

AMA Journal of Ethics

Formerly *Virtual Mentor*

May 2015

Volume 17, Number 5: 407-487

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American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 409-415

FROM AN AMA JOURNAL OF ETHICS SPECIAL CONTRIBUTOR

Incorporating Spirituality into Patient Care

Robert D. Orr, MD, CM

Religion and Medicine

The histories of medicine and religion have been interwoven for centuries. Many faith-based communities, organizations, and agencies established hospitals and hospices as part of their ministry. In the modern era, however, the two became increasingly separated as medicine became more scientific, developing what became known as the biomedical model in the mid-nineteenth century. During this period of secularization of medicine, some religious hospitals remained true to their faith-based mission, while many retained their religious identity in name only.

In 1977, George Engel, a professor of psychiatry, wrote a classic article in which he urged medical educators, researchers, and practitioners to abandon the reductionist biomedical model of disease and adopt a broader perspective that could incorporate “the social, psychological and behavioral dimensions of illness” [1]. He called his proposal the biopsychosocial model. This new model was adopted rather widely in Western medicine over the next generation.

In spite of this broader biopsychosocial perspective, or perhaps because of it, the boundary separating the practice of contemporary Western medicine from religion became more sharply delineated. When a patient or even a clinician raises a tenet of religious faith while discussing health care, one often hears the retort, “Medicine is secular; religion is sacred and private.” This answer implies that medicine in its three dimensions (biological, psychological, and social) specifically excludes the spiritual dimension that belongs to a sacred space that a patient need not talk about and that need not be considered in the clinician’s concept of caring for individuals. This distinction is exemplified by the fact that, although nearly all hospitals offer chaplaincy services, in most settings the chaplain is not viewed as part of the clinical team but as an ancillary consultant.

In one sense, however, this recognition that religion is separate and distinct has again broadened the concept of whole-person medicine so that it now encompasses four overlapping domains: biological, psychological, social, and spiritual. A few US medical schools established in the last 175 years expanded the biomedical model, adding the concept of caring for the whole person by including in their mission statements the importance of a spiritual dimension in patient care [2, 3]. This development suggests

that health care professionals should have a better understanding of the patient's personal, cultural, and religious values.

Religion and Medical Ethics

As medical technology began to expand rapidly in the 1960s and '70s, offering means of extending the lives of mortally ill people, some began to ask "should we...?" questions in addition to "can we...?" questions. These are value-based questions, not clinical or even scientific questions. Just because we *can* do something doesn't mean that we *should* do it. Such questions arise very commonly today in situations involving end-of-life care, limitation of treatment, treatment of patients who have what is perceived by others to be diminished quality of life, use of limited or expensive resources, and so on. These questions are often discussed in bedside situations that are referred for consultation with a clinical ethics consultant or committee. The idea that medicine is inherently a moral enterprise—that the practice of medicine involves making decisions between right and wrong, good and bad—entered our conversation at this time of technological expansion [4].

When questions of right and wrong in medicine were first voiced, it was often by people of faith who recognized that religious traditions addressed these values. Indeed, the early medical ethicists were primarily theologians coming from Roman Catholic, Protestant, and Jewish traditions [5]. Although the discipline has largely been taken over by philosophers, clinicians, the courts, and health policymakers, the roots of medical ethics are clearly faith based.

How does the moral dimension of medicine comport with the above-mentioned boundary between medicine and faith? Quite easily, actually. Those involved in medical decisions are people: patients, families, professionals. All of these people have values, often based on faith.

Foundations of Medical Ethics: Secular and Sacred Principles

Although there are several conceptualizations of medical ethics [6], probably the most commonly articulated in North America is principlism. While insufficient of and by itself to thoroughly resolve all dilemmas in medical ethics, principlism is often the beginning point for such discussions. The secular principles of medical ethics are well known and have been discussed at length in many settings [7]. The four foundational principles are (1) nonmaleficence (first of all, do no harm), (2) beneficence (always seek the patient's best interest), (3) respect for autonomy (the patient has a right to self-determination), and (4) justice (we should treat like patients alike, without discrimination). In modern Western culture, respect for autonomy has become the "first" principle "among equals." A person has the right to make his or her own decisions about medical treatment. This principle is often expressed as respect for persons. And, of course, patients are persons, complete with values, some of which are faith based.

The theologians who pioneered contemporary medical ethics also built their foundation on principles, but these were sacred. These sacred principles often parallel or overlap the four secular principles. Elsewhere I have tried to identify some of the sacred precepts and beliefs held by members of one or more of the three monotheistic faith traditions (Judaism, Christianity, Islam) that may be influential, sometimes even determinative, in resolving dilemmas in medical ethics [8]. I will outline 11 of them from my own Christian perspective, recognizing that there is much overlap with Jewish and Islamic perspectives.

The Imago Dei (the image of God in man). From the first chapter of Genesis, the first book of the Hebrew Bible, we learn that each individual, regardless of ability or disability, bears the image of God. This is inherent, not imputed, and may be difficult to understand as we contemplate persons born with anencephaly or afflicted with severe dementia. Although such disabilities are part of the mortal nature of humankind, they do not detract from the underlying principle.

The sanctity of life. Because we bear the image of God, each human life is sacred. Human life is special; it is different from animal life. Our God-given dominion (see below) allows us sometimes to end an animal's life humanely, but it does not allow us intentionally to end a human life. This belief in the sanctity of life does not mean, however, that we must always attempt to postpone human death, another inevitable consequence of the Fall.

The Fall, suffering, disease, and death. Because of Adam's sin, we live in a fallen world with all its manifestations. We should try to relieve suffering. We should try to cure or control disease. We should try to avoid death when possible. But, in the end, we are all finite.

Quality of life. Some people of faith bristle when quality of life is mentioned, arguing that we should only focus on the sanctity of life. But we all experience a quality of life—good, bad, or neutral. And when the burdens of continued life make it impossible for us to carry out God's purpose, we are not obligated to use disproportionate measures to forestall death.

Miracles. Adherents of all three monotheistic faith traditions believe, based on their own sacred texts, that God is capable of intervening in our lives in ways that we cannot explain or understand, in ways that seem to contradict the laws of nature. Unfortunately, we tend to use the word "miracle" too loosely, as in "miracle drugs," "miraculous survival," and so on. True supernatural interventions are not common in my experience. But God can do such things when He chooses. In addition, He does not need our machines or procedures to accomplish His miracles.

Compassion. God's incomprehensible love for us is clearly reflected in the compassion taught and demonstrated by Jesus. It is incumbent on us to remember that compassion

means “to suffer with.” Some misinterpret the word to mean merciful ending of a patient’s life. Instead, in my view, we are called to do our utmost for patients’ suffering: to suffer along with them and not abandon them.

The ministry of health care. Many religious health care professionals believe that the work we do is a ministry to those in need, a way to show forth God’s love.

The hope of eternity. Many people of faith believe that this life, with its suffering and death, is not all there is. We have the hope of eternal life with a loving God. Some people of faith believe that we should always hope for a good outcome to illness. Václav Havel, former president of the Czech Republic, insightfully wrote that hope “is not the conviction that something will turn out well, but the certainty that something makes sense, regardless of how it turns out” [9].

The sovereignty of God. As human beings, we live in a fallen world, beneath the sovereignty of an all-powerful God.

Dominion and stewardship. God has granted us liberty, expecting us to make decisions about the use of our abilities and resources. In contemporary medicine, the timing of death is often a matter of choice. The time of death for a patient may vary considerably based on whether we choose to use cardiopulmonary resuscitation, ventilator support, dialysis, one more round of chemotherapy, antibiotics, or a feeding tube.

Free will. Many people of faith equate the religious concept of free will and the secular concept of autonomy. In one sense, they are similar: both refer to making our own decisions. However, in a clearer sense, the Hebrew prophet Micah placed a limit on our free will when he wrote, “He has showed you, O Man, what is good. And what does the Lord require of you? To act justly and to love mercy and to walk humbly with your God” [10]. We are not to walk arrogantly as free moral agents, making decisions based only on our personal values, desires, and authority. Rather, we are to acknowledge humbly our position under God’s authority.

Justice. Our imperfect efforts at individual and social justice must constantly strive to reflect God’s perfect justice. However, justice involves getting what we deserve. In a Christian context, we should also strive to reflect His mercy (not getting what we deserve), and His grace (getting what we do not deserve).

Some faith-based precepts are absolute, or nearly so, such as the Roman Catholic proscription against intentionally causing death, the Orthodox Jewish prohibition against stopping life-sustaining treatment, and the Jehovah’s Witnesses’ refusal of many blood products. Some are interpreted with a great deal of flexibility, such as an understanding of quality of life. Some are equally shared with nonreligious persons, such as compassion

and justice. As patients and families struggle with some of the difficult issues and questions encountered in medicine, they may or may not recognize that they are dealing with tenets of their own faith. Inquiring about their faith, identifying these precepts, and discussing them openly, sometimes with the aid of a chaplain or their own clergy, will often help bring clarity and resolution.

The Professional's Right of Conscience

Sensitivity to the role of personal and religious values in understanding and resolving dilemmas in clinical ethics focuses primarily on the beliefs of patients and families. However, the professionals involved in these dilemmas are also persons and, as such, have their own personal and religious values. Involvement in counseling about, or especially performing, procedures such as abortion, sterilization, withdrawal of life-supporting treatments, physician-assisted suicide, and so on might violate the precepts of a health care professional's religious values. The professional's [right of conscience](#) has been the subject of a growing literature in medicine and ethics [11]. It is often important to recall the moral difference between a patient's *negative* autonomy (the right to refuse; the right to be left alone) and *positive* autonomy (entitlement to have one's wishes carried out by others).

The Patient's Personal Values

The values used by individuals in making difficult medical decisions can be very personal. Some personal values are based primarily on one's religious beliefs. Some are based more broadly on a person's worldview or philosophy of life. Health care professionals should be careful not to assume a patient holds specific values based only on the designation in the medical record of their "religious preference" or an identification of their cultural background. Different congregations in a particular faith tradition may interpret such values differently, and clearly different individuals within a tradition may adhere to all, some, or very few of the precepts of that faith. Similar diversity of thought is seen within many groups.

So how does a clinician inquire of patients to learn what values are important to them?

There have been many proposals of how to discuss the spiritual element by taking a spiritual history [12]. One of the most commonly used and user-friendly is the model developed by Pulchalski and Romer [13], who propose the following four questions organized by the mnemonic "FICA":

F—Do you belong to a *faith* tradition?

I—How *important* is your faith to you?

C—Do you belong to a faith *community*?

A—How does your faith *affect* how you would like me to care for you?

Since only a portion of personal values are based on a person's faith, I would suggest supplementing this spiritual history with a fifth question: "What personal values do you have that might also affect how you would like me to care for you?"

This information can easily be elicited while taking a patient's medical history without being intrusive. This approach recognizes that the patient's faith may be an important part of his or her self and that the care team is willing, even eager, to incorporate personal and religious beliefs into needed decisions about treatment. In addition, it may be appropriate to ask patients or families if they would like to talk with the hospital chaplain or their own pastor, priest, rabbi, or spiritual advisor.

Conclusion

There is an increasing recognition in modern Western medicine of the importance of patient spirituality in treatment and healing. Nowhere is this more important than in addressing and resolving dilemmas in bedside medical ethics. It is thus important for clinicians to know how to take, and to be comfortable with taking, a patient's spiritual history in a nonintrusive way. Health care professionals must likewise recognize when their own values raise dilemmas in their practice of medicine and must be able to deal with issues that may arise from their own right of conscience.

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ISSN 2376-6980**

American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 416-418

FROM THE EDITOR

Professional Boundaries and Meaningful Care

In September 2013, Gordon Schiff, MD, shared “a piece of his mind” on the patient-physician relationship in the *Journal of the American Medical Association (JAMA)*. His article, “Crossing Boundaries—Violation or Obligation?” detailed the challenges he had faced in navigating the patient-physician relationship. Actions that he felt were an extensions of his services and obligations to provide care for the patient—the whole patient—were met with either full support or complete opposition, and even deemed unprofessional, by colleagues and supervisors. These actions included helping a patient find a job, providing transportation money for a patient in need, and assisting a patient with paying for a prescription when insurance posed a hurdle.

