Case-Based Teaching Guide

Witnessing Incompetent or Inappropriate Behavior

These materials explore the ethical issues related to witnessing a colleague's incompetent or inappropriate behavior.

Overview

Responding to other physicians whose behavior or clinical practice appears to be incompetent or unethical presents a difficult challenge. Many physicians feel some duty of loyalty to their peers. Minimally, this duty requires that they not take action that may harm a colleague's career unless there is sufficient evidence to justify that action. Yet physicians also have independent obligations to protect patients who may be receiving substandard care.

What level of evidence is required before a physician should intervene? How do you respond when a colleague denies needing help? What obligation do you have to inform that physician's patients of your concerns?

These materials explore the ethical issues that arise when a physician becomes aware of a colleague who has delivered substandard care or behaved in a way that appears to be unethical. Participants will discuss their obligations to colleagues and how that must be balanced against their duty to patients. Participants will explore two primary issues: how to decide when intervention is necessary and what strategies are available for dealing with colleagues who deliver substandard care or practice unethically.

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Case summary

A pediatric resident and a surgical resident are seeing a 4-month-old female. Both believe the child needs to have a catheterized urine specimen collected, but they have been unsuccessful at performing the procedure because the child has labial adhesions. The surgical resident grasps the labia and pulls them apart, leaving a raw, bleeding labial surface. When the pediatric resident asks her attending for advice, she is told to make no mention of the event in the chart and to say nothing to the family.

- Has the behavior of the surgical resident resulted in harm to the patient?
- Do you have an obligation to the family to notify them of this harm?
- What is your obligation to make sure the surgical resident understands the implications of his behavior?
- Does this need to be documented on the chart?
- How do you handle the situation if your attending tells you to simply “walk away”?

Alternative cases

1. A child who has clearly been mismanaged is transferred to your hospital. The parents of the child want to know what you think about the care they received from the other physician.
2. You are caring for a 10-year-old who has had a single seizure in the past and who has been placed on Prozac and several other psychotropic medications for the seizure. She has no other medical problems and presents now with deteriorating school performance.
3. You are on staff at a hospital where surgical outcomes of cardiac procedures fall significantly below those of another institution across town. You have a 2-month-old with a cardiac defect that requires surgery. Do you refer him to the cardiac team at your hospital (as expected) or risk repercussions by referring him elsewhere?
4. A colleague (attending) shows up for work with alcohol on her breath and she is slurring her words. She resists any suggestion that she is impaired.
5. A physician colleague has been behaving erratically lately and confides in you that he has AIDS. He requests that you tell no one else.

Learning objectives

After participating in this module, the learner will:

1. Recognize that one has obligations to patients when harm has been witnessed
2. Define the extent of a physician's duties to the patient and to the other parties involved when a colleague has acted incompetently or inappropriately
3. List strategies for dealing with situations in which an authority figure makes a request which may be wrong or inappropriate
4. Understand the implications of "whistle blowing" and the factors which should be considered before deciding to do so
5. Develop strategies for informing another physician about concerns you may have regarding his or her management of a patient

Suggested reading for instructor

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Frader J. Referral back to an incompetent primary care provider. In: Iserson KV, Sanders AB, Mathieu D, eds. Ethics in Emergency Medicine. Second ed. Tucson, Arizona: Galen Press, Ltd.; 1995:276-278.

Knight JR, Palacios JN, Shannon M. Prevalence of alcohol problems among pediatric residents. Arch Pediatr Adolesc Med. 2000;154(Jan):1181-1183.

Morreim H. Am I my brother's warden? Responding to the unethical or incompetent colleague. Hastings Cent Report. 1993;23:19-27.

Weiner J, Snyder L. The impaired colleague. In: Snyder L, ed. Ethical Choices: Case Studies for Medical Practice. Philadelphia: American College of Physicians; 1996:79-84.

