

Psychiatric Professionalism for the 21st Century

The Committee* on Professionalism and Ethics, Group for the Advancement of Psychiatry

Abstract: Psychiatry confronts dramatic changes in its autonomy and scope as practitioners enter into increasingly complex relationships with third parties: industry, insurers, allied health organizations, educational institutions, and government agencies. Earlier role-based efforts to manage competing allegiances contributed to a narrowing of professional scope into situation-specific requirements and loyalties. Frequently the interplay of these new roles and the traditional primary obligation to patients resulted in hardened conflicts or compromises that psychiatrists could sustain only with difficulty. We suggest a concept of professionalism for psychiatrists that maintains a steady focus on the primacy of the patient. It asserts that health care is a relationship, not a

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consumer good. Looking beyond management of competing roles and compromise solutions, we appeal to a definition of professionalism that moves away from the splintering of roles and acceptance of conflicts of commitment and toward a unitary, stable, and morally protective foundation for contemporary psychiatric practice.

Keywords: ethics, professionalism, patient-centered

PSYCHIATRY AS A UNIFIED PROFESSION

Professionalism was conceptualized historically as the affirmation of a group's mission within society. Physicians took oaths that identified a tripartite altruistic commitment to improve the health of patients, accept stewardship over a specialized knowledge base, and train their successors. Uniting research and teaching with the health care of the community, physicians supported their assertion of special privileges, including the right of self-regulation and, at times, the treatment of individuals over their objection.

Psychiatry—like medicine generally—now confronts dramatic changes in its autonomy and scope as practitioners enter increasingly complex relationships with third parties, from insurers and employers, to government and quasi-governmental agencies. Professional obligations to patients are further muddled by conflicts of commitment and mitigation policies based on role-specific duties that vary by practice setting. The effort within medicine to align secondary interests, largely financial, with patient interests has created a language of “confluence” that improperly equates competing interests with medicine's primary commitment to the patient (Cappola & Fitzgerald, 2015).

The Committee on Professionalism and Ethics of the Group for the Advancement of Psychiatry suggests that role-based definitions of professionalism, which may have been appropriate when medicine was a free-standing individual enterprise, now create an unsustainable view of psychiatry's mission. The narrowing scope of physicians' autonomy signaled by tightened economic controls interferes with patient-physician collaboration and the expected advocacy for personalized treatment. The subsequent erosion of patient primacy within complex third-party relationships diminishes our claim to autonomy by virtue of special training (Wynia, Latham, Kao, Berg, & Emanuel, 1999). Moreover, this kind of professionalism evades consideration of the underlying moral basis of the work. It is time to examine—and perhaps to rede-

fine—the core notions of professionalism, and to develop guidance for ethical practice in a time of increasing economic and social complexity.

PROFESSIONAL AUTONOMY AND THREATS TO PATIENT PRIMACY

Contemporary conceptualizations of professionalism are often traced to the role morality of 19th-century English philosopher F. H. Bradley (1876). Reacting to the moral absolutes of his time, Bradley located moral understanding in the cultural and historical settings of his day: one's place in the social order determined one's obligations in society.

This theory differed from previous attempts to define a common morality by the presence of virtues, a social contract, or universal principles (Aristotle, 350 B.C.E.; Kant, 1785; Rousseau, 1762). It resonated strongly for professions seeking to establish their social standing and maintain their autonomy. Medical groups consequently adopted ethics codes—often based on the Hippocratic Oath—and laid claim to a status that would allow them to regulate themselves and guard their practice against incursions by outsiders.

When medicine was a cottage industry, this kind of professional autonomy may have been possible, even desirable, but with an expansion of psychiatric practice beyond treating individual patients it is a model that is no longer tenable. Indeed, economic movements affecting professional autonomy are reflected in a language of commodification that identifies clinicians as “providers.” Quality assurance review by non-clinicians has overtaken peer review, and politicians can determine the content of consent discussions. This is now a stark new reality in the controversies over conversations about guns in the home and in new informed consent requirements for abortion procedures (Guttmacher Institute, 2017; *Wollschlaeger v. Governor of Florida*, 2014). The requirement in five states that clinicians give women misleading information about a link between abortion and breast cancer during consent discussions intrudes into contemporary professional ethics as much as Florida's attempt to prohibit physicians from asking patients about access to firearms.