Dr. Schiff’s piece struck a nerve with me. My reaction to his piece may have been heightened by my personal and global-health experiences in my home country of Malawi and several other limited-resource settings. While some actions I heard about were clearly violations (e.g., sexual relationships with patients), other interactions seemed less clear. Was helping a patient overcome systemic barriers to health by satisfying basic needs for food, clothing, shelter, and employment truly unprofessional? Was forging a personable and caring relationship not fundamental to medicine? Weren’t some of these actions a part of meaningful care?

As I thought more about these questions, I could see how providing *extraordinary* care could have unintended consequences. As much as we may not want to admit it, there are power dynamics at play in the patient-physician relationship. These dynamics can convert a seemingly innocent and caring act into one that exacerbates the vulnerabilities of physicians and patients alike. I then began to wonder how it would be possible to safeguard the patient-physician relationship without hampering meaningful, personable care. I was certain that I could not be the only one looking for guidance on this matter.

Accordingly, this issue of the *AMA Journal of Ethics* seeks to provide perspectives and guidance on navigating the patient-physician relationship and observing professional boundaries. The issue draws from multiple perspectives and uses a multidisciplinary approach. Each contribution is intended not to be prescriptive but, rather, to provide ethical considerations, strategies for critical thinking, and recommendations that can be applied in routine clinical care.

The three ethics cases in the issue were designed to mirror real-life scenarios: deciding whether to assist a patient with a job search, reconciling a practice policy prohibiting home visits with a patient's need, and fielding a friend's request for care. John Mazullo, MD, a family medicine physician, draws from his decades of clinical and teaching experience to advise readers who may be able to help patients find jobs. From his contribution, we learn that empathy, respecting the patient's privacy, not taking advantage of the patient, and offering a "helping hand" rather than setting up a system of dependency are key considerations. In their commentary, medical student Brian Kroener and Eric Goepfert, MD, grapple with the conflict that arises when the policies at a physician's place of work are not aligned with his or her ethical standards. They examine both the actions an individual physician can take under these circumstances and whether the practice's policy is wise. Lastly, Horacio Hojman, MD, addresses the situation in which a physician is approached by his best friend for care. Dr. Hojman highlights best practices, with reference to professional association guidelines.

Two pieces discuss the difficult role of professional self-regulation when it comes to observing boundaries. Building upon his experience equipping medical students with tools to help identify and report on ethical breaches (and issues of conduct) among peers, Leonard L. Glass, MD, discusses the challenges of acknowledging and reporting boundary violations by one's colleagues. Joseph C. d'Oronzio, PhD, a bioethicist and founding director of the Professional Problem-Based Ethics (ProBE) Program, explains the actions taken by state medical licensing boards in response to boundary violations, including mandating rehabilitative educational programs like ProBE. He shares a wealth of information on disciplined physicians and provides a typical example of cases referred to the program and what it seeks to accomplish: to help physicians cultivate their judgment about appropriate boundaries rather than merely promoting obedience.

Four other contributions take up the idea of meaningful relationships with patients. Monica Bharel, MD, medical student Emily Thompson, Shira Heisler, MD, and Gordon D. Schiff, MD, all draw from personal experience to explore relationships with patients that are and should be closer than what we think of as typical when we are treating vulnerable patients. Dr. Bharel, chief medical officer of the Boston Health Care for the Homeless Program (BHCHP), emphasizes the importance of building trust with homeless patients, sometimes before any medical concerns can be addressed. Emily Thompson recounts observing the close bond between pediatricians and their hospitalized patients, arguing that professional boundaries need not be uniform across all specialties and that, in pediatrics, more frequent boundary crossings are beneficial to establish a social as well as a therapeutic relationship with patients. Dr. Heisler describes how Dr. Schiff has served as a "virtual mentor," encouraging her to really see, respect, and partner with patients to combat the systemic forces that can affect their health and well-being. They outline ten useful long-term strategies for helping physicians maintain positive relationships with patients. Dr. Schiff complements this piece with an audio interview

that covers reactions to and reflections on his *JAMA* article and his recommendations to students. We encourage you to listen to the podcast for his thoughts on how students, and even experienced physicians, can work their way through the gray areas of the patient-physician relationship while still providing exceptional care and maintaining meaningful relationships with patients.

At a broader, societal level, Roy Ahn, ScD, Kristina Tester, Zaid Altawil, MD, and Thomas F. Burke, MD, take up the topic of responsible activism. In their piece, they argue the need for more widespread professional standards of conduct for global health organizations.

Technology is changing medicine, and, with it, the patient-physician relationship. What was accepted conduct fewer than 50 years ago (e.g., house calls, close-knit physicians and patients) may be almost nonexistent today. James M. Thompson, MD, examines changes in the patient-physician relationship using his own professional career as an example. There are also new ways of communicating: physicians and patients are readily accessing health information through phones and computers, and social media is becoming ubiquitous, readily used by young and old alike. How should physicians use social media appropriately? Terry Kind, MD, MPH, reviews guidelines for physician conduct on social media, focusing on the formal recommendations of the American College of Physicians and the Association of Federation of State Medical Boards. Dr. Kind highlights social media's potential to extend physician reach and promote healthy behaviors, but also notes that social media should be used thoughtfully and responsibly.

Navigating the physician-patient relationship can be challenging, especially early in our careers. We hope that readers will find this issue of the *AMA Journal of Ethics* practical and that the guiding questions, frameworks, and considerations will serve as useful references.

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Acknowledgement

I thank Dr. Gordon Schiff for being willing to cross boundaries a second time and for providing his time and encouragement to me and two contributions to this issue.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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ISSN 2376-6980**

American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 419-424

ETHICS CASE

Balancing Practice Policies with Patient Needs

Commentary by Eric Goepfert, MD, and Brian Kroener

Dr. Rekai is a psychiatrist who has been working in a private practice with several other physicians for quite some time. The practice recently went through a difficult legal action in which allegations were made about a psychiatrist's conduct during a house call. The action resulted in an out-of-court settlement, and the practice put a temporary suspension on house calls while the system and processes were reviewed. In the interim, the clinic psychiatrists were advised to see patients in the office or link them to emergency services if an office visit was not possible. All of the practice's clients received notices, and verbal and written consent were obtained to ensure that they understood the temporary change in the policy. Psychiatrists who continued to make house calls would risk suspension from the practice.

One day, the practice receptionist received a phone call from a patient who was frantic and repeatedly asked to speak with Dr. Rekai. Dr. Rekai took the call. It was Rebecca, a usually stable patient, who was having a crisis. Dr. Rekai believed that Rebecca should be seen immediately and suggested that she go to the emergency room (ER) or call an ambulance to take her there, but Rebecca adamantly refused.

Dr. Rekai and the receptionist attempted to reach the managing partner (who had overseen the change in policy), but she was out of the office and unavailable. Dr. Rekai had no patients scheduled for the next few hours and contemplated going to Rebecca's house despite the clinic's prohibition on house calls.

Commentary

Dr. Rekai's available options for a plan of care are intertwined with external arrangements that force her to consider factors outside of the patient-doctor relationship. Without necessarily intending to do so, a clinical practice's policies may oppose the ethical standards of individual clinicians' practice of medicine. These ethical standards may be dictated by oaths or codes central to the training, practice, or licensure of individual practitioners in social work, psychology, or medicine. Thus, in certain situations, employees may be left to choose between professional ethical obligations and their employment. One example, described by Frederic Reamer [1], concerns the administration of a juvenile correctional facility that requested staff social workers to notify the administration when a juvenile resident was found to be an undocumented

immigrant. In this instance, the administration's request clearly contradicted the ethical principle of confidentiality and may have exposed the youth to harm, violating the ethical principal of nonmaleficence.

The policy of Dr. Rekai's medical group does not as clearly contradict professional ethical standards, but it may harm patients. In the wider health care context, evidence supports the safety and effectiveness of home visits for psychiatric care, from community-based care for chronic mental illness to emergency in-home psychiatric consultations [2-4]. It is clearly a very effective way of engaging patients who would not go to a clinic or office visit. For patients with limited mobility or who are economically disadvantaged, home visits may enhance access to psychiatric care. Additionally, home visits may help more ambivalent patients who would not travel to office-based appointments. These patients may end up not receiving care if they cannot access home visits, which are not commonly offered anymore. Abiding by her clinic's temporary policy may cause harm to Dr. Rekai's patient.

So how should Dr. Rekai think about helping her patient while weighing the various ethical, clinical, and practical factors? Making a home visit to the patient may be ethically sound but is in conflict with a utilitarian view of justice toward the other patients served by Dr. Rekai, due to her medical group's policy prohibiting home visits. If Dr. Rekai were to breach her medical group's policy to make the house call and therefore be suspended from practicing, she would not be able to provide necessary care for her other patients. Thus, despite our opposition to the policy, we cannot recommend that she break it.

So what should Dr. Rekai do next?

Treating the Patient While Abiding by the Policy

Assess risk of harm. One of Dr. Rekai's first challenges concerns assessing her patient by telephone for risk of suicide and of harm to others. Although a single systematic and predictive suicidality assessment method has not been endorsed at this time, a form of systematic assessment protocol is now commonplace in most psychiatric practices. Evidence-based risk factors, such as gender, age, psychiatric history, family history, and substance use, have been identified that will assist Dr. Rekai in her assessment of the patient [5]. The clinical state of this patient's crisis may imply suicidality or increasing symptoms without suicidal thoughts. Another area of concern is whether the patient intends to harm another person. Dr. Rekai should use evidence-based risk factors [6] and possibly validated, structured assessment tools such as the HCR-20 [7], Violence Risk Assessment Guide [8], or Classification of Violence Risk [9] to perform a multifactorial risk assessment for violent behavior. However, mitigation of modifiable risk factors for suicide, such as psychiatric syndromes (depression, anxiety, psychosis, and maladaptive personality characteristics), substance use, and coping techniques, are the targets of intervention for Dr. Rekai and her patient now. The most important

intervention is inquiring about the patient's access to lethal means of suicide, or to endangering public safety, and eliminating the means, if necessary.

Try to convince the patient to come into the office. If Dr. Rekai is not reassured by telephone regarding the safety of her patient, but the patient will not agree to come to the office, Dr. Rekai could share with the patient her dilemma of needing to establish that the patient is safe, being unable to do so by phone, and being prohibited from making house calls. She could also explain that an office visit is meant to prevent the necessity of a mandated emergency room evaluation. In this case, the harm caused by coercing the patient to come into the office could prevent greater, imminent harm resulting from either the patient's preventable acts or the trauma of an involuntary emergency evaluation.

Telepsychiatric care. Dr. Rekai could also provide psychiatric care by telephone, possibly which may allow her to respond effectively to Rebecca's needs while maintaining her professional relationship with her medical group and thus with other patients. This issue was discussed in Freudenberg and Yellowlees' prior *Journal of Ethics* case response on telepsychiatry [10], drawing on a 2013 review by Hilty et al [11]. Telepsychiatry has been found to be comparable in effectiveness to in-person psychiatric assessment for clinical evaluation of patients and to be appropriate for a wide range of conditions, including depression, PTSD, substance abuse, autism, and ADHD [10, 11]. Importantly, several studies have demonstrated the diagnostic validity of several psychological assessment scales for remote, audiovisual psychiatric assessments of children, adolescents, and adults [11]. However, it is not apparent from the clinical scenario whether telepsychiatric care can meet the needs of this patient—Dr. Rekai may be concerned, for example, that this patient might not reveal important clinical information via telephone—or whether the patient is able to connect with Dr. Rekai through an audiovisual medium that would convey clear, rich information about symptoms.

We do not consider telepsychiatry encounters to be a replacement for in-person patient neuropsychiatric assessment, wherein multiple modalities of patient assessment are possible. But, given the constraints on Dr. Rekai, as long as proper technological resources and appropriate protocols for in-person follow-up are in place, this may be an appropriate option [1].

Involuntary hospitalization. If the patient is declaring herself, or if Dr. Rekai believes her to be, a danger to her own safety or that of others, Dr. Rekai has a duty (derived from the principle of beneficence) to seek involuntary psychiatric emergency care, although it restricts the patient's autonomy. Even if Dr. Rekai believes it is needed, involuntary hospitalization may cause harm to the patient-doctor relationship. Restricting the patient's freedom in this traumatic way is likely to result in feelings of betrayal and contribute to the patient's considering ending the therapeutic relationship [12, 13]. Dr.

Rekai should not casually employ involuntary hospitalization or consider it an alternative to an office visit if it is not indicated. If this form of treatment isn't urgently required, its harms—generating high costs, compromising the high standard of confidentiality for mental health records [14], interfering directly with the patient's autonomy, discouraging patients from seeking care again [12, 13], and possibly undermining long-term adherence and outcomes [12]—are not worthwhile or justified.

