

Decency, Honor, Integrity, and the Law

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In its guidelines for hand care professionals, the American Society for Surgery of the Hand has set the following criteria as guidelines for the ethical hand surgeon in the 21st century: decency, honor, and integrity. This article reviews these criteria in detail, relates how they apply in practice, and describes how they interact with state and federal law in both legislative and judicial aspects. Matters pertaining to informed consent, privacy issues, patient autonomy, shared decision making, and conflict of interest are described, and recent developments in this area are examined. Are hand surgeons ready for an enforceable system of ethics to be handed down by the ASSH or by the government? (*J Hand Surg* 2011;36A:1397–1402. © 2011 Published by Elsevier Inc. on behalf of the American Society for Surgery of the Hand.)

Key words Conflict of interest, ethics, informed consent, patient autonomy, patient confidentiality, shared decision making.

THE THEORY AND practice of modern medical ethics began at the close of World War II. After the Holocaust, during the Nuremberg tribunals, it was learned that well-trained, respected physicians and medical scientists not only violated their oath and creed to “do no harm” to their patients but were actively engaged in a vast, premeditated program of human medical experimentation in the camps, causing needless pain and suffering to thousands of innocent people. This forever shattered the traditional impression of the physician as a wise, selfless, and benevolent healer as set forth by Hippocrates. Although the veritable explosion of medical technology over the past 40 years has improved the length and quality of life of our patients, it has done little to change patients’ impression of doctors as being ordinary people and not the highly moral and ethical practitioners envisioned by Hippocrates. In fact, with the advent of the Internet, the archaic concept of “doctor knows best” has been replaced by a model of shared decision making that takes into account a doctor’s knowledge and experience and the patient’s val-

ues, expectations and choices.¹ In addition, the traditional trust that patients have had in their physicians has been eroded by patients “playing doctor” via the Internet, resulting in endless “doctor shopping” in search of the perfect opinion. Rising patient expectations for care and even sharper rises in the cost of this care have created new social and fiscal forces that threaten to drive an even greater wedge between physicians and their patients. In addition, increased specialization has resulted in the increased compartmentalization of care and the lessening of doctors’ involvement with the patients’ overall well-being. How are today’s physicians to respond to these forces and yet deliver compassionate and effective care? What traits must physicians adopt? How must medical education adapt to teach these values? What role must medical societies assume to teach and enforce ethical codes?

HISTORICAL BACKGROUND

To begin to answer these questions, we need to go back to the beginning. All of us who attended medical school in the United States still remember graduation day, when we were given the Oath of Hippocrates:

I swear by Apollo the physician . . . I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug nor give advice which may cause his death. . . . But I will preserve the

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purity of my life and my art . . . keeping myself from all ill-doing. . . . All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and my practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.²

The Hippocratic Oath is still considered the basic paradigm under which all physicians practice throughout the world. However, as Pellegrino noted in 1989, "The intersections of medicine with contemporary science, technology, social organization and changed human values have revealed significant missing dimensions in the ancient ethic. . . . There is in the Hippocratic Oath little explicit reference to the responsibilities of medicine as a corporate entity with responsibility for its members and duties to the general community. The ethic of the profession as a whole is assured by the moral behavior of its individual members. There is no explicit delineation of the corporate responsibility of physicians for one another's ethical behavior. . . ."³

Although the oath stresses physician's beneficence and the health of the patient, the wishes and overall autonomy of the individual patient are not addressed at all. The oath assumes an all-knowing and paternalistic attitude on the part of the physician. In one of his earliest writings, *Decorum*, Hippocrates notes that the physician should be "... advised to perform all things calmly and adroitly, concealing most things from the patient while you are attending him."⁴ Little has changed for more than 2 millennia. The physician was thus answerable not to the patient but to the dictates of his or her conscience. After Nuremberg, this approach became obsolete. As Pellegrino notes, "... the notion of the physician as a benevolent and paternalistic figure who decides all for the patient is inconsistent with today's educated public. It is surely incongruous in a democratic society in which the rights of self-determination are being assured by law."³

Although much has been written and published in the field of medical ethics over the past 20 years, many of the academics in this field have been outside the medical profession. They have more often than not been theologians, lawyers, sociologists, philosophers, and politicians.