At the same time, calls for greater mental health coverage come from many constituencies. Notwithstanding current rollbacks, the Patient Protection and Affordable Care Act (2010) and the Mental Health Reform Act of 2015 are clear indications of this development. Public sector mental health programs are stressed because patients are more severely disabled and legally involved (Haupt, 2014), and the military must ex-

pand services to returning veterans and their families. Limitation of financial resources undermines long-term planning in private practice, public sector, and military settings alike. These developments require psychiatrists to acknowledge broad ethical and professional claims on their expertise at a time when political, financial, and security interests clamor for primacy.

A diversified society that demands access to mental health resources expects more from physicians than an assertion of autonomy grounded in history and social standing. The fundamental claims of a society which privileges physicians by licensing them, of organizations and insurers which pay them, and regulatory bodies which oversee them, require a more complex understanding of professionalism than is currently available. It seems time for a more unitary approach to discussions of psychiatric professionalism.

Given the multiple claims on present-day psychiatrists, a dominant theme of contemporary professionalism is that of dual, or even multiple, agency. Recognizable from settings that put the physician's primary duty to the patient in competition with obligations to an institution, an employer, a community, or other patients, dual agency has been a framework for organizational, academic, correctional, and military psychiatry, as well as for managed systems of care. Balancing competing obligations, separating roles, avoiding conflicts of interest, and strengthening information disclosures, are commonplace attempts to attenuate these competing obligations. Yet, unacceptable interventions remain familiar, from incentivizing physicians to use specific treatments in oncology even though deviation from the protocol may be better for certain patients, to limiting second opinions by limiting a program's network (Hartzband & Groopman, 2014).

In dual agency analyses, the power of the greater good—often bolstered by outcomes data for populations—easily overcomes the individual patient. Unchecked utilitarian math has a profound effect on patient–physician relationships—relationships historically grounded in the dyadic interaction. As balancing budgets in state formularies and managed systems of care broadens a physician's obligations, the patient faces an uphill battle in asserting rights of physician fidelity, privacy, and optimal care.

In recognition of these persistent difficulties and the increasing pressures on the patient–physician relationship, we suggest that contemporary psychiatrists reject the splintering of obligations and unify competing duties into a clearer definition of psychiatric professionalism (Gray, 2009; Greenhalgh & Hurwitz, 1998; Wynia, Papadakis, Sullivan, & Hafferty, 2014).

A PROPOSAL FOR 21ST-CENTURY PROFESSIONALISM

This proposal seeks to achieve change in several ways. First, it focuses on the intent and motivations that commonly influence behavior. Professional ethics refers to this more nuanced emphasis as a narrative ethic. It is recognizable in the biopsychosocial formulation in psychiatry and narrative-based medicine as a whole. As a tool that respects patients' perspectives, it values modesty as the cardinal professional virtue that guides physician behavior. It supports truly personalized treatment that considers patients' attainable goals and their optimal capacity to recover. The World Health Organization's statement aspiring to health as the patient's "complete, physical, mental, social well-being..." reflects this view (International Health Conference, 2002, p. 984).

