Doctors behaving badly
Physicians are getting the "zero tolerance" message

by David Frenz, MD

Published in the February 2011 issue of Today's Hospitalist

IF YOU BELIEVE SURVEY DATA, bad behavior on the part of physicians in hospitals is still rampant. As recently as 2008, Joint Commission findings indicated that 77% of inpatient physicians and nurses surveyed had witnessed physicians engaged in disruptive behavior—and that 65% had seen bad behavior on the part of nurses. Making the case that such lapses lead to errors and worse outcomes, the Joint Commission now mandates that hospitals have policies in place to police and rectify bad behavior.

David Frenz, MD, a hospitalist for HealthEast Care System in St. Paul, Minn., recently talked with Robert Moravec, MD, the medical director at HealthEast's St. Joseph's Hospital, about the kinds of bad behavior that crop up in the hospital—and the best ways to deal with that behavior.

What sorts of physician-related issues hit your desk?
Each day, I see physician-related grievances and complaints. At our hospital, I help manage patient grievances that involve a physician. These are often best addressed "MD to MD" and involve an understanding of the challenges involved in providing direct patient care.

And I sometimes get complaints from the nursing staff about physician behavior. I make sure that I acknowledge the complaint and then conduct an inquiry or discussion with the physician about what occurred. Sometimes it is a "cup of coffee" conversation, but sometimes the behavior is deemed egregious enough to be forwarded to the physician file for tracking or to the medical executive committee for action.

The Joint Commission has recently focused on disruptive behaviors. What are they?
The Joint Commission has a zero tolerance standard for behavior that is considered...
disruptive. The definition of bad behavior is broad and open to interpretation by the institution, but disruptive behavior is increasingly defined by the beholder. If it is perceived as disruptive and hostile, then we have an obligation to address it as such.

And there is growing recognition that disruptive behaviors increase adverse events and reduce quality of care. Physician care is affected by distrusting, fearful nurses. Similarly, nursing care is undone by physicians who lash out or blame staff. And patients can definitely sense when team members are sniping at each other.

**A surgeon's outburst**—perhaps replete with instrument throwing—is a classic example of disruptive behavior. What other types do you have to deal with?

We have actually seen an example of instrument-throwing in the OR! While it was not directed at anyone, the scalpel did end up across the room out of frustration on the part of the surgeon. But I have also seen physicians yelling at an entire nursing unit for something that occurred on a prior shift.

We have addressed crude and inappropriate jokes, physicians who berate and belittle hospital staff to their patients, and written chart entries that demean or degrade other caregivers. Other issues include physicians who refuse to mark their surgical sites.

I think there is now less tolerance of disruptive behavior, and patients, family and staff are calling physicians on such behavior more so than in the past. The Joint Commission standard and the fact that staff are encouraged to report incidents have increased the overall number of calls I get, but I think the outrageous, overt behavior of the past has definitely decreased.

**How do you hear of grievances and complaints?**

Probably the most common means is through our hospital's patient advocate. Many times, the complaint involves physician communication or "off the cuff" comments made to the patient or family that are inappropriate or made out of frustration. I bring these directly to the physician involved and address them with the family.

I also receive complaints via letters to our CEO or nursing leadership. But the hardest way to receive a complaint is through the Joint Commission or state department of health. Grievances are now finding their way to our accrediting organizations and can potentially trigger a site visit to ensure appropriate resolution.

**Do you ever find problems that arise from simple misunderstandings?**

That's part of the challenge. Sometimes, issues arise because of high-stress situations, and words are blurted out that may offend someone in the room. Many times, these just need to be recognized and followed perhaps with an apology.

The trick is to have a finger on the pulse of the staff and MD interactions to know what is truly disruptive and what are misunderstandings among professionals. We usually categorize behaviors that are understandable and not deemed to be disruptive as "level 1".
We have defined various levels of disruptive behavior all the way to level 4, which is deemed to be dangerous. For each level, we take corresponding actions based on the severity of the behavior.

That said, all complaints have merit. When I was the medical director of an emergency department, I taught the staff to live by the "1-10-100" rule. A complaint that may take a minute to resolve in the ED, such as apologizing for being late, will take 10 minutes to resolve after discharge with a telephone call or follow-up letter. If those 10 minutes aren't invested or fail, that same issue will take at least 100 minutes to address once it gets to me or hospital administration.

Time pressures, language barriers, poor training in customer service, family frustrations and pent-up anger may trigger a significant grievance that may not have much substance, but still needs to be fully addressed.

**How do you investigate and resolve these issues?**

For patient complaints, I conduct a review of the chart or ask a colleague to review the case. I will go directly to patients' rooms while they are still here and meet with their family. I always let the attending physician know that I have been involved.

For physicians exhibiting bad behavior, we have referred some to anger management. We've found that there are many types of courses and consultants, so you need to be specific about what's required. You also need to spell out to the physician what the consequences are for recurring behavior.

We have also issued reprimands, terminated employed physicians and reassigned physicians to another type of job, such as clinic coverage only. And I have seen physicians be able to change significantly. I often tell them that if they need to complain, then I am the one who needs to hear their issues.

The other key is to make your behavior policy very visible, reminding people of it during department and leadership development meetings. Word does get around that you have "near zero" tolerance, and nurses have told a physician yelling on the phone, "Let me put you on speaker phone so the entire staff can hear you." That always stifles the behavior.

*David Frenz, MD, is a hospitalist for HealthEast Care System in St. Paul, Minn., and is board certified in both family medicine and addiction medicine.*