

Compilation of Comments on *Good Medical Practice – USA, Version 0.1*
December 4, 2007

The GMP-USA document was reviewed in several venues since Version 0.1 became available for distribution in August. A compilation of comments appears on the following pages, from sources including the AAMC, ACPE, AMA, FSMB, NBME, www.gmpusa.org, and others.

Please review these comments to discover the full range of opinions they express. Themes that have emerged included the following:

- More attention is needed to the settings and healthcare systems in which medical care takes place. Suggestions in this area ranged from development of a new section or companion document on “Good Medical Systems,” to more interweaving of expectations of doctors with limitations of healthcare settings, given the variable systems in which they deliver care.
- Clarification is necessary regarding the context of the document and expectations of doctors. Is GMP-USA intended to be “aspirational” only, describing an ideal that may never be fully attained by individuals? Or, is GMP-USA a blueprint of accountabilities for which measurements and performance standards have yet to be developed? Or, does it already represent the minimum expected of doctors?
- Might GMP-USA become a tool against physicians in the hands of malpractice litigators? If so, how might this be inhibited?

ACPE comments

1. Excellent document that should be required reading and discussion by all Medical student as they enter medical school and residents as they leave training.
2. Too long, too obvious, too "legislative" in its wording
3. It is a good academic document, but how do we measure each of these metrics?
4. 1- In the section labeled, THE PATIENT'S PERSPECTIVE: EXPECTATIONS FOR PHYSICIAN COMPETENCE has a number of issues not related to competence and are open to interpretation and miscommunication. Example, line 151, enable me to make timely appointments; a physician cannot ensure that an appointment will be available for all working people, there are limited evening hours. Line 154 respond promptly to my calls, what does that translate to, interrupt the physician when he is with another patient? These are too vague to be implemented. Line 160-161, leave complete control to me over any distribution of my medical records. I can give a patient copies of their records, but must keep the records for audits, legal defense and tax purposes, leaving this impossible to implement. 2- Where are the patient's responsibilities listed? They are equally important in any document of this nature. Where does it say that the patient will accept the evidence-based medicine such as not prescribing antibiotics when they are not indicated, or the patient will not ask for a "work excuse" when they were not ill? 3- Conflicts of Interest must be minimized but cannot be completely eliminated; i.e. the physician has a duty to the hospital he works in which, even if he has no direct financial conflict of interest the physician still has a duty to that facility. The wording of the Good Medical Practice document is terribly immature not to consider the full range of responsibilities that a physician must balance. 4- Physicians are taking on too much responsibility in line 339, "help patients understand any limits imposed on their care by their insurance providers." The physician cannot be the apologist for the insurance company, the patient must take that responsibility when they buy the insurance. Or, in line 377, "consult and take advice from colleagues, when appropriate, and negotiate when conflicts exist" The physician has no duty to negotiate for the patient with other physicians, that is completely out of the scope or power of an individual physician. 5- Line 423, develop individual learning plans that focus on areas of weakness; suggests a written document to be produced when a patient feels a physician is weak in an area, where the physician may not agree they are weak, and sets up an unreasonable expectation. 6- Finally, the document is excessively redundant with multiple areas of overlap, particularly in the self-assessment areas and communication. These should be said, but only once there is no additional advantage to repeatedly say the same things in only slightly different language. 7- While this is an honorable endeavor, the language is too vague and redundant that, respectfully, I cannot support the ACPE endorsement as written. I believe it is worth additional work by an experienced team of

ethicists who could accomplish the goal in more reasonable language. Vincent F. Carr, D.O., FACC, FACP, CPE Colonel, USAF, MC "The views expressed in this response are those of the author and do not reflect the official policy of the USUHS, Dept. of Defense or the U.S. Government."

