

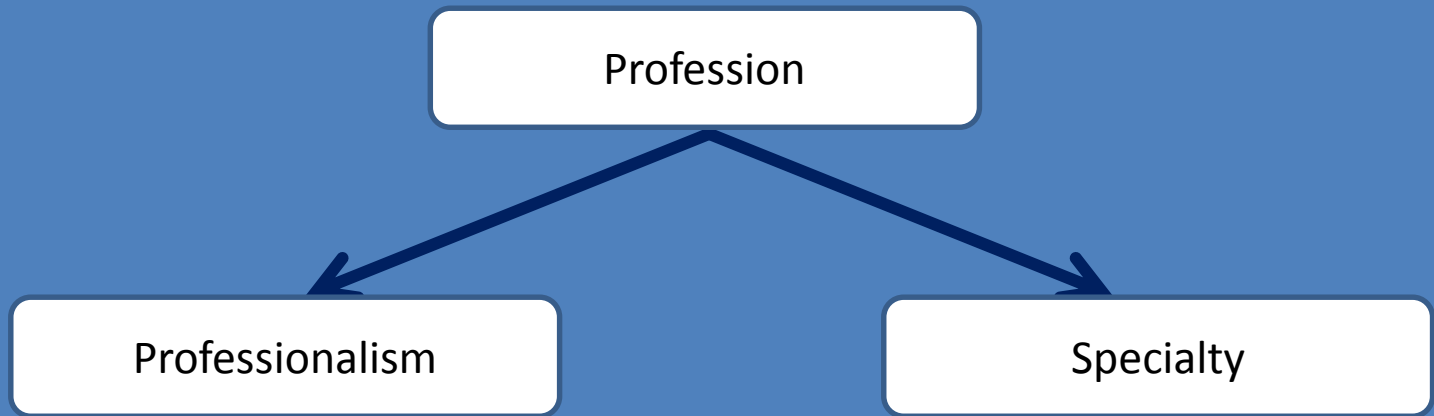
# Medical Professionalism

Gad Segal, MD  
Head, Internal Medicine "T"  
SHEBA Medical Center



# Professionalism Definition







Profession

**Orchestra Player**

Professionalism

Specialty

Notes



Technique



Order of Sitting



Conductor



Profession

**Orchestra Player**

Professionalism

Specialty

Dress



Applause



Notes



Technique



Bowing



Stand / sit



Order of Sitting



Conductor



Profession

## Orchestra Player

Professionalism

Dress



Bowing



Behaviors

Applause



Stand / sit



Specialty

Notes



Order of Sitting



Activities

Technique



Conductor







Profession

Lawyer

Professionalism

Specialty

Litigation



Domain



Law



Ethics



Profession

Lawyer

Professionalism

Specialty

Dress



Confidentiality



Litigation



Law



Costs



Domain



Ethics



Profession

Lawyer

Professionalism

Specialty

Dress



Confidentiality



Litigation



Law



Costs



Domain



Ethics



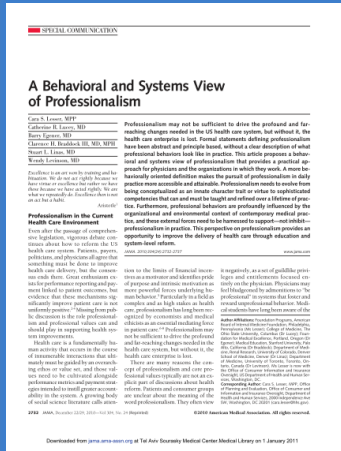
Behaviors

Activities

# Medical Professionalism

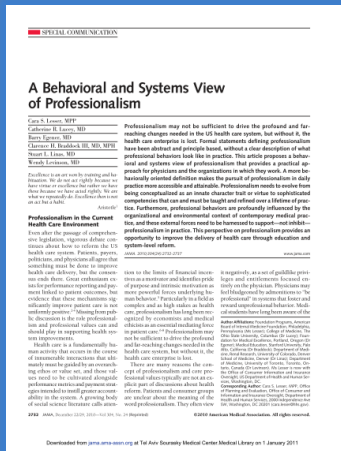
# Medical Professionalism

“In recent years, there have been several efforts to advance a contemporary definition of professionalism and identify specific behaviors that exemplify professionalism in the current practice environment.”



