

## A Critical Pathway to Professional Responsibility

by Oren Renick, JD, MPH, ThM, FACHE

*As the practice of medicine grows more complex with changes in technology, delivery and reimbursement systems, the medical environment demands a heightened awareness of the ethical issues that confront physicians. In response to the need for this awareness, the State Board of Medical Examiners has required that physicians licensed in Texas complete one credit hour of continuing medical education in medical ethics or professional responsibility for each renewal period.*

*TMLT has asked Professor Oren Renick to address the concept of professional responsibility. He is an Associate Professor of Health Administration at Southwest Texas State University, who has been a healthcare executive for 20 years, including 16 years as a senior executive of managed care delivery and evaluation systems. He holds master's degrees in Theology, History, and Public Health, as well as a doctorate of Jurisprudence. He has published over 30 journal articles on managed care, quality improvement, healthcare law and ethics.*

### The Conundrum

What is professional responsibility? It is the obligation to maintain the highest standard of ethical conduct (Mellinkoff, 1976), based on moral principles and specific moral choices (Dell Publishing, 1986). How is professional responsibility proactively and consistently achieved—as opposed to the reactive response of avoiding unprofessional irresponsibility? It is much more than “First, do no harm.” It is a call to professionalism. It is a call to one’s better self, to *be* better and *do* better.

Physicians respond to the call to professionalism in many different and acceptable ways. This response may be fueled by enlightened self-interest, by the desire to fulfill a deep-seated need to contribute to society and the public’s health, or by actions to meet a need for independence and autonomy in plying the art and science of medicine. There are at least as many ways to respond to the call as there are specialty societies, and there may be no single right way.

Most people want to do right, but there is a world of difference between what we say we want to do and what we actually do. The statement “walk the talk” succinctly captures this inconsistency and struggle. For many, the inability to merge motivation with action becomes self-defeating. Admonitions to “just do better” or “you can do it” ring

hollow and only add to existing frustrations. Something else is needed to move us from the hypocrisy of our slogans and platitudes to the higher ground of best practices.

Consider the following paradigm for proactively exceeding the expectations of professional responsibility. It is a model based on a commitment to three principles:

- Do the right thing.
- Do it right.
- Do it consistently.

### Do the Right Thing

To do the right thing is to meet the challenge of the character ethic. Where does one start? Start with the message on the flip side of the 12-inch wood ruler given by the Coca-Cola Company to school children in the 1950s. It said, “Do unto others as you would have them do unto you,”—the Golden Rule. This universal moral principle is expressed as a fundamental statement of truth in all the world religions (Buttrick, 1962). Like the school child’s ruler, it is a means of (symbolically) measuring your actions.

### Do It Right

To do the right thing and do it right is to meet the challenge of competence. It is the application of theory toward the vision of quality. It is to hit the mark of value and thereby achieve the goal of decreasing or

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containing health care costs while maintaining or improving the quality of health care services. It involves finding the zone where high benefit and low cost meet (Annas, 1990), rather than surviving at the lower end of the norm of acceptable professional performance. Striving to thrive at the upper end of the norm moves both the physician and the medical profession toward ever higher standards of quality and improvement in patient care.

Both character and competence are required to practice medicine consistent with professional responsibility (Covey, 1989). The physician of choice is the one with an established pattern of quality patient care (competence) to patients for whom that care was medically necessary (character). Neither competency nor character alone is sufficient to find alignment with the principles of professional responsibility.

### Do It Consistently

Almost anybody can hit a baseball—sometimes. Even Dean Chance, an outstanding former major league pitcher and notoriously bad hitter managed to hit a baseball—sometimes. But what it takes to be an eight time batting champion like Tony Gwynn is . . . consistency. To do the right thing and do it right must become a pattern of performance. When the pattern of excellence in patient care is established, the outcomes of

care bear testimony to quality.

