Everyday Ethics Issues in the Outpatient Clinical Practice of Pediatric Residents

Margaret Moon, MD, MPH; Holly A. Taylor, PhD, MPH; Erin L. McDonald, MPP; Mark T. Hughes, MD, MA; Joseph A. Carrese, MD, MPH

Objective: To describe the ethics issues that pediatric residents encounter during routine care in an outpatient teaching clinic.

Design: Qualitative study including in-depth interviews with pediatric residents and direct observation of interactions between preceptors and residents in a pediatric teaching clinic.

Setting: The Johns Hopkins Harriet Lane Pediatric Primary Care Clinic, March 20 through April 11, 2006.

Participants: A convenience sample including all pediatric faculty preceptors supervising at the clinic during the 19 half-day sessions that occurred during the observation period (N=15) and the pediatric residents seeing patients during these clinic sessions (N=50).

Main Outcome Measure: Field notes of preceptor-resident discussions about patient care were made and transcribed for qualitative analysis.

Results: Qualitative analysis of the ethics content of cases presented by residents in this pediatric teaching clinic identified 5 themes for categorizing ethics challenges: (1) promoting the child’s best interests in complex and resource-poor home and social settings; (2) managing the therapeutic alliance with parents and caregivers; (3) protecting patient privacy and confidentiality; (4) balancing the dual roles of learner and health care provider; and (5) using professional authority appropriately.

Conclusions: Qualitative analysis of the ethics content of directly observed preceptor-resident case discussions yielded a set of themes describing the ethics challenges facing pediatric residents. The themes are somewhat different from the lists of residents’ ethics experiences developed using recall or survey methods and may be very different from the ideas usually included in hospital-based ethics discussions. This may have implications for improving ethics education during residency training.

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that “core residency and continuing physician education need a valid epidemiological description of ethical issues encountered in practice.”4,5

This article presents systematic observations regarding ethics experiences in an outpatient pediatric teaching clinic. The goal of this study was to identify the real-life ethical issues that pediatric residents encounter as they care for patients in an outpatient clinical setting. The outpatient setting is relevant because, although a substantial proportion of pediatric residents plan to go into primary care practice and most pediatric care occurs in the outpatient setting, there are few data available on ethics experiences in outpatient pediatric care.6,7

### METHODS

#### DESIGN

This multimethod qualitative project involved in-depth interviews with pediatric residents and direct observation of encounters between faculty and residents in The Johns Hopkins Harriet Lane Clinic, part of a large urban teaching hospital. Most patients at the clinic are members of the local community. Participants were faculty in the Division of General Pediatrics and Adolescent Medicine at The Johns Hopkins University School of Medicine and residents and fellows affiliated with the clinic. Those observed constituted a convenience sample of all faculty preceptors, residents, and fellows who were present at 19 half-day clinic sessions from March 20 through April 11, 2006.

#### DATA COLLECTION

Before the observation phase of the study, in-depth interviews were conducted with 5 pediatric residents. We noted wide variability in residents’ language about ethics, the issues addressed, and levels of sophistication in identifying and responding to ethics issues. These preliminary observations made it clear that the observers should use a broad interpretation of ethics to frame the observations and not rely on traditional ethics language to trigger observation.

The observation phase of the project involved direct observation of faculty preceptor–resident interactions in the outpatient pediatric clinic by 5 members of the study team; 76 hours of observation occurred during nineteen 4-hour clinic sessions. During each session, at least 2 preceptors and as many as 6 residents were observed. Typically, residents made an initial assessment of their patient and then returned to the preceptor room to discuss the case and plans for treatment with their faculty preceptor. The preceptor would engage the resident in a review of the facts of the case and then discuss questions, initiate a mentoring conversation, or address other contextual concerns.

Observations were documented in field notes that included the time, the participants in the interaction (preceptor and resident), content of the interaction, and observer comments. No names or other personal identifiers were collected. Observer notes were transcribed and prepared for electronic coding using NUD*IST 6 software (QSR International Inc, Cambridge, Massachusetts).

#### DATA ANALYSIS

Transcribed observer notes were independently read and coded by 2 of us (H.A.T. and E.L.M.). The preliminary coding scheme was presented to the rest of the study team for discussion and refinement. Iterations of this process led to development of a consensus coding template that was applied to all observation transcripts. Thematic categories were generated through this coding process and were discussed with the entire study team periodically as analysis progressed, resulting in a final set of consensus themes.