5. One of the more difficult situations a physician may face is in dealing with the willfully non-compliant patient. While the issue is addressed tangentially, under termination of relationship, I'd like to see more about approaches to such patients short of ending the relationship altogether. I.e: Before terminating a patient from – practice, is there a proposed approach or set of step to take first?
6. 1. Much of what is covered is found in AMA ethics section.
7. In general this is a very comprehensive documentation of the social contract that should exist between physicians and patients, and it clearly defines the value and "payment" resulting from that contract. I have taken the liberty of sharing some specific suggestions that could be considered, even though I'm not sure that is the kind of input to the Board you were looking for. Line 168 - ? additional emphasis needed on conflicts of interest from ownership, i.e., ambulatory surgery center. Line 208 - add: actively seek to improve interpersonal and communication skills; probably important for many (?most) physicians. Line 297 - add: serve as role model for our patients and communities. Line 395 - consider adding after records: which documents appropriate patient history and. The cut and paste function in the EMR is leading to documentation overload and upcoding that is not warranted by medical necessity. Line 516 - after this line there should be an additional bullet point - improve patient safety and quality Line 802 - add: include criticism of other providers or their care in the medical record. Line 868 - the next line should clearly state: We serve as stewards of our finite health care resources.
8. These are ideals, not standards. They are a plaintiff's attorney's dream. Any practicing physician who is able to completely comply with these "standards" should be promoted promptly to sainthood, or will likely ascend directly to heaven without having to die first. If JCAHCO, NCQA, or any other credentialing body attempts to use these for regulatory purposes, the medical profession will be decimated.
9. Every medical school should incorporate this into their curriculum.
10. I believe these standards go a long way toward restoring the true professionalism expected of a calling such as ours.
11. The standards are good, but I think most physicians will assume they are compliant unless there are some specific requirements- like how many hours should elapse before a new inpatient is evaluated- are included.
12. excellent. it needs recommended consequences and actions for deviations from the expectations.
13. Too long Highly idealistic and not achievable (eg "discuss the costs of tests, medications and treatment options and take into

account what my insurance will cover" "being prompt for appointments" -without exception, while later on promising to prioritize care for the highest need first - such as medical emergencies...an inherent conflict) I found this to be discouraging and another burden of things we can potentially be held liable for rather than a positive statement of the profession.

14. Hard to find fault with standards that are up there with Mom and apple pie. I have a problem with very idealized behaviours being presented as standards given the potential for medicolegal repercussions. These ideals also underrepresent the importance of physicians maintaining good physical, mental and social (e.g. family) relationships essential to help cope with the high stress of clinical medicine. These ideals are good basis for medical training and CME activities and should be regularly incorporated into educational activities. They are too idealized and subjective to be used to measure individual physicians. Frank P. Castrina MD
15. I think that the document is a well-written and comprehensive attempt to define/re-define some principles for practice. Some of it is a bit redundant, and some of the tenets regarding evidence based practices and dealings with payors might be a bit difficult to actually define and implement since they are variable from community to community, and since they change rapidly in some cases. Having said this, I would be very supportive of efforts to produce a document that may well become the American 21st Century version of the Hippocratic oath.
16. I am unsure about the purpose of these standards. ACPE has already documented decreasing satisfaction withing the medical profession. Use of these standards will not make it any better.
17. This was developed by someone who had way too much time on their hands and was probably offered a grant to write something. It is mom and apple pie wrapped up with St. Teresa and tied with a pink bow. There is very little of value. What is "prompt access"? What is "no conflicts?" I can't imagine where this will be used but I am sure ABIM or ACP will find some esoteric use for it that will not benefit one doctor or patient.
18. A very well-considered set of principles for the profession to live by. This is something that ACPE could endorse and help to disseminate.
19. They look excellent to me. Robert Mikkelsen MD
20. I am specifically concerned about the writing of 5.1.1 second bullet (line 638-639). Often times in practice it is necessary to provide religious and/or moral direction to patients, insofar as it affects their care. (This is especially applicable to mental health providers.) Often these individuals are already distraught because of poor choices that they may have made. I would always err on the side of asking the patient if I could share with them prior to doing so, and attempt to take a good spiritual history prior to doing so. However, I would not want these standards to be construed in a way that either handcuffs nor discourages physicians from discussing these subjects at the appropriate clinical timing. To bar physicians from doing so is, in fact, unethical. Marc Wooten, MD,

