## OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following opinions, 1–2, were presented by Ronald A. Clearfield, MD, Chair:

### 1. MODERNIZED *CODE OF MEDICAL ETHICS*

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

**HOUSE ACTION: FILED**

At the 2016 Annual Meeting, the American Medical Association House of Delegates adopted the recommendation of Council on Ethical and Judicial Affairs Report 2-A-16, "Modernized *Code of Medical Ethics*." The Council issues the Opinions of the modernized *Code*, which will appear in full in AMA PolicyFinder and the next print edition of the *Code of Medical Ethics*.

The Council thanks the members of the House of Delegates who brought typographical errors in the draft modernized *Code* to its attention. These have been corrected.

The Council wishes to advise the House that where appropriate throughout the Opinions of the modernized *Code* the phrase "in keeping with ethical guidelines" has been replaced by the phrase "in keeping with ethics guidance" for clarity. For example, Opinion 1.2.3, "Consultation, Referral, and Second Opinions," would read, "(b) Share patient's health information in keeping with ethics guidance on confidentiality."

### 2. ETHICAL PRACTICE IN TELEMEDICINE

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

**HOUSE ACTION: FILED**

At the 2016 Annual Meeting, the American Medical Association House of Delegates adopted the recommendation of Council on Ethical and Judicial Affairs Report 1-A-16, "*Ethical Practice in Telemedicine*." The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the *Code of Medical Ethics.*

1.2.12 Ethical Practice in Telemedicine

> Innovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another.
>
> Telehealth and telemedicine span a continuum of technologies that offer new ways to deliver care. Yet as in any mode of care, patients need to be able to trust that physicians will place patient welfare above other interests, provide competent care, provide the information patients need to make well-considered decisions about care, respect patient privacy and confidentiality, and take steps to ensure continuity of care. Although physicians' fundamental ethical responsibilities do not change, the continuum of possible patient-physician interactions in telehealth/telemedicine give rise to differing levels of accountability for physicians.
>
> All physicians who participate in telehealth/telemedicine have an ethical responsibility to uphold fundamental fiduciary obligations by disclosing any financial or other interests the physician has in the telehealth/ telemedicine application or service and taking steps to manage or eliminate conflicts of interests. Whenever they provide health information, including health content for websites or mobile health applications, physicians must ensure that the information they provide or that is attributed to them is objective and accurate.
>
> Similarly, all physicians who participate in telehealth/telemedicine must assure themselves that telemedicine services have appropriate protocols to prevent unauthorized access and to protect the security and integrity of

patient information at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who participate in the telehealth/telemedicine service consistent with their individual roles.

Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should:

a. Inform users about the limitations of the relationship and services provided.

b. Advise site users about how to arrange for needed care when follow-up care is indicated.

c. Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed.

Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should:

d. Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically.

e. Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patient's site conduct the exam or obtaining vital information through remote technologies.

f. Be prudent in carrying out a diagnostic evaluation or prescribing medication by:

(i) establishing the patient's identity;

(ii) confirming that telehealth/telemedicine services are appropriate for that patient's individual situation and medical needs;

(iii) evaluating the indication, appropriateness and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and

(iv) documenting the clinical evaluation and prescription.

g. When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options. Patients and surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies.

h. As in any patient-physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patients' preferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patient's primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient.

Collectively, through their professional organizations and health care institutions, physicians should:

i. Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.

j. Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.

k. Routinely monitor the telehealth/telemedicine landscape to:

(i) identify and address adverse consequences as technologies and activities evolve; and

(ii) identify and encourage dissemination of both positive and negative outcomes.

## REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports, 1–4, were presented by Ronald A. Clearfield, MD, Chair:

### 1. COLLABORATIVE CARE

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS EDITORIALLY CORRECTED BY THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REMAINDER OF REPORT FILED**
*See Policy H-140.838*

Traditionally, the practice of medicine was conceived as a single physician providing care directly to an individual patient. But as health care focuses increasingly on quality, efficiency, and the experiences and outcomes of the patient, services are no longer necessarily provided by a single physician. Rather, a patient's care now often lies in the hands of many collaborating health care professionals. Teams may be formal structured units or ad hoc groups of physicians, nurses, social workers and other health professionals, at one or several sites of care, all of whom play various clinical and administrative roles in the care of a single patient.

Systemic changes in the nation's health care system are also driving the movement toward collaborative care as a tool for pursuing coordinated, patient-centered care [1]. Collaborative care has been tested and measured in clinical settings around the country and its importance has been translated into law and policy [2, 3]. A growing body of research indicates that collaborative care can enhance health care quality and outcomes for individual patients, may enhance access to care, and may help lower—or slow the rate of increase of—health care costs [4, 5, 6, 7]. Further, well-functioning teams that provide safe, efficient, high-quality care can reduce burnout and improve morale among health care personnel [8].

This report examines key ethical considerations for health care teams engaged in providing care collaboratively and develops guidance for physicians as leader-members of care teams.

ETHICAL PRINCIPLES FOR COLLABORATIVE CARE

A well-functioning team capable of optimizing patient outcomes is defined by dedication to providing patient-centered care, protecting the integrity of the patient-physician relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.

*Patient-Centered Care*

Collaborative care is first and foremost patient-centered care. The physician's duty to hold the patient's interests paramount (Principle VIII) does not diminish when care is provided by professionals working as a team. Like individual health care professionals, teams must ensure that the care they deliver aligns with the values and needs of the patient [9]. Teams must support patients as decision makers (and families where appropriate) and afford them opportunities to participate actively in treatment as members of the team. Patients and their families should feel they are understood and respected by the health professionals who provide care. They must be able to ask questions and must be confident that all health care personnel will address any issues openly and honestly.

