Chapter 1 : Medical Ethics / Professional Responsibility Medical News, State Required CME Medical News

corporate social responsibility a set of generally accepted relationships, obligations, and duties that relate to an institution's impact on the welfare of society.

Franco-German model[edit] The first model, arguably the oldest, is generally described as the Franco-German model. There is ample evidence indicating that at the turn of the 20th century, many North American hospital-based ambulances in larger centres were staffed by ambulance surgeons; physicians who responded in the ambulance and provided care in a manner which very much resembles the current Franco-German model. In the German version of the model, there are paramedics called Rettungsassistenten. Medical control is on-line , immediate, and direct. The training of the Rettungsassistent is comparable to that of many North American paramedics, but they may be limited in their scope of practice. Paramedics may practice advanced life support skills at all times when the physician with whom they work is physically present. In , there was a reform movement to expand the "standing competency", especially in the realm of pain treatment, by offering additional training to the level of "Notfallsanitaeter". As a result, in addition to conventional ambulances, most communities have physicians called Notarzt who respond directly to every life-threatening call to provide care. This system does not recognize emergency medicine as a medical specialty , in the sense that North Americans understand it. In most areas of Europe, there appears to be little interest in developing emergency medicine as a specialty , although recent developments in Italy suggest that this attitude may be changing. The physician attempts to provide some or all of the intervention that is necessary in place, with transportation to hospital occurring only for those with a legitimate need of a hospital bed, and urgent transportation to hospital being extremely rare. Many patients will never be transported to hospital. In the French version of this model, even the triage of incoming requests for service is physician-led, with a physician, assisted by others, interviewing the caller and determining what type of response resource, if any, will be sent. In this model, the medical director is typically more of a leader of physicians, and an advisor on the training of, and quality control for, subordinate staff. This model has evolved significantly since its origins in the late s. The development of this role, the professionalization of emergency medical services, the profession of paramedic, and the medical specialty of emergency medicine, have all developed in a symbiotic relationship since the early years. Prior to , there was no formal specialty training certification for emergency medicine. Prior to , there was no concerted effort to formally train physicians in its practice in the U. This has not always been the case. In the earliest days of paramedicine, paramedics were required to contact a physician for formal orders for each intervention that they performed. Control was absolute and immediate; there were examples of paramedics being trained, but not legally permitted to perform their skills, or in other cases, they could take action only with a physician or nurse present, much like the existing Franco-German model. The Canadian province of Ontario continues to have such a system, as of In the 21st century, most paramedics function based on complex written protocols or standing orders committed to memory, often numerous pages in length, and contact a physician only when standing orders have been exhausted. To begin with, the medical director is much more a leader of paramedics than of other physicians. They generally perform a leadership role among the small group of physicians tasked with providing delegation to paramedics in the field. The medical director plays a key role in the professional development of paramedics as well. In almost all cases, the medical director will have, at a minimum, input into the curriculum of paramedic training at a local level. In a great many cases, they will also teach some portions of the program, supervise clinical rotations of paramedics, and in some cases, precept their initial field practice, prior to formal certification or licensing. In almost all cases, the medical director will be charged with the creation of all protocols and standing orders, [11] and with any research that goes into their creation. Finally, medical directors will act as expert advisors to those in the EMS system administration and government administration, with respect to policies and legislation required by the EMS system, and in guiding its future direction. It is rare to see physicians in the field, unless they are precepting new paramedics or performing quality assurance activities, or are residents in emergency medicine training programs, gaining required field experience or conducting research. Medical