Concluding thoughts. Of course, if Dr. Rekai's assessment is that her patient does not require involuntary psychiatric emergency evaluation for concerns of safety but would benefit from immediate psychiatric care, she must balance beneficence with her patient's right to refuse all or parts of the recommended treatment.

In the case that her patient refuses all plans of care except a home visit, Dr. Rekai is left to weigh the risks and benefits of no care or involuntary care for her patient. Because it would be potentially devastating for Dr. Rekai to lose her practice and for her patient panel to subsequently lose access to her care, however, we cannot recommend that she breach the policy in the interest of this individual patient's needs.

Recommendations for the Practice

Why did the clinic temporarily suspend home visits? Perhaps the clinical administration sought to protect patients from further clinical boundary violations by physicians. If it is to serve the highest number of patients—a utilitarian argument—the clinic must not put its malpractice coverage or sustainability at risk. Assuming that the practice group's policy change was not legally mandated, the policy was most likely developed to mitigate risk. In this case, the ongoing threat of lawsuits against the medical group's clinicians, frivolous or otherwise, has shifted the usual way some patients receive care. Ongoing legal proceedings, judicial mandates, recommendations from legal counsel, and pressure from malpractice insurance providers may each restrict the clinicians' options. This organizational decision seems unduly restrictive and cautious, given the likelihood that certain patients need the home-based care that they receive and may be harmed by the policy.

Furthermore, the idea that patients consented to this policy change may not be entirely defensible. Seeking patients' verbal and even written consent to continue the relationship with the practice after the policy change does not necessarily mean they had much choice, if their refusal to accept the new conditions would mean they would have to find new psychiatrists. Furthermore, even if it was not coerced, no mention is made of patients' capacity to make this decision. Some of the practice's patients may not have this capacity. Capacity requires being able to communicate a choice, to understand information conveyed, to appreciate the significance of this information and its consequences, and to do so rationally. When patients suffer from mental illness, their states of mind and views about treatment can vacillate dramatically. They may not have

much insight or recollection of being depressed or disorganized when they are not experiencing these symptoms, or conversely, they may not remember their past experience of mental stability when they are in the midst of mood symptoms, panic, or psychosis. All of this casts doubt upon the idea that this policy was genuinely consented to by the patients.

The medical group should re-examine the appropriateness of this policy as a response to its recent legal difficulties, in light of the ethical challenge it places on clinicians who are attempting to do the utmost for their patients, especially those who need home-based care. In particular, the medical group should recognize that the avoidance of real or perceived legal and financial risk in providing home visit care to patients may compromise individual patient-doctor relationships and induce physicians to consider less ideal or ethically defensible treatment options. The threat of suspension from practice if the practice's doctors pursue a home visit is unreasonable and unethical as it is applied by the medical group in this case. We consider the position this policy has put Dr. Reikai in to be untenable.

The practice's physicians should ask for reconsideration the policy of forcing clinicians to pursue treatment options that may impact optimum care of patients, a just allocation of resources, and the beneficence and nonmaleficence duties of physicians. Physicians should strongly encourage their administrators to form policies that support physicians' ethical duties and minimize their ethical dilemmas.

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ISSN 2376-6980

American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 425-427

ETHICS CASE

Does Helping a Patient Find a Job Violate Professional Boundaries?

Commentary by John M. Mazzullo, MD

Dr. Manning had been Mr. Hayden's primary care physician for two decades. Previously in general good health, at 51 Mr. Hayden experienced severe chest pain and shortness of breath. His wife drove him to the local emergency room. After receiving a work-up for his symptoms, Mr. Hayden was diagnosed with an arrhythmia and transferred to the cardiology unit. He received a pacemaker and was prescribed medication to help manage his condition. He was also advised to take things easy and cautioned that, even after his recovery, he could not return to his job as a metalworker in a machine fabrication shop.

Some months after the pacemaker surgery, Mr. Hayden visited Dr. Manning for follow-up. He told Dr. Manning that, because he could not return to his job, he would lose his employer-sponsored insurance at the end of the month when he had exhausted his sick time and vacation. He said he had been unsuccessful in finding less strenuous work that fit his skills and knowledge. Even with the provisions provided by the Affordable Care Act, maintaining basic payments and covering his necessary medications would be difficult.

The following day, a friend of Dr. Manning who owned a small business told him that she was hiring for a position that seemed to fit Mr. Hayden's education and skills and would not, it seemed to Dr. Manning, jeopardize Mr. Hayden's health. The position came with benefits, including health insurance coverage. Dr. Manning wondered whether he should tell Mr. Hayden about the position.

Commentary

In Dr. Manning's position, I would without any hesitation help this patient by speaking to my friend. I realize that some doctors, who have firm barriers between their professional relationships and the lives of their patients, would not do so. They may be truly empathetic but do not cross certain lines in the patient-doctor relationship. They seem to never take off their white coats. They are armored against being too involved with their patients and therefore stick to the medical aspect of the relationship at all times.

Others, who follow a strict interpretation of the Health Insurance Portability and Accountability Act (HIPAA), never share who their patients are with anyone. This approach certainly follows the letter of the law, if not the spirit of it. I think this strict interpretation is slowly changing but is still the generally accepted view.

In primary care, however, the physician's areas of concern are broader than they might be in subspecialty care, and there is more latitude in defining the borders of the patient-doctor relationship. Primary care doctors deal with "dis-ease," which can be defined as a problem, whether it is medical or psychosocial, that is causing dysfunction in the patient's life.

I have always thought that a more compassionate, open style was the better approach to patient care. It allows me to use my "helping personality." The opportunity to truly help a patient, medically or otherwise, during a difficult time, is personally rewarding to me. Obviously, there has to be a certain professional distance or boundary between the doctor and the patient. The doctor certainly should maintain patient confidentiality, but his or her humanistic, helping self should be present. In fact, I learned a long time ago that an emotional relationship with patients is a critical tool in helping them get well.

The question always is where to draw the line in helping? There are a number of issues I hear my students struggle with all the time:

What should patients call me? Are first names ever appropriate?

Should I wear a white coat or dress like my patients dress?

Should I give out my home phone number, especially when I can do more than the on-call doctor?

Should I accept gifts?

Should I go to dinner at a patient's house when invited?

Should I go to a patient's funeral?

And—the important question raised in this case—should I help a patient cope with life's obstacles or limit my help to purely medical issues?

When I was a student, one of my professors said to me: "John, when you practice, friends will become patients and patients will become friends. You have to learn to handle the situation ethically and morally."

Some basic rules are important. Do not use the patient for your own advantage. You are there to help your patients. As the old saying goes, "If I give you a fish, you eat for one day, but if I teach you how to fish, you'll eat for your whole life." So our helping should not foster dependence but, instead, aid someone in starting something positive in his or her own life.

With that in mind, it seems clear that you certainly may network with a friend to help your patient get a new job. It would be a good idea to talk with your patient first and get his or her permission to discuss the situation with your friend. Assure the patient that there will be no divulging of medical information and then inform the friend that the patient might be in contact. It should be noted that there may be taking some risk—if

your patient is hired and doesn't work out, there might be some discord between you and your friend. But by facilitating this communication, perhaps you can provide some life-changing good for your long-time patient.

John M. Mazullo, MD, is an assistant clinical professor and maintains an active teaching schedule at Tufts School of Medicine in Boston. He was a primary care doctor in general medicine for almost 40 years and for 30 years also maintained a primary care practice in HIV medicine before retiring from clinical practice in 2010.

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ISSN 2376-6980**

American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 428-431

ETHICS CASE

A Friend's Request for Treatment

Commentary by Horacio Hojman, MD

Peter and Tom have been best friends for more than a dozen years. Peter, a surgeon, is reputedly the best gastroenterological surgeon in the region. He is known for polyp resections, colectomies, and related surgical procedures of the gut. Tom teaches math at the county community college. They have been meeting to play golf at Peter's golf club on the first Saturday of the month for many years. One Saturday, Tom approaches Peter with a look of concern, telling him that his last colonoscopy revealed a tumor and that he has to have surgery to resect part of his ascending colon. Peter listens intently. Then Tom says, "You're the best colorectal surgeon around."

Peter nods his head. "So they say."

"Well, I know you don't usually operate on your friends, but can't you make an exception for me?"

Peter is slightly taken aback but remains silent. Tom continues, "It doesn't seem to make sense for me to go to a 'runner-up' surgeon just because we happen to be friends."

Commentary

The dilemma facing Peter is not uncommon. Almost all physicians, at one time or another, have been asked to provide care or advice for a relative or a friend. Sometimes the advice requested is for trivial medical conditions like a minor cut. But in other cases these requests can be particularly burdensome.

The American College of Physicians [1], the General Medical Council of Great Britain [2], and the Medical Council of New Zealand [3] advise against providing medical care to anyone with whom a physician has a close personal relationship. Similar recommendations have been issued by the American Academy of Pediatrics [4], the College of Physicians and Surgeons of Ontario [5], and the College of Physicians and Surgeons of British Columbia [6].

The American Medical Association (AMA) *Code of Medical Ethics* states: "Physicians generally should not treat themselves or members of their immediate families" [7]. Although these guidelines do not specifically mention friends, the reasons given for not treating family members apply equally to friends. First and foremost, patients deserve

objectivity from their doctors. When a physician is emotionally involved with a patient, that [physician's objectivity](#) can be called into question. Perhaps his friendship with Tom could cause Peter to overlook a potentially life-threatening complication or not to offer an objective and fair assessment of Tom's clinical condition. Peter might be the best surgeon in town, but he might not be the best surgeon for Tom.

Even if Peter thinks he could treat Tom as if he were any other patient, humans are known to be self-deceiving when it comes to recognizing their own biases or limitations [8]. Peter might feel uncomfortable asking personal questions about Tom's past medical history. Despite his eagerness to have Peter as his surgeon, Tom might also feel embarrassed about revealing certain confidential information or, worse, lie to him. One or both of them might feel uncomfortable about a complete physical exam and omit an important part of it.

If Peter and Tom are friends, most likely they know each other's families. This shared personal knowledge could result in confidentiality and trust problems. If Tom chose to withhold certain information from his loved ones—for example, how serious his condition is—he might ask Peter not to reveal this information to his wife. Under normal circumstances, physicians can avoid disclosing information to family members by just invoking the patient's right to privacy. This might be difficult for Peter, however, since Tom's wife would most likely approach him as a trusted friend rather than merely Tom's physician.

Furthermore, all surgical procedures, regardless of how experienced the surgeon is, can result in serious complications. Although obviously the consequences of one of those complications could be tragic for Tom, it could also have devastating emotional consequences for Peter.

Despite these concerns, there is scant information regarding their validity. Surveys indicate that physicians [treat friends and family](#) frequently [9-11]. Although doing so can cause physicians distress [11], it is unclear whether medical errors are more common when treating intimates. Many physicians could cite personal experiences of treating a family member or a friend in which their judgment was clouded by their emotional involvement. However, we tend to better recall experiences that confirm our fears, like a bad outcome, rather than uneventful ones that fail to confirm our fears [12].

Based on all the concerns expressed above, it would be prudent for Peter to politely decline to perform the surgery. He should tactfully explain his concerns to Tom. Perhaps he could offer to be Tom's advocate during the process and help Tom with finding another qualified surgeon to do his case and navigating the maze that health care can be [13]. Having major surgery can be a distressful and frightening experience, and the advice of a knowledgeable friend during this time can be invaluable.

However, all the guidelines mentioned above make exceptions for emergencies or when no other qualified physician is available. We do not know the size of the community where Peter and Tom live, the degree of access to other qualified surgeons within it, or Tom's ability to access a surgeon outside it. Perhaps some of these options put a significant burden on Tom's access to adequate care. If there is a reasonable cause that prevents Tom from accessing adequate care, Peter should agree to perform the surgery.

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ISSN 2376-6980**

American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 432-434

THE CODE SAYS

The AMA *Code of Medical Ethics*' Opinions on Observing Professional Boundaries and Meeting Professional Responsibilities

Opinion 9.124 - Professionalism in the Use of Social Media

The Internet has created the ability for medical students and physicians to communicate and share information quickly and to reach millions of people easily. Participating in social networking and other similar Internet opportunities can support physicians' personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunity to widely disseminate public health messages and other health communication. Social networks, blogs, and other forms of communication online also create new challenges to the patient-physician relationship. Physicians should weigh a number of considerations when maintaining a presence online:

- (a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.
- (b) When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.
- (c) If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines, just as they would in any other context.
- (d) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.
- (e) When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the

individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.