*Protecting the Patient-Physician Relationship*

The patient-physician relationship remains central in collaborative care environments, just as in any other health care setting [9]. Physicians remain advocates for their patients and are responsible for putting the patient's welfare above obligations to others [10]. The relationship that the team as a whole has with the patient should be supportive of the interaction between the patient and physician.

*Mutual Respect and Trust*

To provide efficient, effective care, all members of a health care team must contribute actively, which requires that members mutually respect and trust one another. Health care professionals must be confident that their colleagues are performing at their highest standard of practice, and that the team, overall, is providing optimal care. When members do not respect and trust one another, individual contributions can be misinterpreted or ignored, leading to tension or lapses in communication that can in turn compromise a patient's health and safety. Members of a well-functioning team will acknowledge and appreciate the contributions made by each and every team member [9]. Mutual respect and trust strengthen the clinical team and give all members an opportunity to serve as positive role models for one another and to inspire and motivate their colleagues [9]. Honoring the work of one's colleagues not only underscores the importance of individual contributions, but also emphasizes the contribution of the team as a cohesive unit [9].

*Effective Communication*

Effective communication is fundamental to providing safe, optimal care to patients [9]. Every member of the team shares the responsibility to communicate effectively, clearly, and consistently. Physicians can play a leading role by modeling effective communication strategies. When physicians provide clear, concise information or instructions to colleagues they demonstrate behaviors that others on the team can utilize to communicate efficiently and effectively themselves [9].

*Accountability*

Accountability is likewise a core ethical principle for collaborative care. Given the fiduciary nature of the patient-physician relationship as well as the expectations society places on physicians because of their knowledge and training, physicians are accountable for patient care and outcomes [9]. Nonetheless, all members of the team are accountable for their individual practice and each shares responsibility for the functioning of the team as a whole, while protecting patient well-being and ensuring that the team focuses on patient care as the common goal.

Beyond accountability to individual patients, physicians and health care teams also have a responsibility to the communities in which they work to be prudent stewards of community resources [11]. Physicians and teams have a responsibility to ensure that providing care collaboratively not only benefits individual patients, but also helps to achieve efficiency and value for the health care system to benefit the whole community.

KEY ATTRIBUTES OF EFFECTIVE TEAM MEMBERS

The attributes that individual members bring to a team are also important for effective team functioning. The Institute of Medicine, for example, suggests the following five key attributes: honesty, discipline, creativity, humility, and curiosity [1].

Within a successful team, members are honest and transparent about goals, decisions, mistakes, and fears [1], and engage in open dialogue that creates mutual trust [12].

A functional team also has disciplined members, with each performing assigned duties and sharing new information with other members to improve individual and team operations [1]. They fulfill responsibilities even when doing so is inconvenient or uncomfortable [1]. Such disciplined performance allows members not only to comply with established protocols, but to develop mutual respect and pursue improvement while doing so [1, 12].

Creativity is another important attribute that allows the team to work together effectively on complicated health issues. Creativity involves team members enthusiastically engaging new problems to find innovative solutions [1]. Further, creative teams do not view failed attempts and negative outcomes as the destruction of team goals, but as opportunities to learn [1].

With humility, team members recognize differences in training among the group, but do not view one form of training as wholly superior to all others [1]. Also, members understand that they are all humans susceptible to making mistakes [12]. These attitudes enable members to rely on one another, regardless of hierarchy [1], and to share constructive criticism to overcome professional and ethical obstacles.

Lastly, effective members of collaborative care teams exhibit curiosity and actively use knowledge gained from their daily lives toward the continuous improvement of individual and team efforts [1].

The composition of the team that delivers care—more or fewer physicians relative to other clinicians, mix of expertise, etc.— may vary in different contexts, such as chronic versus acute care or in-patient versus outpatient settings. For example, chronic illness is often managed most effectively by a team whose membership is stable. In contrast, acute care, especially in-patient care, is frequently provided by specialists who may work with different teams from day to day. Yet in every context, an identified individual needs to play a leadership role and take responsibility for collecting and synthesizing the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan for the patient [9]. In most contexts, a physician is best able to serve as team leader.

## LEADERSHIP BEHAVIOR AND CONCEPTS

An effective team requires a clinical leader who takes responsibility "for maximizing the expertise and input of the entire team in order to provide the patient with comprehensive and definitive care" [9]. Clinical leaders ensure that the team as a whole functions well and facilitates decision-making [9], and is ultimately accountable to patients. Clinical leaders must use their training and experience to interpret and synthesize the information provided by team members to make a differential diagnosis and develop a plan of care. Effective clinical leaders foster common understanding about responsibilities and encourage open communication among patients, families, and the entire health care team.

Physicians are uniquely suited to serve as clinical leaders by virtue of their thorough and diverse training, experience, and knowledge [9]. Their distinctive appreciation of the breadth of health issues and treatment options in their field of practice also enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient. This expertise, as well as patient expectations—which hold as much in a setting of collaborative care as in a one-on-one office visit—make it most appropriate that a physician serve as a team's clinical leader although this does not necessarily mean that physicians will take the helm for every aspect of decision-making or coordinate every detail of treatment. Other health care personnel bring expertise and knowledge to the team and in many instances will be in charge when their expertise is most needed [9].