directors and ED physicians will occasionally go into the field for large incidents, such as multi victim accidents and disasters to assume on site medical command. Autonomous practice[edit] In some parts of the world, most notably the U. In such cases, individual paramedics may function in much the same manner as Physician assistants or Nurse Practitioners , assessing patients and making their own diagnoses , clinical judgments, and treatment decisions. In all such cases, a scope of practice is predetermined for the role, and within that scope of practice all treatment decisions are made and care rendered at the discretion of the individual paramedic. In many cases, the scope of practice will focus more heavily on primary care , although providing a more comprehensive level of care, such as suturing , or the management of long-term conditions, such as diabetes or hypertension , than is normally permitted to the paramedic. In some jurisdictions, such practitioners even have the authority to both prescribe and dispense a limited and defined set of medications. In many cases, the practice of these individuals has gone well beyond what we normally consider to be the role of traditional EMS. In this type of model, the role of the medical director includes the teaching of the practitioners, in both the classroom and the clinical setting. Most such training programs tend to feature very large components of hands-on clinical experience, generally conducted in the emergency room or similar environment, and usually in a one-to-one ratio with the physician. The medical director will have a major role in determining the permitted scope of practice, and will investigate practice-related complaints. Crossover models[edit] There are some models, most notably the Netherlands , which use a blend of a number of these models, including the Franco-German, Anglo-American, and Autonomous Practice models. In Netherlands, for example, all paramedics are in fact registered nurses with one year of additional training, usually in anesthesia but other critical care training is also acceptable, who then complete an additional year of training in ambulance care. The model looks very much Anglo-American on its surface, however, in most cases Dutch paramedics are for all practical purposes autonomous practitioners. The scope of practice and permissible procedures are determined at a national level by the Dutch Ambulance Institute, and all paramedics must function within this guidance. Within the scope of practice, however, all judgment and treatment decisions fall to the paramedic, as in the Autonomous Practitioner model. Each ambulance service is required to employ a medical manager whose role is oversight and quality assurance, and who may be contacted for directions by any paramedic who has reached the limits of their scope of practice, just as in the Anglo-American model. When necessary, however, the paramedic may request a rapid response by a physician, usually by either vehicle or helicopter. In these cases, a great deal of emergency intervention will occur on the scene, with the patient transported ultimately by land ambulance, as in the Franco-German model. Scope of practice and all treatment protocols are developed by the Dutch Ambulance Institute on a national basis, and cannot be unilaterally changed at the local level by individual physicians. Scope and protocols are reviewed, revised, and announced every four years, and any physician who wishes a change to those protocols must provide sound reasons and present a successful argument before a committee of the DIA. These individuals do perform quality service functions such as chart audits and complaint investigation, but they cannot unilaterally change treatment protocols. They may provide guidance, advice and direction to paramedics by telephone or radio, or they may attend the scene in person to provide care. The Dutch system also operates a network of four helicopters staffed by physicians for rapid response to support paramedics in the field. Creator of the concept of the Golden Hour for trauma care. Eugene Nagel [31] - Founding medical director, Miami , Florida paramedic program.

Chapter 2 : Typical Responsibilities of Medical Office Managers | www.nxgvision.com

A medical biller is responsible for submitting medical claims to insurance companies and payers such as Medicare and Medicaid. It is a position that is critical for the financial cycle of all health care providers, from single-provider practices through large medical centers.

You might manage a specialized division, or an entire facility. The job outlook is optimistic for medical office managers, according to the Bureau of Labor Statistics, growing at about 22 percent at least through Operational As a medical office manager, your primary job is to make sure the practice is running smoothly. In a new practice, you most likely will develop standard procedures for a number of different activities within the practice. To help the facility run as efficiently as possible, you may address various situations such as reducing wasteful and redundant costs such as repeat paperwork. On the other hand, you also allocate funds towards necessary spending to keep the practice running. Office and medical supplies, computers and computer programs and any other supplies are normally purchased by the office manager. Sometimes, the medical office manager even handles space rental and advertising as well. Legal Medical office managers need to be aware of all the laws that govern the operation of their practices -- federal, state and municipal. Your job is to keep up with changing laws to ensure the practice you manage is operating legally. This includes such matters as confidentiality and proper storage of information for patients, health and safety regulations and equipment maintenance. Medical office managers also are responsible for making sure that all of the medical personnel on the staff are up to date on their licensure and certification so they can practice legally. Clerical As a medical office manager, a good part of your job is to keep everything organized and orderly. Depending on the size of the office, you may often have to answer the phone and schedule appointments for patients. Medical office managers, or your staff, also refer patients to other services and sometimes schedule appointments for them. Finally, you may serve as the accountant for the practice and keep financial records. Communications As the medical office manager, one of your main jobs is to act as a liaison for different parties. You may propose operational changes to the staff and the medical practitioners. You will most likely be in charge of staffing, including advertising open positions, creating job descriptions, hiring new employees and developing personnel policies. The office manager typically develops and carries out staff performance evaluations. You also may act as a liaison to solve conflicts between staff members or address patient complaints and concerns. Bureau of Labor Statistics. In , , people were employed in the U.