For the purposes of discussion and coding, we defined ethics issues as conflicts about what ought to be done that appeared to arise from competing moral obligations and that were not obviously resolvable by application of accepted professional standards or medical standards of care.

### HUMAN SUBJECTS PROTECTION

Written informed consent was obtained from each faculty preceptor at the beginning of the first session at which they were observed. Faculty preceptors explained the observation project to residents at the beginning of each clinic session. Residents were informed that participation was voluntary. Oral consent was obtained from residents who agreed to participate. The final study proposal was approved by a Johns Hopkins University School of Medicine Institutional Review Board.

#### RESULTS

#### DEMOGRAPHIC CHARACTERISTICS

During 13 days of observation, 50 residents (35 women [70%]) participated in the clinic, representing 62% of the residency program (N=81) and including 17 senior residents, 19 second-year residents, and 14 interns. Two fellows in adolescent medicine (both were women) and 15 preceptors (11 women [73%]) participated.

#### CONTENT OF OBSERVATIONS

Content analysis of the observational data indicated that ethics issues arising in routine clinical practice in this outpatient pediatric teaching clinic can be categorized as follows:

1. Promoting the child’s best interests in complex and resource-poor home and social settings;
2. Managing the therapeutic alliance with parents and caregivers;
3. Protecting patient privacy and confidentiality;
4. Balancing the dual roles of learner and health care provider;
5. Using professional authority appropriately.

Each of these themes was developed by analyzing specific clinical encounters and associated ethical challenges. The themes are not mutually exclusive, but each represents the predominant content of the related observations. In turn, each theme will be described based on our qualitative analysis of the pertinent observations. For each theme, field notes from at least 1 representative case are presented, and ethical challenges are described in terms of the ethical duties or moral values that are in conflict in the clinical scenario. The Table summarizes the 5 themes, provides specific case examples, and describes the associated ethical challenges.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Examples</th>
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<tbody>
<tr>
<td>1. Promoting the child’s best interests in complex and resource-poor home and social settings;</td>
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<td>5. Using professional authority appropriately.</td>
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Promoting the Child’s Best Interests in Complex and Resource-Poor Home and Social Settings

Residents in this pediatric teaching clinic are routinely challenged by complex medical and social demands exacerbated by poverty and limited family resources. We identified 3 types of experiences within this theme: responding to unstable home settings and homelessness, navigating complex caretaking systems, and balancing competing medical and social demands.

Home settings for patients in this clinic can be chaotic and inconsistent, often even unsafe. For some patients, homelessness is a persistent threat. Residents, most of whom have no personal experience with such instability, must tailor their care so that it is feasible and does not overburden the child’s family socially or economically. In doing so, residents are faced with the uncomfortable fact that the specific medical interests of their patient may conflict, at least superficially, with the general interests of the family. They must identify both sets of needs and prioritize care, attempting to find a balance between avoiding harm and fulfilling their obligation to the patient while supporting family stability as critical to the child’s interests. In the following case, the resident accepts that caring for this child means caring for the family, precluding any narrow focus on immediate medical goals:

“I have a difficult family for you.” Patient is a 13-year-old male with hereditary disease causing some disfigurement. He has been physically aggressive and has been expressing homicidal and suicidal ideation. Mental health crisis team scheduled to visit family that afternoon in their home. Mother is distraught in clinic room; she feels overwhelmed by behavioral problems and is also out of formula for a younger sibling. Social work is involved. Discussion turns to medical