Lesser C. S. et al. A behavioral and systems view of professionalism.  
*JAMA* 2010;304(24):2732-2737.

# Medical Professionalism

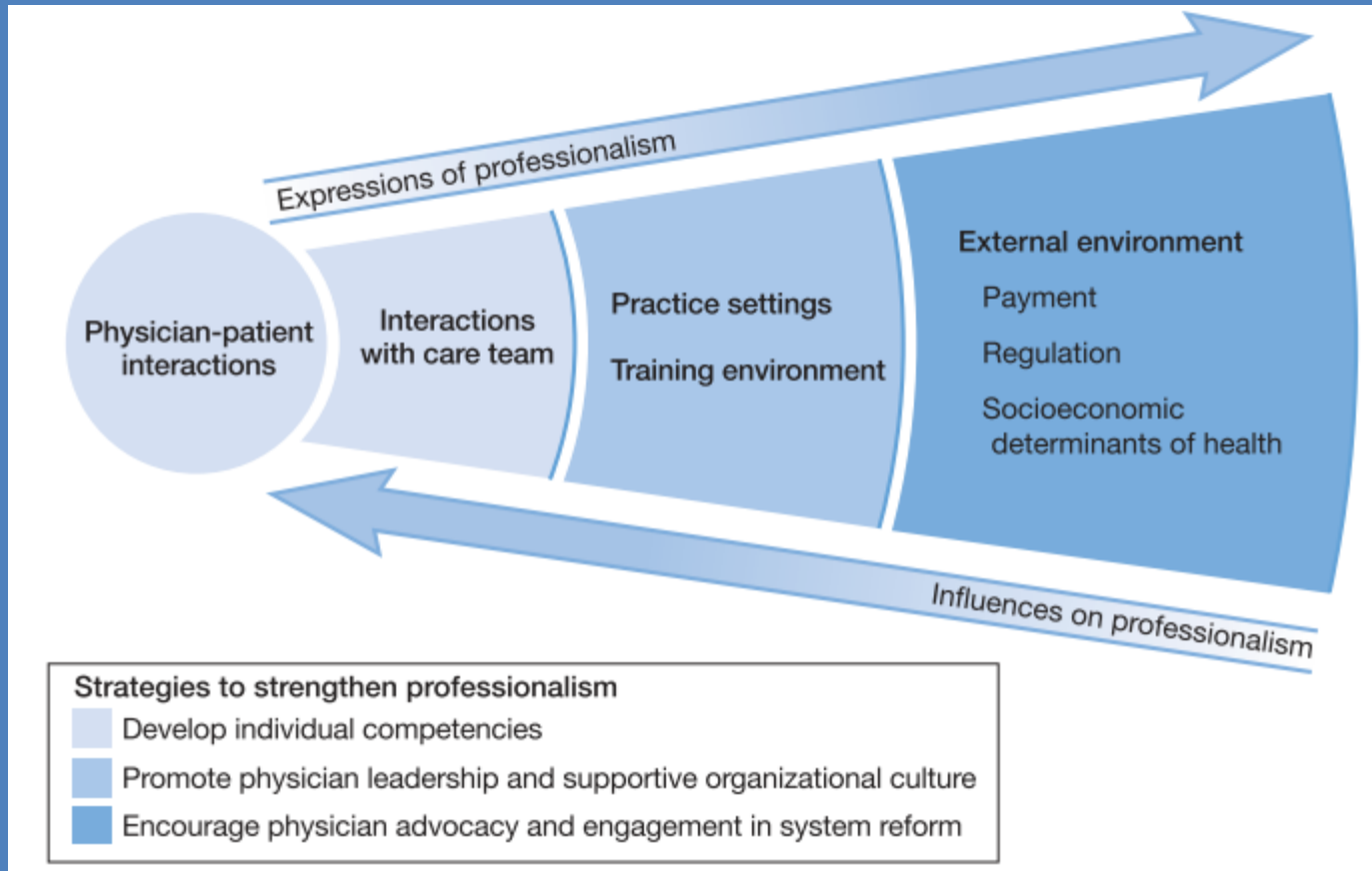


“In recent years, there have been several efforts to advance a contemporary definition of professionalism and identify specific behaviors that exemplify professionalism in the current practice environment.”