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White BD. The questionably impaired health care professional. In: Iserson KV, Sanders AB, Mathieu D, eds. Ethics in Emergency Medicine. Second ed. Tucson, Arizona: Galen Press, Ltd.; 1995:284-292

Case discussion

You are a pediatric resident seeing a 4-month-old female who is post-op from pyloric stenosis repair. The child presents with a high fever and no obvious focus of infection. Because of her post-op status, the general surgery resident is seeing the patient along with you in the ED. Both of you believe the child needs to have a catheterized urine specimen collected, but you have been unsuccessful at performing the procedure (as have the nurses) because the child has labial adhesions.

As you both stand over the baby, the surgical resident looks at you and says, "We need the urine sample, and there is an easy way to fix this." He grasps the labia and pulls them apart, leaving a raw, bleeding labial surface. He then walks out of the room.

> **Did the surgical resident do anything wrong? Is this the proper way to manage labial adhesions in an infant?**

It is generally recommended that fused labia not be pulled apart because it is painful, and the labia are likely to fuse again. Generally, if any treatment is recommended for labial adhesions, it is the application of small amounts of estrogen cream.

> **Has any harm been done to the baby?**

The primary harm is the pain caused to the baby by pulling the labia apart, pain that will persist until the raw surfaces have healed. Most likely, no permanent damage will occur as a result of the surgical resident's actions. The labia will almost certainly re-adhere. In rare cases, scarring might occur.

Furthermore, except in emergency situations where a child's life is imminently threatened, or a delay would result in significant suffering or risk to the child, the physician cannot do something to a child without the permission of the child's parent or guardian. Touching without consent is considered a battery under the law.

In this case, the surgical resident did something that is not accepted as good medical care, caused pain to the baby, and did it without the permission of the parents (who at this point are not aware that anything unusual was done).

> **You now have a crying 4-month-old baby with raw, bleeding labial surfaces. After calming the baby, you realize there are several issues you will need to address in the next several minutes. Beyond taking care of the baby, what is your responsibility in this situation?**

Allow the group to discuss this question.

It seems reasonable that the first step is to determine whether the surgeon's action constitutes substandard care or inappropriate behavior. What factors are important in making that determination?

Good ethics requires good facts. Before confronting the surgeon, reporting his behavior, or having a discussion with the family, you have a duty to establish that the surgeon's action did in fact breach some well-established standard of care.

1. Do you know for certain who is responsible for the behavior in question?
2. Are you certain that the decisions made constitute a violation of well-accepted standards of practice?
3. Is there a genuine impropriety, and to what degree?
4. Or is this a reasonable disagreement over technical decisions and options regarding care (i.e., are there other reputable physicians who might be willing to defend both sides)? Is there substantial data to support you (i.e., to show that what was done is harmful, and what you think should have been done is beneficial)?

It might be helpful to consider five categories of medical decision-making that results in a bad outcome for the patient (Morreim):

1. Adverse events that occur independent of any control of the provider (a parent gives their child an overdose of medicine at home despite good instructions, a properly dosed prescription and appropriate instructions on the bottle).
2. Adverse events that occur despite following standard practice (like side effects from standard-of-care medication).
3. Situations where good physicians disagree about the proper course of action. In these situations, we may not manage a patient the same way as a colleague, but we must recognize that they are nonetheless practicing in an acceptable fashion.
4. Situations in which a physician exercises poor, but not horrible, judgment or skill. All physicians do this from time to time. When reviewing these cases, we might be inclined to say, "There but for the grace of God, go I." These are cases where a mistake has been made, but if there is not a pattern, the mistake does not identify a physician as incompetent.
5. Egregious violations of the accepted standard of care (and nearly all physicians would agree with that assessment).

If the medical care we have observed fits into one of the first three categories, the provider has acted reasonably, even if there is a bad outcome, and we should not consider the physician to have acted incompetently.

The last two categories represent situations in which lapses in judgment occurred and education or correction may be appropriate. This is where a proper "diagnosis" is important. Was this simply misguided? Did he simply not know better? In that case, education may be sufficient. If it was a case of simply not knowing better, is there a pattern of behavior suggesting that the provider may not be capable of practicing safely?