The narrative account of the patient-physician interaction includes influences that are outside the common institutional power structure and thus less commonly considered—the social and cultural features of non-dominant or historically oppressed groups. This is particularly important in settings not purely devoted to patient care and that are more heavily populated by non-dominant groups: the judicial and correctional systems, and the military (Gray, 1999; Griffith, 1998; Howe, 1989). Similarly, psychiatrists working in disadvantaged communities or among those who experience a steep power gradient with treaters may recognize the usefulness of relational rather than institutional theory (Kim & Gray, 2009). Overall, a moral rather than contractual relationship can identify elements of a shared humanity that enhances the doctor-patient-physician relationship and improves sensitivity to cultural, systemic, and community differences. This approach is based not on role definitions or intellectual principles, but on person-to-person interactions and an appreciation of patients' narratives (Greenhalgh, 1999; Wynia et al., 1999). It counteracts forces that turn health into a commodity and physicians into providers by viewing health care as a relationship rather than a consumer good. From this perspective, professionalism is defined by the moral quality of the relationship between patient and psychiatrist (Ward, 2013; Wynia et al., 2014).

Reprioritizing competing narratives will not obviate the need to choose when resources are scarce. It does not resolve which model of financing healthcare is optimal. It does not relieve the tension between duties to warn and patient confidentiality, between school counselors and students' families, or prison security and inmate privacy. Narratives must still confront actuality and the general rules of social discourse: the appropriate use of available treatments, recognition of the limits of science, and the imperfection of clinical interventions.

But a relational patient-centered ethic is also not a naive rebuttal to the practical economics of the marketplace. Even for advocates of a for-profit healthcare system, there is empirical evidence on the effect of the clinical relationship on depression and substance use, as well as on adherence as a whole (American Psychiatric Association, 2006; Ikkos, McQueen, & St. John-Smith, 2011). Collaboratively taking patient preferences into account boosts both appointment and medication adherence. In poverty-stricken areas, where outcomes are poor and hospitals close psychiatric beds (or hospitals entirely) in favor of more lucrative medical-surgical wards, advocacy for patients and communities addresses both the need to diminish the economic burden of disease and the crisis of hospital solvency. Indeed, guiding principles that favor definitive treatment, improved quality of life over time, and the maintenance of good health remain central for all approaches that prioritize patient needs as well as economics.

A relational patient-centered professionalism offers a buffer against the social and economic controls that interfere with the patient-physician relationship. It supports an examination of the narratives, intentions, and motives of the parties involved, re-establishing primary patient-physician bonds by focusing on the journey to the treatment encounter. It moves beyond a simplistic balancing of the needs of powerful economic or social institutions against those of an individual patient.

This endeavor begins with an aspiration of professionalism as a “structurally stabilizing, morally protective force,” and plants roots deeper than a clinician’s work setting or technical proficiencies (Wynia et al., 1999, p. 1612). Certainly, the patient’s environment will set limits or even economic restrictions; but a stabilizing, protective professionalism integrates the patient’s perspective and his or her setting into patient-centered care. This will follow the patient’s narrative, call for a collaborative response, and ultimately provide structure and stability. All parties can then evaluate conflicts between patients, professionals, and institutions by their adherence to this aspiration.

It seems likely that the professionalism we propose can also mitigate the emotional stress that psychiatrists encounter in practice settings that devalue their input and render them powerless against competing interests. It is a clear counter to the view of physicians as institutional assets and re-establishes them as partners with their patients in the task of recovery (Wolgast, 1992).

PUTTING 21ST-CENTURY PROFESSIONALISM INTO PRACTICE

This relational patient-first approach can be operationalized by a series of habits and skills already known to the profession (Dyer, 1988; Roberts & Hoop, 2008). They include the recognition of and efforts to reduce the power differentials between clinicians and the people they treat, and the rigorous examination of the professional's own biases and heuristics. Psychiatry is already a profession that values self-reflection. This forms a base from which to engage in practices that lead to definitive action. Self-reflection acknowledges the self-interest and subjectivity of the human condition, not only of patients but also of clinicians. It supports formation of a treatment relationship in which the physician's knowledge and skills and the patient's own illness experience are equally powerful. Effective care depends on the integrative work of physician and patient. So, we teach medical students that the patient knows what is wrong but may lack words to describe it, while the physician has the vocabulary but does not know what is wrong. The diagnosis emerges from their cooperative work within the doctor-patient relationship. Practicing openness and transparency, and obtaining consultation and education are among these habits and skills, and are already recognized by accreditation agencies such as the Accreditation Council on Graduate Medical Education (ACGME), which appropriately includes professionalism as an essential focus for developing psychiatrists.