“...we offer a framework for conceptualizing professional behaviors in 2 key domains: individual interactions with patients, family members, and colleagues in the health care team and organizational interactions in the management and governance of care delivery settings and in professional organizations.”

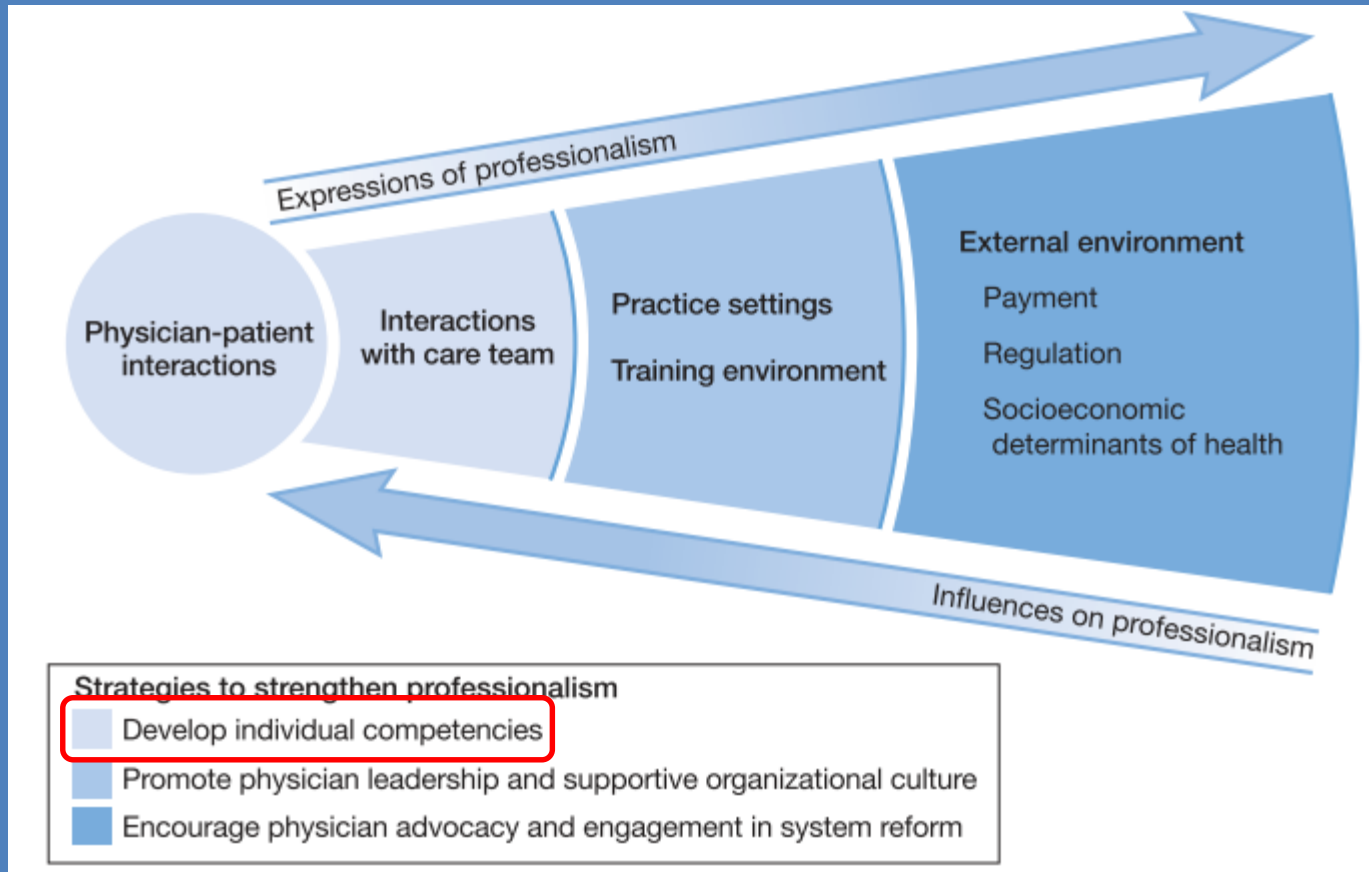
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# Medical Professionalism



