Physician codes of conduct becoming a norm

Hospitals in North America and around the world are increasingly asking doctors to sign codes of conduct as a precondition of hospital privileges. Supporters of this trend say it will improve professionalism and reduce disruptive behaviour. Critics warn that it reeks of authoritarianism and is insulting to physicians.

In some jurisdictions, codes of conduct are relatively new. The Ottawa Hospital in Ontario, for instance, has only recently drafted what it calls a “physician engagement agreement,” which includes such commitments as “Engage with others, actively listen to them, communicate respectively, and consider their ideas” and “Communicate with patients and families in a clear, timely, supportive, engaged and empathetic manner.” The Alberta College of Physicians and Surgeons drafted a code of conduct in 2009.

“I think they are becoming more common,” says Dr. Janet Wright, assistant registrar of the College of Physicians and Surgeons of Alberta, citing the increased presence of such codes not only in Canada, but also in other countries, including the United States, New Zealand and Australia.

The purpose of a physician code of conduct is to clearly establish the expectations of professional behaviour for doctors and to create a consistent process for handling complaints about disruptive behaviour. It is important that the codes are implemented properly and that breaches are handled fairly, says Wright.

“There needs to be a fair process,” she adds. “The doctor should be notified and both sides of the story should be heard.”

Then again, perhaps the very notion of fairness is impossible for codes of conduct that only apply to particular individuals in a workplace. “I’m not condoning bad behaviour, but putting these rules up there that are applied solely to physicians is demeaning. I wonder if it’s more about control than about quashing bad behaviour,” says Dr. Lawrence Huntoon, a US neurologist and editor-in-chief of the Journal of American Physicians and Surgeons. “I think there is a bias regarding disruptive physicians. You rarely hear about disruptive nurses or disruptive hospital administrators.”

Huntoon wrote in a 2008 editorial that codes of conducts are insulting to doctors and that their underlying purpose is to diminish “the professional standard of physicians on staff and in so doing increases the hospital's authority and control over physicians” (JPANDS 2008;13:2–4).

They are sometimes put into effect without feedback from medical staff, he says. The language in the codes is also vague and could turn highly subjective incidents, such as potentially offensive body language or facial expressions, into grounds for dismissal.

Subjecting physicians to a long list of prohibited behaviours is akin to treating doctors like juvenile delinquents who don't know right from wrong, he says, adding that it damages the medical profession. “To actually write some of these things down, it sets the physician at such a low level. … It says, ‘We don’t trust you. We have to spell it out for you.’ It gives the impression to the public that doctors can’t be trusted.”
Similar concerns were raised in a paper challenging the merits of a code of conduct drafted by the Australian Medical Council (MJA 2009;190:104-5). The paper claims that the code, though seemingly benign, would be difficult to enforce, contribute to a “insidious, creeping authoritarianism,” and ultimately impoverish medical practice. “Codes of conduct can foster and reinforce the strength and effectiveness of professional communities and moral norms and processes,” it concludes. “However, they can also provide a vehicle for oversimplifying the moral world, stripping ethics of its context, and supporting an excessively rigid, restrictive and narrow moral regime.”

That’s not how Dr. Paul Schyve sees it. Schyve is senior vice-president of The Joint Commission, a nonprofit body that accredits and certifies US health care organizations. Roughly two years ago, it began requiring codes of conduct as a condition of hospital accreditation. The codes have to define acceptable, disruptive and inappropriate behaviours, Schyve says, adding that the purpose of such codes is to encourage a culture of safety, where people feel free to report adverse events, close calls, hazards and unsafe conditions. Intimidation in the workplace discourages such reporting.

“Specific behaviours can sour the work environment,” says Schyve. “We often use the phrase ‘disruptive behaviors,’ though that is probably not the best phrase. A better one would be ‘intimidating behaviours,’ which keep people from reporting important incidents.”

As for criticisms that hospital codes of conduct single out doctors and don’t apply to other medical staff members, that is not the case at all, according to a Joint Commission paper, Behaviors that undermine a culture of safety (www.jointcommission.org/sentinel_event_alert_issue_40_behaviors_that_undermine_a_culture_of_safety/). It notes that although most research in the area has focused on “disruptive behaviors among physicians and nurses, there is evidence that these behaviors occur among other health care professionals, such as pharmacists, therapists, and support staff, as well as among administrators.”

Therefore, the Joint Commission suggests that all hospitals employees, “both physicians and non-physician staff,” be educated on appropriate professional behaviour as defined in their codes. Furthermore, hospitals should “enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline.”

US hospitals can’t be forced to adopt codes of conduct, but without accreditation from The Joint Commission, they can’t receive payments from Medicaid or Medicare, so most do — around 80%, says Schyve. Hospitals are granted latitude in terms of the exact content of their codes, and, for the most part, there have been few complaints about them.

“There has been very little negative reaction from hospitals,” says Schyve.

Hospitals that adopt codes of conduct should also determine how they will handle cases that violate the code, says Kathryn Clarke, senior communications coordinator for the College of Surgeons of Ontario. “The second part is establishing a protocol so that if the code of conduct is breached, you know how people will be treated.”

The best way to handle incidents is to intervene early, identify the people involved and the alleged violations, and then resolve the issue before it escalates, according to the college’s guidebook for managing disruptive physician behaviour (www.cpso.on.ca/policies/positions/default.aspx?id=1730). There is nothing unusual, adds Clarke, about employers clearly defining the expectations they have for their employees.
“Codes of conduct are not unique to hospital settings,” says Clarke. “It’s a universal principal. You set expectations for people in advance, and you implement a fair process for dealing with concerns as they come up.” — Roger Collier, CMAJ