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

One purpose of physician codes of conduct is to encourage a culture of safety in hospitals by reducing intimidating behaviours, which discourage open reporting of adverse events, hazards and unsafe conditions.

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 Commision suggests that all hospital 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*

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Audit concludes Infoway missed program targets

There's an ongoing disconnect between Canada Health Infoway's plan for a national electronic health record (EHR) system and a model that would be useful at the physician–patient level, according to an external performance evaluation commissioned by the agency.

While largely positive, the evaluation of the federal government's $2.1-billion investment in the federal ehealth agency cautions that Infoway hasn't yet adequately addressed the needs of patients and health care providers.

Or, as a government information officer told the auditors during their study: "Infoway has still not demonstrated a real working model at the coal-face (be it the clinician, physician, clinic or other level)."

But Dan Strasbourg, Infoway's director of media relations, takes issue with that proposition. A working model has been developed, Strasbourg writes in an email. "We would strongly suggest that you visit Alberta and see the Netcare solution that is being actively used by over 20,000 clinicians. Furthermore, PEI [Prince Edward Island] has implemented their EHR solution. In addition, Mohawk College in Hamilton has developed a working model of the interoperable EHR which they demonstrate on a regular basis."

The performance evaluation also indicates that Infoway has delayed release of a revised strategy that could shift its focus toward the provision of electronic medical records at the physician–patient level.

Infoway has missed its self-established targets in all eight major program areas, and has only set adoption targets (basic accountability indicators which are used to measure electronic records usage) for about 40% of its spending in areas where such targets would be warranted, according to Bell Browne Molnar & Delicate Consulting, an Ottawa, Ontario-based management consulting firm, which conducted the evaluation.

Strasbourg, though, says the failure to reached established targets is a function of jurisdiction. "Infoway is dependent on the ability of the jurisdictions to implement the solutions. ... Although progress may have been slower than the jurisdictions originally expected on some components, at a program level the national progress is measured through the 50 per cent goal line target for Canadians having an EHR available and that was achieved in March, 2011."

While endorsing Infoway's governance and management practices, as well as its efforts to hammer out national standards for health information technologies, the auditors indicated there's a need for change. Infoway should be rethinking its plans "if pro-