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# Medical Professionalism




Lesser C. S. et al. A behavioral and systems view of professionalism.  
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**Table 1.** Framework for Conceptualizing Professionalism—Individual Physician Behaviors in Interactions With Patients and Family Members and Other Health Care Professionals

Values	Examples of Individual Physician Behaviors	
	Interactions With Patients and Family Members	Interactions With Colleagues and Other Members of the Health Care Team
Compassionate, respectful, and collaborative orientation, “in service” of the patient	<p>Provide patient-centered care, demonstrating empathy, compassion, and actively working to build rapport</p> <p>Promote autonomy of the patient; eliciting and respecting patient preferences, and including patient in decision making</p> <p>Be accessible to patients to ensure timely access to care and continuity of providers</p> <p>Act to benefit the patient when a conflict of interest exists</p>	<p>Work collaboratively with other members of the care team to facilitate effective service to the patient</p> <p>Demonstrate respect for other team members in all interactions</p>
Integrity and accountability	<p>Maintain patient confidentiality</p> <p>Maintain appropriate relationships with patients</p> <p>Promptly disclose medical errors; take responsibility for and steps to remedy mistakes</p> <p>Actively manage conflicts of interest and publicly disclose any relationships that may affect the physician’s recommendations related to diagnosis and treatment (eg, part ownership of surgery center)</p>	<p>Report impaired or incompetent colleagues</p> <p>Participate in peer-review and 360-degree evaluations of team</p> <p>Specify standards and procedures for handoffs across settings of care to ensure coordination and continuity of care</p>
Pursuit of excellence	<p>Adhere to nationally recognized evidence-based guidelines (eg, guidelines issued by Agency for Healthcare Research and Quality or US Preventive Services Task Force), individualizing as needed for particular patients but conforming with guidelines for the majority of patients</p> <p>Engage in lifelong learning and professional development</p> <p>Apply system-level continuous quality improvement to patient care</p>	<p>Participate in collaborative efforts to improve system-level factors contributing to quality of care</p>
Fair and ethical stewardship of health care resources	<p>Do no harm; do not provide unnecessary or unwarranted care</p> <p>Commit to deliver care equitably, respecting the different needs and preferences of subpopulations, and to provide emergent care without regard to insurance status or ability to pay</p> <p>Deliver care in a culturally competent and resource-conscious manner</p>	<p>Establish mechanisms for feedback from peers on resource use and appropriateness of care</p> <p>Work with clinical and nonclinical staff to continuously improve efficiency of care delivery process and ensure that all members of the care team are optimizing their contributions to care delivery and administration</p> <p>Actively work with colleagues to coordinate care, avoid redundant testing, and maximize prudent resource use across settings</p>

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## Lynne M. Kirk, MD

...are expected by a read

Our position is not neutral. In a patient encounter, we consider a right and good healing action for that patient in his or her particular circumstances. A right/healing action is one informed by the scientific and clinical evidence. A good action, in contrast, takes into account the patient's values and preferences and is consistent with the physician's own clinical judgment. Clinical judgment consists of three steps: 1) the diagnostic question—What is wrong with this patient?—taking into account the patient's medical history, physical examination, laboratory test results, and other data; 2) the therapeutic question—What can be done for this patient?—which is frequently informed by the scientific evidence and which comprises the array of treatment choices that might help the patient; and 3) the prudential question—What should be done for this patient?—which clearly needs to involve the patient to determine the option that will work best.

In 1999, the Accreditation Council for Graduate Medical Education (ACGME) implemented general competencies applicable to every specialty, that need to be imparted during

Table 1. The professionalization requirements of the Accreditation Council for Graduate Medical Education\*

Readers must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse

- Demonstrable respect, compassion, and integrity, a responsiveness to the needs of patients and society that is genuine self-interest, accountability to patients, society, and the profession, and a commitment to excellence and on-going professional development

- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices

From reference 2.

residency or fellowship training. One of these six components

The same year that professionalism was listed as an ACGME general competency, the Medical Professionalism Project was launched by the American Board of Internal Medicine Foun-

tion, the American College of Physicians Foundation, and the European Federation of Internal Medicine. The result was professionalism charter, which was published in 2002 (3) and has subsequently been adopted by many major professional associations.

