, who in a way serves as a coach. Training individuals to provide quality feedback is essential. It's not about the data or narrative; it's the conversation. After reading the MSF based on his leadership role at the Royal College, Dr. Campbell contemplated early retirement, he half-heartedly joked. But his coach helped him view the data in a positive way and use it to make him a better leader. Without the facilitator's coaching, however, it is difficult to use the data to create a positive response.

Dr. Keegan led participants in small group, tabletop conversations. The first discussion focused on the most important professionalism attitudes and/or behaviors that physicians in practice should be expected to demonstrate. The following themes emerged:

- Holding individuals accountable for their behavior; including responding to, and reporting, unprofessional behavior.
- Engaging in self-improvement by seeking/receiving feedback and making positive changes to address negative feedback.
- Embracing self-awareness by engaging in self-reflection.
- Maintaining competence throughout one's career.
- Respecting others from peers to patients.
- Always striving to be and do better.

Regarding how to best assess these attitudes/behaviors in continuing certification, 360° reviews or MSF tools topped the list. Other suggestions were to incorporate journal articles about professionalism and self-reflection activities into the continuing certification process. Topics could include, for example, how to conduct a 360° review, effectively communicate, and demonstrate respect in the workplace.

The knowledge and skills that serve as a foundation for professionalism should be taught and assessed starting in UME, continuing into GME, and once the physician enters practice on an ongoing basis. Professionalism should be assessed longitudinally throughout a physician's career.

Member Boards should consider certain, specific more egregious professionalism lapses as a cause for revoking one's certification without an opportunity for remediation. Among the lapses they should use to make this determination are criminal convictions and guilty pleas for specific types of crimes (e.g., a pediatrician convicted of child molestation). There should be a mechanism to address physicians who move from one state to another after losing their license to practice in the first state. ABMS Chief Legal Officer John D. Mandelbaum, JD, MBA, noted that Member Boards receive this information from the SMBs. The boards should determine the number of states in which a physician can lose his/her license before the Member Board revokes his/her certification. Should it be one? Two? More?

Dr. Williams noted that in her experience if a physician's behavior is very egregious, as in the case of sexual misconduct with a minor, and the SMB had sufficient evidence of the physician's involvement, the SMB often suspends the physician's license, whether or not the criminal process has run its course. In her experience, an SMB might recommend a fitness for duty evaluation. As another example, in the case of a surgeon who has a history of causing harm and even death to patients, the certifying boards should be able to investigate and determine whether the surgeon's certification is valid, even if the SMB has not taken action.

Another option could be to place the physician on “administrative leave,” while the unprofessional behavior is being investigated. In some states and in other countries, a restriction is placed on how the physician can practice while the case is being investigated, Dr. King added. As an example, if a male physician is accused of sexual misconduct with a female patient, he would be limited to seeing only male patients.

Mr. Mandelbaum pointed out that the Member Boards are usually not privy to information regarding an SMB’s ongoing investigation unless it is made public. If a certifying board revokes a physician’s certification prior to an SMB revoking his/her license and the SMB ultimately decides not to take any action against the physician, then the board may be subject to legal action by the physician.

Many certifying boards revoke certification when a physician has a restriction placed on his/her license. ABOHNS recently revised its bylaws to address this issue by stating that under “extraordinary circumstances,” it could summarily revoke an individual’s certification, Dr. Nussenbaum said. The physician, who must be informed immediately, is still afforded due process to try to get his/her certification back.

Some Member Boards address the issue of revocation by relying on their eligibility standards. George Wendel, Jr., MD, Executive Director of the American Board of Obstetrics and Gynecology (ABOG), noted that some boards have moved away from revoking certification because of the requirements for due process and appeals. Instead, as part of their eligibility standards, ABOG and other boards have an annual application process for participation in their continuing certification programs. The boards ask applicants about license revocation and restrictions issued by an SMB or loss of privileges by the local hospital. ABOG has a zero-tolerance policy regarding sexual misconduct and boundary violations. A chaperone requirement, for example, makes the physician ineligible for certification because it’s a license restriction. There is no need to revoke these physicians’ certification because it expires due to their behavior, Dr. Wendel said.

Physician buy-in for assessing professionalism in continuing certification may be an issue as it is unclear whether the average physician embraces the concept. There could be some lessons learned from the opioid crisis. Initially, physicians were against any restrictions being placed on their prescribing habits, but they eventually did accept some restrictions. Similarly, once physicians have clear expectations of what they must do to meet professionalism standards, they will do so in order to maintain their certification. This is especially true if it requires, for example, participating in MSF.