One consequence of the appropriation of the ethics debate by non-physicians is that it has alienated physicians and medical educators. Gillon, a physician and moral philosopher, noted that "Non-doctors were warned that their involvement in medical ethics dis-

course risked it being seen as 'pedantic irrelevance' by the medical profession."⁵ For example, how many physicians subscribe to or even read the *Journal of Medical Ethics*? For many years, there was resistance by medical schools to include the systematic study of medical ethics into their curricula, although that is beginning to change. Gillon writes, "There is something wrong with medical education if it has to go in for all this discussion and debate about medical ethics. In my day we learned about medical ethics by learning to become good doctors. We had a good moral education before entering medical school from home, church or school. Our consciences were already formed and we learned what was done and not done by following the examples of our teachers . . . with an emphasis on character development, personal integrity and obeying our conscience . . . we never studied the theories of ethics . . . we just learned what was appropriate. . . ."⁵

The current interest in medical ethics will be useful only if a partnership develops between ethicists of all stripes and the medical profession in its entirety. Ethical theory must be put into practice with intensive education and enforcement. Currently, most codes of medical ethics issued by medical societies are simply optional guidelines to encourage analysis and food for thought. There have been only recent attempts to create a coherent body of work designed to define what makes a physician an ethical and moral one. Medical societies are attempting to introduce a structured, corporate conscience that is enforceable for its members.⁶

DECENCY, HONOR, INTEGRITY, AND THE LAW

In trying to create an ethical code of conduct for hand and upper extremity surgeons, one must focus on some basic aspects of what it means to be a physician in the 21st century. For example, hand surgeons must, despite all external challenges, maintain a moral compass that guides them in their daily conduct. To this end, the American Society for Surgery of the Hand has compiled a code of conduct for the ethical practice of hand surgery. The following 2 articles pertain to the hand surgeon as an individual:

II. Decency and Integrity: The Hand Surgeon should maintain a reputation for decency, honesty, tolerance and truthfulness with patients and colleagues. The Hand Surgeon should not engage in any behavior that would undermine the public's trust in the profession. The Hand Surgeon should cooperate with any legitimate investigation of a healthcare professional alleged to be deficient in character or competence,

or to have engaged in illegal or inappropriate activity relating to the practice of medicine.

III. Honor and the Law: The Hand Surgeon must obey the law and uphold the dignity and honor of the profession. The Hand Surgeon should support the adoption of federal, state and local regulations designed to improve patient care.⁷

Decency can be divided into 3 subcategories: compassion, discernment, and trustworthiness. Honor, too, can be divided into 3 subcategories: integrity, fidelity, and conscientiousness. Compassion represents a sincere empathy with others' pain, suffering, and disability. Health care providers who show no compassion to their patients fail to provide what the patients often need the most. On the other hand, taken to an extreme, too much compassion—especially when one is in constant contact with extreme suffering—can impair impartial judgment and cause burnout. A good balance is achieved with compassionate detachment, which takes time and effort to achieve.⁸

Discernment includes the qualities of insight, astute judgment, practical wisdom, and understanding, and these qualities must be used not only in clinical decision-making but also in supporting the patient's emotional needs. Trustworthiness arises from the notion that when patients are vulnerable and are putting their faith in the doctor's ability to heal and care for them, the physician must work to earn that trust. Patients expect doctors to put their interests first, above all other considerations, including the physician's own interests. The current erosion of trust has been caused by managed care organizations that encourage physicians to limit the quality and quantity of care they provide. Patients can see and know this is happening. Loss of trust in a physician can be a primary cause of malpractice claims.

Integrity includes 2 aspects of a physician's character. The first aspect represents an integration and balance of a physician's positive character traits, emotions, feeling, and intellect. The second aspect is being faithful to an external set of moral values and prepared to defend them if necessary.⁸ At times, a physician might have to abandon integrity when there is a conflicting principle that might force the issue. For example, a military physician might be under orders to treat his patient in a certain way and divulge private information to a superior officer, despite the fact that it might violate his relationship to that patient.⁸ When doctors have such difficult moral dilemmas, they should consult outside opinions.

Fidelity means always being truthful to the patient, and if promises are made, they should be kept. Fidelity also means that if a complication occurs in the operating room due to a technical error or an error in judgment, the doctor should immediately inform the patient about what happened, the consequences of the error, and how it can be fixed. If necessary, the doctor should also apologize to the patient in a meaningful way.⁹

Conscientiousness is determining and doing what is right and exerting appropriate effort in executing the decision so that it is done appropriately. This trait can be compromised by conflicting pressures, such as when a doctor is told by a superior to perform a procedure that he or she feels is not in the patient's best interest.