DOWNLOAD PDF MEDICAL RESPONSIBILITY

Chapter 3 : Responsibility of Students | Department of Medicine

Abstract. These comments seek to take issue with the contention that society has a responsibility to provide its members with any needed health care.

Ward Responsibilities On first coming to the Medicine Service, you will be assigned one to two patients already in the hospital. You are expected to work-up approximately two to three patients per week, patients per the six week inpatient portion of the clerkship. The day of admission, you should review a general medical text see Reading Resources and be prepared to answer general questions about your patient the next day at work rounds or attending rounds. Call Most services will be admitting new patients on 3 of every 4 day cycle. The timing of the admissions will be variable according to which day in the cycle the team is on. Your resident will assign to you patients on long and short call days in order to keep pace with new patient evaluations per week. Do not wait for the "perfect" patient. Every patient admitted to Morgan has a tremendous number of learning opportunities at this stage of your medical education. Only with increased patient exposure will you improve your clinical and diagnositic reasoning skills. There is no overnight call. However, if you would like to take overnight calls with the night-float team, you are permitted to do so. You can work out the schedule for this with your resident. Many mornings there are new pateints for the team to admit. Your resident will instruct you on whether you are to evalute a new patient before attending rounds, as it is difficult to gather all the necessary information in such a short period of time. Because most patients are evaluated early in the day, students usually have time to work-up the patient and write the admission note before 6: See Guidelines for Write-Ups for assistance. You will present your new patients on post-call rounds in less than five minutes. You will also present your follow-up patients on rounds and write daily progress notes on them. See Guidelines for Presentations for assistance with oral and written presentations of follow-up patients. A detailed assessment consists of a thoughtful review of the differential diagnosis or a focused aspect of the case e. A short assessment consists of a. In order to create balance between too much detailed writing and less detail, we ask for a detailed assessment on 2 out of 3 new patient write-ups. Often there is benefit to students turning in a write-up with a short assessment of each problem on the first day of admission. This information benefits the team on a busy day. Finally, do not forget to assign your notes to the appropriate VC3 problem in Star Panel as you write them, for the details of the case are salient in your mind at that time. See Guidelines for Presentations for assistance with oral presentations on work rounds. To prepare yourself for work rounds, you should pre-round on all of your patients. Pre-Rounding For each patient, you should review the chart for any notes left by consultants or cross-covering caregivers. Pre-rounding requires approximately minutes per patient. Writing Orders Writing orders is not an essential curricular goal for the clerkship. Rather, as you gain experience in evaluating and managing your medicine patients during the eight-week block, you will have opportunities to learn to write orders. The house-staff will assist you in this endeavor. Orders written by students are unofficial and cannot be carried out until the house-staff cosign them. Procedures You are encouraged throughout your third year of medical school to become proficient with basic procedures on your patients nasogastric tube, IV, ABG, Foley catheter, blood culture. You will know what procedures you have and have not mastered as you progress on the clerkships in the third year. Since members of the support staff perform most basic procedures at all of the hospitals, you must be assertive and ask your residents for assistance to perform procedures you have not mastered. Residents may allow and assist you in more advanced procedures lumbar puncture, paracentesis, thoracentesis , if the intern has mastered the technique. Prioritizing Your Own Patients vs. For this reason, your main priority is to get to know your patients and their problems. Spend extra time with them, establish rapport and show your keen interest in them. Read extensively about their problems. Accompany them to major procedures e. Should one of your patients die, leave your regular ward duties to participate in the autopsy. Still, there are many learning opportunities to be gained from other patients than your own. As the clerkship progresses, students generally gain experience and speed in working up new patients, leaving time for them to take on more new patients two during a call day or encounter other patients on the team. Lectures, Conferences, Preceptor Rounds You are expected to be on time

and participate in the discussions of all lectures, conferences, and rounds. For a schedule of the teaching sessions at each hospital, see Weekly Schedule. For a description of each venue, see Teaching Sessions. This is acceptable with the condition that the teachers provide the students ample time and guidance in preparing a topic.