Professionalism standards should be introduced as a constructive, rather than punitive, requirement. They should be framed in the bigger context of professionalism and not just about continuing certification. The bigger picture entails looking at organizational responsibilities and creating a health care system that supports professionalism and professional behaviors.

Panel B: Steps Forward Toward Innovation and Collaboration Reactor Panel

Panelists:

Carolyn L. Kinney, MD
Executive Director of the American Board
of Physical Medicine and Rehabilitation
(ABPMR)

Helen Burstin, MD, MPH, MACP
Executive Vice President and Chief Executive
Officer, CMSS

Christie Morgan, MD
Senior Staff Surgeon at Henry Ford Health
System Department of Otolaryngology and
Clinical Assistant Professor at Wayne State
University School of Medicine

The reactor panelists shared their thoughts and insights about how the community of assessment professionals can work together to address professionalism.

TAKE-AWAYS

- *The medical profession must commit to working across silos to develop clarity of goals, shared definitions, standards, and an assessment approach for professionalism.*
- *Although remediation may not be entirely the Member Boards' responsibility, they could incorporate a remediation component in their assessment of professionalism.*
- *To accommodate the disparities in resources among the Member Boards, ABMS should take a leadership role, for example, in developing educational tools that are applicable across the boards as most professionalism issues are not specialty specific.*
- *Professionalism domains could be incorporated into Improvement in Medical Practice activities or a program akin to the ABMS Portfolio Program™, enabling diplomates to meet continuing certification requirements for professionalism.*
- *To move toward consistent use of data across the SMBs, Member Boards should collaborate with SMBs to create models and best practices for framing DAs.*



Professionalism is a core element of ABMS board certification, Dr. Kinney noted, and is very important

to patients. Every lapse of professionalism is a publicly reported failure, drawing a wider audience than any other certification domain. The ABMS Member Boards believe board certification sets a higher standard of professionalism than state licensure and they use that perspective as the basis for their processes. But when it comes to taking action against physicians for unprofessional behavior, some boards currently are constrained by the risk of legal retaliation. Despite these challenges, there are surely opportunities for the boards to collaborate with each other and their partner specialty societies to move the assessment of professionalism forward.

The medical community should agree to adopt consistent language and processes for addressing unprofessional behavior. Currently, the Member Boards have different designations in the area of professionalism. Some boards have a probationary status, while others have a suspension status. Some boards have neither; they make only a binary “revoke” or “do not revoke” decision. On a larger scale, there is an opportunity for the House of Medicine to agree on the language and framework for professionalism, which, based on discussions during the Symposium, are a struggle not just for the certifying boards but across the profession.

Consistency and care in the language used might help promote opportunities for education, particularly for physicians once they are in practice, because the language the Member Boards use may make physicians less receptive to feedback about their behavior. Medical students and residents are in settings in which they’re being observed, instructed, and given immediate feedback. But once physicians are in practice, they don’t get much feedback and they miss those educational opportunities. Despite the increase in hospital-employed physicians, many doctors are still practicing in relative isolation. For example, 60% of PM&R physicians are in private practice. “We talked earlier today about what physicians do when no one’s looking,” she said. “Well, no one is looking at most physicians most of the time.”

Member Boards should partner with their specialty societies to develop a shared vision for education around a renewed commitment to professionalism.

While remediation may not be entirely the Member Boards’ responsibility, if revocation of certification for unprofessional behavior is being contemplated, the boards could have a

better sense of remediation options available to physicians, even if the boards don’t directly provide remediation services. After all, the boards are responsible for assessing physicians’ knowledge and providing an opportunity for remediation if physicians fail a recertification exam. Professionalism assessment could incorporate a similar remediation component.

Because resources differ significantly among the larger versus smaller Member Boards, ABMS should take a leadership role in assisting the boards to address these issues. ABMS could help develop some shared educational tools for use by all the boards, as most professionalism issues are not specialty specific.

Given that professionalism is a competency that can always be further developed, Dr. Kinney suggested professionalism domains could be the target of improvement in the medical practice component of continuing certification. Such an approach would add value to the diplomates without creating additional burden. The Continuing Board Certification: Vision for the Future Commission (Vision Commission) has recommended strongly that the boards reduce burden and increase the value of recertification to participating physicians.

ABMS could enter partnerships with health care organizations to engage their physicians in professionalism assessment and improvement, much like it partners with organizations to engage their physicians in quality improvement efforts through the ABMS Portfolio Program™. Using this model, physicians who engage in activities related to professionalism through their health care organization could receive credit toward meeting continuing certification requirements, Dr. Kinney concluded.