Although traditional notions of liability map poorly against the changes taking place in how, where, and by whom health care is delivered, physicians still can be held legally accountable for the actions of medical personnel working under their supervision [13]. To this extent, it currently makes sense from a legal perspective to have the physician serve as clinical leader. However, as health care continues to evolve and roles become increasingly fluid there is need for a more nuanced understanding of how teams and their members are mutually accountable to patients and to one another over the course of a patient's care, legally as well as ethically.

The role of clinical leader should be distinguished from that of clinical coordinator. While a physician should be the clinical leader of the health care team, the clinical coordinator of the team need not be. The clinical coordinator is the team member who, "based on his or her training, competencies and experience, is best able to coordinate the services provided by the team so that they are integrated to provide the best care for the patient" [9].

### *Transactional versus transformational leadership*

The concepts of "transactional" versus "transformational" leadership offer a powerful framework for thinking about physician leadership in the context of collaborative care. Briefly, transactional leaders largely intervene in a "corrective" mode episodically when members deviate from a defined standard [14]. Transformational leaders, in contrast, are continuously engaged in relationships that inspire followers through charisma, clearly articulated visions, and ongoing personalized guidance [14, 15]. In a clinical context, for example, a transformational physician leader might hold informal five- to ten-minute "huddles," in addition to weekly team meetings, to keep the team on the same page [16].

Some evidence suggests that transformational leadership has positive effects on followers' task performance and perceptions of job characteristics and their leaders, and that such leadership behaviors can be taught [14, 15, 17, 18]. Leadership behavior influences how well a team functions. Clearly communicating a shared vision, connecting well

to emotional needs, seeking consensus and collaboration, role-modeling, or coaching can each enhance the effectiveness of a team [19].

*Responsibilities as Individuals, Team Members & Institutional Leaders*

As clinical leaders in collaborative care, physicians have ethical responsibilities as individuals, as members of the team, and as leaders in their institutions [12].

As individuals, physicians have a responsibility to respect other team members, understand their own and other team members' range of skill and expertise and role in the patient's care, and master broad teamwork skills [12]. Like all team members, physicians should be open to adopting insights from other members. They should communicate respectfully with other team members, even in the face of controversy, and should be welcoming to new members. Physicians can model ethical conduct for fellow team members—e.g., by avoiding intimidating body language or speaking disrespectfully about patients—and should encourage other team members to behave accordingly [20].

As clinical leaders in health care teams, physicians are in a position to foster the key attributes of effective team members and to promote respect among team members. They can and should help clarify expectations so that the team can establish systematic and transparent decision making. As leaders, physicians can likewise encourage open discussion of clinical and ethical concerns and help ensure that every member's opinion is heard and considered [21], and that team members share responsibility and accountability for decisions and outcomes [12].

Teams need support and resources to optimize patient-centered care [12]. Such resources might include additional training in teamwork skills, clerical support, flexibility in staff scheduling to promote continuity of team membership, or additional staff to provide skills not already represented among team members. Teams also need the organizations in which they provide care to recognize and respect the unique relationship between team and patient. Further, explicit recognition of effective teams by organizational leadership conveys the message that teamwork is valued and important to the organization. Finally, teams need their organizations to provide fair mechanisms for assessing the team's performance [12]. As leaders within their institutions, physicians should help ensure that teams are well supported and that their contributions to the quality and patients' experience of care are appropriately recognized.

CHALLENGES TO COLLABORATION

Teams can face a variety of challenges to effective collaboration, many of which are tied to the culture and structure of the health care institution within which they work. Of particular concern, teams may fall short of the goal of optimizing patient-centered care and outcomes when they lack resources, when institutional barriers inhibit effective team functioning, and when there is ongoing conflict within the team.

*Inadequate Resources*

While some individuals may naturally possess the necessary traits to work successfully in a team, many others do not. Physicians have ultimate responsibility and expect accountability within a team; development of team leadership skills will foster effective teamwork. Changes in how physicians and other health care personnel are taught to view teamwork, such as the use of RACI charts (which delineate who is Responsible, Accountable, Consulted, or Informed in the given context)[22], as well as specific training in teamwork skills can reduce conflict and improve team performance [23]. Ideally, interdisciplinary training begins early in medical education, a concept that has been embraced by the medical community [24]; the Accreditation Council for Graduate Medical Education identifies interpersonal and communication skills as a core competency. The ACGME notes that these skills "result in effective information exchange and teaming with … professional associates" [23]. Organizations may also find it useful to implement their own training for teamwork tailored to the culture of the institution. Such training can provide common structures, processes and expectations for health care professionals who work together on a regular basis.

Institutions also need to provide adequate administrative support for teams, promote scheduling practices that help ensure workload and duty hours are distributed fairly across personnel, and sustain stable team membership to the extent possible. Teams function best when they have input into the structure and function of the institutions in which they practice.

*Institutional Culture*

The culture of an institution can also pose challenges for effective teamwork. In order to create a practice environment that encourages collaborative care, an organization's leaders must actively foster this new environment. Leaders must commit fully to change over the long term; adhering to new methods of communication and teamwork requires diligence and oversight, lest old patterns reemerge [25]. Organizations have the opportunity and responsibility to nurture supportive environments by helping teams develop shared goals and establish and maintain clear roles within the team. Leaders foster collaborative environments by being seen to value other health care professionals in addition to physicians; fostering mutual trust within teams; supporting effective communication and fair, objective measurement of processes focused on improving team function and outcomes [1].

Health care institutions share accountability both to individual patients and to their communities for ensuring high quality care, although other influences, including, prominently, the decisions and policies of third-party payers, also may be involved. Physicians can play an important role in holding institutions to this responsibility by advocating for the resources teams need to function effectively and by identifying aspects of institutional culture that create barriers to effective teamwork.