FACPE, FACP, FACR

21. There is nothing to be critical of when evaluating so called good medical practice standards. My objection would only be that doctors are constantly being subjected to two ethical standards. One is the standards outlined in these proposed standards and the other is a business standard. The doctor in private practice is involved with the insurance industry which clearly dictates how we behave on a daily basis. No one holds them to the standards being proposed.
22. There is very little specific deliverables required. Very warm and fluffy but not enough measureable action items to be able to show a consumer what is a good or less good physician. The discussions are certainly reasonable but not sufficient. All physicians could state they qualify as a good medical practice even when we all know there is a bell curve. Needs work to be useful for employers or health plans or patients
23. They are all good in principle but if we could adhere to all we should apply apply for pre-mortem sainthood. There is nothing in there about patient responsibilities and not making unreasonable demands on practitioners and systems.
24. Excellent principles. I only wish that the doctors who spend their time creating regulations and reporting requirements based on these principles were required to return to practice so they could "walk the walk" and carry them out.
25. Not agreeing with this would be like being against baseball, mothers and apple pie. The problem is all those nearly impossible things to measure like "evidence-based knowledge", or "well-qualified" or "timely appointments". I am reluctant to say that I agree with what is written here until I know to what use it would be put - given what has been happening to physicians and hospitals over the past decade, I fear that somehow this seemingly innocuous document would be turned on us in some rigid and unforgiving way like so many things before it have been.
26. I may be a but jaded, but this says we are supposed to be honest, communicate well, keep up to date, and put patients' interest first. I think that physicians who do this will continue to do so and others will not be swayed by this or any document, for that matter. Nobody will see this and say "oops, my bad" and change...
27. very good, patient centered, system focused. well done and should be validated by all relevant medical organizations.
28. Fairly comprehensive, but process orientation shows through. Outcomes more important... When we are still trying to get surgeons to show up in the OR on time and sober, it is perhaps a stretch to think that we will hit this level of professionalism any time soon...
29. 25 hours of CME associated with one's scope of practice annually; evidence of PARQ with full patient/client participation and understanding; use of practice guidelines of some sort, with some science basis for the process particularly of polypharmacy; outcome expectations with timelines built into treatment decisions

and a process for adjusting the treatment if outcomes are not achieved in the time allotted.

- 30.** Primum Nonsincere! The patient comes first! All of the rest is nothing other than a bureaucratic straitjacket designed to assure compliance with one particular view of the way patients and doctors should interact. I would hate to see this document enshrined in any kind of regulations anywhere. I find it interesting and highly arrogant that a few individuals or their organizations would attempt to speak on behalf of all patients and all physicians. Their willingness to TELL the rest of us how practice medicine implies that they have the moral authority to do so. I see nothing in the document or in the organizations that created it that gives them the moral authority to write this document much less disseminate it. I grant the moral authority to Aesculapias, and recognized medical leaders. These arrogant self important busy bodies don't make the grade! I would ask them to refrain from further work on this.

Comments Entered at www.gmpusa.org

Comment from Steve Schabel:		
<p>"I have now seen it is a variety of settings. Atr the NBME Exec Board retreat we discussed it again. I along with some others was a little upset with the absoluteness of the expectations of physicians. It could be read that doctors are never to make errors, are always to see their patients promptly and answer emails and phone calls immediately... I know that this is not what has been intended but I think a lay reader or a bureaucrat could read it as saying perfection is expected. It needs to have a lead that talks about this as being the GOAL toward which we should strive even while we realize it can never be achieved. It has nothing of substance that anyone could argue with."</p>		
Dr. Stephen Clyman	10/31/2007 12:00:00 PM	Para(s) 6.3
Line 941 – Most of these apply if we’re working within a team as well, not just leading it. How about, “When participating on a team”		
Dr. Stephen Clyman	10/31/2007 11:42:00 AM	Para(s) 5.2.2
“mind altering” might be phrased more technically (eg, psychoactive)		
Dr. Stephen Clyman	10/31/2007 11:39:00 AM	Para(s) 3.2
Change “scientific” to someting like “persuasive”; there may be evidence that is empirical or other that is not published or highly substantiated, but nonetheless useful to assimilate.		
Dr. Stephen Clyman	10/31/2007 11:37:00 AM	Para(s) 1.2
The use of the word “adequate” as an adjective in line 274 might be seen as minimal or less (it was used as an adverb in line 273).		
Dr. Stephen Clyman	10/31/2007 11:35:00 AM	Para(s) A.1
<p>“Patients” are a limited group but the word occurs 11 times in the About section; use broader wording where appropriate (persons, public, etc.). In the document, there is often a complementary or broader term used (public health).</p> <p>The use of “is expected” (line 46) is stronger than “source of guidance” (line 67); these should be reconciled.</p> <p>This is written without any nod to the important role of other members of the health care team and our responsibilities to them. It is embedded in the details of the document, but should be highlighted here.</p> <p>Use “health records” rather than “medical records.” Medical is a physician centric view?</p> <p>Should the word “art” occur anywhere in the document (it currently does not), acknowledging when a practice is based on experience and life knowledge?</p>		
Dr Ruth Hoppe	10/29/2007 5:48:00 PM	Para(s) 1.0