A related skill for contemporary professionalism—and one previously outside psychiatry's purview—is purposefully seeking to “witness,” not merely to narrate (Martinez, 2014). This concept is perhaps best known from the suffering of the prisoners in the Nazi concentration camps and owes much to those who provided testimony from that terrible setting (Frankl, 1946; Wiesel, 1960). Even when change cannot be achieved in the moment, witnessing—and professing when possible—are habits and skills that enhance any patient-physician relationship and support a contemporary psychiatric professionalism.

A professionalism practiced in this way is sensitive to historic and cultural influences and seeks to apply similar sensibilities to every context in which psychiatrists and their patients interact. Like the view of a profession as a “structurally stabilizing, morally protective force,” (Wynia et al., 1999, p. 1612) self-reflection and witnessing become sta-

bilizing influences that pursue personalized care as a primary professional obligation. The testimony of conflicted administrators who bore witness to the evolution of managed systems of care is a clear reminder of the power of this approach (Lazarus, 2010). Validating one's perspective with recognizable behaviors consequently stabilizes the profession even when the ground shifts and the rules appear to change. It elevates the human condition beyond the bounds of institutions and re-establishes the focus of physician interactions on relationships with individuals.

This view of professionalism was intimated by the classic *The Perspectives of Psychiatry* (McHugh & Slavney, 1998) and developed more fully for forensic psychiatry as Robust Professionalism (Candilis, Weinstein, & Martinez, 2007). McHugh and Slavney (1998), for example, wrote powerfully on the importance of seeing illness from all sides: not only from the perspective of a biological disease, but also from the perspective of the patient's personality, behaviors, and narrative, developing a multidimensional view of the person before them. This continues the tradition of physicians such as Francis Weld Peabody, who wrote almost a century ago, "One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient" (Peabody, 1927, p. 882).

In contemporary situations of economic constraint, psychiatrists who maintain this patient-centered perspective may research and develop cost- or time-efficient treatments that maintain patient primacy. Menchaca and colleagues, for example, developed Intermittent Continuous Eclectic Therapy (ICE), a dynamic group psychotherapy that is useful for treating borderline personality disorder in public sector facilities (Menchaca, Pérez, & Peralta, 2007). Promoting patient-centered solutions is a clear ethical alternative to restricting formularies and limiting care.

In their discussion of Robust Professionalism, Candilis and colleagues (2007) similarly describe an approach to forensic psychiatry that integrates personal, professional, and community values. They consider this approach superior to role-based ethics because it resists the temptation to serve the system first. It is more sensitive to socio-economic and cultural inequities and allows practitioners to answer to their profession and the individual rather than the immediate setting. Consequently, a robust professionalism values individuals above the systems that insure, imprison, adjudicate, or deploy them. It follows that in ordinary practice, physicians will advocate broad financing of and access to treatment and preventive services—patient-centered

themes that govern modern health care—and to work with a range of parties to achieve these goals.

For individual practitioners, a robust patient-centered ethic means that psychiatrists will work to enhance adaptive skills regardless of social or economic context; that they will place the patient's capacity for emotional growth ahead of organizational incentives and quotas. Moving from incentives that limit diagnostic tests or patient visits toward policies that optimize health over a lifetime are examples of strategies systems and governments may pursue in service to this ethic. Ethical treatment plans that take into account the patient's socioeconomic reality can mitigate impediments to adherence. In sum, this is a structurally supportive, morally protective professionalism that supports personal goals of function and well-being.

In daily practice, psychiatrists may use habits and skills that improve the patient relationship by underscoring openness and transparency; they can do more for the patient than offer information on the restrictions imposed by third party insurers; they can go beyond merely warning of the limits of confidentiality in correctional and forensic settings; they can offer explanations that lead to genuine informed consent for those entering clinical or research protocols.