*Fluctuating Team Membership*

The complex nature of health care delivery means that a team's composition is not always constant [26]. For example, in emergency care scenarios, teams often are abruptly created to address a patient's imminent needs only to disband when the patient is transferred or discharged. An institution's rotation of health care personnel can also lead to new teams continuously being created, with each individual joining a new team during his or her next shift. Since trust and mutual respect between team members is often built over time, a constant fluctuation of membership can pose significant obstacles for effective team performance. Educating individual staff members on the principles of effective teamwork enables them to bring their understandings to each newly founded collaboration [1].

*Conflict within Teams*

Constructive debate is necessary for a group of individuals to come to a consensus on a complicated health decision [12]. Because each team member adds a distinct perspective to the team, conflict may arise when the team's decision is at odds with a member's training, experience, or personal beliefs and values, or when a member's behavior hampers team performance [9, 12]. A conflict resolution mechanism is needed when the degree of conflict interferes with team performance [12].

Without institutional means to address conflicts, teams risk demise when members are unable to voice their concerns and frustrations without fear of reprisal [12]. Conflicts that are not addressed or resolved, or not handled fairly, undermine the team and degrade any trust and mutual respect that has been built [25]. Because collaborative care has become essential to contemporary health care, conflict must be minimized to prevent the reduction of team functionality [1]. Institutions must establish standards for determining when conflict interferes with achieving the team's goals and must be addressed and what procedures should be used to resolve the situation [9, 12].

RECOMMENDATION

In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

> In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, protecting the integrity of the patient-physician relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.
>
> An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and

treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As leaders within health care teams, physicians individually should:

a. Model leadership by:

(i) understanding the range of their own and other team members' skills and expertise and roles in the patient's care;

(ii) clearly articulating individual responsibilities and accountability;

(iii) encouraging insights from other members and being open to adopting them; and

(iv) mastering broad teamwork skills.

b. Promote core team values of honesty, discipline, creativity, humility, and curiosity and commitment to continuous improvement.

c. Help clarify expectations to support systematic, transparent decision making.

d. Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member's opinion is heard and considered and team members share accountability for decisions and outcomes.

e. Communicate appropriately with the patient and family and respect their unique relationship as members of the team.

As leaders within health care institutions, physicians individually and collectively should:

f. Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.

g. Encourage their institutions to identify and constructively address barriers to effective collaboration.

h. Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.

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## 2. COMPETENCE, SELF-ASSESSMENT AND SELF-AWARENESS

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

**HOUSE ACTION: REFERRED**

The expectation that physicians will provide competent care is central to medicine. This expectation shaped the founding mission of the American Medical Association (AMA) and runs throughout the AMA *Code of Medical Ethics* [1-4]. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society [5]. The profession promises that practitioners will have the knowledge, skills, and characteristics to practice safely and that the profession as a whole and its individual members will hold themselves accountable to identify and address lapses [6-9].

Yet despite the centrality of competence to professionalism, the *Code* has not hitherto examined what the commitment to competence means as an ethical responsibility for individual physicians in day-to-day practice. This report by the Council on Ethical and Judicial Affairs explores this topic to develop ethics guidance for physicians.

DEFINING COMPETENCE

A caveat is in order. Various bodies in medicine undertake point-in-time, cross-sectional assessments of physicians' technical knowledge and skills. However, this report is not concerned with matters of technical proficiency assessed by medical schools and residency programs, specialty societies (for purposes of board certification), or hospital and other health care institutions (e.g., for privileging and credentialing). Such matters lie outside the council's purview.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole. For purposes of this analysis, competence is understood as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served" and as "developmental, impermanent, and context dependent" [10].

Moreover, the council is keenly aware that technical proficiency evolves over time—what is expected of physicians just entering practice is not exactly the same as what is expected of mid-career physicians or physicians who are changing or re-entering practice or transitioning out of active practice to other roles. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues.

The concept that informs this report differs as well from the narrower legal definition of competence as the knowledge and skills an individual has to do a job. Rather, this report explores a broader notion of competence that encompasses deeper aspects of wisdom, judgment and practice that enable physicians to assure patients, the public, and the profession that they provide safe, high quality care moment to moment over the course of a professional lifetime.

SELF-ASSESSMENT & ITS LIMITATIONS

Health care institutions and the medical profession as a whole take responsibility to regulate physicians through credentialing and privileging, routinely testing knowledge (maintenance of certification, requirements for continuing education, etc.) and, when needed, taking disciplinary action against physicians who fail to meet expectations for competent, professional practice. However, the better part of the responsibility to maintain competence rests with physicians' "individual capacity, as clinicians, to self-assess [their] strengths, deficiencies, and learning needs to maintain a level of competence commensurate with [their] clinical roles" [11].

Self-assessment has thus become "integral to many appraisal systems and has been espoused as an important aspect of personal professional behavior by several regulatory bodies and those developing learning outcomes for students" [12]. Undergraduate and graduate medical education programs regularly use self-assessment along with third-party evaluations to ensure that trainees are acquiring the knowledge and skills necessary for competent practice [5, 10, 13-16].

Yet how accurately physicians assess their own performance is open to question. Research to date suggests that there is poor correlation between how physicians rate themselves and how others rate them [5, 12, 13]. Various studies among health professionals have concluded that clinicians and trainees tend to assess their peers' performance more accurately than they do their own; several have found that poor performers (e.g., those in the bottom quartile) tend to over-estimate their abilities while high performers (e.g., those in the top quartile), tend to under-estimate themselves [5, 12, 17].