Chapter 4 : AAMA - What is a Medical Assistant

Responsibilities of Medical Examiners are outlined in CFR Title 49, Chapter II Supart E Â§ Medical examination; certificate of physical examination.

According to the Bureau of Labor Statistics, employment for Medical Assistants is likely to increase by 31 percent from to This is because a lot of physicians are hiring more medical assistants to help them with certain administrative and clinical duties so that they can have more time to see more patients. If you are thinking of becoming a medical assistant, or are about getting your first medical assisting job, here are some tasks you will be expected to perform. Take and process specimens; prepare patients for examination; and perform point of care testing. Provide support to physicians by performing various procedures. Take vital signs and other relevant information, such as weight, height, drug allergies, current medications and recurring problem; send instructions to patients and or families from physician; take calls and provide important and relevant information. Make requisitions and complete forms as required. Responsible for managing charts to ensure information is accurate and documented correctly. The medical assistant may perform these tasks by employing the electronic medical record EMR system or by manually means. Make orders using the electronic medical record EMR system. Responsible for performing inventories, ordering, and stocking of medical items as necessary. Follow established sterilization techniques and infection control policy of the hospital in treating and handling instruments, as well as in setting up of examination room. Responsible for maintaining logging system as needed for refrigeration of medications, point of care testing, sterilization process, crash cart, or others as needed. Find out the expiration dates on all medications and medical items, and follow hospital policy in disposing them. Ensure to follow all hospital established rules regarding the use of personal protective equipment that protect healthcare providers against exposure to potentially harmful substances, including body fluids, chemical disinfectants, and radiation. Responsible for maintaining medical charts, such as Op Reports, filing, test results, home care forms. Perform scheduling of surgeries and other procedures solely, or work with Surgical Coordinator to confirm dates with patients. Produce charts, pre-admissions and consent forms as required. Perform maintenance, adjustment and confirmation of patient office schedule. Perform and confirm pre-certification for procedures as necessary. Perform other duties that may be assigned. Notice that the duties Medical Assistants are expected to perform vary with the size of the healthcare facility, location, and specialty. You may therefore not be required to perform all the tasks above. A Day in the Life of a Medical Assistant Student You may need to pass a job test to be hired for a position, improve your chances of making high scores today! The goal of this phase is to determine if the candidate has the appropriate set of skills and qualities to excel on the job. Find out the tests you will be needing to take for the position you are applying for; get lots of success proven Practice materials to prepare with now: Sure way to make high scores in job tests.

Chapter 5 : Responsibility | Definition of Responsibility by Merriam-Webster

PATIENT FINANCIAL RESPONSIBILITY STATEMENT WellStar Douglasville Medical Center Hospital Drive, Douglasville, GA Patient Name: Date of Birth: _ Patient Account No: Initial Encounter Date: _ Statement Term Date: Valid for One year from the date below, unless new insurance coverage is presented.