Consistency at its best is moving toward doing the right thing the right way with increasing frequency. Continuous Quality Improvement (CQI) is based on a model attributed to Walter Shewhart that features a recurring cycle of four activities—Plan, Do, Study, and Act. The activities are defined as follows:

1. Plan change by studying a process, deciding what could improve it, and finding data to help you,
2. (Do) test the proposed change by a small-scale trial,
3. Study the effects by checking the results and modifying the planned change if necessary, and
4. Act to improve the process by implementing change (Renick, 1994).

To achieve consistency, a physician must build win-win systems and processes. Find mutual benefit through win-win thinking, rather than “you win” or “I win.” To commit to win-win thinking is to accept and consistently pursue mutual benefit, practicing the Golden Rule. It is to have the mind of abundance mentality: There is plenty for everyone, so the strengths of others are not a threat. It involves mentoring others and not being threatened by

their success. Knowledge, recognition, gain, and profit are shared to mutual benefit (Covey, 1989).

When all is said and done, what is professional responsibility? It is an ethical duty, but it is far more. It is a call to be one’s best.

### References

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- Covey, S.R. *The Seven Habits of Highly Effective People*. New York: Simon and Schuster, pp. 32-35 and 217-20.
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- Renick, O. “The Search for Value: A Quality Improvement Cycle Linking Process, Outcomes and Patient Satisfaction.” *The Journal of Health Administration Education* (Winter 1994), pp. 29 and 31.
- The American Heritage Dictionary*. New York: Dell Publishing Company, 1986, p. 242.

## CME FAQs

### *How many hours of continuing medical education are required for license renewal in Texas?*

Twenty-four hours per year are required, at least 12 of which must be in formal continuing medical education. The physicians must count the hours from expiration date to expiration date. The Board has a system of four expiration dates: February 28, May 31, August 31, and November 30.

### *What kinds of courses qualify as medical ethics/professional responsibility education and how many hours are required?*

One hour of medical ethics/professional responsibility education is required for each renewal period. These hours are subject to the carryover provision so that up to two hours may be carried over for a two-year period beyond the date they are earned, unless these hours are needed to meet the total 24-hour requirement. (Note: The rule is effective 1-1-99; therefore, hours earned prior to the physician’s 1998-1999 renewal period are not eligible for carryover.)

Regarding the content of the course, it will be up to the sponsor of the course to determine that the course contains medical ethics or professional responsibility education. The title of the course does not necessarily need to reflect the title “medical ethics” or “professional responsibility.”

*From: Levy, Bruce A., MD, JD; TSBME Update on CME Requirements for Texas Medical License Renewal, Presented June 11, 1998, Austin, Texas.*

# Golden Rule for Residents

by Kerry Farias

As an employee of a residency program, a resident is under the supervision of many different parties, including attending staff and clinical faculty members, senior residents, the residency program director, and the hospitals where the resident is trained. Although supervised by others, a resident has independent professional accountability. In addition, those supervising the resident are usually held accountable for the supervision.

## Whose Liability is It, Anyway?

An important liability issue for those supervising residents is the establishment of procedures for informing patients of a resident's status. These might include requiring residents to wear nametags designating them as residents, or requiring residents to explain their status to patients. If a resident does discuss his status with a patient, it is important that the resident document this discussion in the patient's medical record.

A major source of liability for the resident is the failure to meet the appropriate standard of care. Residents are held to the same standard of care as any other physician. With this in mind, residents should perform only those procedures or treatments that they are fully trained to perform. It is the responsibility of both the supervising physician and the resident to provide quality care to a patient. Communication between the resident and the supervising physician is vital in achieving this goal, and this is especially important if the resident feels that a patient's condition falls outside the realm of his or her expertise. It is imperative that the resident and the supervising physician communicate clearly with each other regarding the urgency of the problem as well as the scope of the problem.

Physicians who direct or supervise residents may be held responsible for the resident's actions under the legal theory of vicarious liability. The supervising physician's responsibility for the resident's actions arises out of an agency relationship: The resident is an agent of the supervising physician, authorized to act for or represent the physician. In an agency relationship, the parties are also referred to as the master and the servant. The legal doctrine is known as *respondeat superior* (let the master speak). Under this doctrine, supervising physicians may be vicariously liable for the negligent acts of their residents.