(f) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession.

Issued June 2011 based on the report "Professionalism in the Use of Social Media," adopted November 2010.

Opinion 9.065 - Caring for the Poor

Each physician has an obligation to share in providing care to the indigent. The measure of what constitutes an appropriate contribution may vary with circumstances such as community characteristics, geographic location, the nature of the physician's practice and specialty, and other conditions. All physicians should work to ensure that the needs of the poor in their communities are met. Caring for the poor should be a regular part of the physician's practice schedule.

In the poorest communities, it may not be possible to meet the needs of the indigent for physicians' services by relying solely on local physicians. The local physicians should be able to turn for assistance to their colleagues in prosperous communities, particularly those in close proximity.

Physicians are meeting their obligation, and are encouraged to continue to do so, in a number of ways such as seeing indigent patients in their offices at no cost or at reduced cost, serving at freestanding or hospital clinics that treat the poor, and participating in government programs that provide health care to the poor. Physicians can also volunteer their services at weekend clinics for the poor and at shelters for battered women or the homeless.

In addition to meeting their obligation to care for the indigent, physicians can devote their energy, knowledge, and prestige to designing and lobbying at all levels for better programs to provide care for the poor.

Issued June 1994 based on the report "Caring for the Poor," adopted December 1992.

Opinion 8.145 - Sexual or Romantic Relations between Physicians and Key Third Parties

Patients are often accompanied by third parties who play an integral role in the patient-physician relationship. The physician interacts and communicates with these individuals and often is in a position to offer them information, advice, and emotional support. The more deeply involved the individual is in the clinical encounter and in medical decision making, the more troubling sexual or romantic contact with the physician would be. This

is especially true for the individual whose decisions directly impact on the health and welfare of the patient. Key third parties include, but are not limited to, spouses or partners, parents, guardians, and proxies.

Physicians should refrain from sexual or romantic interactions with key third parties when it is based on the use or exploitation of trust, knowledge, influence, or emotions derived from a professional relationship. The following factors should be considered when considering whether a relationship is appropriate: the nature of the patient's medical problem, the length of the professional relationship, the degree of the third party's emotional dependence on the physician, and the importance of the clinical encounter to the third party and the patient.

Issued December 1998 based on the report "Sexual or Romantic Relations between Physicians and Key Third Parties," adopted June 1998.

Opinion 8.14 - Sexual Misconduct in the Practice of Medicine

Sexual contact that occurs concurrent with the patient-physician relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well-being.

If a physician has reason to believe that non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact. At a minimum, a physician's ethical duties include terminating the physician-patient relationship before initiating a dating, romantic, or sexual relationship with a patient.

Sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship.

Issued December 1989; updated March 1992 based on the report "Sexual Misconduct in the Practice of Medicine," adopted December 1990.

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ISSN 2376-6980**

American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 435-440

MEDICAL EDUCATION

Where the Rubber Meets the Road: The Challenge of Reporting Colleagues' Boundary Violations

Leonard L. Glass, MD

You expect crises to arise in the course of your caring for patients. But, unexpectedly and inevitably, some crucial moments can involve your responsibility to report ethical breaches by your colleagues. Unwelcome, uninvited, prompted by nothing but circumstance and acts of good will, such moments will challenge and partly define you—in your own eyes and, quite possibly, those of your professional community [1].

Cases

Case 1. Your best friend in the residency comes to join you for your overnight rotation with alcohol on his breath. He's been through a rough break-up and you've had to drive him home twice recently because he was too drunk to drive himself. Each time you spoke to him the next day about it, but he's blown you off. Tonight he's shown up for work intoxicated and he won't let you send him home sick.

Commentary. Any discussion of ethical breaches by clinicians must include the concept of boundaries. While a broad use of the term "boundary" has entered popular speech, its professional use is more exacting. It refers to respect for the personal bodily and psychological integrity and separateness of the patient. Boundary violations are actions that improperly disregard a patient's boundaries and range from breaking the patient's confidentiality (e.g., using the patient's clinical information in a case report without consent and insufficient disguise) to, at the other extreme, gross sexual exploitation [1].

Case 1 presents a classic conflict between loyalty to a friend and professional duty to protect patients. Clearly, you should report the intoxicated friend to authorities who can pursue the matter—an appropriate combination of the attending physician on call, the service chief, the director of residency training, the hospital's ethics committee, the physicians' assistance program of the state medical society. But, as seemingly clear-cut as this case is, such reporting duties are often honored in the breach [2, 3].

No one wants to feel like a snitch, even less when a good friend is involved. Gutheil and Brodsky [4] eloquently describe the shock that may be experienced by the young physician or medical student encountering boundary issues: "Unprepared by training, overwhelmed by personal vulnerability, ambushed by circumstance, lulled into

complacency by high professional achievement," he or she is frozen, caught in the headlights, with no easy way out.

All too often the yearning for relief from this conflict leads to avoidance and denial, some rationalized means of looking the other way: "maybe he was just overtired;" "I'll tell his dad—he'll take care of it;" "it's not my call;" "he's trusted me with his pain—I can't violate his confidentiality." Yet there is no duty of confidentiality in this situation; nothing supersedes the ethical and legally mandated duty to report an unfit colleague. But do bear in mind that when the offender is your patient or someone having a formal consultation with you, then confidentiality is your primary duty (except in dangerous emergencies).

Most states have required as a condition of licensure that physicians formally report to the state board of registration in medicine when they have a reasonable basis to believe that a licensee has violated any of the board's regulations [5]. Most states also immunize those who do report from lawsuits as long as the report was made in good faith [6]. Although abuse of domestic partners, the elderly, and children has garnered great public concern in recent times and there is widespread agreement that these abuses should be reported even if they jeopardize the physician-patient bond, reporting of fellow clinicians is the *bête noire* of clinical ethical compliance, even though nonreporting can lead to more destructive abuse.

Case 2. You are a recent graduate of a university hospital residency program who enjoyed a good rapport with several senior attending physicians. Now you've continued on as a preceptor in the residency and hope to build your practice in part by referrals from the teaching staff you have worked with. When a close friend you know to be a survivor of sexual abuse asks you for a referral, you give her the name of one of your most respected, most caring former teachers. Your friend makes an appointment and thanks you for your help. One evening several months later, you go out with your significant other to a charming candlelit restaurant outside of town, and you see your former mentor sitting in the corner chatting intimately with your friend, seemingly lost in her company, his hand massaging her neck, their faces barely six inches apart.

Commentary. Case 2 is highly suggestive of a romantic relationship between your residency mentor and his patient, the vulnerable close friend you referred to him for treatment. A sexual relationship concurrent with a treatment relationship is sexual misconduct. A sexual relationship with a former patient is prohibited by the American Psychiatric Association—"Sexual activity with a current or former patient is unethical" [7]—and viewed with grave concern by other professional associations because of the potential for undue influence and abuse of power [8].

Of course, your first temptation is to back out of the restaurant in hopes that no one has noticed you noticing them. And you might well do that to avoid an embarrassing moment. But that will not do as an adequate response, and you know it. On reflection, you wonder if you are just deluding yourself: you know what you've seen, and you clearly have a reasonable basis for believing that you have witnessed a frank boundary violation.

But there are many conflicting interests here. You don't wish to harm your old mentor or jeopardize your cordial and potentially helpful referral relationship with him. You fear that your close friend may believe she's in love with her physician, but you know from the literature that she is vulnerable to abuse and that this relationship, if it is what it seems, is quite likely to end in emotional devastation for her. Then there is the matter of your own uncertainty: could he have ended his formal treatment relationship with your friend? Could she still be under his care and he just be consoling her in some Dutch uncle way that is unconventional but not really a problem?

Now it becomes clearer why it's so hard for physicians to report ethical breaches of fellow clinicians. Celenza [9] summarizes the obstacles: our fear of hurting our colleagues and of their retaliation and our confusion about what precisely has happened, what must be reported and to whom, and whether it would breach confidentiality. Gabbard and Lester [10] identify concerns over the loss of friendships and apprehension about having our own motives questioned. Finally, various institutions (hospitals, professional societies, licensing boards) may have conflicting and unpredictable responses to reportable violations, which further undermine physicians' motivation and clarity of purpose in reporting [11].

Case 3. Over lunch in the cafeteria, a second-year resident in your headache clinic tells you in an animated way about an unusual treatment relationship he has with a patient. She is a young and attractive woman whom he has followed in the clinic for six months every other week. She is angry at the clinic nursing staff, who, she says, have treated her rudely and feels more comfortable meeting him in the Starbucks across from the hospital. And so they have. Over time he's allowed her appointments to extend beyond the designated time; he begins to schedule them at the end of the day so they can linger; they have been texting between appointments about her life; she's shared pictures of her recent Caribbean vacation; and she's just suggested they catch an upcoming concert together.

Commentary. The concept of boundary *crossings* adds important nuance to our understanding. Boundary crossings (as opposed to boundary violations) are appropriate modifications of the treatment on behalf of the patient; they can be discussed and altered (unlike boundary violations that are rarely negotiated but emerge and persist unacknowledged); they do not form part of a pattern of progressive exploitation (i.e., do not progress along the notorious slippery slope); and they enhance treatment for the

patient without harm [12, 13]. As in most considerations of boundary issues, the context is crucial [14, 15] and differs significantly from specialty to specialty. Examples of boundary crossings (which, again, are benign modifications of the therapeutic relationship on behalf of the patient) might include agreeing to a gift of modest value from a grateful patient; accepting an invitation to his high school play from the teenager you've treated for severe trauma following an auto accident; accepting a brief hug initiated by an appreciative patient when a milestone in recovery is reached; and making a home visit to assess the environment for a patient's rehabilitation.

But, in case 3, while you recognize that the patient is reportedly more at ease in the informal Starbucks setting, the boundaries of the treatment are undeniably fraying. There is the expansion of appointment times, the elaboration of contacts unrelated to the treatment per se, and the suggestion of a date-like meeting. Nothing appears to have occurred yet that requires reporting, but neither does this add up to what could be reasonably called simply a boundary crossing. Rather, the aggregation of elements looks like progression down the slippery slope. Here you have an opportunity and a responsibility to say something to your colleague like, "It's obvious that you care about this patient, but it sounds like things are evolving in a way that could be misunderstood by her and could end up as a problem for you." Doing so will fulfill your responsibility to your colleague, patient welfare, your profession, and your own self-regard.

Concluding Comments

Why do we have such a hard time policing ourselves as a profession? Why is it so difficult for individual physicians to do the right thing when it comes to reporting colleagues' ethical breaches? Many of the main obstacles have been identified above: not wanting to damage a colleague and risk his or her retaliation or being seen as disloyal or a snitch; not knowing what is reportable or where to go with what you've discovered; not wanting to acknowledge what you've become aware of; hiding behind imagined requirements of confidentiality; and not remembering what was perhaps insufficiently taught to you about boundaries. For all these reasons, we look away and rationalize our failure to meet our responsibilities to our patients, our colleagues, and the law and to uphold our own values.

How can we do better?

- Learn and bear in mind your ethical and legal obligations regarding reporting.
- Seek a consultation from an experienced clinician when something is troubling you in this domain.
- Understand the function of physicians' assistance organizations, which are often supported by state medical societies. They give colleagues with addiction and other problems that interfere with safe practice an opportunity for rehabilitation and are a benign alternative to reporting some issues directly to the licensing board.

- Don't give in to rationalized avoidance. Remember the big picture: physicians are entrusted by patients with their most personal secrets and given wide authority to prescribe dangerous substances and, with scalpel and endoscope, invade the body. Proportionate to that trust is the obligation to protect patients from exploitation and maltreatment by those who are, at a given time, not deserving of that trust.
- Finally, ask yourself not just, "What should I do?" but, when the rubber meets the road, "Who do I hold myself to be?" [16].

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Acknowledgement

The author gratefully acknowledges the helpful suggestions of Drs. Thomas Gutheil and Andrea Celenza.

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ISSN 2376-6980**

American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 441-447

IN THE LITERATURE

Professional Guidelines for Social Media Use: A Starting Point

Terry Kind, MD, MPH

Farnan JM, Snyder Sulmasy L, Worster BK, et al. Online medical professionalism: patient and public relationships: policy statement from the American College of Physicians and the Federation of State Medical Boards. *Ann Intern Med.* 2013;158:620-627.