Sensitivity to imbalances of power and to social and cultural influences is useful in overcoming the potential confinement of moral and scientific certainty. We acknowledge that psychiatric science, expertise, and experience do not confer moral authority; they offer only an opportunity to prove their worth (Veatch, 1973). Even in scientific areas where the scholarship may appear settled, conscientious psychiatrists remember the evolution of our views on homosexuality, autism, and schizophrenia, and the way experts communicated those flawed views to the public. Humility and self-reflection continue to be important tools for overcoming temptations to absolutism and arrogance, common pitfalls for contemporary professions. Ultimately it is our connection with the patient's story, his or her own narrative, and our interaction with that individual that crystallize good evidence-based care.

Psychiatrists pursuing this contemporary professionalism will sometimes determine that they must make an exception to the ideal of patient primacy. Conflicts will inevitably arise. But if they reject the notion that the patient is simply one variable to be balanced against competing interests, and instead begin their deliberation from the patient-centered standpoint of humility and witnessing, from a respect for narrative, and from the core question of whether professional behavior is socially stabilizing and morally protective, they will have taken an important step beyond dual or multiple agency thinking.

CONCLUSION

Expanding on views recognizable from *The Perspectives of Psychiatry* (McHugh & Slavney, 1998) and Robust Professionalism (Candilis, Weinstock, & Martinez, 2007), we advance a concept of psychiatric professionalism that maintains a steady focus on the primacy of the patient. We ask whether our profession has too easily accepted the notion of role theory as a cardinal consideration—splitting roles and parceling out obligations according to the situation—as the best that psychiatrists can achieve. We appeal instead to a definition of professionalism that is more enduringly stable and morally protective. We recommend moving away from the splintering of roles and mitigation of conflicts of interest and toward a unitary foundation for contemporary patient-centered psychiatric practice.

REFERENCES

- American Psychiatric Association. (2006). *Practice guideline for the treatment of patients with substance use disorders* (2nd ed., pp. 316-317). Washington, DC: Author.
- Aristotle. (350 B.C.E.). *The Nicomachean ethics* (Further rev. ed., 2004). (H. Tredennick, Ed., & J. A. K. Thompson, Trans.). London: Penguin.
- Bradley, F. H. (1876). *Ethical studies* (2nd ed.). Oxford, England: Oxford University Press.
- Candilis, P. J., Weinstock, R., & Martinez, R. (2007). Robust professionalism: Beyond role. In P. J. Candilis, R. Weinstock, & R. Martinez (Eds.), *Forensic ethics and the expert witness* (pp. 97-122). Boston, MA: Springer.
- Cappola, A. R., & Fitzgerald, G. A. (2015). Confluence, not conflict of interest: Name change necessary. *JAMA: Journal of the American Medical Association*, 314(17), 1791-1792.
- Dyer, A. R. (1988). *Ethics and psychiatry: Toward professional definition*. Washington DC: American Psychiatric Press.
- Frankl, V. E. (1946). *Man's search for meaning: An introduction to logotherapy* (I. Lasch, Trans.). Boston, MA: Beacon Press.
- Gray, S. H. (1999, August). *Impact of military confidentiality policy on psychotherapeutic technique*. Poster presented at the Army Behavioral Sciences Short Course, Bethesda, MD. <http://jaffee-redmond.org/docs/gray-mil.htm>
- Gray, S. (2009). Evidence and narrative in contemporary psychiatry. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 37(3), 415-420.
- Greenhalgh, T. (1999). Narrative based medicine in an evidence based world. *BMJ: British Medical Journal*, 318(7179), 323-325.
- Greenhalgh T., & Hurwitz, B. (Eds.). (1998). *Narrative based medicine*. London: BMJ Books.
- Griffith, E. E. H. (1998). Ethics in forensic psychiatry: A cultural response to Stone and Appelbaum. *Journal of the American Academy of Psychiatry and the Law*, 26(2), 171-184.