On the other hand, if the action represents willful disregard of standard of care, punishment or discipline may be appropriate. Judgments about competence can be difficult in medicine because in many cases there are not clear standards or consensus, and uncertainty may make reasonable decisions look "wrong" in retrospect.

With moral lapses, a similar set of questions must be asked. When assessing whether a colleague has acted unethically, one must also establish that there would be widespread agreement about that—that it is not a situation where reasonable physicians would disagree about the ethical appropriateness of the behavior.

> **Which of the five categories do you think the surgeon's actions fall into? If they constitute substandard or unethical behavior, are they of sufficient magnitude to require some intervention?**

This action clearly falls into one of the latter two categories, where a standard of care has been violated. Some would argue that this constitutes an egregious violation, but there may not be sufficient evidence (since our management of labial adhesions is based on expert opinion rather than evidence) to allow one to make this claim.

Nonetheless, this was not a simple, harmless mistake, and the surgeon did not seem to recognize his management strategy as flawed. Since the patient was harmed and the surgeon gave no indication of recognizing this as a mistake, some response is necessary. To fail to respond is to allow a colleague to continue to practice inappropriately.

A proper "diagnosis" of the behavior is necessary to formulate an appropriate response (Morreim). A couple of distinctions may be helpful. There are differences between impaired behavior, incompetent behavior and unethical behavior.

An impaired physician is one who is unable to practice medicine with reasonable skill and safety because of physical or mental illness (addiction, depression, loss of skills from illness). Treatment of illness or addiction may allow recovery of skills (Morreim). The proper response to an impaired colleague is to ensure that they get evaluation and help from a formal treatment program.

Incompetent behavior occurs when a physician provides substandard medical care out of ignorance or lack of skill that is not the result of physical or mental illness. Education and practice may allow sufficient skills to practice medicine safely. Many physicians occasionally make a mistake out of ignorance or lack of skill and can be readily corrected through education. This education can often occur on the spot or at a later time. More global incompetence occurs when a physician demonstrates a pattern of ignorant or unskillful practice (Morreim) and may not be easily correctable by simply providing education at the time.

Unethical behavior occurs when physicians knowingly and willfully violate fundamental (and well-accepted) norms of conduct toward others, especially their patients (Morreim).

What has occurred in this case would be considered incompetent behavior (the surgeon may simply not know that this is an inappropriate treatment strategy and approach), but it might also represent unethical behavior (if, for example, the surgeon knows that this is not good medical care, does it anyway, and does it without consulting the parents). It is important to note that at this point, you do not know whether this is simply ignorance or whether it constitutes unethical behavior, and you should not make assumptions about the surgeon's motives and reasons.

Your primary duty to your surgical colleague is to discern whether this was done out of ignorance and, if so, take the opportunity to educate.

Would you confront the surgical resident about this? How would you do this? (Have residents offer language they might use in having this discussion.)

It is always most appropriate to confront the individual who you feel did something wrong before bringing the issue to the attention of that person's supervisor. This should be done collegially. It is appropriate to give your colleague the benefit of the doubt. This may simply be an educational issue, and your duty in that case is to educate (not seek punishment).

You confront the surgical resident, who responds, "I fixed the problem, didn't I? I don't know why you have an issue with it. We need the urine today, not next week. I have other things to do and don't have time to talk about how you'd manage this. It's not like your way is the only way." Now what do you do? Do you go to a higher authority? His attending? Your attending?

Your first duty is to protect patients—both the current patient and future patients. Doing so requires, at a minimum, that this surgical resident be educated. Before considering going "over his head," several considerations are important:

- How sure are you that his behavior breached accepted standards of conduct or medical practice? This first step was discussed above.

