Physicians Criticizing Physicians to Patients

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BACKGROUND: Teamwork is critical to providing excellent healthcare, and effective communication is essential for teamwork. Physicians often discuss patient referrals from other physicians, including referrals from outside their primary institution. Sharing conflicting information or negative judgments of other physicians to patients may be unprofessional. Poor teamwork within healthcare systems has been associated with patient mortality and lower staff well-being.

OBJECTIVE: This analysis explored how physicians talk to patients with advanced cancer about care rendered by other physicians.

DESIGN: Standardized patients (SPs) portraying advanced lung cancer attended covertly recorded visits with consenting oncologists and family physicians.

PARTICIPANTS: Twenty community-based oncologists and 19 family physicians had encounters with SPs.

APPROACH: Physician comments about care by other physicians were extracted from transcriptions and analyzed qualitatively. These comments were categorized as Supportive or Critical. We also examined whether there were differences between physicians who provide supportive comments and those who provided critical comments.

KEY RESULTS: Fourteen of the 34 encounters (41 %) included in this analysis contained a total of 42 comments about the patient's previous care. Twelve of 42 comments (29 %) were coded as Supportive, twenty-eight (67 %) as Critical, and two (4 %) as Neutral. Supportive comments attributed positive qualities to another physician or their care. Critical comments included one specialty criticizing another and general lack of trust in physicians.

CONCLUSION: This study described comments by physicians criticizing other physicians to patients. This behavior may affect patient satisfaction and quality of care. Healthcare system policies and training should discourage this behavior.

KEY WORDS: physician communication; teams; criticism; cancer.
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BACKGROUND

Teams are now the basis for healthcare designed to deliver low cost, high quality, reliable population-based care.[1] No one physician can manage all aspects of patients' care. To improve continuity, coordination, and patient experience, team care depends on clear and effective communication between generalists and specialists, as well as other health professionals directly involved in a patient's care.[2] Poor teamwork can result in unsafe practice and poor healthcare outcomes.[3,4] Behaviors such as poor coordination, conflicting information, blaming others, and disrespect are all signs of poor teamwork, which is associated with higher patient mortality and lower staff well-being.[3–7]

While data show that only 5 % of physicians engage in disruptive behavior,[8] 95 % of physician executives report that they regularly must manage disruptive physician behavior, including conflicts between physicians.[9] The American Medical Association includes "belittling or berating statements, disrespectful language, and inappropriate comments" by physicians with other staff in its discussion of the definition of "disruptive behavior."[10] From anecdotal reports, we know that patients complain to administrators about physicians criticizing other physicians and other health professionals.[11] No systematic study has been done about this phenomenon. As part of a larger study of patient-centered care, the objective of this analysis was to explore how physicians talk about other physicians to patients with advanced lung cancer.

METHODS

Study Design

This study is a qualitative analysis of transcribed dialogues between medical oncologists and family physicians with

standardized patients (SPs) playing the role of a patient with advanced lung cancer. SPs are actors trained to portray a patient role accurately and convincingly. The present analysis was exempted by the University of Rochester research subjects review board, because we used data from a larger study conducted by a team at Purdue University, and approved by the Purdue and the Indiana University (IU) research subjects review boards.

Physician Participants

The research team at Purdue University recruited 23 practicing community medical oncologists and 23 practicing community family physicians between 2006 and 2008 as part of a study that focused on communication behaviors associated with appropriate pain management in cancer patients. Physicians were reimbursed $300 to cover visit costs, practice costs, and pre-questionnaires and post-questionnaires. They averaged 48.1 (SD=9.2) years of age. Seventy-one percent were male. There were no significant differences in the demographic variables between the medical oncologists and the family physicians.

Approach: Standardized Patient Visits

This study used unannounced SPs to provide uniform encounters with physicians, avoiding confounding factors such as the Hawthorne effect, case-mix, mutual accommodation to each others' communication styles, and self-selection of physicians by patients.[12] This method allowed a focus on the physicians' contribution to communication while holding patient presentation stable across visits. Three SPs were trained to portray a middle-aged man with advanced lung cancer who recently moved to town and presented to the study physician for a first visit, having been cared for previously by another physician but still not entirely clear about his diagnosis or prognosis. Experts in medicine and communication developed the SP role to promote clinical realism and SP reliability. (The script is available upon request.) An extensive medical record was constructed by a medical oncologist to represent standard care.[13] Role adherence ratings averaged 92 % on a scale developed from the clinical biography used to train the SPs.