Professionalism is at the core of the work the specialty societies and Member Boards do, Dr. Burstin said, adding, “It is the poster child for collaboration.” It will require some visionary thinking because MSF data and 360° evaluations are still relatively new in this arena, but that will drive innovation. In the meantime, incremental steps can be taken to move forward. First and foremost, the medical profession

must commit to working together across silos to develop clarity of goals and then shared definitions, standards, and an assessment approach.

The Member Boards can start by using data consistently across the SMBs and the NPDB to obtain the information they need. Tread carefully when focusing on the assessment piece, Dr. Burstin cautioned, because rushing to build something into continuing certification before it’s ready will raise the hackles of the average doctor. There are ways to position the concept of professionalism so that it is viewed as improvement and an opportunity for learning.

There are opportunities to collaborate with SMBs by creating models and best practice guidelines for framing DAs. Having models/guidelines also would make it easier for Medical Boards and others to use the data for DAs. If the SMBs see that these models are agreed upon by all the

certifying boards, some states may be willing to adopt what they view as best practices.

Understanding that the continuum really begins the moment people apply to medical school is essential. It's clear that there are some remarkably innovative new tools on the UME and GME side to address professionalism, but it's important to consider how those tools could be used outside of those settings for which they were developed and validated. Will the same tool that works for medical students be the best tool for residents and practicing physicians? "Context really matters," she emphasized. Think about how the learner may be very different in a different context. The concept of a national MSF process, akin to the one evolving in Canada, is appealing as it brings together

multiple data sources and puts into place a longitudinal assessment.

Professionalism should be assessed in health care systems as well as in individuals. Work to improve the system, taking into consideration the existential threats that negatively impact professionalism. Among those are the growth in health system integration and private equity, both of which are resulting in an increase in the number of employed physicians.

At the end of the day, unprofessional behavior is really about power, Dr. Burstin concluded. "The same way we treat patients is often the way we treat each other."



Addressing professionalism is an incredibly complex, multifaceted problem that extends, not just to one group or silo, but rather across the continuum impacting the entire medical profession, noted Dr. Morgan, who is Chair of the ABMS Professionalism Task Force. Created to address the aspirational Vision Commission recommendation to develop approaches to evaluate professionalism and professional standing, the Task Force members attended the Professionalism Symposium one day before their first in-person meeting. "I don't represent any one of your silos, but I am very much a product of your raising," she added.

"Our profession has so much to offer every single person who we encounter, whether it's trainees, patients, or individuals in the broader community," Dr. Morgan said. "I want to harness all the wonderful knowledge in this room to make us better as a community of physicians and show our patients what we have to offer. I believe that with all our input, knowledge, and commitment we're going to get there, even though it's hard work."

Dr. Keegan asked for final thoughts, questions, future directions, and/or recommendations for the Professionalism Task Force.

Dr. Barone suggested that the Task Force evaluate how compassion and humanism in medicine interrelate with professionalism. Another attendee noted the power of storytelling and if it was possible to share stories highlighting professionalism in medicine to influence the culture and instill more trust in the profession.

Dr. Campbell emphasized the importance of having an educational strategy, beyond curriculum, that is responsive to the ever-changing nature of professionalism, and linking this strategy to assessment. The strategy could unfold in case studies or stories as the discourse around the principles and how it informs physicians' thinking and behavior.

Dr. Burstin suggested asking the average doctor what he/she thinks about assessing professionalism instead of relying on hypothetical accounts presented at the Symposium. In this era of social media, it should not be difficult to capture the perspectives of physicians in practice. She mentioned the Physician Moms Group on Facebook, which brings together 71,000 female physicians who are also parents. Harnessing social media groups such as this one could provide a plethora of opinions. Dr. Keegan pointed out the importance of hearing physicians' voices, particularly of early career physicians, who have a real stake in how professionalism will be assessed moving forward.

CLOSING REMARKS

DRS. HAWKINS AND BARONE SUMMED UP THE OPPORTUNITIES AND CHALLENGES, RESPECTIVELY, PRESENTED DURING THE SYMPOSIUM.