Providing education and counseling to patients and their families is listed under Compassionate Care. While we certainly want information to be given to patients in a compassionate and supportive way, I would argue that this 'loop' of dialogue (ie FROM dr TO patient) is important in terms of achieving desired clinical outcomes and belongs outside the domain of compassionate care. Data gathering seems to qualify in terms of a section all to itself (what I call the afferent loop: FROM pt TO dr). But the efferent loop is missing. The closest one gets is in the Patient Management section, but there I don't see some key communication competencies dealing with the particular loop:
 providing information accurate and understandable so that patients and their families understand what is going on and what needs to happen next
 providing information to patients that is actionable...ie, sufficient detailed and clear as to allow the patient to accomplish next steps
 assessing the patient's willingness and ability to carry out desired next steps

Ms. Ann Mowery	10/23/2007 3:28:00 PM	Para(s) 5.2.1
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I think physicians need to be sensitive to sexual orientation which is not a choice and which affects so many aspects of one's life.

Ms. Ann Mowery	10/23/2007 3:28:00 PM	Para(s) 5.2.2
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Physicians need to be sensitive to confidentiality in their practice and be quick to handle staff, peers or subordinates who may fail to keep a patient's confidence. Physicians should advocate for their patients in this area with management if issues surface related to how patient information is taken in public space as the waiting room, etc.

Ms. Ann Mowery	10/23/2007 3:28:00 PM	Para(s) 5.2.3
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Physicians need to be available to provide informed consent. So often this task is relegated to other staff who simply doesn't know the answers to patients' questions.

Ms. Ann Mowery	10/23/2007 3:28:00 PM	Para(s) 5.4.2
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Physicians should report adverse settlements or judgments to state medical boards.

Ms. Ann Mowery	10/23/2007 3:07:00 PM	Para(s) 2.1
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What about keeping records that document training.

Ms. Ann Mowery	10/23/2007 3:04:00 PM	Para(s) 1.5.2
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Something needs to be said about sending requested medical records in a timely manner.

Ms. Ann Mowery	10/23/2007 3:04:00 PM	Para(s) 1.3
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I don't think that screening tests are a "preventive measure." It seems to me that they address early detection.

Ms. Ann Mowery	10/23/2007 3:04:00 PM	Para(s) 1.4.1
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It seems to me that referral is often an important part of getting to diagnosis and treatment. I would like to see something on facilitating referral to competent practitioners when they have something to offer outside of the doctor's scope of practice. This could be to a more specialized MD or DO or an acupuncturist or whomever that has something of value to offer in the process.

Ms. Ann Mowery	10/23/2007 3:04:00 PM	Para(s) 1.4.2
I think it is reasonable to treat patients with similar conditions differently if the patients make different choices. I think they need to be offered evidence based choices but the resulting treatment stems from that and what the patient wants.		
Ms. Ann Mowery	10/23/2007 2:49:00 PM	Para(s) D.1
The first bullet should include some recognition for end of life when diagnosis and treatment and the promotion of health may move to comfort care. Collaborating with the team is so often overlooked and I'm happy that it is included here. I am curious why "healthcare teams" is plural. It seems to me that in the case of a patient that the "team" is what revolves around that particular person's care. If so, then I would see using "team" rather than the plural.		
Ms. Ann Mowery	10/23/2007 2:49:00 PM	Para(s) D.6
"Recognizing the value of teaching and training others" doesn't give as much emphasis as this should have. Good doctors are involved in teaching and training others, whether it's the patient or caregivers or other staff that interact with the patient or professionals in other organizations that serve the patient in their home environment. I'd like to see a stronger word than "recognize" used in the last bullet point. I also think there's an imperative for the physician to be responsible for their staffs' skills and their growth. For example, the doctor should be aware of the knowledge and skill level of the individuals they have answering call-ins, for PA's, and others.		
Ms. Ann Mowery	10/23/2007 2:49:00 PM	Para(s) D.2
I'm not sure where my comments fit best but I have concern that a physician's scope of supervision not exhaust the physician's competence. For example, it doesn't seem reasonable to me that a physician supervise a PA or nurse practitioner who provides care that the physician isn't competent to practice. For example, we have seen an internist hire a pediatric nurse practitioner to cover pediatrics in the practice. Physicians also take on the title of "medical director" in organizations where they do not take on the role and are not competent in the area of the practice, e.g., a psychiatrist who is the medical director of a laser hair removal clinic.		
Ms. Ann Mowery	10/23/2007 2:35:00 PM	Para(s) P.5
I really like the inclusion of the patient's point of view and all that is included here.		
Dr. Carol Carraccio	10/20/2007 8:29:00 PM	Line(s) 782-815
This is a wonderful document and the authors should be congratulated for the clarity and practical wisdom embodied here. I have only one suggestion about something that I feel is missing. In the section under professionalism on "Responsibilities to colleagues and the profession" there is no mention of our responsibility to our learners (students, residents and fellows). Tom Inui has been quite articulate about this in his paper " A flag in the wind: Educating for professionalism in medicine." He raises the issue of our silence when we witness lapses in professional behavior and contrasts this "hidden curriculum" with what we teach in seminars. When behavior is antithetical to didactic teaching, the former is what is learned. It may be helpful to add a bullet that addresses our need to model professionalism for our learners so that they learn by example and do not receive mixed		