Of 46 SP visits involving an SP portraying a patient with advanced cancer, 39 visits (20 with medical oncologists and 19 with family physicians) were successfully audio-recorded. When asked by questionnaire 2 weeks later, five physicians (15 %) indicated that they suspected they were seeing an SP at the time of the visit, leaving 34 undetected visits for this study. Although some studies show no differences between communication in detected and undetected visits with SPs,[14] to avoid contamination, these detected visits were not included in this study. (See Shields et al., 2009 for additional details.[15])

Analysis and Text Management

First, informed by discourse analysis,[16] we conducted a conversation analysis of the 34 transcripts using an iterative process to first generate themes, subsequently create a coding system, and finally explore coded dialogue sequences in context to further refine the coding scheme. In this process, all members of the interdisciplinary research team read a sub-sample of ten transcripts to generate categories or themes relevant to the inquiry. During this phase of immersion crystallization,[17] we noted key words and phrases and developed codes related to areas of interest in patient-physician communication. Each transcript was coded by two randomly paired team members. Coding development continued until saturation. After the final coding revision, all previously coded interviews were re-coded by a minimum of two researchers. Any differences in coding were brought to the larger group for verification or resolution.[18] We resolved any disagreements by consensus.

Next, research team members reviewed the coded dialogues in the context of the preceding and subsequent statements.[17] This review allowed the team to interpret Supportive or Critical physician statements.

For the present analysis, we examined dialogues in which physicians commented to the patient about the patient's previous cancer care by another physician as described in the medical record. In none of the dialogues did patients initiate conversation about their previous physician. We categorized these exchanges regarding other physicians as Supportive or Critical. From the analyzed dialogues, we defined Supportive statements as supportive or affirming of the previous physician, agreeing with the patient's prior care, including diagnosis and treatment, or providing additional information in a respectful way. Critical statements were critical, blaming, or dismissive of previous medical care or another physician. (See Table 1.)

Table 1. Categories and Frequencies of Physician Comments about Other Physicians

Supportive	N= 12
Positive comments about another physician	3
Agree with prior diagnosis or treatment	6
Good communication	3
Neutral	N= 2
Office scheduling	1
Electronic health records	1
Critical	N= 28
Disrespectful criticism of prior medical care	14
Criticism of prior physician's communication to patient	8
Criticism of another medical specialty	4
Criticism of physicians in general	2
(Personal attacks on other physicians	6)

All codes were entered into Atlas ti, (version 5.7.1, 1993–2011, Gmbh, Berlin Program).[19] Team members again extracted and reviewed all coded communication by the physician about previous care in context. After we completed the qualitative inquiry, we examined whether Supportive or Critical statements varied by age, gender, race, or specialty of the physician using a Chi Square test.

RESULTS

Fourteen of the 34 encounters we analyzed (41 %) contained a total of 42 comments by the participating physicians about the patient's care by a previous physician. Twelve of the 42 comments (29 %) were coded as Supportive; these supportive comments were made by eight physicians (24 % of participants). Twenty-eight of the comments (67 %) were coded as Critical; these critical comments were made by ten physicians (or 29 % of participants). Two comments (4 %) were coded as Neutral, related to office scheduling and electronic health records.

Communications coded as Supportive seemed likely to increase patient comfort and confidence in their care. Following are three examples of comments about previous physicians that were rated as Supportive:

Positive Qualities About Another Physician

Dr. 10. You had a needle biopsy on your lung. Uh, this is a good doctor, by the way.
Dr. 20. …we need to get [a specialist] to get to know you.
Pt. I think that's the reason I am here.
Dr. 20. ….that would probably be Dr. ()…she's our wonderful radiation oncologist here in town.
Pt. Okay.

Positive About Prior Diagnosis or Treatment

Dr. 18. For now I think we will just sit tight, and I think that the doctors treated you perfectly…with what they did. And hopefully you will stay in remission for quite a while until we have to worry about you.
Pt. I appreciate that.

Communications coded as Critical to the previous physician seemed likely to generate discomfort or concern for the patient about previous treatment. Following are three examples of comments by physicians about other physicians that were coded Critical:

Criticism of Another Specialty

Dr. 8. Did anybody talk to you at all about chemotherapy…?
Pt. Well, I heard them talking to each other at times.
Dr. 8. Cause the radiation doctor's not…
Pt. They said I didn't need it basically.
Dr. 8. They're not skilled in that area; their tool is the radiation machinery.

Criticism of Prior Treatment

Dr. 25. So he radiated your ribs, not your….
Pt. Yeah
Dr. 25 This guy's an idiot!

Criticism of Physicians in General

Dr. 26. *Well, you've got to have at least one [caregiver]. I mean, it's just, you need to have somebody, really, you need to have somebody who is going to look out for you. Hell, you don't want to trust the doctors. I mean, Jiminy Christmas, you know those guys, I don't know.*

Of the 28 comments about another physician coded as Critical, six were also coded as personal, ad hominem attacks on the previous physician. In this study, no examples occurred of physicians respectfully disagreeing with the previous medical care and providing this information to the patient.

After the qualitative analyses, using a X^2 test, we found no significant differences by physician specialty, gender, race, or age in Supportive or Critical comments about other physicians.