The available findings suggest that self-assessment involves an interplay of factors that can be complicated by lack of insight or of metacognitive skill, that is, ability to be self-observant in the moment. Similarly, personal characteristics (e.g., gender, ethnicity, or cultural background) and the impact of external factors (e.g., the purpose of self-assessment or whether it is designed to assess practical skills or theoretical knowledge) can all affect self-assessment [12, 18]. The published literature also indicates that interventions intended to enhance self-assessment may seek different goals—improving the accuracy of self-assessors' perception of their learning needs, promoting appropriate change in learning activities, or improving clinical practice or patient outcomes [12].

Self-assessment alone is not a reliable enough tool to ensure that physicians acquire and maintain the competence they need to provide safe, high quality care. Feedback from third parties is essential—or as one researcher has observed, "The road to self-knowledge may run through other people" [19]. However, physicians are often wary of assessment. They have indicated that while they want feedback, they are not sure how to use information that is not congruent with their self-appraisals [20]. Physicians can be hesitant to seek feedback for fear of looking incompetent or exposing possible deficiencies or out of concern that soliciting feedback could adversely affect their relationships with those whom they approach [20]. They may also question the accuracy and credibility of the assessment process and the data it generates [21].

To be effective, feedback must be valued by both those being assessed and those offering assessment [14]. When there is tension between the stated goals of assessment and the implicit culture of the health care organization or institution, assessment programs can too readily devolve into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20]. Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews ("360° reviews"), for example, are generally better suited to providing feedback on communication and interpersonal skills than on technical knowledge or skills—and easy for evaluators to understand and use [14]. High quality feedback will come from multiple sources; be specific and focus on key elements of the ability being assessed; address behaviors rather than personality or personal characteristics; and "provide both positive comments to reinforce good behavior and constructive comments with action items to address deficiencies" [22].

## EXPERTISE & EXPERT JUDGMENT

On this broad understanding of competence, physicians' thought processes are as important as their knowledge base or technical skills. Thus, understanding competence requires understanding something of the nature of expertise and processes of expert reasoning, themselves topics of ongoing exploration [23, 24, 25, 26]. Prevailing theory distinguishes "fast" from "slow" thinking; that is, reflexive, intuitive processes that require minimal cognitive resources versus deliberate, analytical processes that require more conscious effort [25]. Some scholars take expertise to involve "fast" processes, and specifically decision making that involves automatic, nonanalytic resources acquired through experience [23]. Others argue that expertise consists in using "slow," effortful, analytic processes to address problems [23]. A more integrative view argues that expertise resides in being able to transition between intuitive and analytical processes as circumstances require. On this account, experts use automatic resources to free up cognitive capacity so that they maintain awareness of the environment ("situational awareness") and can determine when to shift to effortful processes [23].

Expert judgment is the ability "to respond effectively in the moment to the limits of [one's] automatic resources and to transition appropriately to a greater reliance on effortful processes when needed" [23], a practice described as "slowing down." Knowing when to slow down and be reflective has been demonstrated to improve diagnostic accuracy and other outcomes [25]. To respond to the unexpected events that often arise in a clinical situation, the physician must "vigilantly monitor relevant environmental cues" and use these as signals to slow down, to transition into a more effortful state [24]. This can happen, for example, when a surgeon confronts an unexpected tumor or anatomical anomaly during a procedure. "Slowing down when you should" serves as a critical marker for intraoperative surgical judgment [23].

## INFLUENCES ON CLINICAL REASONING

Clinical reasoning is a complex endeavor. Physicians' capabilities develop through education, training, and experiences that provide tools with which to shape their clinical reasoning. Every physician arrives at a diagnosis and treatment plan for an individual in ways that may align with or differ from the analytical and investigative processes of their colleagues in innumerable ways. When something goes wrong in the clinic, it can be difficult to discern why. Nonetheless, all physicians are open to certain common pitfalls in reasoning, including relying unduly on heuristics and habits of perception, and succumbing to overconfidence.

### *Heuristics*

Physicians often use various heuristics—i.e., cognitive short cuts—to aid decision making. While heuristics can be useful tools to help physicians identify and categorize relevant information, these time-saving devices can also derail decision making. For example, a physician may mistakenly assume that "something that seems similar to other

things in a certain category is itself a member of that category" (the representative heuristic) [27], and fail to diagnose a serious health problem. Imagine a case in which a patient presents with symptoms of a possible heart attack or a stroke that the physician proceeds to discount as stress or intoxication once the physician learns that the patient is going through a divorce or smells alcohol on the patient's breath. Or a physician may miscalculate the likelihood of a disease or injury occurring by placing too much weight "on examples of things that come to mind easily, … because they are easily remembered or recently encountered" (the availability heuristic) [27]. For example, amidst heavy media coverage of an outbreak of highly infectious disease thousands of miles away in a remote part of the world, a physician seeing a patient with symptoms of what is actually a more commonplace illness may misdiagnose (or over diagnose) the exotic condition because that is what is top of mind.

Clinical reasoning can be derailed by other common cognitive missteps as well. These can include misperceiving a coincidental relationship as a causal relationship (illusory bias), or the tendency to remember information transferred at the beginning (or end) of an exchange but not information transferred in the middle (primary or recency bias) [25, 27, 29].