The basic traits outlined in the Code of Conduct attempt to assist in the doctor-patient relationship and to bolster the patient's sense of control, autonomy, and trust. For the hand surgeon, this is best achieved in several areas:

1. Obtaining informed consent
2. Maintaining freedom from conflict of interest
3. Providing full and honest disclosure
4. Maintaining confidentiality
5. Empowering patients in decision making and care
6. Giving patients a sense that we are listening to them and treating them accordingly
7. Comprehending patients' emotional, religious, and cultural background and adjusting decision making accordingly
8. Knowing that educated patients have already looked up their conditions on the Internet and are using that as a resource rather than an impediment to care
9. Being available to patients to answer their questions, no matter how trivial they might seem, and giving them a sense that their questions are important

Managing patient care according to the Code of Conduct is not only good medicine but also helps to create a strong, therapeutic, trusting, and professional relationship with a patient. It will also decrease the incidence of lawsuits, should complications arise in the course of care.¹⁰

Respecting a patient's autonomy is acknowledging and reinforcing their right to hold views, to make choices and decisions, and to take actions based on their personal values and beliefs, free of coercion, while helping allay fears and other conditions that destroy or disrupt autonomous action.¹¹ Some physicians feel that health care is best delivered by fostering a sense of dependency on the part of the patients, giving the physician the leeway he or she needs to control the flow of care.^{9,12} This paradigm has vastly shifted in favor of

shared decision making. In this model, patients should be given 3 things:¹³

1. Access to medical information relevant to proper decision making
2. The advice of the treating physician
3. The autonomy to make decisions in accordance with their personal values and goals¹⁴

Physicians must be cognizant of the amount and quality of information that patients receive, especially when informing patients about a bad diagnosis and/or prognosis.⁹ Although it is true that there is a wide cultural variation in the percentages of patients that want to have full disclosure about these things,¹⁵ physicians should ask their patients if they wish to receive the information, in how much detail, and what should be shared with family members.¹⁶ Some patients are unable to handle too much information, or they might require other family members to assist in making a medical decision. The patient's choice should be respected and noted early on in history taking.¹⁷ We cannot dictate how much autonomy a patient should have.^{18,19}

When there is a question about a patient's competence in making a decision, unless it is a clinical emergency, specific medical and/or legal consultation should be sought to assess competence or capacity, and these have specific psychiatric and legal ramifications.²⁰ Legally, hand surgeons do not have the authority to declare patients incompetent.¹¹ When the patient is a minor or has already been deemed incompetent, power of attorney is sought to obtain the necessary authorization to proceed.

The concept of informed consent has evolved over the past 50 years. Born from a reaction to the Nuremberg trials, informed consent has moved far beyond simply the obligation of physicians or medical researchers to disclose information to avoid coercion or deception. Today, the quality of information that the patient receives is critical so that the patient becomes an active partner in his or her treatment.²¹ Patients must authorize their medical treatment in a legally binding document after being fully informed of the risks, benefits, alternatives, and possible complications of the treatment. In a landmark decision in 1972, the District of Columbia Circuit Court ruled that "... bad outcomes sometimes result even when there is no negligence in the performance of clinical duties but... the physician negligently breached his fiduciary or trust duty to act in the patient's best interests, by failing to make certain that the patient's consent to undergo risky and invasive procedure was based on proper information..."²²

Informed consent has other ramifications. Recently, the California Supreme Court ruled that when seeking an informed consent "a physician

must disclose personal interests unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment."²³ This has become particularly relevant lately as many hand and orthopedic/plastic surgeons have developed financial and professional relationships with equipment and implant manufacturers and radiological and outpatient surgery centers. One study disclosed, however, that although 93% of patients surveyed believed they benefited from information disclosed, only 12% said that the information given to them influenced their decision to consent to treatment.⁸

Physicians' fidelity to patients has recently come under attack by third-party payers. The pressure to control costs has put physicians in the uncomfortable position of choosing between their traditional role as patient advocate and their role within an institutional structure that is designed to control costs, such as a health maintenance organization.¹¹ In these circumstances, patients might not even be aware that their care is being compromised by their health maintenance organization while they are placing full trust in their physician. In one study, 39% of physicians surveyed admitted that they had exaggerated the severity of their patient's condition or altered the diagnosis so that the patient would be covered by a third-party payer for their care.²⁴ This trend is likely to continue as resources continue to shrink and the relationships between physicians and payers become more adversarial.

The issue of patient confidentiality has risen sharply with the advent of the Health Insurance Portability and Accountability Act.²⁵ In 1890, Warren and Brandeis wrote that "the legal right to privacy flows from the fundamental rights to life, liberty, and property."²⁶ Nowadays, physicians are bombarded with requests for information about patients from attorneys, insurance companies, the government, employers, workers' compensation companies, case worker nurses, physical and occupational therapists, and other physicians, as well as family and friends. All too commonly, doctors freely divulge information without proper release.²⁷ Most of the time, there is no harm done, and the matter passes without incident. Occasionally, however, the results can be devastating and have a profound effect on the patient, resulting in the loss of livelihood or breakup of a marriage.²⁸ Patients assume that doctors will discuss their medical information only appropriately and when required for their care. They do not expect their medical records to be shared casually with others.¹ With the advent of electronic health records, the problem of

patient confidentiality has become acute due to many cases of data theft.¹⁴

Finally, the issue of conflict of interest has risen to prominence in the medical field. Conflict of interest might exist when an impartial observer would judge a physician's actions or opinions as being biased by their personal agenda, which can include the following:

1. Fee splitting
2. Self referral to surgical centers, diagnostic imaging, physical therapy, or laboratories
3. Receipt of gifts
4. Paid lecturing
5. Financial interest in a device or service offered to a patient
6. Acceptance of a fee from the manufacturer of a drug or device that is offered either clinically or for research purposes²⁹
7. Loyalty to a health maintenance organization panel to the detriment of a patient's interest
8. Pharmaceutical company-funded research into the drug they are marketing³⁰

It is clear that the definition of a conflict in many of these categories remains controversial and is evolving with time. To date, these conflicts have mostly been managed with disclosure—that is, informing the patient of the conflict and presenting different options so that the patient can make an informed decision. There is growing evidence that patients feel that any financial ties to a drug company or equipment manufacturer will diminish the quality of their care.³¹ Simple disclosure might not be enough. It might be necessary to combine disclosure with a detailed discussion of the quality of medical evidence on which a treatment plan is based.³² There is evidence that this can increase physician trust.³³

It is possible for a governing body of a specialty society, the American Medical Association, or even government legislation to take a stand and decide clearly what is and what is not a conflict of interest. Recently, the pharmaceutical industry has limited gifts to physicians to no more than \$100.³⁴ In 2005, the American Academy of Orthopaedic Surgeons published its *Guide to the Ethical Practice of Orthopaedic Surgery*, which states, "The AAOS believes that it is acceptable for industry to provide financial and other support to orthopaedic surgeons if such support has significant educational value (such as medical textbooks) and has the purpose of improving patient care." The following year, the following caveat was added: "... but must be carefully scrutinized to avoid pitfalls or improper inducement whether real or perceived."³⁵

However, there is evidence to suggest that even these small gifts do influence prescribing behavior.³¹

In 2007, the Department of Justice filed criminal conspiracy complaints against 5 orthopedic device manufacturers (all of whom service the hand surgery community), charging them with using consulting arrangements and other inducements to use a specific company's orthopedic implants, notably artificial hips and knees. In addition, the physicians involved failed to disclose these relationships to the hospitals in which they used these implants and to the patients who received them. This violated the Federal Anti-Kickback Statute. The companies avoided prosecution by entering into a non-prosecution plea agreement with the government. It was agreed to tighten criteria for professional consultants, strictly regulate payments to these consultants, have full public disclosure, establish public databases to record all transactions, and have strict governmental monitoring and enforcement.³⁶ In 2009, the United States Senate introduced the Physician Payments Sunshine Act, which mandates that all gifts to physicians be reported and recorded in a public database to be implemented by September 2010.³⁷ This act has prompted several academic centers to disclose all industry relationships among their medical staff.^{38,39}

This year, Gelberman et al³⁵ published guidelines to limit ethical exposure of physicians when dealing with the device manufacturing industry. While stating that a partnership between physicians and industry is essential to advance the field of orthopedics, Gelberman et al also stated that measures must be put in place to ensure ethical transparency and remove industry influence from patient care decision making. Gelberman et al proposed the following:

1. Require written, detailed disclosure directly to patients and in public database format as part of the informed consent process
2. Limit royalties to physician inventors by setting institutional preferences for types of implants used based on price and cost effectiveness
3. Establish compensation pools to reward inventors separated from volume of sales.³⁵

Medical schools are beginning to include the rigorous study of medical ethics as part of their curriculum. Residents who are accustomed to being taught by example now require formal training in ethics. Hand surgeons, too, should include the study of bioethics in their continuing medical education study. This can be achieved through regular journal articles, meeting presentations, and board review.

The Hippocratic Oath does not fully address the complex ethical issues faced by today's physicians.

Issues such as patient autonomy, informed consent, confidentiality, and conflict of interest have arisen that must now be addressed in a formal way. In addition, patients must be treated with respect, fidelity, and integrity. There are new legal ramifications to some of these issues that must become part of medical school curriculum, residency programs, and continuing medical education classes for practicing physicians. Today's clinicians are buffeted by many forces that have a direct impact on their ability to deliver ethical quality care. We are surrounded by many moral ambiguities that shape our decisions. This is exacerbated by the fact that moral and ethical behavior in the clinical setting has, for the most part, been left to the conscience of the individual clinician. The time has come for the medical community to set practice standards both for clinical decision making and for medical ethical behavior in general. Only this will lead to best practices standards of behavior in the medical community.

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