<table>
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<tr>
<th>Theme</th>
<th>Case Example</th>
<th>Ethics Challenge as Competing Obligation</th>
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<tbody>
<tr>
<td>Promoting the child’s best interests in complex and resource-poor home and social settings</td>
<td>Plans for necessary care are modified to fit the needs of a chaotic home setting</td>
<td>Balance adverse effects of incomplete medical care and burden on family</td>
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<td>To find a child lost to follow-up, health information is shared with nonfamily members</td>
<td>Find the proper balance between privacy and safety</td>
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<td>Familial relationships and guardianship are unclear or unstable; reliance on “kinship” caregivers</td>
<td>Respect family law while advocating for the child; respect cultural norms while upholding family law</td>
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<td>Patient has acute medical needs, and family has urgent psychosocial distress(^a)</td>
<td>Recognize conflict between the needs of the child as an individual and in the context of the family; recognize that medical concerns may be secondary in the context of overall needs; balance conflicting sets of needs to promote overall health and safety</td>
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<tr>
<td>Managing the therapeutic alliance with parents and caregivers: managing parental frustration with care; managing health care provider frustration with parents; negotiating with challenging or disruptive parents</td>
<td>Adequate but suboptimal medications are prescribed for insurance reasons</td>
<td>Advocate for the child while supporting fair use of resources within the health care system</td>
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<td></td>
<td>Parents distrustful of care, angry about clinic rules and management, or impatient with limits of medicine</td>
<td>Respect impact of culture on health care values while maintaining honesty; establish appropriate limits while promoting a therapeutic alliance</td>
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<td>Parenting techniques seem inadequate or neglectful; parents do not adhere to established plan of care; parent abuses clinic services or physician resources</td>
<td>Maintain fairness while establishing appropriate limits</td>
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<td>Disruptive parent threatens to remove child with complex medical issues from care(^a)</td>
<td>Maintain therapeutic alliance for child’s welfare while establishing limits and protecting clinic setting</td>
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<td>Telephone follow-up when identity of caller is ambiguous</td>
<td>Identify practical limits of confidentiality</td>
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<td></td>
<td>Nonlegal guardians request confidential information(^a)</td>
<td>Balance privacy vs best interests of child and family</td>
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<td></td>
<td>Parents request confidential information</td>
<td>Uphold commitment to provide confidential care while promoting safety and respecting family</td>
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<tr>
<td></td>
<td>Breach of confidentiality needed to ensure that sexually transmitted disease is adequately treated(^a)</td>
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<tr>
<td>Balancing the dual roles of learner and health care provider: clinical task is at or beyond the current limits of competence; patients’ needs limit access for learning</td>
<td>Potentially difficult clinical task; resident has to choose to attempt care independently, refuse task, seek assistance, or request subspecialty referral</td>
<td>Balance obligation to learn vs obligation to provide competent care</td>
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<td>Teenaged patient requests same-sex provider for a gynecological examination(^a)</td>
<td>Respect autonomy while fulfilling duty to learn relevant skills</td>
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<td>Request for letter to get better housing(^a)</td>
<td>Advocate for child while upholding duty to be truthful; promote justice as fairness</td>
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<td></td>
<td>Request for letter to confirm parental competence(^a)</td>
<td>Advocate for parent while upholding duty to be truthful</td>
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<tr>
<td>Protecting privacy and confidentiality: sharing medical information appropriately; adolescent care issues</td>
<td>Telephone follow-up when identity of caller is ambiguous</td>
<td>Balance privacy vs best interests of child and family</td>
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<td>Using professional authority appropriately: patients or families want to use the physician’s authority to accomplish social, legal, or educational goals</td>
<td>Potentially difficult clinical task; resident has to choose to attempt care independently, refuse task, seek assistance, or request subspecialty referral</td>
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\(^a\) Field notes from the case are included in the text.
issues of hereditary disease, laboratory and radiology tests for puberty issues. Resident redirects: really the behavior issues are more important because mother is worried that she will lose her children. Preceptor agrees it will be alright to reschedule medical tests. Prioritize today. First issue is mother’s well-being, then the child’s behavior.

Managing the Therapeutic Alliance With Parents and Caregivers

A hallmark of pediatric practice is the need to include both patients and their parents or caregivers as primary participants in the therapeutic alliance. Preserving the relationship with the parents can be as challenging as it is necessary to promote the child’s well-being. We observed residents balancing several ethical duties, including the obligations to be truthful, to promote fair use of resources, to promote respect for clinic resources and staff, and to establish and maintain reasonable limits for the physician-parent relationship with the obligation to keep the parent allied with the clinic and health care provider. The stakes can be very high; failure to achieve the necessary multidimensional balance may result in the child losing his or her medical home. The case below reflects how these challenges affect not just the immediate therapeutic relationships with the parent and child but professional relationships and obligations as well.

A 15-month-old child had history of pulmonary hemorrhage (etiology unknown, but abuse was on differential). Mother has history of being “difficult” and angry, shouting at staff, missing appointments, and not adhering to care plans. Resident had avoided negative interactions with the mother so far and was focused on maintaining a useful relationship with her to keep her attached to the clinic. At the same time, he wondered a little if he should challenge her on her behavior toward clinic staff. . . . Child was doing fairly well despite nonadherence (elemental formula per gastrostomy tube and ravioli by mouth!). The social situation was difficult, housing was dangerous. Plans for the day included laboratory evaluation. Resident obtained approval for blood draw in clinic [contrary to insurance guidelines] as nonadherence was likely if mother was allowed to leave clinic first.