messages from witnessed behavior that does not align with what is being taught in the classroom.		
Dr Dennis Ledford	10/17/2007 10:17:00 AM	Para(s) 3.3
Professionals strive for doing the best but this document is suggesting an unfunded mandate as analysis, audits, appraisals and performance reviews which incorporate medical practice are costly. How is this incorporated into practice when overhead costs are increasing faster than reimbursement.		
Dr Dennis Ledford	10/17/2007 10:10:00 AM	Para(s) D.6
this all sounds good but does not reflect the reality of time constraints. We are creating expectation of everything when we cannot afford everything. Physicians should be caring, competent, motivated by patient concerns but they cannot do everything for everyone as stated in these "ideals". Therefore I do not see the value in this document other than an exercise that is not realistic.		
Dr Anthony Whitemore	9/26/2007 12:38:00 PM	General
Please include a list of the member organizations participating in the consensus document. This will lend substantial credibility and clarify the composition of the NAPC.		
Ms. Ann Mowery	9/18/2007 12:43:00 PM	Para(s) A.1
The important points are included here. I like that it has made use of the UK document and the prior work of ACGME and ABMS, in partnership.		

COMMENTS FROM NBME EXECUTIVE BOARD RE GOOD MEDICAL PRACTICE – USA

October 2007

Comments from Small Group Discussions

Use GMP-USA as an external reference to support NBME's mission and as linkage to other organizations:

- Organize NBME “products” around the GMP-USA competencies and formulate more coherent NBME plans and rationales for development
- Expand NBME's portfolio to include
 - More competencies
 - More levels in the continuum
- Expand NBME's vision, consider a culture shift from focusing on knowledge assessment to other approaches; adopt a new focus on a formative role to add to summative approaches
- Note the possible public perception that only a small number of competencies are currently assessed!

Limitations of/suggestions to improve GMP-USA:

- Include more on healthcare teams and responsibilities to “non patients.” GMP focuses on individuals, but physicians practice in systems. Gap analysis needed?
- Note that the object of communication in the document changes between the Patient Expectations section and the rest of the document and needs to be clarified.
- Note that Executive Board review resulted in two conflicting views:
 1. GMP-USA is not real or realistic; it's an “idealistic, goody 2 shoes” document.
 - Add a statement that the document is “aspirational” or a “best practices” document? Enhance the “executive summary” to talk about the document as an “ideal”
 - Are there implications that failure to meet perfection and bad patient outcomes are equivalent to malpractice? If physicians do as GMP-USA suggests, will patient care outcomes improve? Data?
 2. GMP-USA represents reasonable expectations of doctors and should guide education and assessment systems.
 - Next steps should include further delineation of measures and methods for establishing performance standards.
- The major problem is communication.
 - What systems are needed to enable operationalization of GMP-USA? What are the patient's responsibilities?

Summary of Plenary Discussion

Retreat participants encouraged PACP summit participants to assure the practicality of GMP-USA and to develop a parallel description of the characteristics of “good medical systems.” The Executive Board suggested that setting expectations as outlined in GMP-USA needs to be accompanied by development of infrastructure to support the practices described in the document.

Executive Board discussion of implications indicated that the detailed framework of competencies in the document could provide guidance for the development of NBME’s portfolio of products and services, with the goal of developing effective tools to measure the described competencies. It was also noted that such a strategic direction would demand changes in the culture of the NBME, since many of the competencies are not currently amenable to assessment using highly reliable, standardized assessment tools.

**COMMENTS OF THE AMERICAN MEDICAL ASSOCIATION
COUNCIL ON MEDICAL EDUCATION
ON GOOD MEDICAL PRACTICE-USA, VERSION 0.1**

The Council on Medical Education appreciates the opportunity to comment on this document. We have included both general comments on the focus and tenor of the document, as well as specific references to sections of the report.