- How imminent and serious is the threat from this impropriety? Was harm done to the patient and might harm be done to future patients if there is no correction? If the physician simply has some areas in which they practice unconventionally, but those practices cause no harm to patients, we should probably tolerate them. Distinguish between practices that are eccentric but harmless and practices that are harmful.
- Can the problem be solved without involving a higher authority? If the other physician is open to feedback, recognizes that he or she acted in error, and seems committed to practicing differently in the future, it may be sufficient to simply educate and not "report." In our case, the fact that harm has occurred may change that somewhat. Certainly if institutional policies require reporting this kind of event, that should be done.
- If you must report the behavior to a higher authority, it is always better (more respectful) to notify the physician of your intent to do so.

Do you have an obligation to tell the parents of this child what happened and that it did not meet the standard of care?

Yes, the parents should be informed. For one thing, their child now has raw, bleeding labial surfaces that require explanation and some instruction for how to care for them. They may think that this was standard practice, but it would be disrespectful not to inform them otherwise. That can be done in a way that does not place blame. For example, one might say, "I think it's important for you to know that I would have done this differently. I don't generally recommend that anyone pull apart labia that are fused, because it hurts and it is not necessary. The other doctor apparently felt differently, and I've expressed my concerns to him."

When you know that another physician has injured a patient that you are also caring for, whether out of negligence or not, you have a legal obligation to disclose it. To not do so can constitute fraudulent concealment.

You find your attending and tell him what has happened, along with your feeling that the surgical resident needs some kind of correction and that the parents need to be told what happened. Your attending says, "I'll talk with the surgical resident, but I don't see any need to tell the family anything. I would do your workup, and tell them there was a little bleeding from the procedure, but that it will heal." When you ask what you should write in the chart, the attending says that you should not write anything about the other physician's actions. Now what? Do you just keep quiet and move on?

Occasionally, residents will disagree with their attending. In one survey (Shreves), 89% of house staff reported one or more ethical disagreements in the preceding year with attending physicians. In contrast, only 20% of faculty surveyed could recall a situation in the previous year in which a house officer had

been troubled by an ethical disagreement with them regarding patient care. Only one-third of residents had discussed their disagreement with the attending physician.

James Dwyer talks about the ethical principle "Primum non Tacere" (Do Not Be Silent)—the obligation to speak up when something wrong has been done. The danger of this, of course, is that it may not be well-received by a superior and you could create complications for yourself. On the other hand, by not acting, you may also put yourself in legal jeopardy (fraudulent concealment). Furthermore, the ethical duty you have remains, even if speaking up would cause you difficulty. This requires the virtue of courage and discernment. While you don't have a duty to make sacrifices over trivial disagreements, if you feel the patient has been caused or might be caused substantial harm, you have a duty to advocate on behalf of that patient. You have a duty to voice your disagreement and question the rightness of the suggested course of action.

Keeping quiet may represent a failure to care. The trick is to find the most effective way to voice your concerns.

How might you "speak up" in a responsible way? Thus far, you have spoken to the individual involved and your own attending. Should you take this to a higher level?

Having unsuccessfully attempted to address this with the person involved, you should take this to a higher level. Physicians need to know who they can go to if they are not having their concerns addressed. Residents should start with their attending or supervising physician when that is appropriate, but they can also contact the chief resident, the house staff director, or an ethics consultant. Attending physicians might contact a division head, department head, ethics consultant or medical director. There is almost always more than one person to whom concerns can be addressed if your concerns do not seem to be addressed adequately.

How do you handle the chart?

The chart should not be changed. Charting should reflect what you know objectively. In this case, it should reflect that the surgical consultant pulled open the fused labia for the purpose of catheterized urine, resulting in raw labial surfaces. It might also be appropriate to convey in the chart that you disagreed with this management strategy and conveyed that to the parents. The chart is not the place to make accusations, however. The attending is free to write his or her own note, but you have an independent obligation to chart your involvement with the patient accurately and honestly.

Case 2: What do you think about the way my doctor handled this?

You are caring for a 10-year-old in the Emergency Department who was referred by the primary care physician because of deteriorating school performance. He wants a CT-scan done.