- Guttmacher Institute. (2017). *State laws and policies: Counseling and waiting periods for abortion*. Retrieved February 03, 2017 from <https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion>
- Hartzband, P., & Groopman, J. (2014, November 19). How medical care is being corrupted. *The New York Times*, p. A25.
- Haupt, M. B. (2014). *The vital role of state psychiatric hospitals* (J. Parks & A. Q. Radke, Eds.; Technical Report No. 18). Alexandria, VA: National Association of State Mental Health Program Directors Medical Directors Council Publications and Reports.
- Howe, E. G. (1989). Confidentiality in the military. *Behavioral Sciences and the Law*, 7(3), 317-337.
- Ikkos, G., McQueen, D., & St. John-Smith, P. (2011). Psychiatry's contract with society: What is expected? *Acta Psychiatrica Scandinavica*, 124, 1-3.
- International Health Conference. (2002). Constitution of the World Health Organization. 1946. *Bulletin of the World Health Organization*, 80(12), 983-984.
- Kant, I. (1785). *Groundwork of the metaphysics of morals* (Rev. ed.). (M. Gregor & J. Timmermann, Trans.). Cambridge, England: Cambridge University Press.
- Kim, E. H., & Gray, S. H. (2009). Challenges presenting in transference and countertransference in the psychodynamic psychotherapy of a military service member. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry*, 37(3), 421-437.
- Lazarus, A. (2010). The clinical voice of managed care hits a sour note. *Physician Executive*, 36(5), 4-6.
- Martinez, R. (2014, October). *Witnessing as a duty of professionalism*. Paper presented at the meeting of the American Academy of Psychiatry and the Law, Chicago, IL.
- McHugh, P. R., & Slavney, P. R. (1998). *The perspectives of psychiatry* (2nd ed.). Baltimore, MD: Johns Hopkins University Press.
- Menchaca, A., Pérez, O., & Peralta, A. (2007). Intermittent-continuous eclectic therapy: A group approach for borderline personality disorder. *Journal of Psychiatric Practice*, 13(4), 281-284.
- Mental Health Reform Act of 2015, S. 1945, 114th Cong. (2015). Retrieved from ProQuest Congressional Database.
- Patient Protection and Affordable Care Act, 42 U.S.C. §18001. (2010).
- Peabody, F. W. (1927). The care of the patient. *JAMA: Journal of the American Medical Association*, 88(12), 877-882.
- Roberts, L. W., & Hoop, J. G. (2008). *Professionalism and ethics: Q & A self-study guide for mental health professionals*. Washington, DC: American Psychiatric Publishing.
- Rousseau, J. J. (1762). *On the social contract* (G. Cole, Trans.). New York: Dover Publications.
- Veatch, R. M. (1973). Generalization of expertise. *The Hastings Center Studies*, 1(2), 29-40.
- Ward, T. (2013). Addressing the dual relationship problem in forensic and correctional practice. *Aggression and Violent Behavior*, 18(1), 92-100.
- Wiesel, E. (1960). *Night* (S. Rodway, Trans.). New York: Bantam Books.
- Wolgast, E. (1992). *Ethics of an artificial person: Lost responsibility in professions and organizations*. Stanford, CA: Stanford University Press.
- Wollschlaeger v. Governor of Florida, 760 F.3d 1195 (11th Cir. 2014).

- Wynia, M. K., Latham, S. R., Kao, A. C., Berg, J., & Emanuel, L. (1999). Medical professionalism in society. *The New England Journal of Medicine*, 341(21), 1612-1616.
- Wynia, M. K., Papadakis, M. A., Sullivan, W. M., & Hafferty, F. W. (2014). More than a list of values and desired behaviors: A foundational understanding of medical professionalism. *Academic Medicine: Journal of The Association of American Medical Colleges*, 89(5), 712-714.

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