The Council has two major concerns with the GMP-USA as written: (1) the lack of attention to the context of care, in that the document includes unfounded assumptions of physician control of and autonomy in patient care situations and in conflicting priorities and (2) expectations of behaviors that are not proven to be related to patient outcomes or an evidence base to support the value of their measurement. Language throughout this document calls on regulators to use the document as a baseline standard of care, which is contrary to the realities inherent in (1) and (2) above. The AMA Council on Medical Education firmly believes that the GMP-USA is inappropriate as a standard for certification, licensure, or as a standard of care to which physicians should be held. Adoption of this document by regulators would place physicians at significant legal risk for circumstances that are not within their control and that have no proven link to good patient outcomes. The Council would prefer to view the GMP-USA document as a draft of an aspirational document for the medical profession that needs to be grounded in more established professional standards such as the AMA Code of Medical Ethics.

The Context of Care

Physicians today work in a health care and financing environment which influences physician actions, such as the amount of time that they can spend with patients and the types of patient management decisions that they can make. These can affect patient satisfaction and the outcomes of care. Lines 231 and 232 state the inherent contradiction well

(Good doctors) “ are aware of the healthcare system in which we work and adapt the care we provide to its realities, while making the best interests of our patients our first priority at all times.”

The document assumes these two issues can be easily reconciled, but this is not often the case. The document also does not indicate how such conflicts should be resolved. Another example comes from line 293-295 under maintaining health, where the expectation is to “offer patients appropriate preventive measures, such as screening tests...”, another area that may be limited by the patient’s insurance status or other external factors. Thus, while “good doctors” are to be aware of the healthcare system, the same “good doctors” are expected to blindly ignore the patient’s circumstances within the health care system and “offer” tests or procedures without regard to the patient’s ability to truly access these services. The document is replete with these inherently conflicting admonitions for “good doctors” to follow.

While the document comprehensively addresses the responsibility of physicians to patients, it is silent on the corresponding responsibilities of patients. The document focuses on expected physician behaviors, but a physician is limited in the care that he/she can provide based on the patient's response. For example, lines 273-277 on gathering information about patients presuppose full patient disclosure. This often is beyond the physician's control. Is the physician to be held accountable if the information on which he/she makes decisions is faulty or limited based on incomplete patient disclosure? The section on "The Patient's Perspective" often holds the physician to a more stringent and, perhaps, unrealistic standard than the rest of the document. For example, line 152 expects that physicians be "prompt for appointments" rather than "being as prompt as possible" (line 685).

The document also is relatively silent related to the movement of health care into multidisciplinary teams. For example, Chapter 1-Patient Care fails to note that care in many circumstances is best provided when the physician collaborates with other health professionals, each contributing valuable knowledge and skills.

These are only a few specific examples of the problems we have identified in the GMP-USA. The document is lengthy and encyclopedic in its scope and requires substantive revision to adequately address these concerns fully.

Evaluating "Good Medical Practice"

If the guidelines in the GMP-USA document are to be used in regulatory situations, as is stated multiple times in the introduction (for example, lines 43, 53), it would be essential to assure that each required physician behavior is linked by evidence to meaningful patient outcomes and can be assessed with validity and reliability. The AMA has been deeply involved in and supportive of the creation of performance guidelines, for example, through the Physician's Consortium for Performance Improvement. The basis of guidelines are that they are evidence-based and measurable, and an assessment of the strength of evidence for each guideline is a current best-practice in guideline development. However, most of the elements of GMP-USA are difficult to quantify and do not lend themselves to standard setting or measurement. For example, an analysis of the section on Professionalism was done by a member of our Council. About one-half of the 70 goals can now only be assessed through the physician's personal attestation. A far smaller number could be quantified in hospital or physician office records through audit, or found in the National Practitioner Data Bank or other external sources. In addition, the GMP-USA does not weight each goal in its importance to patient care or the strength of evidence for its influence of important patient outcomes.

In summary, the GMP-USA lacks the most elemental components essential as a professional standard for use in regulation. This lengthy document is, in contrast, very broad in its scope to describe idealized patient care and professional aspirations.

The GMP-USA document could be an excellent teaching tool for physicians at all levels of training. There are many areas of synergy with the American Medical Association's

Initiative to Transform Medical Education (ITME). For example, ITME has identified many gaps in physician preparation that have relevance here, including:

- Physicians are not prepared to evaluate their own practice and to use the results of the evaluation to improve the quality of care and patient safety.
- Physicians are not prepared to be team players with other physicians and health professionals.
- Physicians are selected and trained for the ability to acquire knowledge and to problem-solve, to the exclusion of the qualities of caring and the ability to see patients as individuals in need.