In real estate, it's all about where—location, location, location. In comedy, the key is timing. In social media, it's about both when and where. The timing and context—the community norms, membership, privacy, and searchability of the platform—of a post will affect how it is perceived, and yet a message can be reposted, shared, and disseminated at any future time in other contexts. It is at once fleeting and permanent. Given this complexity, as well as the relative novelty of social media, it is not surprising that guidelines have been issued regarding the use of social media by those in medicine.

What Should Guidelines Be, and When Should They Appear?

What are guidelines for? When should a given set of guidelines be developed and disseminated? When do we seek, use, ignore, or update guidelines? Guidelines are particularly useful in new or changing areas. If a knowledge or practice gap is identified, we seek guidelines to fill that gap. Guidelines are employed to avoid errors or might be used *after* an error is made, in remediation or reflection. Effective guidelines often include key questions with discussion rather than proclamations. Proclamations are for policy; they delineate consequences. Guidelines are instead intended to advise, explore, and even mentor [1] the learner through a set of questions and scenarios. Rather than each individual student, trainee, attending physician, or other health care professional going it alone and making mistakes that impact the public trust (even if he or she learns from them), guidelines allow those with experience to inform others' behavior.

Social media guidelines should be designed to help social media users (or social media contemplators) recognize the types of opportunities and challenges that arise in new and changing online platforms. Guidelines applicable to professional conduct in "offline" in-person settings can also provide a useful model for how we should conduct ourselves online.

The ACP-FSMB Guidelines on Online Medical Professionalism

Following the AMA's policy on professionalism in the use of social media in 2010 [2], the American College of Physicians (ACP) and the Federation of State Medical Boards (FSMB) together issued guidelines on online medical professionalism in 2013 and explicitly stated that their guidelines are "meant to be a starting point, and they will need to be modified and adapted as technology advances and best practices emerge" [3]. Table 1 reproduces the ACP-FSMB official positions on online medical professionalism and identifies key considerations that arise from them.

Table 1. Online Medical Professionalism: Considerations Raised by the ACP-FSMB Guidelines

Guidelines' Position—The Starting Point	Further Considerations/Questions
1: "Use of online media can bring significant educational benefits to patients and physicians, but may also pose ethical challenges. Maintaining trust in the profession and in patient-physician relationships requires that physicians consistently apply ethical principles for preserving the relationship, confidentiality, privacy, and respect for persons to online settings and communications" [4].	<ul style="list-style-type: none"> • What is the intent of the online conversation? How will you use social media for educational benefit? What are other beneficial uses? • Will you be able to—and how will you—maintain the public's trust in the profession? • How will you maintain confidentiality? • How will you handle emergency/urgent situations?
2: "The boundaries between professional and social spheres can blur online. Physicians should keep the two spheres separate and comport themselves professionally in both" [5].	<ul style="list-style-type: none"> • Is professionalism an identity or a persona? • How much self-disclosure is the right amount? • Is it possible to keep your professional and social selves "separate" online? How is this accomplished offline?
3: "E-mail or other electronic communications should only be used by physicians in an established patient-physician relationship and with patient consent. Documentation about patient care communications should be included in the patient's medical record" [6].	<ul style="list-style-type: none"> • What is your plan for when patients request to connect on social media? • What is your plan for when you are asked medical questions online?
4: "Physicians should consider periodically "self-auditing" to assess the accuracy of information available about them on physician-ranking Web sites and other sources online" [7].	<ul style="list-style-type: none"> • How do you portray yourself and how are you viewed, online? • Is representation of who you are accurate, or have you been misrepresented or misrepresented

<p>5: "The reach of the Internet and online communications is far and often permanent. Physicians, trainees, and medical students should be aware that online postings may have future implications for their professional lives" [7].</p>	<p>yourself?</p> <ul style="list-style-type: none"> • For those growing up in a digital age and living their lives online, how will the permanence of your Internet presence impact your career? How can you tip the balance towards a beneficial (rather than harmful) impact? • Can you delete "former versions" of your self-representation online, and should you do so? • Will we become more accepting of personal growth and change online?
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The ACP-FSMB guidelines discuss the ways in which our interactions on social media are not private and remind us that we are not interacting with just one person. Social media is a public forum.

One notably helpful component of the ACP-FSMB guidelines is the recommendation to *pause* before posting. Trust yourself, but pause before posting to reflect on how best to protect and respect patients, their privacy, and your professional relationships and responsibilities. It is helpful to think of the use of social media as a public speaking arrangement in which everything is recorded and shared.

Social media is not one particular environment or location; there are more and less private settings and more and less individual (one-on-one) conversations. It helps to think about your conduct on social media as occurring in a setting where you are exposed to patients and the public at large—as *media*. It is the *mixed* setting of social media that should be acknowledged. Social media is everywhere and anytime, both private and public, both in the present, the past, and indefinitely into the future. That awareness should give you that "professional pre-post" pause moment.

The "starting point" should always be our existing norms of communication, confidentiality, and all the relevant tenets of professionalism, applied to new settings. Consider the following questions. How should you, and how do you, conduct yourself with patients, when you are with them in person? Does this change when you are speaking with them on the phone or by email [8]? How should you, and how do you, conduct yourself when near patients (in a hospital elevator, the cafeteria, the open physician or nurse workstation)? If the answer is "it depends," then perhaps one set of guidelines is insufficient or cannot capture the nuances. That is why the ACP-FSMB recommendations are only a starting point.

The Evolution of Online Medical Professionalism

These ideas about online medical professionalism are rooted in traditional boundaries, but even those may change over time. For example, I don't insist that my patients call me Dr. Kind, as many doctors might once have done. My outpatient pediatric colleagues don't necessarily wear the traditional white coats anymore. Like offline customs, social media conventions will change over time.

We should, however, retain the principles underlying norms of professionalism and apply them to new contexts. Twenty years ago we were cautioned against "excessive self-disclosure," and this remains useful advice in the present social media era [9]. In accordance with the Association of American Medical Colleges' (AAMC's) core "entrustable professional activities" (EPAs) for entering residency [10], physicians should maintain their integrity; compassion; respect for others; responsiveness to patient needs that supersedes self-interest; respect for privacy and autonomy; accountability to patients, society, and the profession; sensitivity to diverse populations; and commitment to ethical principles regarding care, confidentiality, informed consent, and business practices. These should be upheld irrespective of "when" and "where."

The peer-reviewed literature pertaining to use of social media in medicine began with cautions about potential problems of social media and then recognized opportunities [11-13]. Then came a debate about separating professional and personal identities online [14, 15], which is called for in both the ACP-FMSB [3] and AMA policies [2] but also criticized as either unnecessary or impossible.

Next has been the move to include social media in medical student education (i.e., both teaching about social media and using it in curricular delivery) and to trust trainees to use it properly [16] rather than to limit their access. With competencies in professionalism, ethical conduct, and communication, physicians should be equipped to enter residency entrusted with responsible social media use. Social media is now part of quality improvement initiatives, patient engagement efforts, and the measurement of scholarly impact using "altmetrics" (alternative, nontraditional metrics such as online activity) [17]. We will continue to move forward where best practices take us, careful to ensure that we secure the public's trust as we move forward in online spaces towards reflection, lifelong learning, and discovery in medicine using social media [18, 19].

Conclusion

Ultimately, we are in a public space when we use social media and, with sharing, the timing of any given post is undefined and indefinite. The reach is far and permanent. We'll keep the one-on-one, in person, clinical encounters to treat our patients, but we can go on to have an even greater public health and educational impact online. There are many positive social media uses for health care professionals. There are lifelong learning

[18] and academic sharing and public health opportunities. It is an invitation to communicate and to share ideas.

As technology advances, social media guidelines will be modified, and yet the underlying principles of professionalism will remain. Best practices will emerge, and outpace the guidelines, but if they are “best” they should maintain—and even enhance—the public’s trust in health care professionals. And in moving beyond the starting point, we note that there is no end to the need for professionalism and doing good; it is perennial.

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ISSN 2376-6980**

American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 448-455

POLICY FORUM

Professional Codes, Public Regulations, and the Rebuilding of Judgment Following Physicians' Boundary Violations

Joseph C. d'Oronzio, PhD, MPH

"In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill doing and all seduction, and especially from the pleasures of love with women or with men."

Hippocratic Oath [1]

The phrase "physician-patient boundary violation" conjures up the image of a physician taking sexual advantage of a patient—the physician with wandering hands who improperly touches a patient or who makes suggestive entrées of a sexual nature—actions repulsive and demeaning to the patient and fundamentally inconsistent with the role of the clinician. The physician has simultaneously overridden the normal requirements of ethical interpersonal behavior and undermined the integrity of his or her profession.

Much as high-profile cases grab headlines, sexual coercion is not the only violation of boundaries in the practice of medicine. Prior or current social or emotional attachment to patients (as when treating a family member or special friend) disrupts the required objectivity; so does favoring a VIP patient or forming dual or reciprocal relationships such as business partnerships. Any motive not related to the patient's care radically disrupts professional objectivity and trust in the profession. These are all boundary crossings that often rise to the level of violations.

Neither demographic data nor prevalence of specific boundary violations is conclusive. The sources for such information come from state-specific disciplinary records in which sex-related offenses are more clearly identified than other general boundary violations. The formal classification of what counts as other boundary violations differs from jurisdiction to jurisdiction and is often generalized as "unprofessional" or "unethical" conduct, and thus is difficult to specifically quantify [2]. Moreover, the actual extent of sexual violations and perhaps other boundary violations is difficult to determine. Disciplinary action data is generated by complaints registered by the offending physician or his or her colleagues and by patients, sources that can be compromised and unreliable. In the former cases, the professional and career ramifications of a report are an inhibiting force, and in the case of patient complaints, physician sexual misconduct is thought to be even less likely to be reported than sexual assault by other individuals [3].

That said, some generalizations can be made from research and analysis of disciplinary records focused on sexual misconduct summarized over the period from 1989 to the present [4-6]. The number of licensed physicians in the United States disciplined for sex-related boundary violations in 1989 was 42; in 1996 the number rose to 147 [4]. This reflected a rise in the percentage of all disciplinary actions for such violations from 2.1 percent in 1989 to 4.4 percent in 1996 [4], a range that is representative of state-specific percentages. The incidence in some states is twice this rate (10 percent of disciplinary orders in California) [5]; in others it is negligible [5, 6].

Some medical specialties and practice settings are at greater "risk" of sexual or other boundary violations. Psychiatry is often identified as a specialty with a higher-than-average percentage of membership cited for sexual misconduct [4, 7, 8], and various reports and analyses have also pointed to high incidence in the primary care specialties [2, 9-11]. The ambulatory or office-based setting is thus the most common venue for boundary-violating behavior [12], perhaps due to there being less scrutiny in this domain where the physician is the sole authority [2].

Where might a patient who has experienced this bad behavior turn?

Professional Codes and their Limits

One might turn to the medical profession itself for guidance. Professional associations codify principles of ethics and their applications to current and past practices for their members. While the proscription on sexual relations seems obvious and, indeed, reaches back to the Hippocratic Oath, so, as we observe, does the violation of that proscription. Indeed, the very existence of codes is evidence that professional associations must attend to the possibility. A recent survey revisits the issue, finding a decline among physicians who would rule out the possibility of physician-patient romance [13].

Thus, the American Medical Association (AMA) proscription concludes, "A sexual relationship with a former patient is unethical if the physician uses or exploits the trust, knowledge, emotions or influence derived from the previous professional relationship" [14]. And the American College of Physicians (ACP) adds practical advice: "Because it may be difficult to judge the impact of the previous professional relationship, the physician should consult with a colleague or other professional before becoming sexually involved with a former patient" [15]. And still, the problem continues.

These codes are perfect expressions of professional self-regulation and autonomy—what the profession expects of its members. Thoughtful and exacting, such codes posit the profession's interests and ideals and the standards that members are expected to maintain. Professions, however, are limited in dealing with violations of code: generally, neither their investigative power nor their enforcement mechanisms are very robust.

Violation of a professional code may result—at worst—in censure and loss of association membership.