Protecting Patient Privacy and Confidentiality

The duty to respect confidentiality in the physician-patient relationship derives from the principle of respect for a patient’s autonomy but also reflects practical concerns about establishing a relationship within which patients feel free to tell the truth. Respecting confidentiality is a challenge when the interests of the patient and legal guardian may not be parallel, particularly in caring for adolescent patients. Residents learn to be committed to protecting the right of adolescents to confidential care for reproductive health issues but struggle to promote safety and well-being while respecting that right. Respect for confidentiality in pediatrics can also conflict with the duty to promote the child’s well-being when guardianship, parenthood, and caretaking roles are not coincident. As the following 2 cases show, the challenges of telephone follow-up and the realities of kinship care highlight the limits and challenges of confidentiality.

Case 1. A letter was sent regarding a positive chlamydia test but the patient had not returned [for treatment]. The fellow reached the patient by phone and then recounted what she referred to as a disturbing exchange. Patient confirmed having received the letter and was asked about plans to get care. Patient did not understand what chlamydia was. Fellow explained it to her and talked to her about the need for her to come in for a follow-up visit. Patient asked what she needed to be treated for. Fellow replied “chlamydia,” and patient asked, again, what that was. Patient asked if fellow would like to talk to her aunt. Fellow was not sure what to do at that point; it was not clear if the aunt was aware of the child’s sexual activity.

Case 2. Mother of child is not the legal guardian, but calls to request a note from the child’s doctor stating that child is doing well. (Note was to be directed to an unidentified social services authority.) Grandmother is the legal guardian. Resident asked, “What are the rules? Can I send such a note to her?”

Balancing Dual Roles of Learner and Health Care Provider

Residents have 2 inherently conflicting roles: trainee and provider of health care. Residents must learn to identify not only the limits of their knowledge and skill but also when to provide care despite imperfect knowledge and when to request help from more expert peers or faculty. Patients and families may refuse to participate in the teaching process or may request care that limits access for teaching and learning. Residents must negotiate a balance between learning and providing health care, both internally, as they recognize their limitations, and externally, as they engage patients as willing participants in their education. In the following case, the resident works to balance his need to develop clinical expertise with the duty to ease the patient’s discomfort.

Preceptor went with resident to chaperone an external vaginal exam for a patient with a long history of behavior problems. Returning, preceptor discussed the experience. Patient was uncomfortable with something, [and] her mother encouraged her to speak up. Patient revealed that she would rather have a female doctor perform the exam. Resident supported her in that choice. Preceptor offered to do exam; asked if resident could stay in room and observe. All OK, went well. Preceptor praised the resident for handling situation gracefully and keeping the patient at ease.

Using Professional Authority Appropriately

Residents routinely receive requests from parents or guardians to intervene with outside agencies on behalf of the child or the family. Examples in our data set ranged from requests for letters to avoid eviction or obtain better housing to requests for confirmation of parental competence. Residents are faced with the competing duties of advocating effectively for the child and the family while being truthful and fair. In the following case, the resident works to balance sympathy with the parental request for more resources with the obligation to avoid using the authority of medicine in an unfair manner.

The resident brought up the point that the mother had requested that the resident write a letter stating that her children, both of whom have ADHD [attention deficit/hyperactivity disorder], need separate rooms because of their behavior. The preceptor suggested that there was probably no evidence that this was actually needed or would be helpful, but then discussed how and whether to accommodate the mother’s request in terms of maintaining a therapeutic relationship with the mother. The resident speculated about whether this was the mother’s way of trying to get a larger apartment. Later, the resident returned with a draft of a letter. The preceptor felt that the letter did a very nice job of “walking the line” between maintaining a relationship with the mother by writing the letter but avoiding being misleading or dishonest about the medical facts and what was called for as a result of those facts.
This observation project yielded a set of themes describing ethics experiences in an urban outpatient pediatric teaching clinic. The use of direct observation to generate a description of the ethics issues encountered by trainees is novel. Previous studies of medical trainees have generated typologies of ethics issues based on subjects’ recall of important incidents or selection from menus of possible ethics challenges. In our preliminary interviews with pediatric residents, we learned that residents may not use standard ethics language in describing their experiences, so the use of menu-driven surveys may fail to capture actual experiences. Studies relying on recall of ethics events risk identifying only the most memorable or more conventional ethics experiences. Our goal was to observe all of the ethics content in the residents’ discussions of routine patient care in this clinic.