The AMA has begun the implementation phase of ITME, to address how the educational system can be changed to better prepare physicians in these and other areas. As many of the areas that require a change in physician education map to segments of the GMP-USA-version 0.1, it would be useful to initiate a dialogue between the two initiatives when the GMP document has been finalized.

Other groups committed to meaningful change in medical education also would likely find a revised and more focused GMP-USA document helpful to direct their own efforts at educational improvement. The GMP-USA may be most helpful in pointing out the many competing goals and conflicts physicians have to resolve in practice as they strive to meet their patient's needs. A regulatory focus for the GMP-USA would not have the general acceptance by the profession and create unrealistic expectations of patient care.

In summary, the Council on Medical Education recommends the following.

- The stated purpose of the GMP-USA should be educational enhancement, not regulation, and the language related to its use in certification, licensure, and other regulation should be removed.
- The document should become much more focused and include fewer goals that are weighted in importance to patient care.
- The goals should be revised to include the context of the actual health care environment in which both physicians and patients have to act. This should also include statements about patient responsibilities for their own care and for their roles as members of the healthcare team, thus incorporating principles of patient-centered care.
- The document should more explicitly acknowledge the conflicts between different goals in the document and the challenges faced by physicians in resolving them.
- Each goal should explicitly include the strength of the evidence related to the goal's impact on defined patient outcomes.

Thank you for the opportunity to comment.

Communication from AMA Board of Trustees

November 29, 2007

On behalf of the entire American Medical Association Board of Trustees, I want to express appreciation for your having come to our meeting to update us on the Physician Accountability for Physician Competence initiative, and, in particular, one of its products, Good Medical Practice--USA, Version 0.1. The commitment of the Federation of State Medical Boards to assuring physician competence aligns with AMA's ongoing dedication to quality care for all patients.

Having acknowledged the commonalities in our purposes, I bring to your attention that the Board of Trustees has grave concerns about the Good Medical Practice draft and how it might be used. The appearance of the Good Medical Practice document also called into question the structure and processes of the Summits. Our specific high-level concerns are the following:

- We view Good Medical Practice--USA as a listing of behaviors to which physicians should aspire, not as a regulatory document by which they will be judged. There was great concern that it might be the intention of the licensers and certifiers to use the document for the latter purpose; and that, even if unintended at this time, regulatory or liability uses would ensue. We judge it as wholly inappropriate for those purposes.
- Even as a representation of aspirations, the Board found Good Medical Practice--USA, Version 0.1, to be too detailed. We suggest that the document be reframed at a higher level, that is, as a statement of general principles. As the document is revised, we ask that there be particular scrutiny in regard to our expectations for the physician's interaction with the health care system. We believe it would be unfair for attributions concerning a physician's competence to be compromised by problems inherent in a system the physician is powerless to remediate.
- Though care has been taken to assert that participation in the Summits does not imply organizational approval of Summit products, we believe that just the listing of participants' organizational affiliations adds a certain level of assumed credence to the process and products. Given that this may be unavoidable, we believe it argues for clear and transparent Summit governance processes and sign-off procedures and urge that these be put in place. We believe that the Federation of State Medical Boards needs to clarify its current level of responsibility for the Good Medical Practice—USA document.
- Finally, we are in complete harmony with the detailed comments on Good Medical Practice--USA, Version 0.1 submitted by the AMA Council

on Medical Education and recommend those comments to your attention. They are attached.

We plan to have increased representation at Summit V in December, because we believe medical societies have much to contribute and require a clear voice in the Summit. No doubt, the above issues will be raised by AMA participants and others.

Again, we appreciate your having discussed the Summits and the Good Medical Practice--USA document with us in person and ask that you register our serious concerns.

Communication from the American Osteopathic Association Executive Director

November 20, 2007

The Good Medical Practice USA document is an excellent document. If only all physicians practiced and behaved that way! Overall, it presents a balanced approach that encompasses both allopathic and osteopathic medicine. It represents and reflects good, honest and ethical behavior.

However, page 2 in the introduction makes reference to its development based on the ACGME competencies with the support of ABMS. In footnote #4, it notes that the AOA has adapted the ACGME competencies to address our unique aspects. We wonder why we're in the footnote rather than the body as an official recognized organization in the profession of medicine. In addition, the document should state that osteopathic medicine has a 7th competency regarding the integration of osteopathic principles and practice into all aspects of our medical care and specialties.