*Habits of Perception*

Like every other person, physicians can also find themselves prone to explicit (conscious) or implicit (unconscious) habits of perception or biases. Physicians may allow unquestioned assumptions based on a patient's race or ethnicity, gender, socioeconomic status, or health behavior, among other features, to shape how they perceive the patient and how they engage with, evaluate and treat the individual. Basing one's interactions with a patient on pre-existing expectations or stereotypes demeans the patient, undermines the patient's relationship with the physician and the health care system, and can result in significant health disparities across entire communities [30]. This is of particular concern for patients who are members of minority and historically disadvantaged populations [30]. Physicians may fall victim to the tendency to seek out information that confirms established expectations or dismiss contradicting information that does not fit into predetermined beliefs (confirmatory bias) [27]. These often inadvertent thought processes can result in a physician pursuing an incorrect line of questioning or testing that then leads to a misdiagnosis or the wrong treatment.

No matter how well a patient may seem to fit a stereotype, it is imperative that the physician look beyond categories and assumptions to investigate openly the health issues experienced by the patient. Although all human beings exhibit both conscious and unconscious habits of perception, physicians must remain vigilant in not allowing preconceived or unexamined assumptions to influence their medical practice.

*Overconfidence*

Finally, another obstacle to strong clinical reasoning that physicians may encounter is overconfidence. Despite their extensive training, physicians, like all people, are poor at identifying the gaps in their knowledge [27, 29]. Physicians may consider their skills to be excellent, when, in fact, their peers have identified areas for improvement [29]. Overconfidence in one's abilities can lead to suboptimal care for a patient, be it through mismanaging resources, failing to consider the advice of others, or not acknowledging one's limits [27, 29].

To avoid falling into such traps, physicians must recognize that many factors can and will influence their clinical decisions [27]. They need to be aware of the information they do and do not have and they need to acknowledge that many factors can and will influence their judgment. They should keep in mind the likelihood of diseases and conditions and take the time to distinguish information that is truly essential to sound clinical judgment from the wealth of possibly relevant information available about a patient. They should consider reasons their decisions may be wrong and seek alternatives, as well as seek to disprove rather than confirm their hypotheses [27]. And they should be sensitive to the ways in which assumptions may color their reasoning and not allow expectations to govern their interactions with patients.

Shortcomings can be an opportunity for growth in medicine, as in any other field. By becoming aware of areas in which their skills are not at their strongest and seeking additional education or consulting with colleagues, physicians can enhance their practice and best serve their patients.

FROM SELF-ASSESSMENT TO SELF-AWARENESS

Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally conceived has significant shortcomings, several scholars have argued that a different understanding of self-assessment is needed, along with a different conceptualization of its role in a self-regulating profession [31]. Self-assessment, it is suggested, is a mechanism for identifying both one's weaknesses and one's strengths. One should be aware of one's weaknesses in order to self-limit practice in areas in which one has limited competence, to help set appropriate learning goals, and to identify areas that "should be accepted as forever outside one's scope of competent practice" [31]. Knowing one's strengths, meanwhile, allows a physician both to "act with appropriate confidence" and to "set appropriately challenging learning goals" that push the boundaries of the physician's knowledge [31].

If self-assessment is to fulfill these functions, physicians need to reflect on past performance to evaluate not only their general abilities but also specific completed performances. At the same time, they must use self-assessment predictively to assess how likely they are to be able to manage new challenges and new situations. More important, physicians should understand self-assessment as an ongoing process of monitoring tasks during performance [32]. The ability to monitor oneself in the moment is critical to physicians' ethical responsibility to practice safely, at the top of their expertise but not beyond it.

Expert practitioners rely on pattern recognition and other automatic resources to be able to think and act intuitively. As noted above, an important component of expert judgment is transitioning effectively from automatic modes of thinking to more effortful modes as the situation requires. Self-awareness, in the form of attentive self-observation (metacognitive monitoring), alerts physicians when they need to direct additional cognitive resources to the immediate task. For example, among surgeons, knowing when to "slow down" during a procedure is critical to competent professional performance, whether that means actually stopping the procedure, withdrawing attention from the surrounding environment to focus more intently on the task at hand, or removing distractions from the operating environment [24].

Physicians should also be sensitive to the ways that interruptions and distractions, which are common in health care settings, can affect competence in the moment [33, 34], by disrupting memory processes, particularly the "prospective memory" —i.e., "a memory performance in which a person must recall an intention or plan in the future without an agent telling them to do so"—important for resuming interrupted tasks [34, 35]. Systems-level interventions have been shown to help reduce the number or type of interruptions and distractions and mitigate their impact on medical errors [36].

A key aspect of competence is demonstrating situation-specific awareness in the moment of being at the boundaries of one's knowledge and responding accordingly [32]. Slowing down, looking things up, consulting a colleague, or deferring from taking on a case can all be appropriate responses when physicians' self-awareness tells them they are at the limits of their abilities. The capacity for ongoing, attentive self-observation, for "mindful" practice, is an essential marker of competence broadly understood:

> Safe practice in a health professional's day-to-day performance requires an awareness of when one lacks the specific knowledge or skill to make a good decision regarding a particular patient … This decision making in context is importantly different from being able to accurately rate one's own strengths and weaknesses in an acontextual manner.… Safe practice requires that self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of self-efficacy and ongoing 'reflection-in-practice,' addressing emergent problems and continuously monitoring one's ability to effectively solve the current problem [31].

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills [31]. Self-aware physicians are also alert to how external stressors—the death of a loved one or other family crisis, or the reorganization of their practice, for example—may be affecting their ability to provide care appropriately at a given time. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient's well-being.

MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

For physicians, the ideal is not simply to be "good" practitioners, but to excel throughout their professional careers. This ideal holds not just over the course of a sustained clinical practice, but equally when physicians re-enter practice after a hiatus, transition from active patient care to roles as educators or administrators, or take on other functions in health care. Self-assessment and self-awareness are central to achieving that goal.