This is where the licensing boards come into play. The facile historical truth is that the failure of professions to self-regulate has generated the need for public regulation. State medical boards function in a way that is contrapuntal to the professions, implementing a “social contract” model of accountability [16]. The boards have investigative power and the ability to impose punitive measures through regulatory statute (each state’s Medical Practice Act [17]), which, while often consistent with professional codes, is aimed at protecting public health and the welfare and rights of patients, along with the integrity of the professions. It is instructive, in this regard, to note that since 1984, when Wisconsin first criminalized sexual boundary violations, subsequent state initiatives aim to strengthen the role and prerogatives of the board’s administrative powers. Rather than mandating direct police intervention, they allow, or require, the public board itself to remand a case to criminal jurisdictions [18-20]. This legislation is a perfect expression of state regulation of professional integrity—what society expects of the profession.

Another alternative for a patient experiencing physician misconduct is to register a complaint with the state medical licensing board. What happens next?

How State Medical Boards Respond to Patient Complaints

An investigative process is set in motion that aims at determining the veracity of the claim and exploring all its dimensions. Interviews are conducted; patient charts are audited; undercover agents may be deployed to pose as hapless patients, perhaps with concealed audio or video tapes; charges are issued; and hearings and legal encounters ensue in which the complaint is refined and the physician offers defenses both factual and mitigating.

If the physician is found culpable, the medical board report details the relevant particulars of the incident(s) and cites the section(s) of the state Medical Practice Act that have been violated. The board then issues an order that aims to match the infraction with a punishment. Boards have at their disposal a broad range of possible retributive sanctions. In one analysis of medical board responses to sexual boundary violations, the authors counted two dozen possibilities, which are, from most to least severe:

revocation of license, surrender of license, disallowance of the right to renew a license, revocation of controlled substance license, surrender of controlled substance license, disallowance of the right to renew a controlled substance license, denial of a license, denial of license reinstatement (from a revocation or surrender), reinstatement (from a revocation or surrender), suspension, suspension of controlled substance license, emergency suspension, license probation, probation of controlled

substance license, fine, license restriction, restriction of controlled substance license, reprimand, education, enrollment into an impaired physicians program or alcohol or other drug treatment program, cease and desist order, monitoring of the physician's practice, participation in community service, and exclusion from Medicare (only the department of Health and Human Services can take this action). In about one third of the orders...state medical boards imposed more than one action in a single disciplinary order [4].

The severity of the discipline meted out for violation of sexual boundaries varies with the severity of the infraction, including aggravating and mitigating factors. Some doctors receive sanctions on the most punitive end of the spectrum, but a larger group finds itself back in practice after an encounter and settlement with their board, and there is still another cohort for whom the case, generally of the "he-said-she-said" variety, never gets past the complaint stage. By 1998, 23 states had laws that criminalized various sexual boundary violations by a physician independently of and in addition to board sanctions [19, 20], and in cases that are found to be "predatory" behavior or "sexual addiction," action will generally include a requirement that the doctor receive psychiatric care [4].

Education, Remediation, and the Cultivation of Judgment

Remedial educational programs can be one component of disciplinary orders that satisfies both profession and society. There is a trend since the early 1990s of agencies' offering programs for medical boards to use to assess competence, performance, or neuropsychological status [21]. In 1992, at the request of the New Jersey Board of Medical Examiners, three colleagues and I developed such a program for state medical licensing boards and their physician licensees. We named it the ProBE Program, an acronym for "Professional Problem-Based Ethics," and it became a resource to which a board might refer errant physicians for a kind of ethical rehabilitation as part of a disciplinary order [2]. ProBE was groundbreaking and is unique in its focus on professional ethics and the specific infraction for which an individual is referred. Thus, it is not surprising that boundaries are the most common topic about which we educate physicians. Between 1992 and 2013, 11.4 percent of ProBE participants were referred for sexual misconduct, included within a total of 38 percent referred for boundary violation more generally [2].

ProBE referrals for sexual boundary violations do not include predatory or addictive sexual behavior. Rather, what we characteristically see are physicians who encounter an attractive potential sexual partner in a professional setting, act on the attraction, and find that it is reciprocated. Typically, it is not the proscribed relationship itself, but its unhappy demise that triggers the complaint. Our physicians' ex-lovers know the rules and are seeking revenge by filing a sexual misconduct complaint with the state medical

board. In these instances, the famous power differential favoring the physician over the patient is suddenly and decisively reversed. We do not know how many physicians have relationships or breakups that do not result in complaints. We do know that almost all of the 11.4 percent of clients referred to us by the boards for sexual misconduct simply exercised poor judgment in a personal relationship that created a professional vulnerability.

Physician accountability comes from these two sources—the professional code and the state medical board—and, while they rarely intersect in practice (I have never seen a medical board disciplinary order refer to a professional code), in the ProBE Program we speak both languages. That is, the physician behavior that generated a patient complaint and led the physician and the board to negotiate this discipline is both ethically and legally problematic, against both professional and regulatory rules. Physicians who are able to benefit from such an educational intervention internalize this new understanding, translating, as it were, these two sources of accountability into the language of judgment.

This is an ongoing theme of ProBE interventions that applies to virtually all of its cases: the importance of the role of judgment and self-regulation rather than mere knowledge of the “rules.” The maintenance of appropriate physician-patient boundaries is largely a matter of judgment by the professional, who is (correctly) assumed to be in control. With this authoritative role comes the responsibility to manage the myriad sensitive interactions that are part of medical practice and that may pose a boundary dilemma.

Not all boundary crossings are violations, even though nonexploitive behavior can well become “harmful and untrustworthy.” This is where mindful judgment, careful introspection, and clear communication come into play. Merely addressing the ambiguous distinction between boundary violations and harmless boundary crossings tends to undercut the strict, rule-based approach to professional boundary maintenance that stresses uniformity, vigilance, obedience, and external controls. Paradoxically, the “graded-risk” approach to boundary dilemmas, as developed by Martinez [22], which focuses on careful analysis of risks and benefits to patients in negotiating patient-physician relationships, may speak more directly to professional integrity than obedience to rules. This approach has the virtue of stipulating an active and thoughtful examination of the relevant boundary and has the potential to reduce the power differential in the patient-physician relationship that underpins the “absolutist,” rule-based approach. The flip side of the paradox is that the rule-based approach puts the physician in a position of “power” and control that is not always realistic.

Future Directions

This examination of boundary crossings and boundary violations, drawn from my experience directing the ProBE Program, elucidates the need for reconsideration of how

we define as well as how we address boundary violations. Whatever the violation, there needs to be an emphasis on enhancing the value and power of physicians' judgment rather than on promoting obedience to strict rules. This suggests a parallel with basic clinical training in which we provide essential information and best practices, but at the same time, discourage and disparage "cookbook" medicine. In professional ethics, to the degree that the principles get calcified in their application, their validity is compromised. Between the broad articulation of ethical standards that cannot be enforced by the profession and the narrow codification of the administrative law applied by regulatory agencies lies the domain of judgment.

In medicine, clinical judgment gets played back into and informs the best practices, redefining them in light of experience and application. Similarly, the flux and alterations in the physician-patient relationship and the general transformation of the social and moral context of health care delivery needs to be taken into account here. We need to find ways to organize this experience and redefine our ethical concepts and the ways in which they are applied to enhance both the integrity of the profession and the public expectations of physicians.

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ISSN 2376-6980**

American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 456-460

POLICY FORUM

The Need for Professional Standards in Global Health

Roy Ahn, MPH, ScD, Kristina Tester, Zaid Altawil, MD, and Thomas F. Burke, MD

A large international nongovernmental organization (INGO) health project shuts its doors in sub-Saharan Africa, with no advance notice, leaving chaos in its wake. Key health stakeholders in the local community, including the Ministry of Health, are completely caught by surprise, and the questions (and recriminations) begin to mount: Who will treat the people formerly served by this INGO health project? Which organizations will provide jobs to the local health care workers, formerly earning above-market wages, who have been abruptly handed their walking papers? How could this lack of foresight by the INGO have occurred in the first place? Who is minding the shop, ensuring that the local health system is functional in the face of this pull-out?

This all-too-common scenario underscores the need for discussions about the ethics of INGO behavior in the context of global health and development [1]. This essay addresses the need for professional rules of conduct in the field of global health, drawing parallels to the related topic of professional conduct in medicine, and proffers a set of solutions to address these issues in the field. Given the dramatic rise of interest among physicians and medical students in global health service, such guidelines are critical to ethical and appropriate practice.

Professional Conduct in Medicine

The topic of professional conduct is well-traveled terrain in the medical literature. Some of these discussions focus on the delineation of the hierarchies and roles of health care professionals within health care organizations. Other normative discussions center on demarcating ethical from unethical clinician behavior. Certain professional boundaries are clear-cut, like a third rail that a physician or medical student should never touch (e.g., engaging in romantic relationships with patients), while other boundaries are murky. Consider, for example, whether a physician should provide personal funds so a patient can afford to buy medication [2] or how to ensure that medical students provide more benefit than harm during their short-term global health trips [3]. These discussions highlight the critical importance of establishing (and adhering to) core principles and codes of conduct in clinical medicine. Examples include discussion of the patient-physician relationship in the American Medical Association *Code of Medical Ethics*, which stipulates, "The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups..." [4]. Another oft-cited example is

Beauchamp and Childress's seminal work, *Principles of Biomedical Ethics*, which articulates four main principles of ethics in medicine—respect for autonomy, nonmaleficence, beneficence, and justice—and rules for engaging patients—veracity, privacy, confidentiality, and fidelity [5].

Professionalism in Global Health

A similar need exists at a macro-level for focused discussions about professional conduct in the field of global health, especially for INGOs working in global health and development. Global health is public or population health on a global scale. Public health is itself an amalgamation of fields; as one former World Health Organization leader put it, “public health assembles and then tries valiantly to assimilate a wide variety of disciplinary perspectives, from economists, political scientists, social and behavioral scientists, health systems analysts, and a range of medical practitioners” [6]. In 2009, Koplan et al. accommodated the aforementioned amalgamation of viewpoints in defining global health as

an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care [7].

Professional rules of conduct in global health are a worthwhile topic, first of all, because INGOs are so numerous. While not all INGOs are health-focused, many work to mitigate the effects of the social determinants of health in society and thus contribute to positive change in population health. Because of the enormous size and scope of their collective activities—all ostensibly pointing towards the public good—there is a need to articulate principles of ethical behavior for INGOs working in global health. Also, similar to the primacy in biomedical ethics of the integrity of the patient-physician relationship, it is crucial to ensure that INGOs working in global health are accountable to the communities they are serving according to their mission statements. Two of the authors of this essay have witnessed firsthand how this INGO-community trust can be violated in the absence of relevant rules of conduct. We recently operated a health program in Juba, South Sudan and saw many expensive INGO-purchased Toyota Land Cruisers dotting the landscape (no doubt the residue of a massive, rapid influx of foreign aid into the country), standing out in sharp relief against the abject human poverty we saw in the streets of this city. While hardly naive, we wondered aloud how the INGO community could so ostentatiously put its interests ahead of those of the poor and disenfranchised whom they had been asked to serve.

Toward a Pragmatic Framework to Define Professional Conduct in Global Health

Given the multidisciplinary nature of the field, it is appropriate to consider inter- and intra-professional conduct in global health. The good news is that several global initiatives have begun thinking through these topics. For example, the INGO Accountability Charter—comprising large INGO members such as Care and Oxfam—requires its members to report on several domains of accountability, such as “respect for human rights” (how the organization “advances” human rights), “ethical fundraising,” “diversity/inclusion,” and “professional management” (including how well it evaluates its own performance) [8]. Similarly, the Global Standard Project, composed of several large networks of civil society organizations (CSOs), is currently working towards a unified global standard for CSO accountability that will synthesize existing codes of conduct for organizations working in the field [9]. The World Association of Non-Governmental Organizations (WANGO) has developed its Code of Ethics and Conduct to guide good management practices for NGOs [10]. In the global humanitarian space, in 2014, Groupe URD, HAP International, People In Aid, and the Sphere Project promulgated nine “core humanitarian standards” [11] to guide ethical practices among humanitarian response organizations globally:

- Humanitarian response is appropriate and relevant....
- Humanitarian response is effective and timely....
- Humanitarian response strengthens local capacities and avoids negative effects....
- Humanitarian response is based on communication, participation and feedback....
- Complaints are welcomed and addressed....
- Humanitarian response is coordinated and complementary....
- Humanitarian actors continuously learn and improve....
- Staff are supported to do their job effectively, and are treated fairly and equitably....
- Resources are managed and used responsibly for their intended purpose [11].