This article has been cited by other articles in PMC. Abstract The function of a medical director is presented along with features of efficiency and deficiencies from the perspective of healthcare system improvement. Institutional healthcare quality is closely related to the medical director efficiency and deficiency, and a critical discussion of his or her function is presented along with a focus on the institutional policies, protocols, and procedures. The relationship between the medical director and the executive director is essential in order to implement a successful healthcare program, particularly in private facilities. Issues related to professionalism, fairness, medical records, quality of care, patient satisfaction, medical teaching, and malpractice are discussed from the perspective of institutional development and improvement strategies. In summary, the medical director must be a servant to the institutional constitution and to his or her job description; when his or her function is fully implemented, he or she may represent a local health governor or master, ensuring supervision and improvement of the institutional healthcare system. Though medical responsibilities are directly related to the attending physician liability, the impact of the IHS on an individual medical practice is significant, including organization, availability of critical care units, equipment, interdisciplinary work, and quality of nursing care. These value undoubtedly have a significant impact on the quality of the IHS. Background In general, the quality of IHS is mainly affected by governmental policy and national resources; however, when national policy has minimal influence on private hospitals, local policy and resources become the main issues involved in the function or malfunction of the IHS. The executive director ExD also known as the chief executive officer, CEO and the MeD have both a major role in the implementation of local policy for an efficient IHS, and their collaboration is critical for an optimal outcome. Theoretically, the MeD is typically recruited according to his competencies and professional records. A human resources manager is naturally qualified to evaluate a candidate for a MeD position, though the final decision belongs to the administrative council or board. Among these, three are publicly and apparently active, including the MeD, the staff director, and the nursing director. Position Profile and Job Description General duties The medical field became a turbulent environment due to extreme regulatory and financial constraints; 9 accordingly, physician determination and competency are more than ever a must in order to continue to provide social health promotion. The MeD must ensure an adequate environment for the professional well-being of the working forces, notably the physicians. The MeD is responsible for developing and improving the foundation policy, protocols, and procedures given that these issues reflect the core of the institutional constitution. Theoretically, the MeD is responsible for every process that may interfere directly or indirectly with the quality of the IHS; he or she must develop cooperation between medical departments, physicians, paramedics, and other working personnel; also, the MeD must be available and capable of evaluating and managing any acute dysfunction in any medical unit and with the shortest reasonable delay. Moreover, the MeD must ensure that adequate implementation of these processes is achieved according to predefined standards. Notably, medical commissions are a valuable tool for assessing the performance of protocols and procedures, including regulations for medical care in case of emergencies, use of pharmaceutical drugs, 14 and use of medical equipment and supplies. In addition, the MeD must assess the applicability of processes regarding emergency plans supposed to be executed in case of fire, natural disasters, or massive casualties war, epidemic, etc. Continuous quality improvement In an environment where competitiveness has become a major issue, professionalism and high standards must prevail; accordingly, the MeD must develop and approve an applicable continuous quality improvement program, including a plan and a timetable to assess the efficiency of corrective measures. Accordingly, improvement procedures with measurable outcomes are created and applied. Patient care audits Performed by qualified appointees, audits must be scheduled regularly. They involve any feature that may interfere with the quality of IHS, including quality of care and patient

safety. Medical audits are required as a rule to ensure that patient care meets the expected standards and the audits reports must be analyzed. Corrective measures are then adopted before being archived. The objective of audits is to assess the quality of care and to fix any potential deficiency regarding the clinical performance. The audits must also document the availability and efficacy of physicians and para-medical personnel in case of emergencies or critical cases. Continuing education programs for physicians is essential for maintaining standards in the institution; moreover, medical students, paramedics, technicians, and registered nurses are required to pursue a continuous education program. Certifications with continuous medical education credits delivered upon completion of an education or training are mandatory to keep administrative files up-to-date for each individual involved in the IHS. The MeD must have an evolutionary behavior to pursue a continuous training, and this is a key issue for efficiency of MeD in healthcare facilities. Table 1 Summary of the different subsets of traits belonging to the MeD role [1 behavioral and Ethical; 2 Medical and Scientific; 3 Administrative and managerial].

Chapter 6 : Medical director - Wikipedia

The American Medical Association (AMA) states that medical websites have the responsibility to ensure the health care privacy of online visitors and protect patient records from being marketed and monetized into the hands of insurance companies, employers, and marketers.

