MEDICAL ETHICS LECTURE SERIES

Lecture 6

Physician's Duties to Other Physicians

Department of Psychiatry • Jordan University Hospital
Psychiatry Residency Training Program

Duration: 40 minutes

LECTURE OVERVIEW

Learning Objectives

- Describe the ethical basis for collegiality and mutual respect among physicians
- Explain physicians' obligations as teachers and supervisors within a hierarchy
- Apply the correct process for addressing an impaired or incompetent colleague
- Recognise bullying, harassment, and abuse of power within medical hierarchies
- Describe respectful, collaborative relationships with other health professionals

LET'S BEGIN WITH A SCENARIO

Case Study

CASE VIGNETTE

A second-year resident notices that a senior attending has smelled of alcohol before rounds twice this month, and has made two concerning medication errors in the past three weeks. The resident is intimidated by the attending's seniority and worried that raising the issue could damage her evaluation and career prospects.

Discussion: Does the resident's junior position change what she owes her patients and her colleague? Hold this question; we will return to it.

This is one of the hardest situations in medicine — a conflict between loyalty, hierarchy, fear, and patient safety.

NOT JUST ETIQUETTE

Collegiality as an Ethical Duty

> *"The physician must engage with other physicians, health professionals, and other personnel in a respectful and collaborative manner, without bias, harassment, or discriminatory conduct."*[1]
>
> — WMA International Code of Medical Ethics, Art. 30

Medicine is a team endeavor. How physicians treat each other — across specialties, seniority, and professions — shapes patient safety, not just workplace culture.

Six areas of duty this lecture covers:

Respect & consultation

Everyday collegial conduct and referral etiquette.

Teaching & supervision

Obligations across the hierarchy — teachers, trainees, students.

Addressing unsafe practice

When and how to act on a colleague's impairment or incompetence.

EVERYDAY COLLEGIALITY

Respect and Support Among Colleagues

Professional, constructive disagreement	Clinical disagreements are normal — express them professionally, and preferably away from the patient or team at large.
No undermining a colleague's care	Do not criticise a colleague's care in front of a patient; raise concerns directly and privately, or through proper channels.
Fair, honest peer feedback	Provide feedback to colleagues, trainees, and supervisors constructively, focused on improvement rather than blame.
Solidarity without complicity	Support colleagues facing difficulty — without covering for behaviour that puts patients at risk.

Consultation & Referral Etiquette

“The physician should respect colleagues' patient-physician relationships and not intervene unless requested by either party or needed to protect the patient from harm.”[2]

What this means when you consult, refer, or offer a second opinion:

Communicate directly with the treating physician	Share findings and recommendations with the referring or treating colleague, not just the patient.
Recommend, don't override, without cause	You may suggest alternative approaches; you should not unilaterally change another physician's plan without discussion, except to prevent harm.
Document clearly for continuity	Clear documentation supports both the patient and the colleagues who will read your notes.

TEACHERS, TRAINEES, STUDENTS

Relationships Across the Hierarchy

Duty to teach well

Senior physicians owe trainees clear instruction, honest feedback, and genuine supervision — not just delegated workload

Duty to learn actively

Trainees owe engagement, honesty about their own limits, and willingness to ask for help

Duty of graduated autonomy

Supervision should scale down as competence is demonstrated — not remain static regardless of skill

Duty of psychological safety

Hierarchy should never be used to silence legitimate patient-safety concerns raised by a trainee

A CORE DUTY IN ACADEMIC MEDICINE

Teaching & Supervision Responsibilities

Every senior physician who supervises trainees carries dual responsibility: to the patient receiving care, and to the trainee developing competence to provide it safely in the future.

Good supervision, concretely:

- Give feedback that is specific, timely, and actionable — not only at formal evaluation points
- Never let a trainee perform a procedure or make a decision beyond their demonstrated competence unsupervised
- Model ethical behaviour — trainees learn as much from what supervisors do as from what they say
- Protect trainee well-being; excessive workload without support undermines both learning and patient safety

Directly relevant to this residency programme's own supervision and milestone structure.

TEAM-BASED CARE

Relationships with Other Health Professionals

Mutual respect, not hierarchy alone

Nurses, pharmacists, social workers, and allied health professionals bring essential expertise — status differences should not silence their input.

Speak-up culture

Every team member should feel able to voice a safety concern, regardless of professional rank.

Clear role boundaries

Respect scope-of-practice distinctions while collaborating toward the same patient outcome.

Shared accountability

Patient safety is a team responsibility — not solely the treating physician's individual burden.

Addressing Impaired or Incompetent Colleagues

> *"The obligation to report incompetent or unethical conduct that may put patients at risk is recognised in both the ethical standards of the profession and in law."*[3]

This duty exists precisely because self-regulation is a professional privilege:

- The obligation applies regardless of the colleague's seniority relative to you
- The goal is dual: protecting patients now, and helping the colleague access appropriate support
- Malicious or false reporting is itself a serious ethical breach — concerns must be genuine and good-faith
- You should be able to report without fear of retaliation — institutions are obliged to protect that

[3] *AMA Code of Medical Ethics, Opinion 9.4.2, Reporting Incompetent or Unethical Behaviors by Colleagues.*

HOW TO RAISE A CONCERN

The Reporting Process

As a resident, this almost always starts with your programme director or a trusted supervisor — you should not have to navigate this alone.