This theory of law may also be extended beyond the clinical faculty member to any physician who works with a resident, based on the legal concept of the "borrowed servant" or the "captain of the ship." An individual may be liable for the acts of an employee of another if the negligence occurs while the employee is under the first individual's direction or control. For example, a physician is responsible for the actions of the healthcare team whose members are borrowed servants while under the physician's supervision. Liability may be imposed even though the physician in no way aided

or encouraged a negligent act. Courts in many states have replaced the borrowed servant doctrine with a dual servant doctrine. In this case, not only would a supervising physician be held liable for the acts of the resident, but the hospital and the residency program might also be held liable under the doctrine of *respondeat superior*.

## Ethical Dilemmas

According to the Principles of Medical Ethics of the American Medical Association, "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services." These ethical considerations give physicians the right to choose their patients and to refuse to render treatment that they consider morally inappropriate.

As supervised trainees, however, residents do not usually have the freedom to pick and choose whom they will and will not see as patients. As a result, the resident may be confronted with situations that require difficult decisions on what is "the right thing" to do. These situations may include: 1) being asked to perform a procedure that is beyond the resident's expertise, 2) encountering a complication the resident is not yet trained to handle while performing a routine procedure, 3) being asked to participate in or to perform a procedure to which the resident is morally opposed, 4) becoming aware of an impaired or incompetent physician who is providing patient care.

Although these are just a few of the ethical dilemmas that may present themselves, a resident would be well advised to determine whether the facility in which he or she is employed has procedures in place to deal with potential problem situations. The resident should obtain copies of any departmental protocols, policies and procedures, and become familiar with the proper chain of command within the institution.

A resident who is confronted with an ethical dilemma or an area of conflict should discuss the issues and attitudes with the supervising physician as early as possible. The supervising physician may be more cooperative in resolving the conflict if he or she is apprised of potential areas of conflict early on, allowing ample time to consider alternative arrangements or to help resolve the conflict. The best advice for any resident confronted with an ethical dilemma is to follow the appropriate chain of command to resolve any situation and to remember that quality patient care is the number one priority.

## Reference

The American College of Obstetricians and Gynecologists, "Professional Liability: A Resident's Survival Kit," 1989.

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## Ethics Home Study Program Available

In order to meet the education needs of TMA physicians, TMA and TMLT have co-sponsored the development of a risk management home study program, *Medical Ethics for the Practicing Physician*. This program provides a case-study presentation of issues such as informed consent, the doctor/patient relationship, treatment refusal/demands, and death and dying. Completion of the program

provides the participant with 5 hours AMA/PRA Category I Credit. In addition, TMLT insured physicians who complete the program are eligible for a 5% premium discount (not to exceed \$1,000), applied to their next policy renewal. To order this home study program, please call TMA at 800-880-1300, ext. 1421.

## 1998 TMA/TMLT Risk Management Workshops

The physician risk management seminar, *Document, Document, Document*, has two versions, Medical and Surgical. The Medical Session will be in San Antonio on 9/24, in Tyler on 10/8, Harlingen on 10/22, Fort Worth on 11/5, and Houston on 11/12. The Surgical Session will be in Houston on 9/24 and Dallas on 10/8. There will be a combined session in Victoria on 9/10.

A seminar intended for office staff called *For the Record* will be in San Antonio on 9/16, Abilene on 9/30, Houston on 10/14, McAllen on 10/28, Fort Worth on 11/18, and Tyler on 12/2

Additionally, the following home study programs are available: *Medical Ethics for the Practicing Physician; The Law of Managed Care; Managed Care Liability: Avoiding Sand Traps and Other Hazards; Witness for the Defense: Strategies for Defendant Physicians; and Preventing Medical Malpractice Suits.*

For more information on these seminars and home study programs, please call the Texas Medical Association at 800-880-1300, ext. 1421.