A number of authors have identified ethics issues encountered by physicians in training by asking them directly or reviewing the literature.11-13 Their lists have significant shared themes, including respect toward patients, limits to intervention, defensive shielding of professional colleagues, boundaries, disclosure and confidentiality, concern about telling the truth, preventing harm, and managing the limits of one’s competence. Other lists of common ethics experiences have been developed by investigators focused on practicing physicians rather than those in training. In addition to many of the issues identified by physicians in training, practicing pediatricians also identified resource allocation, demands for innovative or unproved treatments, and conflicts over judgments about the right thing to do as important ethics issues.7 These studies yield findings that support our work, particularly themes 3 and 4, protecting patient privacy and confidentiality and balancing the dual roles of learner and health care provider. It is important to note, however, that these studies differ from ours in that they do not involve actual observation of interactions that raise ethics issues but rely on subject recall or selection from lists of typical ethics issues.

Through direct observation, we were able to identify ethics issues that go beyond the “usual suspects” generated by recall and surveys of ethics experiences. This approach identified the individual trainees’ specific ethics experiences in an educational setting. In this way, we were able to capture the complexity of “everyday” ethics in a busy teaching clinic. For example, the themes of promoting the child’s welfare in complex and resource-poor home and social settings; managing the therapeutic alliance with parents and caregivers; and using professional authority appropriately, in particular, were not clearly identified in previous studies and seem to address issues that are at the heart of current pediatric primary care training and practice.

Our findings draw attention to the relationship between ethics and professionalism. Although we did not set out to observe experiences related to professionalism, the intersection between ethics and professionalism is important and inescapable. The American Board of Internal Medicine and American Academy of Pediatrics statements on professionalism reflect the basic principles of biomedical ethics.14,15 The Accreditation Council for Graduate Medical Education definition of professionalism includes “adherence to ethical principles” and cites specific examples of respect, compassion, integrity, and confidentiality.16 To this extent, the challenges of ethics and professionalism are closely related, and our findings, although focused on ethics, may have bearing on matters of professionalism.

This study has some limitations. Observations occurred at a single institution, were limited to a primary care clinic setting, and involved a predominantly low-income urban clinic population. Ethics issues may be different in other clinical settings. However, the issues reported have considerable face validity and are likely encountered in pediatric training programs similar to this program. Another limitation is that we observed only interactions between preceptors and residents and not the original interaction between resident and patient. Our results reflect only those concerns that the resident or preceptor raised during the clinical case discussions. Similar investigation in other clinical settings and research that included observation of patient interactions would be useful.

As established in the introduction to this article, to the extent that there is a gap between current and necessary education in ethics, it may best be addressed by empirical work to better identify critical educational content. The report from the Future of Pediatric Education II Project calls for an educational model that begins with needs assessment and curriculum development that speaks to competencies and takes into account the needs and capacities of programs and learners.17 Observation of interactions between trainees and preceptors in this outpatient pediatric setting identified ethics issues arising in the everyday clinical practice of pediatrics. Our findings could contribute to a new typology of ethics issues based on actual experiences that are empirically observed, which could in turn form the basis for more relevant ethics education in residency training.

Competence in ethics is part of good clinical practice. Understanding the specific content of ethics experiences can help focus educational efforts on the skills necessary to identify, analyze, and manage ethics issues arising in everyday practice. Although superficially less dramatic than the high-intensity ethics topics usually encountered in tertiary care settings and reflected in traditional bioethics scholarship and teaching, the everyday ethics issues reported in this study identify challenges to quality care for many children and families. A report from the American Academy of Pediatrics Task Force on the Family echoed the importance of an education that prepares pediatricians to face the actual challenges of the day, specifically the challenges created by increasingly complex and stressed families.18 This observational study identified the ethics issues that arise in the outpatient setting when families are complex, the medical safety nets are patchwork, the legal system is confusing, and residents have to negotiate and protect fragile therapeutic relationships. An ethics curriculum that addressed these issues would help meet the American Academy of Pediatrics goals, better serve trainees’
current educational needs, and likely better prepare trainees, especially those entering primary care, for their future roles as pediatricians.

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