- **The primacy of patient welfare:** This principle focuses on a physician's trust, and patient interests. The charter states: "Medical decisions are made on the basis of the patient's best interests."

From the Division of General Internal Medicine, Department of Internal Medicine, The University of Texas Southwestern Medical Center, Dallas, Texas.  
Presented at the Lloyd Wade Kilbreth Memorial Lectureship, Internal Medicine.

**Corresponding author:** Lynne M. Kirk, MD, Harmon Professor of Medicine, Associate Dean for Graduate Medical Education, and Associate Chief, Division of General Internal Medicine, The University of Texas Southwestern Medical Center, 5323 Harry Hines Boulevard, Dallas, Texas 75390 (e-mail: Lynne.Kirk@UTSouthwestern.edu).

specific behaviors

Values	Behaviors
Responsibility	<ul style="list-style-type: none"> <li>Follows through on tasks</li> <li>Arrives on time</li> </ul>
Maturity	<ul style="list-style-type: none"> <li>Accepts blame for failure</li> <li>Doesn't make inappropriate demands</li> <li>Is not abusive and critical in times of stress</li> </ul>
Communication skills	<ul style="list-style-type: none"> <li>Listens well</li> <li>Is not hostile, derogatory, sarcastic</li> <li>Is not loud or disruptive</li> </ul>
Respect	<ul style="list-style-type: none"> <li>Maintains patient confidentiality</li> <li>Is patient</li> <li>Is sensitive to physical/emotional needs</li> <li>Is not biased/discriminatory</li> </ul>

Kirk L. M. Professionalism in medicine: definitions and considerations for teaching.  
*Proc Bayl Univ Med Cent* 2007;20:13-16.



## Defining the core competency of professionalism based on the patient's perception.

Davis R. L. et al. *Clin Experiment Ophthalmol* 2007;35(1):51-4.

**RESULTS:** Patients desire a degree of formality from their physicians in the form of a handshake (61% +/- 7%), greeting of family members (69% +/- 7%) and in addressing oneself as doctor. They also prefer note taking by the physician while speaking with them. However, patients do not think that the wearing of a white coat is necessary. Most patients assume (84% +/- 5%) that the physician washes his/her hands. Surprisingly, patients (60% +/- 7%) are willing to maintain a relationship with a physician despite the use of medical jargon. We found few differences related to gender and none related to race. Women (64% +/- 9%) preferred a closed door during the exam. Men (81% +/- 8%) either did not want the physician to wear a white coat or said that it made no difference. Those younger than 46 years (67% +/- 10%) preferred the door closed compared with those who were older (45% +/- 10%).



## Changes in professional development.

### Educating the gastroenterologist for the year 2000.

Meryn S. *Digestion* 1998;59(5):619-23.

Center for Advanced Medical Education and Health Communication, Medical Faculty, University of Vienna, Austria.

#### Abstract

Recent changes in society, the practice in medicine, the health care delivery and new technologies will have a direct impact on the development of the medical profession...

**.. CME in one's own speciality interest is not enough. CME has to be extended into a broader context of continuing professional development (CPD) including personal, social and political aspects of medical practice...**

... All honorable gastroenterology, hepatology and endoscopy societies throughout the world should further define professionalism and develop leadership and management programs for their members. Nevertheless, every doctor always has a personal responsibility for lifelong learning.

**Eclectic behaviors which could be endowed and improve the clinical practice although not directly related to the physician's knowledge and experience:**

1. **Clear explanations** to patient & family enabling them to take part in decision making
2. **Solidarity to colleagues** in front of patients and professionals alike
3. **Taking responsibility and debriefing errors** – both activities and behaviors
4. **Assuming behavioral codes:** clothing, schedule, hand hygiene etc.
5. **Peer consultation** as part of routine, not only when in doubt



## Medical Professionalism in the New Millennium: A Physician Charter

Project of the ABIM Foundation, ACP-ASIM Foundation, and European Federation of Internal Medicine\*

*To our readers:* I write briefly to introduce the Medical Professionalism Project and its principal product, the Charter on Medical Professionalism. The charter appears in print for the first time in this issue of *Annals* and simultaneously in *The Lancet*. I hope that we will look back upon its publication as a watershed event in medicine. Everyone who is involved with health care should read the charter and ponder its meaning.

