Joint Commission Tackles Medical 'Road Rage'

Disruptive behaviors can cause medical errors, lead to patient dissatisfaction, and increase the cost of care.

BY MARY ELLEN SCHNEIDER
New York Bureau

They are in every hospital—physicians and other professionals who throw tantrums, throw instruments, refuse to answer pagers, roll their eyes at colleagues, and otherwise disrupt the care of patients.

Now the Joint Commission is cracking down on these problem individuals. Under new Joint Commission standards that go into effect in January 2009, hospitals and other health care organizations will be required to establish a code of conduct that defines unacceptable behavior and establishes clear consequences for misconduct.

The issue is so important to the Joint Commission that officials there decided to highlight it this summer through the release of a Sentinel Event Alert. The alert warns that disruptive behaviors ranging from verbal outbursts and physical threats to refusing to perform assigned tasks can cause medical errors, contribute to patient dissatisfaction, and increase the cost of care.

"This is the medical version of 'road rage' and sometimes it's just little passive-aggressive things and other times it's very, very flagrant," said Dr. Peter B. Angood, vice president and chief patient safety officer for the Joint Commission.

These events are not uncommon, according to the Joint Commission. About 40% of clinicians have declined to question medication orders in the past year because they wanted to avoid interacting with an intimidating prescriber, according to a 2003 survey of more than 2,000 health care professionals conducted by the Institute for Safe Medication Practices. And even when clinicians spoke up, 49% said they felt pressured into dispensing or administering the medication despite their concerns, the survey found.

Other surveys have found similar trends. A 2004 survey of more than 1,600 physician executives, conducted by the American College of Physician Executives, found that 14% of respondents observed problems with physician behavior in their own organizations on a weekly basis.

In addition to establishing a code of conduct, the Joint Commission is recommending that hospitals and other health care organizations:

- Educate their physician and nonphysician workforce on appropriate professional behavior and provide training and coaching to managers on conflict resolution.
- Enforce the code of conduct consistently among staff members regardless of seniority or clinical specialty.
- Adhere to a "zero tolerance" policy for the most egregious incidents such as assault and put in place a progressive system of discipline for lesser violations.
- Protect those who report incidents and include nonretaliation clauses into policy statements.
- Develop a system to assess the prevalence of unprofessional behaviors in the organization and implement a reporting surveillance system to detect unprofessional behavior.

Those organizations that have already successfully addressed disruptive behaviors have found it helpful to establish anonymous reporting systems, Dr. Angood said. Another essential component of a successful system is ensuring that every report will be investigated, regardless of the stature of the person involved.

"There's nothing more frustrating than for someone to be intimidated and feel that they can't report it or if they do report it, that nothing is going to happen," Dr. Angood said.

The Joint Commission alert is "important" because it raises the issue, said Dr. Gerald B. Hickson, associate dean for clinical affairs and director of the Center for Patient and Professional Advocacy at Vanderbilt University Medical Center in Nashville, Tenn.

Since 1996, Vanderbilt has been using the Patient Advocates Reporting System, which collects and analyzes patient complaints, to identify problem physicians. Over the last decade, the system has also been adopted by several large academic medical centers and community medical centers.

The information is used to try to alter physician behavior by first alerting them to the complaints. Later, if problems persist, physicians may be required to participate in wellness programs, or take classes on risk management or on improvement of communication skills. If problems continue after that, corrective action may be taken.

Overall, the Vanderbilt data suggest that about 4%-6% of the physician population engages in some form of disruptive behavior, Dr. Hickson said. Some clinicians who behave in hostile or disruptive ways may have family life problems or even personality disorders. It's important for organizations to offer support and counseling services but in many cases clinicians won't utilize these services until their problems have boiled over into a disruptive event, he said.

"We really don't play well in the sand box together," said Hedy Cohen, R.N., vice president of nursing at the Institute for Safe Medication Practices.

Any organization that is interested in safety needs to pay attention to this issue, Ms. Cohen said, because it creates a huge obstacle to communication among members of the health care team. Even passive behaviors—such as rolling eyes at a colleague or hanging up the phone on someone—make it difficult for clinicians to question orders or advocate for patients.

And this can lead to real safety issues for patients, she said. For example, during surgery a nurse may observe a physician break with sterile protocol when placing a subclavian central line. That nurse is in a position to stop the procedure but only if he or she feels comfortable to question the physician. Without a culture that allows for that action by the nurse, the patient is the one who suffers, Ms. Cohen said.

