a broader mandate of professional responsibility than just providing emergent care, we hope to raise the collective responsiveness to the needs of the public.

Mr Fesnak and Dr Rajput express concerns about physicians’ professional responsibility to promote fair and ethical stewardship of health care resources. Physicians may be uncomfortable with their role when they define their professional responsibilities from the narrow perspective of the physician “at the bedside” and only as an individual, direct care provider. Taking a systems view of professionalism offers a more expansive understanding of how physicians can influence and promote the fair and ethical stewardship of health care resources. Physicians can pursue a range of activities via professional organizations and advocacy efforts to fulfill their responsibility to advance fair and ethical stewardship of health care resources. We agree that this is a shared responsibility that must be carried out in collaboration with payers, policy makers, and the public. But we also reaffirm the critical role of the medical profession in this important work. As the United States continues to confront unsustainable growth of health care spending, it is imperative that physicians engage in the collective effort to ensure that limited resources are effectively deployed to optimize health and health care for all residents.

Finally, we agree with Dr Gale that key Supreme Court decisions pertaining to professionalism provide important context for understanding professionalism in the current environment. However, we interpret these rulings as largely consistent with the “systems view” of professionalism, recognizing that medical care is delivered in the context of the organizational and policy environment. We do not view these decisions as limiting physicians’ professional responsibilities as individual clinicians or as members of the profession as a whole. Further, the legacy of court decisions in this area does not obviate physicians’ collective responsibility to continue to reflect on and more clearly articulate the profession’s expectations of physicians in service of society.

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one patients (25%) had significant single-organism bacteriuria at baseline (Table). Only 1 (1.9%; 95% confidence interval, 0.86%-3.1%) developed a subsequent febrile UTI after completing induction BCG therapy. Another patient with sterile urine developed a UTI. The UTIs developed 1 week and 3 weeks, respectively, after the patients completed 6 weeks of induction BCG therapy. Both infections resolved with oral antibiotics. None of the patients was admitted for bacterial or BCG sepsis. UTI developed with equal frequency ($P = .15$) despite presence of bacteriuria, and there was no difference ($P = .97$) in the 3-month response to BCG between infected and uninfected patients (Table).

Comment. In this study, instillation of BCG into bladder cancer patients with asymptomatic bacteriuria did not result in sepsis or reduced response. The study is limited by a small number of patients treated by 1 surgeon in a single center. If the findings are replicated, screening urinalysis and culture to detect and treat bacteriuria in afebrile patients with bladder cancer may be unnecessary before starting weekly intravesical BCG therapy, as long as attention is paid to meticulous instillation technique and patients are closely monitored. Such a strategy would result in timely administration of BCG therapy and avoid overuse of antibiotics.

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CORRECTION

Clarified Text Description: In The Rational Clinical Examination article entitled “Does This Patient Have Splenomegaly?” published in the November 10, 1993, issue of JAMA (1993;270[18]:2218-2221), the description of “Percussion of Traube’s Space” has been clarified. In the middle column on page 2219, the paragraph should read as follows: “The patient is supine, with the left arm slightly abducted for access to the entire Traube space (after its description by Ludwig Traube, who ascribed its disappearance to pleural effusion, not an enlarged spleen), defined by the sixth rib superiorly, the anterior border of the spleen, and the left costal margin inferiorly (Figure 4). With the patient breathing normally, the surface of this triangle is percussed across 1 or more levels from its medial to the lateral margin, which is approximately the midaxillary line. Normal percussion yields a resonant or tympanic note. Splenomegaly is diagnosed when the percussion note is dull.”

Abbreviations: BCG, bacille Calmette-Guérin; cfu, colony-forming unit of single organism defined as significant bacteriuria; CI, confidence interval; CR, complete response to BCG at 3 mo by negative cystoscopy and biopsy findings; UTI, urinary tract infection (resolved with culture-sensitive oral antibiotic).

<table>
<thead>
<tr>
<th>Voided Urine Culture</th>
<th>Patients, No. (%)</th>
<th>CR to BCG, No. (%) [95% CI]</th>
<th>Febrile UTI, No. (%) [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>No growth</td>
<td>149 (75)</td>
<td>115 (77) [74-81]</td>
<td>1 (0.6) [0.5-1.7]</td>
</tr>
<tr>
<td>$&gt;10^4$ or $&gt;10^5$ cfu/mL</td>
<td>51 (25)</td>
<td>39 (76) [73-79]</td>
<td>1 (1.9) [0.86-3.1]</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>154 (77)</td>
<td>2 (1)</td>
</tr>
</tbody>
</table>

Abbreviations: BCG, bacille Calmette-Guérin; cfu, colony-forming unit of single organism defined as significant bacteriuria; CI, confidence interval; CR, complete response to BCG at 3 mo by negative cystoscopy and biopsy findings; UTI, urinary tract infection (resolved with culture-sensitive oral antibiotic).