The charter is the product of several years of work by leaders in the ABIM Foundation, the ACP-ASIM Foundation, and the European Federation of Internal Medicine. The charter consists of a brief introduction and rationale, three principles, and 10 commitments. The introduction contains the following premise: Changes in the health care delivery systems in countries through-

out the globe will read the charter. Does this document represent the traditions of medicine in cultures other than those in the West, where the authors of the charter have practiced medicine? We hope that readers everywhere will engage in dialogue about the charter, and we offer our pages as a place for that dialogue to take place. If the traditions of medical practice throughout the world are not congruent with one another, at least we may make progress toward understanding how physicians in different cultures understand their commitments to patients and the public.

Many physicians will recognize in the principles and commitments of the charter the ethical underpinning of their professional relationships, individually with their patients and collectively with the public. For them, the challenge will be to live by

## PREAMBLE

*Professionalism is the basis of medicine's contract with society. It demands placing the interests of patients above*

principles. It calls upon the profession to promote a fair distribution of health care resources.

There is reason to expect that physicians from every point

within our societies.

Recently, voices from many countries have begun calling for a renewed sense of professionalism, one that

*Ann Intern Med.* 2002;136:243-246.

\*This charter was written by the members of the Medical Professionalism Project: ABIM Foundation: Troy Benson, MD, JD (*Project Chair*), Brigham and Women's Hospital, Boston, Massachusetts; Linda Blank (*Project Staff*), ABIM Foundation, Philadelphia, Pennsylvania; Jordan Cohen, MD, Association of American Medical Colleges, Washington, DC; Harry Kimball, MD, American Board of Internal Medicine, Philadelphia, Pennsylvania; and Neil Smetzer, PhD, University of California, Berkeley, California. ACP-ASIM Foundation: Robert Capeland, MD, Southern Cardiovascular Associates, LaGrange, Georgia; Rita Lavinia-Monney, MD, MBA, Robert Wood Johnson Foundation, Princeton, New Jersey; and Walter McDonald, MD, American College of Physicians-American Society of Internal Medicine, Philadelphia, Pennsylvania. European Federation of Internal Medicine: Cecilia Borenstein, MD, University Hospital, Uppsala, Sweden; Christopher Davidson, MD, FRCP, FESC, Royal Sussex County Hospital, Brighton, United Kingdom; Philippe Jaeger, MB, MD, Centre Hospitalier Universitaire Vaudois, Lausanne, Switzerland; Alberto Malliani, MD, Università di Milano, Milan, Italy; Hein Muller, MD, PhD, Ziekenhuis Gooi-Noord, Rijkswaagweg, the Netherlands; Daniel Neroni, MD, Hôpital Saint-Louis, Paris, France; and Eugene Soteriou, JD, Faculteit der Rechts Geleerdheid, Amsterdam, the Netherlands. Special Consultants: Richard Gross, MD, and Sylvia Gross, MD, McGill University, Montreal, Canada; and Jaime Merino, MD, Universidad Miguel Hernández, San Juan de Alicante, Spain.

www.annals.org

5 February 2002 | *Annals of Internal Medicine* | Volume 136 • Number 3 | 243



Gadi Segal

עורך פרופיל



מועדסים

חדשות

הודעות

אירועים

תמונות

קבוצות

Dolphin Association

פנימאים צעירים

צוללות דור ה"גל" בין השני...

סטאזרים - איכילוב

החברה הישראלית ל...

פנימית ט, המרכז הרפואי ע...

MIRSHAM - מרש"ם

התאחדות הסטודנטי...

ארגון הסטאזרים לר...

אחים ואחיות בישראל...

העמותה הישראלית...

קבוצת סטאזרים שנ...