The neutrality of this section is disputed. Relevant discussion may be found on the talk page. Please do not remove this message until conditions to do so are met. February Learn how and when to remove this template message There is disagreement among American physicians as to whether the non-maleficence principle excludes the practice of euthanasia. Around the world, there are different organizations that campaign to change legislation about the issue of physician-assisted death , or PAD. This argument is disputed in other parts of the world. In state courts, this crime is comparable to manslaughter. The same laws apply in the states of Mississippi and Nebraska. Informed consent Informed consent in ethics usually refers to the idea that a person must be fully informed about and understand the potential benefits and risks of their choice of treatment. A correlate to "informed consent" is the concept of informed refusal. An uninformed person is at risk of mistakenly making a choice not reflective of his or her values or wishes. It does not specifically mean the process of obtaining consent, or the specific legal requirements, which vary from place to place, for capacity to consent. Patients can elect to make their own medical decisions or can delegate decision-making authority to another party. If the patient is incapacitated, laws around the world designate different processes for obtaining informed consent, typically by having a person appointed by the patient or their next of kin make decisions for them. The value of informed consent is closely related to the values of autonomy and truth telling. Confidentiality Confidentiality is commonly applied to conversations between doctors and patients. This concept is commonly known as patient-physician privilege. Legal protections prevent physicians from revealing their discussions with patients, even under oath in court. However, numerous exceptions to the rules have been carved out over the years. For example, many states require physicians to report gunshot wounds to the police and impaired drivers to the Department of Motor Vehicles. Many states in the U. More recently, critics like Jacob Appel have argued for a more nuanced approach to the duty that acknowledges the need for flexibility in many cases. Importance of communication[edit] Many so-called "ethical conflicts" in medical ethics are traceable back to a lack of communication. Communication breakdowns between patients and their healthcare team, between family members, or between members of the medical community, can all lead to disagreements and strong feelings. These breakdowns should be remedied, and many apparently insurmountable "ethics" problems can be solved with open lines of communication. Guidelines[edit] There is much documentation of the history and necessity of the Declaration of Helsinki. The first code of conduct for research including medical ethics was the Nuremberg Code. This issue called for the creation of the Declaration. There are some stark differences between the Nuremberg Code and the Declaration of Helsinki, including the way it is written. Nuremberg was written in a very concise manner, with a simple explanation. The Declaration of Helsinki is written with a thorough explanation in mind and including many specific commentaries. Ethics committees[edit] Often, simple communication is not enough to resolve a conflict, and a hospital ethics committee must convene to decide a complex matter. These bodies are composed primarily of healthcare professionals, but may also include philosophers , lay people, and clergy â€” indeed, in many parts of the world their presence is considered mandatory in order to provide balance. With respect to the expected composition of such bodies in the USA, Europe and Australia, the following applies. The REB should include people knowledgeable in the law and standards of practice and professional conduct. Special memberships are advocated for handicapped or disabled concerns, if required by the protocol under review. The European Forum for Good Clinical Practice EFGCP suggests that REBs include two practicing physicians who share experience in biomedical research and are independent from the institution where the research is conducted; one lay person; one lawyer; and one paramedical professional, e. They recommend that a quorum include both sexes from a wide age range and reflect the cultural make-up of the local community. They suggest a chairperson be preferably someone not employed or otherwise connected with the institution. Members should

include a person with knowledge and experience in professional care, counseling or treatment of humans; a minister of religion or equivalent, e. Aboriginal elder; a layman; a laywoman; a lawyer and, in the case of a hospital-based ethics committee, a nurse. The assignment of philosophers or religious clerics will reflect the importance attached by the society to the basic values involved. Medical ethics in an online world[edit] In increasing frequency, medical researchers are researching activities in online environments such as discussion boards and bulletin boards, and there is concern that the requirements of informed consent and privacy are not applied, although some guidelines do exist. While researchers wish to quote from the original source in order to argue a point, this can have repercussions when the identity of the patient is not kept confidential. Some cultures have spiritual or magical theories about the origins and cause of disease, for example, and reconciling these beliefs with the tenets of Western medicine can be very difficult. Truth-telling[edit] Some cultures do not place a great emphasis on informing the patient of the diagnosis, especially when the diagnosis is serious. American doctors rarely used truth-telling especially in medical cases, up until the s. In vice versa, a physician might be hesitant to report an incident because of personal friendship he or she may have with his or her colleague. The delivery of diagnosis online leads patients to believe that doctors in some parts of the country are at the direct service of drug companies, finding diagnosis as convenient as what drug still has patent rights on it. The American Medical Association AMA states that medical websites have the responsibility to ensure the health care privacy of online visitors and protect patient records from being marketed and monetized into the hands of insurance companies, employers, and marketers. One such example being how political forces may control how foreign humanitarian aid can be utilized in the region it is meant to be provided in. This would be congruous in situations where political strife could lead such aid being used in favor of one group over another. Another example of how foreign humanitarian aid can be misused in its intended community includes the possibility of dissonance forming between a foreign humanitarian aid group and the community being served. In some cases, conflicts are hard to avoid, and doctors have a responsibility to avoid entering such situations. Research has shown that conflicts of interests are very common among both academic physicians [43] and physicians in practice. Other academic institutions that have banned pharmaceutical industry-sponsored gifts and food include the Johns Hopkins Medical Institutions, University of Michigan, University of Pennsylvania, and Yale University. Studies from multiple health organizations have illustrated that physician-family member relationships may cause an increase in diagnostic testing and costs. Doctors who do so must be vigilant not to create conflicts of interest or treat inappropriately. Out of the many disciplines in current medicine, there are studies that have been conducted in order to ascertain the occurrence of Doctor-Patient sexual misconduct. Results from those studies appear to indicate that certain disciplines are more likely to be offenders than others. Psychiatrists and Obstetrician-Gynecologists for example, are two disciplines noted for having a higher rate of sexual misconduct. Male physicians aged 40â€”49 and 50â€”59 years are two groups that have been found to be more likely to have been reported for sexual misconduct, while women aged 20â€”39 have been found to make up a significant portion of reported victims of sexual misconduct. Futile medical care The concept of medical futility has been an important topic in discussions of medical ethics. What should be done if there is no chance that a patient will survive but the family members insist on advanced care? Previously, some articles defined futility as the patient having less than a one percent chance of surviving. Some of these cases are examined in court. Advance directives include living wills and durable powers of attorney for health care. See also Do Not Resuscitate and cardiopulmonary resuscitation In many cases, the "expressed wishes" of the patient are documented in these directives, and this provides a framework to guide family members and health care professionals in the decision-making process when the patient is incapacitated. Undocumented expressed wishes can also help guide decisions in the absence of advance directives, as in the Quinlan case in Missouri. The key question for the decision-making surrogate is not, "What would you like to do? In some hospitals, medical futility is referred to as "non-beneficial care.