The themes underlying these initiatives—transparency, sustainability, equity—can all contribute to professional standards for organizations working in the broader field of global health. Had such principles been developed (and adopted), perhaps the INGO fiasco described at the beginning of this essay could have been averted—a rational exit strategy for the INGO could have been developed early on (sustainability), other INGOs or government agencies could have planned well ahead of time to address the gap in service provision left behind and strengthened the health care delivery system in the local area (transparency), and the local health care workers could have been paid market wages (equity). Downstream efforts to adhere to these principles in the delivery of global health programs will undoubtedly enhance the positive impacts of INGOs on communities’ health, make it possible to identify best practices for the field, and help organizations both understand and adhere to these principles.

Conclusions

As physicians and medical students increasingly work in global health, the onus is on all of us in the field to safeguard the covenant between health-focused INGOs and the communities they serve. Professional codes of conduct represent an important first step in promoting good practices and rejecting ethically dubious ones. The ideal guiding principles for INGOs in global health will focus on communities, prioritizing communities' wants and needs over the INGO's. Perhaps not coincidentally, these guiding principles are not dissimilar from Beauchamp and Childress's seminal principles of physician-patient relationships: autonomy, nonmaleficence, beneficence, and justice [4].

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ISSN 2376-6980**

American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 461-464

MEDICINE AND SOCIETY

Necessary Boundary Crossings in Pediatrics

Emily Thompson

"Tammie?" I watched the attending physician lean over the bed in a darkened hospital room. A heap of blankets shifted slightly to reveal the eyes and forehead of a 16-year-old girl undergoing chemotherapy. "Did you get up today?"

"Mmm-mmm," she groaned. The blankets returned to their original position.

"You know I want you to get out of bed and get moving. Can you do that for me?"

"Mmm," groaned the blankets.

"OK, tell you what. I have five dollars, and I'm going to leave it on your table here. But to keep it you have to walk all the way down to the gift shop and buy something, and you have to show it to me when I get back later today. How does that sound?"

Silence from the blankets.

"Tammie?"

"OK."

Light bribery—whether with candy, cash, or toys—was a common occurrence on the pediatric floor. So were coloring sessions at the nurses' stations, foosball games with medical students, and piggyback rides during rounds. Residents went back to visit former patients who had been readmitted, even if they were off service. Emotions went unbridled—clinicians celebrated with their patients in good times and wept with their families in the worst times. They attended graduation parties. They attended funerals. On my pediatrics rotations, everywhere I looked I saw clinicians going above and beyond what was required for their patients' physical well-being. To treat each child as a whole person, they were involving themselves in their patients' lives in ways clinicians seldom would with adult patients. Arguably, at times they were crossing [professional boundaries](#) to do so. And they were better pediatricians for it.

Professional boundaries are meant to protect patients. Patients are vulnerable: they may be ill or injured, alone, physically exposed, at extremes of age, or just plain scared. They

are required to reveal intimate details about themselves to strangers in order to receive treatments they may or may not understand. The only way this relationship can be therapeutic is if the patient can trust the clinician not to violate his or her position of power for personal gain—in other words, to place the patient's benefit first.

Professional boundaries also protect clinicians. Sharing intense experiences with clinicians may lead patients to seek out inappropriately intimate relationships with them. Clinicians can experience personal heartbreak and burnout if they do not maintain some professional distance from their patients' suffering. And a personal relationship may damage a clinician's objectivity, causing him or her to spare a patient a painful procedure or to continue treatment beyond the hope of help. The need for professional boundaries is exemplified by the principle that clinicians should not treat family members or friends [1, 2]—the therapeutic relationship must be paramount to all others. When those boundaries are violated, that relationship is jeopardized.

Professional boundary violations are not to be confused with boundary crossings. Boundary violations refer to situations in which clinicians take advantage of their patients' vulnerability for selfish ends, thereby damaging the therapeutic relationship, and they should be universally recognized as inappropriate. They include romantic relationships, financial exploitation, the venting of personal problems, and reversal of the caregiving roles. Boundary crossings, on the other hand, are nonharmful, nonexploitative actions that briefly transgress professional boundaries in an effort to meet a particular patient need.

My belief is that boundary crossings are necessarily more frequent in pediatrics than in other specialties because establishing a therapeutic relationship with pediatric patients requires a social relationship as well. Clinicians must establish trust with pediatric patients on a deeper level than with adults. Most adults are fully autonomous, able to make their own decisions about treatment, and able to cooperate with procedures. This is not true for children. While older children have some influence over their care, treatment decisions are generally made by their parents. As a result, children may undergo necessary but painful and frightening procedures against their will. If they do not trust their clinicians, they may be less likely to cooperate, and visits to the hospital could become terrifying and traumatic. Pediatricians must gain this level of trust by making the extra effort to connect with children socially, in order to effectively care for them medically. Spending time on activities not related to medical care, giving small gifts, comforting with physical touch, providing rides home, and sharing brief personal anecdotes for encouragement may all be entirely appropriate in the course of caring for a pediatric patient.

Pediatricians must establish a good relationship with the parents as well as the patient. Due to advances in modern medicine, children are generally expected to be healthy. A

chronic illness in a child throws the entire family into crisis. Since a sick child is not autonomous, his or her family is inextricably part of care. Caring for a child with a chronic illness is thus, in a sense, caring for the family as well. This means that extra measures such as getting to know the patient's siblings, home visits, and exchanging personal cell phone numbers may be beneficial and even necessary to provide the context for proper medical care of a child.

One of the roles of a pediatric clinician is to maintain a semblance of normalcy for their patients. Children with chronic diseases spend enormous amounts of time in the hospital. It is virtually impossible, even unnatural, for clinicians not to develop friendships with children and families that they see so often. Additionally, children with chronic illnesses miss school days and many normal childhood experiences. However, they generally still want to spend time with their friends, play, and "be kids," which is necessary for their continued resilience and eventual recovery. Allowing them to lose their desire for normal childhood experiences or fall into a victim role can be devastating for them. They may refuse to eat, decline activity, and stop pursuing any goal of recovery. Thus a pediatrician must be much more than a sympathetic person in a white coat who knows a few personal details. It is impossible for a clinician to help a child in this situation without knowing how to motivate him or her and then going to extra lengths to do so.

All this does not mean that pediatricians abandon the doctor role. In fact, there are times when they must step back and clarify professional boundaries. They must never try to take over the parents' role. They must make sure that the patient has relationships and coping mechanisms with people outside the medical team. They must also avoid favoritism and be willing to make the same efforts for all of their patients. And they must recognize that the needs of their patients differ; some of them may not want or benefit from a more personal therapeutic relationship. Boundaries must only be crossed in service of the patient. The best pediatric clinicians are those who can best balance the therapeutic and social, and who can offer patients and families the therapeutic relationship they need, whether they are suffering through a vaccination day or surviving cancer.

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ISSN 2376-6980**

American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 465-468

MEDICAL NARRATIVE

An Intergenerational Conversation about Frustrations, Lessons, and Hope in Physician Activism

Shira Heisler, MD, and Gordon D. Schiff, MD

SH: There is a common narrative among interns and residents. We work crazy hours. We often feel like we're in over our heads and don't know what we're doing. And yet, somehow, we are expected to be taking good care of very sick patients, among the sickest in our cities. While being a first-year intern is well understood to be overwhelming, one of the most significant challenges is rarely discussed and confronted: that our patients, especially in distressed environments, have urgent nonmedical problems that stem from systemic injustices.

Patching patients up in order to "discharge them" (the omnipresent priority of a resident), sending them out to the same environments and situations that led to their admission, often seems even crazier than the hours we are working. Sometimes, no matter how diagnostically astute or compassionate we try to be, it seems that inadequate housing, poverty, substance misuse, and other socioeconomic forces continue to overwhelm our best efforts. For instance, how can we discharge an uninsured patient with end-stage liver disease secondary to hepatitis C into homelessness when he has ascites so severe that he will need repeated therapeutic paracentesis with sterile dressing changes on a regular basis? How do we manage the care of a transgender woman with AIDS who is in and out of the hospital with opportunistic infections requiring a long course of IV antivirals? We can't keep her in the hospital for the six-week duration of treatment because she is not "acutely" ill enough to meet the criteria for admission. And the one rehabilitation facility that accepts patients with a history of recent drug use makes her feel so alienated and stigmatized about her gender identity that homelessness becomes her most reasonable option.

So, after long hours on the floors, writing endless notes, and talking to social workers until 9 p.m. about discharge planning, I'm left with perpetual questions. How can I help my patients while simultaneously working to create a more equal, just, and truly caring world?

After months of feeling this sense of hopelessness and helplessness, I was fortunate to reach out to Gordon Schiff. He has been a primary care physician and an activist for nearly 40 years, somehow maintaining both his idealism and love for medicine. I was inspired by an essay he had recently published in *JAMA* about crossing boundaries to care

more fully for patients [1], and I was able to connect with him by phone. During the next hour, Dr. Schiff walked me through some ideas and strategies for surviving my internship year and the years to follow and for most effectively helping my patients.

GS: After first setting some overall priorities for managing feelings of hopelessness as physicians, we can then look at specific approaches to helping patients and ourselves. I would offer the following ideas.

<p>Setting Priorities</p> <p>1. <i>Focus on relationships: the source of joy, meaning, and efficacy in our work.</i> Engaging the twin problems of our patients' day-to-day medical needs and all-encompassing social and economic issues can feel overwhelming. But building meaningful, caring relationships with our patients and advocating for their needs is a gift that nourishes our ability to feel that our efforts matter and are making a difference.</p> <p>2. <i>Take advocacy seriously.</i> Advocacy and activism are often disparaged as "not real medicine." On the contrary, engagement enhances our integrity, empathy, compassion and skills that are crucial for effective professionals—teamwork, transparency, listening to patients and placing their needs first, discerning what is best given a patient's context, and understanding social determinants of health .</p> <p>3. <i>Respect patients' amazing resilience, resourcefulness, and accomplishments.</i> Patients' ability to survive clinical and environmental challenges never ceases to amaze me. Many overcome adversity with dignity, humor, and calm.</p>
<p>How to Help Patients</p> <p>4. <i>Remember that small bits of help can make an enormous difference.</i> For our neediest patients, what seems to us like a drop in the bucket can have catalytic effects. A call to a housing agency or spouse or a letter to an employer or parole officer can be life changing and often doesn't require much work on our part.</p> <p>5. <i>Leverage your relationship to help patients.</i> Medications or surgery aren't all we have to give patients. Working with patients in need continuously over time as their clinician, cheerleader, trusted friend, nudger (to encourage them to stop smoking, change to healthier lifestyles) produces results. And, if treated with trust and respect, patients respond in myriad positive ways, such as adhering to our recommendations, admitting when they've gone astray, and appreciating our efforts.</p> <p>6. <i>Sympathetically engage substance abuse issues, homelessness, and incarceration.</i> The war on drugs has been a tragic (expensive, lethal) failure. Patients have been ill served by stigma, incarceration, and a lack of adequate treatment programs and effective approaches. Reach out to marginalized patients and advocate for needed help and programs we know work.</p>
<p>How to Help Yourself</p> <p>7. <i>Seek out hidden or dispersed sources of support.</i> You are not alone in both caring about these issues and in feeling frustrated and isolated in your efforts to ameliorate</p>

them. Look for local kindred souls, including sympathetic attending physicians, fellow residents, social workers, nurses, or even clinic administrators. They are out there and they need you as a source of fresh energy and ideas, just as you need them. Get together inside and outside the hospital to discuss patients and issues.

8. *Pace yourself; you are in this for the long haul.* Actions that will result in lasting change don't happen overnight or when you most expect them. You will have to pick and choose your battles; you will be making compromises every day. But keep your "eye on the prize" of the larger goals and don't forget that when you fight injustice you are on the right side of history.

9. *Work collectively with others in the community for change.* Acting alone can have limitations, and people organizing together can be powerful. Taking risks, testing strategies, and learning from mistakes together can lead to meaningful change.

10. *Leverage other initiatives, movements, and imperatives for change.* Align your efforts with residency and hospital accreditation requirements to teach and practice system-based improvements and conduct performance improvement projects. Join national initiatives to organize for a better, fairer health care system (such as Physicians for a National Health Program) or for more humanism in medicine (like the Gold Foundation).