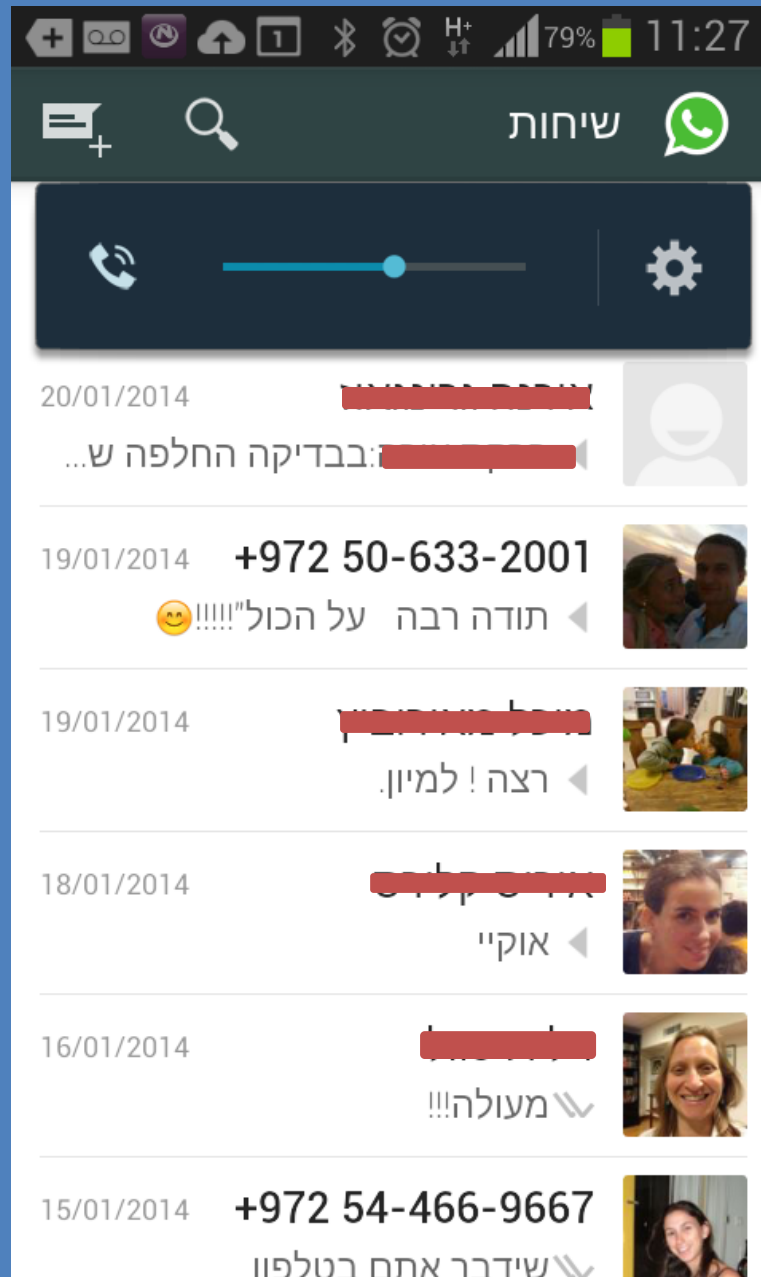
רופאים ישראלים באוסטרליה

מבחן רישוי חורף 2013

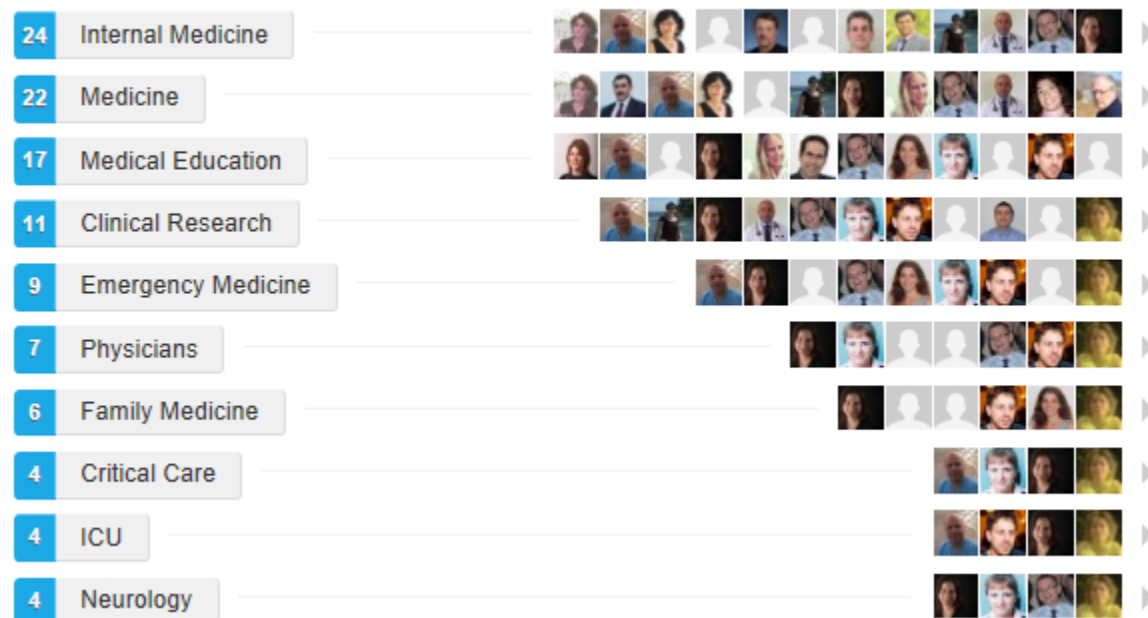
מתמחים ומומחים צע...