A variety of strategies are available to physicians to support effective self-assessment and help physicians cultivate the kind of self-awareness that enables them to "know when to slow down" in day-to-day practice. One such strategy might be to create a portfolio of materials for reflection in the form of written descriptions, audio or video recording, or photos of encounters with patients that can provide evidence of learning, achievement and accomplishment [16] or of opportunities to improve practice. A strength of portfolios as a tool for assessing one's practice is that, unlike standardized examinations, they are drawn from one's actual work and require self-reflection [15].

As noted above, to be effective, self-assessment must be joined with input from others. Well-designed multi-source feedback can be useful in this regard, particularly for providing information about interpersonal behaviors [14]. Research has shown that a four-domain tool with a simple response that elicits feedback about how well one maintains trust and professional relationships with patients, one's communication and teamwork skills, and accessibility offers a valid, reliable tool that can have practical value in helping to correct poor behavior and, just as important, consolidate good behavior [14]. Informal arrangements among colleagues to provide thoughtful feedback will not have the rigor of a validated tool but can accomplish similar ends.

Reflective practice, that is, the habit of using critical reflection to learn from experience, is essential to developing and maintaining competence across a physician's practice lifetime [37]. It enables physicians to "integrate personal beliefs, attitudes, and values in the context of professional culture," and to bridge new and existing knowledge. Studies suggest that reflective thinking can be assessed, and that it can be developed, but also that the habit can be lost over time with increasing years in practice [37].

"Mindful practice," that is, being fully present in everyday experience and aware of one's own mental processes (including those that cloud decision making) [38], sustains the attitudes and skills that are central to self-awareness. Medical training, with its fatigue, dogmatism, and emphasis on behavior over consciousness, erects barriers to mindful practice, while an individual's unexamined negative emotions, failure of imagination, and literal-mindedness can do likewise. Mindfulness can be self-taught, but for most it is most effectively learned in relationship with a mentor or guide. Nonetheless, despite challenges, there are myriad ways physicians can cultivate mindfulness. Meditation, which may come first to mind, is one, but so is keeping a journal, reviewing videos of encounters with patients, or seeking insight from critical incident reports [38].

"Exemplary physicians," one scholar notes, "seem to have a capacity for self-critical reflection that pervades all aspects of practice, including being present with the patient, solving problems, eliciting and transmitting information, making evidence-based decisions, performing technical skills, and defining their own values" [38].

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

> The profession of medicine promises that throughout their careers practitioners will have the knowledge, skills, and characteristics to practice safely and that the profession as a whole and its individual members will hold themselves accountable to identify and address lapses. Medical schools, residency and fellowship programs, specialty societies, and other health care institutions regularly assess physicians' technical knowledge and skills.
>
> However, the ethical responsibility of competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should:

a. Routinely exercise skills of self-awareness and active self-observation;

b. Recognize that different points of transition in professional life can make different demands on competence;

c. Take advantage of tools for self-assessment appropriate to their practice settings and patient populations;

d. Regularly seek feedback from peers and others;

e. Be attentive to environmental and other factors that may compromise their ability to bring their best skills to the care of individual patients, immediately or over the longer term.

Medicine as a profession should continue to refine mechanisms to meaningfully assess physician competence, including:

f. Developing appropriate ways to assess knowledge and skills across the professional lifecycle;

g. Providing meaningful opportunity for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment;

h. Supporting efforts to develop more and better techniques to address gaps in knowledge, skills, and self-awareness.

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## 3. CEJA AND HOUSE OF DELEGATES COLLABORATION

*Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.*

**HOUSE ACTION: REFERRED**

Policy D-600.957 asks the AMA to evaluate:

- how the collaborative process between the House of Delegates and the Council on Ethical and Judicial Affairs can best be improved to allow HOD input to CEJA deliberation while still preserving CEJA autonomy; and

- how a periodic review of *Code of Medical Ethics* guidelines and reports can best be implemented.

Testimony supported looking more closely into the collaboration between the Council on Ethical and Judicial Affairs and the House of Delegates and encouraged a more clearly delineated review process for the *Code of Medical Ethics.* It also was noted that ethics guidance is intended to be timeless.

RELEVANT AMA POLICY

AMA policy is largely silent with respect to the means by which CEJA should collaborate with the House of Delegates. The Bylaws grant CEJA authority to interpret the Principles of Medical Ethics (6.5.2.1) and to investigate

and make recommendations to the House regarding "general ethical conditions and all matters pertaining to the relations of physicians to one another or to the public" (6.5.2.3). Bylaw 2.13.1.1 provides that all matters pertaining to the Principles of Medical Ethics, including CEJA reports, be referred to the Reference Committee on Amendments to Constitution and Bylaws. Bylaw 2.13.1.7.2 provides that CEJA Opinions be treated as informational and filed and that motions may be made to extract an opinion and a request made to CEJA to withdraw or reconsider it. Bylaw 2.13.1.7.2 also provides that the House may adopt, refer, or not adopt CEJA reports, but that they may be amended only with the concurrence of the Council.

Policy G-615.040, "Opinions and Reports of CEJA," provides that CEJA will present its opinions as informational and may provide to the House an analysis of issues and explanation for its opinion at the council's discretion. G-615.040 also replicates provisions of Bylaw 2.13.1.7.2 regarding treatment of CEJA opinions, as well as provisions regarding the treatment of CEJA reports.

CEJA's internal administrative rules provide only that matters under consideration by the council be treated as confidential until the council itself approves its report and recommendations. This has been interpreted to mean that CEJA reports in development are confidential until the council itself releases them, whether by formally presenting a report for House action or otherwise making a report available for review and comment (eg, through the council's online forum).