1

Ensure immediate safety

a patient is in immediate danger, act o protect them first — the reporting process follows.

2

Report to clinical authority

Initial reports go to a department head, chief resident, or peer review body to assess patient impact.[3]

3

Escalate if unaddressed

If concerns continue unaddressed, escalate to a higher institutional authority.

4

Licensing board if urgent

Direct reporting to the licensing authority is appropriate where there is immediate threat to patient safety.

5

Follow up appropriately

You should be informed that action was taken, except where reporting w anonymous.

Whistleblowing: Protections & Practicalities

Legal & institutional protections

Many jurisdictions and institutions have formal protections against retaliation for good-faith reporting — know your institution's policy before you need it.

Document as you go

Keep a private, factual record of what you observed and when — dates, specifics, and your own actions.

You don't have to act alone

Raise concerns with a trusted senior colleague or your programme director first, where the situation allows time to do so.

Proportion the response

The response should match the severity — informal conversation for early concerns, formal reporting for immediate risk.

A RECOGNISED, NAMED PROBLEM

Bullying, Harassment & Abuse of Power

“The hierarchical nature of medicine and the inherent power imbalance associated with this can create a culture of bullying and harassment which, in some cases, becomes pervasive and institutionalised.”[4]

The WMA's position, and what it means for training culture:

- Bullying is “entirely unprofessional and destructive behaviour” that should not be tolerated, regardless of tradition or seniority
- Junior doctors face real barriers to speaking out — fear of career retaliation is recognised, not dismissed as oversensitivity
- Professionalism includes how colleagues treat each other, not only how they treat patients
- Witnessing bullying and staying silent is itself a professionalism concern — intervention is expected, not optional

PREVENTION BEFORE CRISIS

Supporting Colleague Well-Being

Physicians should be able to practise in an environment free from harassment, violence, and excessive, unsupported strain — well-being is a professional issue, not merely a personal one.[5]

Practical collegial support looks like:

Notice early signs	Withdrawal, irritability, declining performance can precede burnout or impairment — check in early.
Normalise seeking help	Encourage colleagues to use physician health programmes or counselling without stigma.
Offer practical coverage	Sometimes the most protective action is simply covering a shift so a struggling colleague can rest.

A PRACTICAL FRAMEWORK

When Loyalty and Patient Safety Conflict

Fear of hierarchy is a real barrier — this framework exists precisely to help you act despite it.

1

Separate fact from discomfort

Distinguish a genuine safety concern rom ordinary interpersonal friction or disagreement in style.

2

Weigh the severity and immediacy

A one-off lapse differs ethically from a pattern that repeatedly places patients at risk.

3

Choose the least disruptive effective step first

A private conversation may resolve an early concern; formal reporting is for when that is insufficient or unsafe.

4

Seek a trusted second opinion

A mentor or programme director can help confirm whether the threshold for action has been met.

5

Act — patient safety outweigh discomfort

Once the threshold is met, hesitatior due to hierarchy or fear should not del appropriate action.

RESOLUTION

Back to the Case Study

The resident's seniority does not excuse silence, and the attending's seniority does not exempt them from accountability. A repeated pattern with signs of possible impairment and real patient harm meets the threshold for action.

A reasonable path forward:

- Document the specific observations — dates, what was observed, and the medication errors — factually
- Bring the concern to the programme director or a trusted supervisor, not directly to the attending alone
- This is protected, good-faith reporting — not disloyalty, and not something to navigate alone
- The goal is dual: protecting current and future patients, and getting the attending appropriate support

KEY TAKEAWAYS

Physician's Duties to Other Physicians

- Collegiality is an ethical duty, grounded in the fact that medicine is delivered through teams, not individuals
- Teaching and supervision carry real ethical weight — both toward the patient and toward the trainee
- Reporting an impaired or incompetent colleague is a professional obligation, not an act of disloyalty
- Bullying and harassment are recognised, named ethical problems in medicine — hierarchy is not an excuse
- Seniority differences do not change what patient safety requires — from either the junior or senior party

References

1. World Medical Association. WMA International Code of Medical Ethics, Art. 30. Adopted 1949; revised 2022.

2. World Medical Association. WMA International Code of Medical Ethics, Art. 31. Adopted 1949; revised 2022.

3. American Medical Association. AMA Code of Medical Ethics, Opinion 9.4.2 — Reporting Incompetent or Unethical Behaviors by Colleagues.

4. World Medical Association. WMA Statement on Bullying and Harassment within the Profession. Adopted 2017.

5. World Medical Association. WMA Statement on Physicians' Well-Being.

6. American Medical Association. AMA Code of Medical Ethics, Physician Health and Wellness (Opinion 9.3.1).

7. World Medical Association. Medical Ethics Manual. 3rd ed., Chapter Four — Physicians and Colleagues. Ferney-Voltaire: WMA; 2015.