צור/צרי קבוצה...





## Most endorsed for...



## Groups



**Dolphin association**  
Visible ▶



**International Associa...**  
Visible ▶



**Investigator-Initiated...**  
Visible ▶



**Medical Affairs Strat...**  
Visible ▶



**Medical e-learning in...**  
Visible ▶

Med Teach. 2012;34(8):e549-56.

## Online professionalism and Facebook--falling through the generation gap.

### Abstract

#### BACKGROUND:

Facebook is the most popular social networking site (SNS) worldwide. The growing popularity of SNSs brings 'e-professionalism' to the forefront.

#### AIMS:

To assess Facebook use, publicly accessible material and awareness of privacy guidelines and online professionalism by students, foundation year doctors (FYDs) and senior staff grades (SSGs).

#### RESULTS:

All 42 students and 20 FYDs had Facebook compared with 6 (30%) SSGs. Of these, 17 students (41%), 15 FYDs (75%) and 3 SSGs (50%) had public 'info pages'. 37 students (88%) reported colleagues behaving unprofessionally online with 16 FYDs (80%) but no SSGs. 32 students (76%) felt their professionalism was threatened online, alongside 18 FYDs (90%) and 2 SSGs (33%). Only 11 students (26%), 10 trainees (50%) and no SSGs were aware of guidelines.

Med Teach. 2012;34(8):e549-56.

## **Online professionalism and Facebook--falling through the generation gap.**

### **CONCLUSIONS:**

**Professionals lack awareness of their professional vulnerability online. They are not careful in restricting access to their posted information and are not mindful that the principles of professionalism apply to SNSs.**

J Med Internet Res. 2013 Aug 28;15(8):e184. doi: 10.2196/jmir.2708.

## **The impact of social media on medical professionalism: a systematic qualitative review of challenges and opportunities.**

### **Conclusions**

The accommodation of the traditional core values of medicine to the characteristics of social media presents **opportunities as well as challenges for medical professionalism**. As a profession that is entitled to self-regulation, health care professionals should proactively approach these challenges and seize the opportunities. There should be room to foster interprofessional and intergenerational dialogue (and eventually guidelines and policies) on both challenges and opportunities of social media in modern health care. This review builds a unique source of information that can inform further research and policy development in this regard.



Med Teach. 2013 Oct;35(10):826-31.. Epub 2013 Jul 5.

**"I have the right to a private life": medical students' views about professionalism in a digital world.**

### **CONCLUSIONS:**

Our findings indicate a disconnect between what students report of what they understand of professionalism, and what students feel is appropriate and inappropriate in both online and real life behavior. Curriculum needs to target understanding of professionalism in online and real environments and communicate realistic expectations for students.

**Eclectic behaviors which could be endowed and improve the clinical practice although not directly related to the physician's knowledge and experience:**

1. **Clear explanations** to patient & family enabling them to take part in decision making
2. **Solidarity to colleagues** in front of patients and professionals alike
3. **Taking responsibility and debriefing errors** – both activities and behaviors
4. **Assuming behavioral codes:** clothing, schedule, hand hygiene etc.
5. **Peer consultation** as part of routine, not only when in doubt

**E – Professionalism:**

1. **Basic acquaintance** with common SN
2. **Inter-Generational Dialogue** regarding present and future professionalism
3. **Actively engaging physician-patient conflicts** in the SN arena



**Thank you for Listening**