TAKE-AWAYS

- *Efforts to assess professionalism by the various stakeholders serve as pre-existing guidance to help focus and prioritize the work ahead, including to more clearly define unprofessional conduct, enhance its transparency, and learn how the public views professionalism in the context of self-regulation.*
- *Opportunities to assess professionalism in terms of knowledge, skills, and underlying attitudes that shape behaviors as opposed to focus exclusively on behaviors should be explored.*
- *A better understanding of how unprofessional behaviors are associated with suboptimal patient outcomes may help determine how professionalism should be defined in continuing certification and how lapses should be addressed.*
- *Among the challenges to assessing professionalism are determining the legal defensibility of revoking a physician's certificate; developing a definition of professionalism that can be measured; determining an accurate baseline of unprofessional behavior; incorporating remediation into the process; addressing institutional cultural norms regarding unprofessional behavior, and tackling the large faculty development effort that will be necessary to do this correctly.*
- *The greatest challenge will be to develop a reliable assessment that fits into existing educational and clinical practice systems, both of which are rapidly changing.*

There are many leaders in the medical profession who are committed to upholding the physician's social contract with society and moving this conversation forward, Dr. Hawkins said. Doing so requires sharing perspectives and experiences, especially when they differ. "It requires working within the profession to discuss, debate, develop, disseminate, and, if necessary, defend our collective standards and the means by which we achieve them," he noted. "We all have a role, and a stake, in professional self-regulation and we need to respect that and come to agreement on how to move forward."

The AMA's Code of Medical Ethics; the Physician Charter from ABIM, the ACP Foundation, and the European Federation of Internal Medicine; and CMSS' Code for Interactions with Companies all serve as pre-existing guidance to help focus and prioritize the work ahead. Lessons can be learned from colleagues' efforts, such as NBME's recent comprehensive review of the assessment strategies used in the UME/GME setting, ACGME's CLER Project, and FSMB's determination to more clearly define unprofessional conduct and enhance its transparency. Learning how the public views professionalism is critical

and certainly has consequences for self-regulation. “If the medical profession doesn’t get this right,” Dr. Hawkins said, “it could be up to lawmakers to decide.”

Automatically focusing on behaviors to assess professionalism to maintain certification may not be the correct route based on NBME’s experience in assessing professional behaviors and the broader view of the stages of Miller’s Pyramid. There may be opportunities to assess professionalism in terms of its knowledge, skills, and underlying attitudes that shape behaviors.

There is much to learn from AAMC’s various initiatives regarding assessment strategies in UME and how the conceptualization of entrustment plays out, but also to understand how accreditation is a strong driver for moving this discussion forward. Considering how organizational professionalism may help promote and support the assessment of professional behaviors by diplomates may be beneficial.

Dr. Barone concluded the Symposium by addressing key challenges.

Whether the Member Boards’ actions to revoke a physician’s certificate is legally defensible is a serious challenge identified today. Other surmountable challenges are developing a definition of professionalism and construct to determine what should be measured. Having better clarity of goals would be beneficial.

From the UME/GME perspective, there is the rather large faculty development effort that will be necessary to do this correctly. Faculty must not only buy into the concept, but they will need to clarify the expectations for residents.

Determining an accurate baseline of unprofessional behavior will be challenging. The small percentage of doctors who are brought in front of SMBs was sobering. Many attendees believe that the problem is likely larger than what is published in the literature.

Addressing the existential threats to the profession that Dr. Burstin mentioned is another challenge. The profession is changing so rapidly that these threats are shaking the core of what it means to be a physician. In fact, some of the erosion of trust that has occurred between the public and medical profession could be a consequence of these threats.

Addressing professionalism in clinical practice must take into consideration the various professional pathways available to physicians who choose to influence patient care through their roles as executives/administrators and medical

A better understanding of how unprofessional behaviors are associated with suboptimal patient outcomes may help determine priorities. Prioritizing risk to patients in the context of certification program development should also be explored. Can professionalism be defined in the requirements? How should lapses be addressed?

It may be helpful to determine why professional lapses in nursing are largely a peer-based issue and in medicine unprofessional behavior focuses on patient-physician encounters. Colleagues experienced in remediating physicians can provide insight and support for the assessment of professionalism in order to successfully remediate these individuals.

“If the medical profession doesn’t get this right,” Dr. Hawkins said, “it could be up to lawmakers to decide.”

educators, among others. Challenges from professionals who remediate physicians with professionalism issues should be addressed as well. ABU is trying to determine how cost fits into one’s professional commitment and how the profession is perceived. As Dr. Mejicano pointed out, there are very deeply embedded cultural issues that present a challenge.

Finally, the greatest challenge is developing a reliable assessment that fits into existing educational and clinical practice systems, both of which are rapidly changing, Dr. Barone concluded. Building an assessment approach for a moving target can only be achieved if organizations, such as those represented here today, tackle it together. The individuals attending this Symposium represent a group organizational mindset. They recognize the importance of assessing professional behaviors for the public and the profession. They expressed a willingness to work together “to do better.” Throughout the day, they presented a unified sense of mission and purpose, which was ultimately about what patients deserve—the very best care possible.

“The individuals attending this Symposium...recognize the importance of assessing professional behaviors for the public and the profession. They expressed a willingness to work together ‘to do better.’”

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