Chapter 7 : Professionalism: Ethical Topic in Medicine

Medical Assistant Duties and Responsibilities. Last updated Jan 4, You might be wondering, what is a medical assistant and what exactly does a medical assistant do?? Medical assistants (MA) job description includes performing a variety of.

Medical Assistant Duties and Responsibilities Last updated Jan 4, You might be wondering, what is a medical assistant and what exactly does a medical assistant do? Medical assistants MA job description includes performing a variety of duties. These duties vary from job to job. Their medical director assigns MA duties. A medical director is a physician under whom the medical assistants work. Each state determines what a medical assistant is allowed to do, so their tasks may vary from one state to another. Search Medical Administrative Assistant Programs Get information on Medical Administrative Assistant programs by entering your zip code and request enrollment information. Vital signs include blood pressure, pulse, breathing rate and temperature. A medical assistant obtains a medical history by asking patients questions about their medical conditions, medications and allergies. The MA records any findings into the patient charts and alerts the physician of the results. Patient care consists of helping patients with mobility, removing clothing covering afflicted parts and activities of daily living that include hygiene and toileting. A doctor will tell the MA which tests to perform on each patient. A MA follows protocols that explain in detail how each test is to be performed. Protocols are typically written by the doctor. Medical assistants are also responsible for collecting samples for laboratory testing. They draw blood when the doctor orders blood work. Medical assistants process samples. They pack and ship samples to their appropriate destination. Preparing Patients Preparing patients is another duty performed by a MA. They get the patient ready for testing, treatment and procedures that the doctor may perform. Medical assistants expose any affected areas by removing bandages or clothing. When needed, they shave any necessary body parts. MA follow their protocols, which will explain in detail how and when to prepare the patient. For example, a MA will prepare a male cardiac patient for his EKG test by shaving areas in which the electrodes are placed to assure they stick properly to the skin. They would dry any moist skin where electrodes will be applied. Once the test is complete, the MA will print the collected data, remove the leads and electrodes from the patient and help the patient re-dress if assistance is necessary. Clerical Duties Front office duties for a MA include clerical duties such as filing and answering phones and scheduling appointments. They also greet patients and obtain their personal information such as address and insurance information. A MA compiles patient charts and files them appropriately. They keep the office organized, allowing it to run more efficiently. Patient charts are constantly changing with new information being added and old information removed. A MA is responsible for assuring patient files are complete and intact before and after each visit. They place pertinent information like test results, patient history and medication list at the front ensuring the physician is aware of the available information. A medical assistant schedules patients for appointments and deletes cancellations from the calendar. Keeping an organized calendar is beneficial because it allows the staff to see how well time is managed. She has been a licensed health care provider since , with work experience as a medical assistant, certified nursing assistant and emergency medical technician. She has been writing since and has been published both on-line and in print.