In reviewing the history, you discover that this child has a history of a single seizure that occurred three years ago. The patient was initially placed on Prozac and subsequently had two other psychotropic medications added for the seizure disorder. She remains on all three medications. She has no other medical problems or complaints.

The mother expresses some concerns about the medications her daughter is taking but says every time she asks her physician, she is told they are necessary to prevent another seizure. She asks what you think about the way he is managing her daughter. What are you going to say?

Your first duty is to the patient and her family.

- You have an obligation to provide them with appropriate and honest information about their care, including your honest recommendations about what would benefit the patient and what would not (principles of autonomy and beneficence, virtue of fidelity/honesty).
- Furthermore, the family has placed trust in you, and you have a duty to be trustworthy. If you are not honest and the family senses that you are being less than straightforward or covering something up, it undermines their ability to trust not only you, but the medical profession as a whole.

That being said, you cannot provide an honest assessment without first being certain that you have all of the facts and that your assessment about whether this constitutes a breach of good medical care is well-substantiated (and that it would fall into the category of an egregious breach of the standard of care). It is important to distinguish between incompetent care and care that may differ from your own but that still falls within the acceptable range of competent care.

Should you call the patient's physician before talking with the patient?

In most cases, it would be appropriate to call the patient's physician. You can tell the patient's parents that you would like to discuss the doctor's reasons for having the patient on these medications before answering their questions. At this point, you simply do not have enough information to know for sure whether his management has breached a standard of care.

For example, it may be that upon talking with the other physician, you discover that the purpose of the medications is not to treat a seizure disorder (as the family

believes), but that the child has serious psychiatric illness for which these medications are appropriate (and which the family neglected to tell you about). Get the facts first!

On talking with the physician, you discover that the family has understood correctly. This physician believes that he is treating a girl with a history of a single seizure appropriately. He realizes that this treatment strategy is a little unconventional, but he personally believes Prozac and other antipsychotic drugs are a neglected class of drugs for use in seizure disorders. It is clear he is not going to be persuaded otherwise.

On hanging up the phone, you now need to decide what to tell the family. Should you share your assessment of the other physician's management strategy with your patient?

This is a situation where you have good reason to believe that the other physician is practicing in a way that represents substandard care. He may also be placing his patient at risk (these are not benign drugs) in a situation in which the patient requires no treatment at all, and the management strategy may be causing the decline in school performance. This is not merely an eccentric but harmless treatment plan. It puts the patient at risk.

Without substantially more information about this physician's practice patterns, you should avoid labeling him as a "bad" physician. One might say, "I disagree with the management strategy your physician has chosen. Your daughter should not require any medication for a seizure she had three years ago, and these medications are not the kind of drugs that most physicians would use to treat seizures. I would recommend you stop the medications."

You might bear some legal liability if you know this is a potentially harmful treatment regiment and don't provide information to the family.

Do you have a duty to report the other physician to the local hospital or medical board?

You may have a duty to prevent harm to other patients by reporting your concerns to the medical staff office of the local hospital (if the physician is on staff) or the medical licensing board. One can report a concern without claiming a physician is incompetent. Nonetheless, this is a serious step that may harm another physician's career; it should be done carefully and with sufficient evidence that this represents a pattern of behavior and not simply a single episode of inappropriate medical care.

The more dangerous the therapy, the higher the duty to intervene: Distinguish between eccentric but harmless and harmful practices.

Conclusion with suggestions

Your first obligation is to the patient and to prevent harm to the patient.

Always make sure *you* are right before acting upon your belief that a colleague is impaired, or has behaved in a way that violates well-established standards of medical care or ethics.

Where the behavior can be readily corrected by educating the other provider, your duty may not require reporting to anyone else.

Patients (or families) should be notified when harm has occurred or when you are concerned that there is a significant risk of harm occurring.

When talking with families, use language like, "I would have handled this differently than your doctor did."

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