SH: As our conversation progressed, I more deeply understood why we call pushing for transformative change a struggle. It's because there are no simple or perfect solutions, and the process can be painful. The growing pains I am feeling are a result of the steep learning curve of a resident paired with the complicated reality of working in a place often full of hopelessness and pain. But as with all growing pains, this is where change and transformation take place.

Furthermore, answers to our questions are always raising new questions, and even after nearly four decades of work as a physician, Dr. Schiff is still struggling with these same concerns, dilemmas, and problems that I am. So how do we do it without getting burnt out and forgetting why we chose this profession in the first place? And how can we make the systems we work in more humane and just? Dr. Schiff's answer is that, first and foremost, we must never lose sight of the power of our smallest actions, because you don't know which of the seeds you are planting will bear fruit. I think my answer today won't necessarily be my answer tomorrow. But, today, it is remembering that this a process.

My patients—who tell me painful stories about living on the streets in freezing temperatures, who describe what it is to go through detox countless times, who talk about the ongoing trauma of living in prison for over 20 years—are the people who can teach us what resilience and strength look like. It is this strength and tenacity that reminds me, and all of us, of the power and perseverance of human beings. If we see what one individual can overcome, oftentimes with little or no support structure, imagine

what a community of physicians, social workers, nurses, and particularly patients who share similar values and goals can do together. Imagine a world where we can help each other process the painful stories we hear and begin to think of new, creative ways of healing.

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ISSN 2376-6980**

American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 469-472

MEDICAL NARRATIVE

Doctoring for the Homeless: Caring for the Most Vulnerable by Building Trust

Monica Bharel, MD, MPH

People who are homeless have a higher mortality rate than the general population, with an average age of death of 51 years [1]. They also have a higher rate of many common medical problems, including hypertension and diabetes mellitus, which is twice as prevalent as in the general population [2]. Their competing priorities of finding daily food, shelter, and safety often obscure their ability to access important medical care. How can the best care possible be provided for this group of people with multiple medical needs that are worsened by abject poverty?

As a team member of [Boston Health Care for the Homeless Program](#) (BHCHP) for more than 12 years, I worked with men and women who were homeless in the Boston area. These men's and women's personal stories are compelling. Two cases stand out.

Gary

As a medical student, I met a man I'll call Gary, who had been hospitalized for unexplained blood loss. Gary had been homeless for several years, regularly sleeping outside or in local shelters. This wasn't his first hospitalization. Gary was [frequently hospitalized](#) for some exacerbation of one of his chronic illnesses that included diabetes and hypertension. He went to the emergency room only when he was too sick to stay outside. In the hospital, he seemed overwhelmed by all of the instructions he was receiving for follow-up care.

My role that day as the medical student was to try to identify and focus on the immediate cause of Gary's hospitalization and then turn to my next patient. But the most critical piece of information Gary shared with me was not about his health condition. It was that he did not trust the medical system. In fact, he distrusted it so much that he would—and did—go to great lengths to avoid medical care.

Before he was discharged, I introduced Gary to the medical team from BHCHP. He agreed to a follow-up appointment if I could arrange to meet him for it. We spent the next year intermittently meeting outside clinics so that I could accompany him to various appointments with his new primary care doctor at BHCHP, hematologists, and gastroenterologists. Gary sometimes kept his appointments but sometimes missed them. I did not have much medical knowledge yet, but I could see firsthand the importance of building a relationship of trust with Gary and connecting him to the right

services. We never identified the cause of his bleeding but, over the next year, Gary had no further hospitalizations and began to work with a case manager to look for housing. For Gary, what made all the difference was trust.

Michelle

Years later, when I was a doctor in the BHCHP urgent care clinic, a patient arrived exhibiting some minor symptoms that would typically take no more than five to eight minutes to address. According to the chart, the patient complained of a runny nose and felt tired. The nurse documented that she had no fever and her vital signs were normal. The likely diagnosis was a viral upper respiratory infection, simple but frustrating, since there is no good treatment other than rest and time.

I closed the clinic room door and smiled at the patient sitting in front of me. The patient I'll call Michelle was a woman in her 30s, hair pulled back, with several layers of sweaters and coats on. Her hands shook a little as she sat down. I opened with my usual line: "How can I help you today?"

She began to sob uncontrollably.

After several moments spent composing herself, she finally explained to me what was wrong. She told me that the day before had been the anniversary of her mother's death, marking the date she witnessed her being beaten and killed by her stepfather. The incident led to her revolving in and out of foster care for years, using illicit drugs to kill the pain, and eventually, as an adult, ending up homeless on the city streets.

As I listened to Michelle talk, I realized she did not come to the urgent care clinic just for her runny nose. She came because she needed to talk to someone about her feelings.

It was almost 20 years later, but I found myself thinking about Gary. With two decades of medical experience under my belt, my first step was still to build a relationship with Michelle. And this is one of the most beautiful aspects of being a physician: practicing the art of healing by being fully present and sharing in another human's responses to life circumstances.

Learning Medicine

The Centers for Disease Control and Prevention (CDC) defines health as complete physical, mental, and social well-being, not just the absence of sickness or frailty [3]. In this definition, the social determinants of health become important. It is clear that without housing and reliable food, clothing, and safety, it is not possible to maintain good health.

In medical school we are taught that a patient's social history is a review of his or her habits, environment, and work. When I was in medical school, I often thought of this as a side point, separate and seemingly not as important as the disease that was manifesting before my eyes. I was focused on discovering whether the murmur was from the aortic or mitral valve, whether the patient met the criteria for endocarditis, and what would be the right antibiotics to start. All of this is critical, and learning the medical sciences well is the foundation of being an excellent doctor.

However, there is another aspect of being a doctor that is less concrete, often labeled the "art" of medicine. As I reflect on my clinical work over the last 20 years, I see this art as the key to being a successful physician. What I have learned is that, while we must diagnose the endocarditis, we must also understand the person to whom we are attaching this diagnosis. For we humans live inside our social histories, and no medical disease or treatment will make sense unless we understand the aspects of a person's existence that directly relate to health care needs. The social determinants of health considered holistically, including the environment in which we live and our life circumstances, are key to how healthy we will be.

Boston Health Care for the Homeless Program

I spent the last twelve years practicing in a clinical setting that emphasizes the importance of this human connection and the surrounding environment in treating patients, specifically people experiencing homelessness. BHCHP was founded almost 30 years ago. The BHCHP model of care is based on starting with patient engagement and then, when a trusting relationship has been built, addressing medical needs. This can sometimes take minutes of nonjudgmental interaction or it can sometimes take years. The focus is on the patient and the community.

I became interested in this work years ago when, as a third-year medical student, I met BHCHP's founding physician, [Jim O'Connell](#). He has dedicated his career to using creative and novel methods to reach patients—finding them under bridges and in alleyways and gaining their trust over time. Role models like Jim helped me understand the value and importance of this work.

The Social Determinants of Health: Going Beyond the Prescription

We know that the health care we provide for our patients is important, but it is only one contributor to their health overall. Health care for the homeless programs can serve as models for providing health care for all patients infused with the necessary focus on social determinants of health—including things like assisting patients in applying for necessary benefits. In our privileged role as physicians, I hope we can all find ways to provide the best medical care possible by focusing our attention on being fully present with our patients and keeping the context of their lives in the forefront of health care delivery.

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ISSN 2376-6980

American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 473-476

MEDICAL NARRATIVE

The Changing Patient-Physician Relationship

James M. Thompson, MD

There is a general perception that the practice of medicine has evolved in a linear way. In my view the progression is quite nonlinear and involves quantum leaps. Periodically, there are major shifts in the standards of practice, and when entering a new paradigm we are met with new rules. In this article, I will briefly outline the continual dynamic evolution of medical practice over the last forty to fifty years, drawing anecdotally from my personal experience as a physician.

Yesterday

In 1960, *Life Magazine* published a photograph of a rural doctor, taken after he had performed a two-hour emergency surgery, that depicted the strain and sleep deprivation that was common in most medical specialties at the time [1]. So why did so many pursue this pathway? I believe there was a shared perception that this total commitment to practice-as-life was what being a doctor meant.

My own career began in 1977 as the director of the emergency department in a small ER in a 100-bed hospital. Because we were a rural hospital and most of the contracting physicians did not live locally, it was the policy to have 48-hour shifts in order to make the commute economical. It was assumed that you would get a few hours of sleep during a shift, but there were many nights that were pretty much nonstop work. No one considered this particularly unusual. My routine was to eat very little and to drink coffee for 48 hours straight. After 36 hours on duty, I realized, my cognitive function was not optimal, and I would have the nurses double-check my prescriptions for dosage errors.

In 1980, I opened a private solo practice in a retirement community 15 miles from the local hospital. I was extremely busy right from the start, with a typical patient load of 35 to 50 patients a day and a hospital census of about 3 to 5 patients. Office hours were from 8:30 a.m. to 6 p.m., and our policy was that, if you were sick today, you were seen today, which meant that I usually did not get out of the office until 7 or 7:30 p.m. Hospital rounds were at 7 a.m. and 8 p.m. At first the office was open Monday through Friday, but soon office hours were extended to Saturday mornings and, finally, a full day on Saturday. Every other Sunday I would go and see six to eight nursing home patients. I was always on call at the ER for admission of my patients.

During these early days in my career, I had wonderful relationships with my patients. There was a high level of appreciation and true friendship between us. However, as group practices enlarged and the use of referrals for specialists increased, physician-patient exposure decreased—visits became shorter, and the patient was exposed to different physicians and nurse practitioners.

Today

As a recent inpatient, I was unable to recognize the inpatient care process I knew as a physician attending to hospitalized patients. I was referred to the ER for my acute condition and to hospitalists for admissions and hospital care. The physician has become even more remote from his or her patients with the proliferation of answering services, making the insulating wall between them almost complete. I don't think that many patients today have any ability to contact their physicians directly.

Patients may be more distant from their doctors, but they have more access than ever to medical information. They are far more sophisticated about their pathology and the available treatments, and they have a desire to participate in treatment decisions.

On the "business" side, the physician no longer appears to have any significant control over his or her practice. The physician has become more like a contract worker with no influence on office management or policies. And since the patients belong to the practice and not to the individual physician, the physician is in a weak position in negotiations with management. Sometimes the only recourse is to leave and look for a new contract position.

Tomorrow

It is my belief that the practice of medicine will take another leap in the next decade. We are not only experiencing exponential growth in our understanding of medicine and the tools at hand, but also witnessing a complex system in motion. In a complex system whatever is reacted upon also produces changes that, in turn, alter the original system. As a trained chemist I dealt with "competitive consecutive reactions," which exhibit these same characteristics.

An interesting book on the type of changes we are likely to see is Ray Kurzweil's *The Singularity Is Near: When Humans Transcend Biology* [2]. He postulates that the progress of artificial intelligence is going to speed up to the point at which artificial intelligence surpasses human intelligence and humans transcend our biological limitations. An example of this progress is IBM's Watson (a giant artificial intelligence computer) examining the medical records of MD Anderson and the Cleveland Clinic to find optimal treatments for cancer and heart disease, respectively [3, 4]. This is a massive big data project.

The process of examining vast collections of big data and scientifically analyzing procedures and outcomes promises more evidence-supported treatments in the future. Big data will likely replace the subjectivity of “the art of medicine” with scientifically derived analysis, a trend that will likely lead to a more formulaic practice of medicine. And, as more structured protocols narrow the scope of treatment, we are likely to see a much increased use of ancillary people and technicians.

Conclusion

Some might think that I am biased toward the old ways, but I am not. I am not nostalgic about man-killing hours, chronic sleep deprivation, and the limited tools (medicines and procedures) we had. It should have been obvious that a sleep-deprived physician is not going to function at full capacity. I do have good feelings about the past patient-physician relationship of the past, but I am not aware of any studies indicating it was better for patients. The economic realities of studying such complex interrelationships of factors make it prohibitively expensive and therefore unlikely to be undertaken.

I am sure that there are those who will disagree with me on some of the points of the future course of medical practice, and my rebuttal is that I don't believe their crystal ball is any better than mine. The only thing that I am positive about is that we are on the steep part of the exponential curve in a changing complex system. I believe we are going to see amazing progress and that the practice of medicine will be very rewarding and interesting, but very different from today. If you were able to walk with me on a typical practice day 35 years ago, most of it would appear very foreign. You may experience the same feeling about 10 years from now thinking back to today.

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American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 477-484

Suggested Readings and Resources

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American Medical Association Journal of Ethics

May 2015, Volume 17, Number 5: 485-487

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