She advised hospital leadership to get started as soon as possible. It takes a lot of work to change the culture of an organization and to get at the root of why the bad behavior is occurring. "There is no easy fix," she said.

At Centra Health in Lynchburg, Va., they have been operating with a practitioner code of conduct for more than a decade and over the years the leadership has tried to enforce it while still keeping the process collegial.

Dr. Chal Nunn, chief medical officer for Centra Health, said he encourages clinicians to confront inappropriate behavior on the front lines and have an informal conversation about it. Under their policy, the starting point is a conversation with the offending clinician. If the problem persists, the complaint is made in writing and the clinician is informed of the consequences.

"The whole point is to try to help the person," Dr. Nunn said.

There are plenty of examples of policies out there. But get started now, he advised. "You just can't let it slide." ■

Link to Hospital Is Important

Medical Homes *from page 1*

Pediatrics are promoting medical homes as a means to improve patient care and outcomes, Dr. Jaffer said. However, "a lot of these organizations talking about medical homes have not linked them to the hospitalist model of care." Therefore, hospitalists need to be proactive.

The Society of Hospital Medicine (SHM) in Philadelphia "has no official policy on the medical home," chief executive officer Dr. Laurence Wellikson said, when he was asked to comment. "SHM has worked with ACP and others on developing a consensus document on transition of care, and we have long supported efforts to bolster primary care."

A link to the hospital is very important to these medical homes, Dr. Jaffer said. However, the hospitalists' role goes beyond communicating with a patient's primary physician during hospital admission. "The idea in the first place is to prevent the hospitalization, to prevent them from getting sick. You may be able to avoid these admissions."

The medical home construct also aims to reduce fragmentation of care. "The medical home is about centralizing care versus everyone working in silos. It's a coordinated care model, and the hospitalists are really vital to this and should be in a position to champion this idea," William J. DeMarco said in an interview. Mr. DeMarco is president and CEO of DeMarco & Associates Inc., a national, independent health care consulting firm in Rockford, Ill.

"Ideally, through better care coordination, medical homes could enhance communication among providers, thereby eliminating redundancy and improving quality," Ms. Boccuti said during the meeting. "They may also improve patients' understanding of their conditions and treatment, and reduce the use of high-cost settings such as hospitals and [emergency departments]."

A hospitalist can work with the primary care physician or specialist to get the patient out of the hospital earlier, Mr. DeMarco said. "Even if they can save 1-2 days of hospitalization per month, the hospitalist[s] would pay for themselves."

"Hospitalists can and should play an essential role," said Dr. David Bronson, chair, Medicine Institute at the Cleveland Clinic. "No one physician can cover 24/7/365, and teamwork amongst physicians will be essential for success of the medical home model."

The main roadblock for physicians regarding medical homes is reimbursement, Dr. Jaffer said. The Centers for Medicare and Medicaid "will have to take into account this continuous interaction we have with patients … versus the episodic, fee-for-service, procedure-based system we have now."

To date, there is no specifically defined, ideal model of reimbursement for the medical home, either for primary care, hospitalists, or specialty care, Dr. Bronson said. "The most likely model is a care coordination fee that rewards the medical home physician for ensuring appropriate coordination of care and care transitions." Mr. DeMarco agreed with this approach: "There should be a management fee in exchange for the extra time to coordinate care and document."

Health information technology, including centralized electronic medical records (EMRs), is essential to the implementation of the medical home model, which focuses on chronic disease management and preventive services, Dr. Jaffer said. "For example, when Mrs. Smith comes in with an asthma crisis, the EMR provides screening information: She may also be due for a colonoscopy and a flu shot."

A centralized record also can improve patient compliance with referrals and recommended services, Mr. DeMarco said. "The patient may say, 'I feel fine. I'm not going to go see this other doctor.' But their medical home doctor will know they did not go, and know to monitor their follow-up."

"The medical home is the best hope for transformation of and reinvestment in primary care," Dr. Bronson said. "The restructuring of our health system to one based on trusting patient-physician relationships and patient-centered comprehensive care in a medical home is exciting." ■

A transcript of the meeting is available at www.medpac.gov/transcripts/04090410medpac.final.pdf.