We would appreciate it if you would make these changes as suggested.

AAMC

From: Carol Aschenbrener
Sent: Monday, October 01, 2007 9:51 AM
To: Carol A. Clothier (FSMB)
Cc: Donald Melnick
Subject: RE: Good Medical Practice--USA available for public comment

Hi Carol,

All five of our administrative boards reviewed GMP-USA at the September Executive Council meeting – and it was clear that many had actually read it! All groups praised the document for its aspirational content, with the students saying, “this is what we’ve been looking for.” There was general agreement that we want to live these principles (minor quibbling on a few) coupled with great concern that it is not possible to achieve all these expectations in the context of the current health care delivery system. Some suggested that discussion of the feasibility of meeting these expectations might help identify specific needs for change in the health care delivery system. Others suggested that there might be a companion document, something I might call “Conditions for Good Medical Practice”, that would describe the characteristics of a delivery system in which achievement of these expectations was feasible. As you might expect, there was some concern that the document would be used prematurely as a “stick” by the regulatory community, or even as a “check list” for government to rate doctors. Would you like me to prepare formal feedback from our group, or enter these comments on the website? I look forward to continued work on this important project.

Carol

ABS

From: Robert S. Rhodes
Sent: Saturday, December 01, 2007 10:12 AM
To: James N. Thompson, MD (FSMB)
Subject: Good Medical Practice - USA

Dear Jim,
Thank you for the introduction to the next PAPC Summit. I look forward to participating.

I also read the Good Medical Practice - USA and would offer the following comment in light of your remarks regard the potential Catch-22 of licensure and certification. On line 849 (p.2 26) it states that physicians have an obligation to inform, without delay, their state medical board if they have been charged or found guilty of a criminal defense. Was there any consideration about including a phrase about also informing their specialty board?

Just a thought.

See you Wednesday.

Bob

December 3, 2007

Dear Ms. Clothier:

The ABIM Foundation was pleased to have the opportunity to review the Physician Alliance for Physician Competency's *Good Medical Practice-USA*. This important document complements the Foundation's work in promoting professionalism, particularly our co-sponsorship with the ACP Foundation and European Federation of Internal Medicine of the *Physician Charter*. In addition, we commend PAPC for organizing the document around the ACGME/ABMS six competencies, and for its work in developing a national framework for portfolios and their use across education, training and practice.

The Foundation has circulated the document among the ABIM Board of Directors, the ABIM Foundation's Board of Trustees and staff for review and comment. Reviewers had many positive comments, calling it "exemplary" and "inspiring." While praising the intent of *Good Medical Practice-USA*, some voiced a general concern about how to operationalize the document. Concerns centered on its length, as well as areas in need of clarification.

Additionally, specific comments on different sections are summarized below:

The Patient's Perspective: Expectations for Physician Competence:

The document should also include a section on society's or patients' responsibility to doctors. Given that care is delivered in complex relationships and that communications and expectations are bi-directional, a section on the patients' (or other stakeholders') responsibilities to the physician would provide a balance to the existing sections.

3.3 Improvement of patient care practices:

This section states that physicians should "apply the outcome of audits, appraisals, and performance reviews to our practice." However, some "third party" companies that conduct audits may have financial interests sometimes not aligned with the patient's interest in mind and physicians' might need to be cautious in their responses to such inquiries.

5.1.3 Caring for ourselves:

One reviewer expressed concern that, the statement that physicians "do not treat ourselves, except as a 'lay person' would engage in self-treatment," is "a little extreme."

5.2.6 Conflicts of Interest:

The definition of "close personal relationship" with a patient should be defined: one physician pointed out that "physicians may develop close friendships with patients ... avoiding having patients as good friends is not an obvious virtue to me."

6.1 Awareness of and responsiveness to the healthcare system:

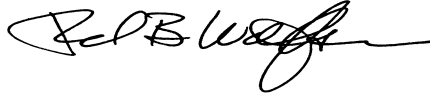
It should be clarified what level of knowledge of and responsiveness to the healthcare system is expected; it may be unrealistic to expect all physicians to have "masterful knowledge of a crazy health care system."

In closing, thank you for allowing us the opportunity to provide feedback on *Good Medical Practice-USA*. We look forward to working further with PAPC to ensure continued competency throughout the careers of physicians.

Sincerely,



Christine Cassel
President & CEO of the ABIM and ABIM Foundation



Daniel Wolfson
Executive Vice President