DISCUSSION

This study described critical comments by physicians to patients about other physicians' care even with a medical

record showing the SP previously received appropriate biomedical care for his illness. In calling for a "culture of respect" in healthcare settings, Leape and colleagues describe some healthcare institutions as having a hierarchical environment that tolerates or even supports disrespect of others as a measure of status.[20] They further explain: "Especially when they are overworked or stressed, doctors who are not confident about their skills may react to stress by blaming others when things go wrong or by making demeaning or hypercritical comments" (p. 849).

Whatever the cause, *The American College of Physicians Ethics Manual* states: "It is unethical for a physician to disparage the professional competence, knowledge, qualifications, or services of another physician to a patient or third party or to state or imply that a patient has been poorly managed or mistreated by a colleague, without substantial evidence…" (p. 93).[21] In this study, in which guideline-concordant care was designed as part of the patient role and well documented in the medical record, these critical comments, or bad-mouthing statements, reflect a form of unprofessional conduct that is not conducive to patient well-being. Critical remarks may result in distress for patients and families, at times leading to lawsuits against the original treating physician.[22–25]

By passing judgment on the previous physician or treatment, the critical physician may believe that he/she is being transparent with the patient in expressing an opinion. However, patients can feel caught between two professionals, a position that may be especially distressing for patients who are facing a serious, life-threatening illness and are just beginning to realize the severity of their illness.

It can be anxiety-provoking for a physician to realize that the previous provider did not convey a diagnosis of advanced cancer in a way that the patient could understand the information. In this kind of situation, a combination of patient and physician factors can be at play. In our study, the physician's realization that the patient does not understand his terminal prognosis sometimes led to expressions of blame or criticism of the previous physician, possibly conveying frustration that the previous physician did not explain this difficult diagnosis to the patient.

Among other factors, physician anxiety can drive maladaptive behavior. Bowen's theory describes a common interpersonal process called "triangulation."[26] In an attempt to defuse anxiety, a person (the current physician) expresses concerns about the source of the anxiety (the prior physician) to a third party (the patient). Talking about another physician in a negative way to a patient may defuse some anxiety for the physician, but it does not address the original disagreement and it can make the patient quite uncomfortable. De-triangulation can occur by speaking directly to the person of concern to resolve disagreement (in this case, the prior physician), rather than to the patient.

Physicians can learn to avoid triangulation if they are educated and trained in compassionate and respectful communication with patients, understanding how to avoid triangulation while building alliances with patients and other professionals. Certainly there are times in which a physician will decide that previous medical care and decision-making have been deficient. When possible, engaging in direct communication with patients' other relevant health professionals may allow for a constructive and coherent recommendation to the patient. When direct communication is not possible, consultation with another colleague may be useful.

Sometimes a physician must help a patient or family address medical care that is clearly inappropriate, and evidence-based concerns must be conveyed sensitively and respectfully. In some cases, a change of physicians is needed. But evidence is not the only driver of comments by physicians about other physicians. In the present study, in spite of prior treatment being evidence-based standard of care, almost one-third of the physicians made at least one negative comment about previous care to the patient. Hence, it is important that physicians must be aware of their own reactions and other reasons that can prompt criticism and negative communication.

Relational skills, team building, and communication training in health care settings may negate some interprofessional negativity.[27] Research on "highly-reliable organizations" emphasizes the relational aspects that contribute to their success, such as support of colleagues, interpersonal responsibility, person-centeredness, friendliness, interpersonal trust, and openness.[28–30] While these elements deserve more systematic study in healthcare organizations, positive comments about other team members may increase patient confidence and trust in their care providers and management plans. Relational coordination, which includes respect between care providers on the same team, has been associated with improved quality of care, decreased pain and length of stay, and patient function and safety.[3,31] Criticism can affect safety through multiple channels: reducing trust (when one discipline or physician criticizes another to a patient or family in the context of a mistake)[32]; communication breakdowns (especially between primary care physicians and specialists, as in our study); demoralization (cited as a result of criticism of primary care by specialists to medical students)[33–35]; creating confusion for patients and families; and reducing adherence (when a medical recommendation is criticized by another professional). Decreasing interprofessional criticism is an important step in creating a "culture of respect"[36] that results in improved physicians satisfaction as well as patient outcomes.

This research has several limitations. Results from a study of SPs portraying a patient with advanced lung cancer may not generalize to other patient and physician populations. Standardized patients control for the patient's behavior, but may not present the same stimulus to physicians that real patients do. Expert raters for the study were multidisciplinary and represented a broad spectrum of perspectives; however, expert raters may not capture the internal experience of the SPs. Future research with real

patients should address both physician comments about other physicians' and patients' self-reports of comfort and satisfaction with the encounter. A larger, quantitative study would be useful to determine how widespread this problem is.

As hospitals and physicians become more focused on patient-centered care, training physicians to be aware and monitor their own expressions of frustration will enable them to achieve this goal. Expressing one's own opinion about diagnosis and treatment and acknowledging disagreement with other physicians, if necessary for patient care, can be accomplished without castigating or insulting another provider to the patient.

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