Chapter 8 : Medical Responsibility Letter

The daily duties of a medical coder are tri-fold -- obtain data from charts, research codes and enter information in a computer. Patient Medical Charts Medical coders use medical charts, created by physicians, to extract patient data on a daily basis.

Jonsen, PhD with Clarence H. Edwards, PhD Write Us Because medicine is a profession and physicians are professionals, it is important to have a clear understanding of what "professionalism" means. As a physician-in-training, you will be developing a personal sense of what it means to be a professional. This topic page outlines some common features. Please see the topic page on the Physician-Patient Relationship for further discussion of the professional responsibilities of physicians. What does it mean to be a member of a profession? The words "profession" and "professional" come from the Latin word "professio," which means a public declaration with the force of a promise. Professions are groups which declare in a public way that their members promise to act in certain ways and that the group and the society may discipline those who fail to do so. The profession presents itself to society as a social benefit and society accepts the profession, expecting it to serve some important social goal. The profession usually issues a code of ethics stating the standards by which its members can be judged. The traditional professions are medicine, law, education and clergy. The marks of a profession are: Competence in a specialized body of knowledge and skill; An acknowledgment of specific duties and responsibilities toward the individuals it serves and toward society; The right to train, admit, discipline and dismiss its members for failure to sustain competence or observe the duties and responsibilities. What is the difference between a profession and a business? The line between a business and a profession is not entirely clear, since professionals may engage in business and make a living by it. However, one crucial difference distinguishes them: This means that professionals have a particularly stringent duty to assure that their decisions and actions serve the welfare of their patients or clients, even at some cost to themselves. Professions have codes of ethics which specify the obligations arising from this fiduciary duty. Ethical problems often occur when there appears to be a conflict between these obligations or between fiduciary duties and personal goals. What are the recognized obligations and values of a professional physician? Professionalism requires that the practitioner strive for excellence in the following areas, which should be modeled by mentors and teachers and become part of the attitudes, behaviors, and skills integral to patient care: A physician is obligated to attend to the best interest of patients, rather than self-interest. Physicians are accountable to their patients, to society on issues of public health, and to their profession. Physicians are obligated to make a commitment to life-long learning. A physician should be available and responsive when "on call," accepting a commitment to service within the profession and the community. Physicians should be committed to being fair, truthful and straightforward in their interactions with patients and the profession. A physician should demonstrate respect for patients and their families, other physicians and team members, medical students, residents and fellows. These values should provide guidance for promoting professional behavior and for making difficult ethical decisions. Subsequently, 90 professional associations, including most of the specialty and subspecialty groups in American medicine have endorsed the Charter. The fundamental principles of professionalism are stated as 1 the primacy of patient welfare; 2 patient autonomy; 3 social justice. Professional responsibilities that follow from these principles are commitment to competence, to honesty with patients, to confidentiality, to appropriate relationship with patients, to improving quality of care, to improving access to care, to a just distribution of finite resource, to scientific knowledge, to maintaining trust by managing conflicts of interests and to professional responsibilities. One of the principal attributes of professionalism is independent judgment about technical matters relevant to the expertise of the profession. The purpose of this independent judgment is to assure that general technical knowledge is appropriately applied to particular cases. Today, many physicians work in managed care situations that require them to abide by policies and rules regarding forms of treatment, time spent with patients, use of pharmaceuticals, etc. In principle, such restrictions should be designed to enhance and improve professional judgment, not limit it. For example, requiring consultation is ethically obligatory in doubtful clinical

situations; penalizing consultation for financial reasons would be ethically wrong. Also, requiring physicians to adhere to practice guidelines and to consult outcome studies may improve professional judgment; requiring blind adherence to those guidelines may be a barrier to the exercise of professional judgment. The presence of rules, policies and guidelines in managed care settings requires the physicians who work in these settings to make such judgments and to express their reasoned criticism of any that force the physician to violate the principles of professionalism.

Chapter 9 : Medical ethics - Wikipedia

A Physician Charter: Medical Professionalism in the New Millennium was issued jointly by the American Board of Internal Medicine, the American College of Physicians and the European Federation of Internal Medicine in