CEJA PRACTICE

Independent of the special project to comprehensively review the *Code*, AMA ethics guidance is regularly updated whenever House of Delegates adopts a CEJA report and the report's recommendations are subsequently issued as an opinion, generally at the next meeting of the House. This includes amendments to existing guidance in response to significant changes in medical science or practice or to address newly raised questions about a particular ethics topic as well as de novo reports on new topics. Normal House processes enable delegations to submit resolutions asking CEJA to re-examine existing guidance.

Historically, in addition to the reference committee process and its Open Forum sessions at each Annual and Interim Meeting, CEJA has used a variety of strategies to obtain input, including individually inviting written review or presenting work in progress in small face-to-face meetings with key stakeholders on a report-by-report basis. In response to concerns about opportunity to provide input to the modernization of the *Code of Medical Ethics*, CEJA also scheduled special informal "open house" sessions at both the 2015 Annual and Interim Meetings to enable delegates to share comments in person.

Since 2012, CEJA has made materials available to a wider audience for input by posting content to its online discussion forum (ama-assn.org/go/cejaforum), allowing anyone with an AMA sign-on to read and post comments. CEJA alerts stakeholders from whom it particularly desires comment that material is available for review online. In general, CEJA has restricted printing, copying, or sharing of documents in development in keeping with its administrative rule regarding confidentiality of work not yet approved by the council for presentation to the House.

Consistent with the experience of online posting of the delegate Handbook, CEJA has had only limited success using its online forum as a means of engaging stakeholders. For the most part, although there has usually been reasonable traffic to the site, few viewers have actually posted comments. CEJA has heard concerns that the platform itself is cumbersome, and that document protections that prohibited individuals from printing or copyediting material significantly reduced the opportunity or ability to provide input.

OPPORTUNITIES TO ENHANCE COLLABORATION

Preserving CEJA's independence is essential to its role as the voice of ethics for the profession, and flexibility in its work processes is important. As a practical matter, experience suggests that opportunities to enhance collaboration between the House of Delegates and CEJA are somewhat limited. An important consideration in this regard is timing.

Over the past several years, CEJA has systematized its process of developing reports in ways that enable the council to seek input at different stages in the process, from an initial outline of salient issues through a draft ethics analysis to draft recommendations. CEJA should take advantage of this evolution to solicit input more proactively, especially

by requesting comment on its outline of issues and its draft recommendations. AMA's technology staff may be able to help identify appropriate tools to enhance delegates' and members' opportunity to offer comment electronically.

However, it seems unrealistic to expect that significant active collaboration with the House as a whole can take place outside the framework of Annual and Interim Meetings. In CEJA's experience, there has been little to no response to materials available online well in advance of meetings. With rare exceptions, it appears that delegations overall understandably deploy their limited resources for reviewing proposed policy almost exclusively immediately in advance of meetings—ie, only after the delegate Handbook has been posted. This limits the opportunity for CEJA to engage around work in development, particularly because there is no mechanism for incorporating work products in their "pre-final" stages into the Handbook.

For the House as a whole, dedicating some portion of the schedule at Annual and Interim Meetings for delegations to share reflections in person seems to hold the best hope for meeting the perceived need for additional or enhanced collaboration. The "open house" model actually worked well with respect to modernizing the *Code*. It offered concerned delegates the opportunity to present critique in person in an informal, collegial environment and allowed CEJA to engage in discussion of points raised as well as to receive valuable feedback. Participants in the A-15 and I-15 open house sessions appeared to find the Saturday morning time slot reasonably convenient.

Sessions could be publicized in the Speakers' Letter and materials posted to CEJA's forum (without protection) for prospective participants to download and print—or could be requested directly from staff by email. CEJA's Open Forum would not be an appropriate venue given the educational criteria the Open Forum must meet to receive *AMA PRA Category 1 Credit*™ and the fact that it competes with multiple other sessions on the Monday morning of Annual and Interim Meetings.

The Council on Ethical and Judicial Affairs therefore proposes to convene "pilot" open house sessions at the 2017 Annual and Interim Meetings; seek ways to enhance its online forum for input between meetings; and evaluate the value of these activities as mechanisms for enhancing collaboration.

## 4. ETHICAL PHYSICIAN CONDUCT IN THE MEDIA

*Informational report; no reference committee hearing.*

**HOUSE ACTION: FILED**

Policy D-140.957 asks that American Medical Association (AMA):

1. Report on the professional ethical obligations for physicians in the media, including guidelines for the endorsement and dissemination of general medical information and advice via television, radio, internet, print media, or other forms of mass audio or video communication;

2. Study disciplinary pathways for physicians who violate ethical responsibilities through their position on a media platform; and

3. Release a statement affirming the professional obligation of physicians in the media to provide quality medical advice supported by evidence-based principles and transparent to any conflicts of interest, while denouncing the dissemination of dubious or inappropriate medical information through the public media including television, radio, internet, and print media.

The resolution seeks to address concerns about the conduct of physicians who make medical information available to the public through various media outlets. The resolution focuses primarily on the potential for medical information to influence behavior, the importance of ensuring the accuracy of medical information, and the obligation to report unethical behavior among physicians. It does not explicitly acknowledge conflict of interest, physicians' responsibilities with respect to health promotion, or physicians' use of online and social media.

Council on Ethical and Judicial Affairs' (CEJA) deliberations on this topic are ongoing; CEJA therefore intends to submit its final report at the 2017 Annual Meeting.