Dealing with the Disruptive Doctor

Urgent message: When a physician is dubbed "Tom the Terror," turning a blind eye can send patients and staff heading for the exit, wreck your reputation, and spark a lawsuit. Here's what to do instead.

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Introduction

Tom P. is a competent, board-certified emergency physician. He is liked and respected by his patients. But Tom's relationships with staffers at the urgent care center where he still works used to be another matter entirely. His medical colleagues were treated with haughty disdain. With office staff, nurses, and techs, he was demanding, caustic, and dismissive. At the least provocation, he would fly off the handle. One time, he opened the supply cabinet, found his favorite pens out of stock, and threw a tantrum in the back office, excoriating the office manager in front of her shocked and appalled staff.

Some staffers complained to Phil R., the center medical director. However, like many physicians in supervisory positions, Phil was reluctant to intervene. When he finally did mention the complaints, Tom brushed them off—and Phil let him, naively hoping that Tom would come to his senses on his own.

Instead, Tom's relationships at the clinic continued to deteriorate. Staffers dubbed him "The Terror" and tried to arrange their work schedules so as not to overlap with his. After Tom exploded at a physician assistant, a group of staffers confronted Phil: unless Tom's behavior changed, they would resign en masse.

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Phil then confronted Tom. Tom dismissed the complaints. Except for a few malcontents, he insisted, his relations with the staff were fine. Now it was Phil's turn to insist that Tom needed to get help. Tom was referred for psychological evaluation and possible intervention.

When Is a Physician "Officially" Disruptive?

There is no universally accepted definition of a disruptive physician. Over a decade ago, the AMA defined a disruptive physician as a doctor whose behavior "interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care."[1,2] Note that this definition focuses on the overt behavior of the physician and the impact of this behav-

ior on patients and the health system in which the physician works. Given the simplicity, clarity, and broadness of this definition, identifying physicians who meet these criteria should be relatively easy.

Among the categories of behavior that could result in disruptiveness are overt psychosis, clinical depression, drug or alcohol abuse or addiction, personality disorders, excessive stress and burnout, and behavioral changes due to aging. Within these categories, examples of disruptive behavior include disrespectful and profane language; angry outbursts; threats; inappropriate criticism of care given by other professionals; sexual harassment; drunkenness; throwing objects (eg, scalpels, clamps, clipboards) at staffers; failure to observe patient/physician boundaries; failure to respond to calls while on duty; failure to show up punctually for work; unauthorized absences during the workday (eg, long lunches, habitually leaving early); and unkempt, disheveled, or otherwise unprofessional appearance.

By displaying inappropriate emotions and uncollaborative behavior in the workplace, disruptive physicians jeopardize the provision of quality healthcare. The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations, or JCAHO) mandates that each healthcare delivery system must "have a code of conduct that defines acceptable, disruptive, and inappropriate behavior." In addition, each system must "create and implement a process for managing disruptive and inappropriate behaviors."[3] We will consider this process in a moment.

How Common Are Unruly Doctors?

Sound, research-based data on the incidence of disruptive physicians does not exist. Based on a survey of the extant literature, Leape and Fromson conclude that 3%-5% of all physicians evince problematic disruptive behavior.[4] In another literature review, Williams arrives at a significantly higher estimate: 6%-12% of physicians are "dyscompetent"—that is, not performing at an acceptable standard for providing patient care.[5] Unfortunately, Williams' analysis does not differentiate disruptive behavior arising from psychological problems and disruptive behavior resulting from lack of necessary knowledge and skill. A relatively large-scale study of physicians, nurses, and administrators at 102 Veteran's Administration hospitals concluded that 1%-3% of physicians display serious disruptive behavior.[6]

These estimates do not suggest an epidemic, so it is easy to conclude that the problem of disruptive physicians is a tempest in a teapot. Not so. According to the Bureau of Labor Statistics, physicians and surgeons held approximately 661,400 jobs in 2008 (the latest year for which statistics are available).[7] If only 3% of those doctors are disruptive, that means 19,842 physicians in the United States are behaving like Tom—or worse.

The Ripple Effects of Disruptive Behavior

The ripple effects of their unruly behavior adversely impact a far wider circle of people than the doctors in question. More than two-thirds of the respondents in the VA hospitals study, for example, had witnessed physicians engaging in disruptive behavior and reported that such behavior led to medical errors in 71% of the cases and patient mortality in 27%.[6]

A 2011 survey of a group of hospital emergency departments found that more than half the respondents (57%) had observed disruptive behavior in physicians.[8] One-third of the respondents felt that disruptive behavior could be linked to the occurrence of adverse events, 34.5% to medical errors, 24.7% to compromises in patient safety, 35.8% to poor quality, and 12.3% to patient mortality. Disruptive behaviors "have a significant impact on team dynamics, communication efficiency, information flow, and task accountability," the authors write, "all of which can adversely impact patient care."

While studies of disruptive physicians have primarily been conducted in hospital settings, problem doctors pose significant risks to any healthcare organization—including urgent cares—in patient safety, quality of care, staff morale, and community confidence and support, not to mention the potential for lawsuits brought by patients or even members of a clinic's staff. Failure to deal promptly and effectively with an unruly doctor undermines staff confidence in the center's leadership and sends a tacit message: "No one here seems to care about how we treat patients, so why should I?" Once allowed to take root, such permissiveness can quickly permeate and undermine a clinic's culture.

Problem doctors severely reduce the job satisfaction of nursing and ancillary staff, further lowering morale and increasing staff turnover.[6] Williams and Williams found that a disruptive team member leads not only to decreased morale of other team members but also reduces their commitment to the profession and to the workplace.[9] This is something that no healthcare facility in a competitive market environment can afford.

Lawsuits Waiting to Happen

The financial risks posed by disruptive physicians are

substantial. Medical errors caused by problem doctors that have direct adverse consequences for patients open the door to malpractice litigation and negative financial impact on an urgent care. When those consequences cause patient morbidity and mortality, the potential negative financial impact is even greater.

In many cases, insurance coverage may defray most, if not all, of a financial settlement. However, the costs in staff time, energy, and stress in preparing for and defending against such litigation will not be mitigated. And when the litigation results in a large settlement against a center, the negative publicity hurts its reputation in the community.

An urgent care also faces substantial financial risks when such behavior is directed at staff members. Imagine if a doctor like Tom had verbally attacked a nurse while absentmindedly holding a scalpel, frightening but not actually physically injuring her, and she subsequently sued the center and scalpel-wielding doctor for damages, citing post-traumatic stress disorder.

While it is difficult to predict how a judge or jury would respond in such a case, how the center had dealt with previous complaints about the disruptive physician would be critical to its defense. If such complaints had been ignored or handled with a perfunctory wrist slap, the center would likely be seen as complicit in tolerating such behavior and could be liable for a portion of the damages, which typically are not covered by malpractice insurance.

If, on the other hand, the problem doctor had been warned about the seriousness of his behavior, had been urged to begin a remedial course of action, and a record of this feedback was carefully recorded and maintained, the outcome would likely be very different.

Medical Culture's Feedback Problem

Despite profound changes in medical organization and practice, medical training—and the underlying culture of which it is an expression—remain largely stuck in yesterday's paradigm of care delivery. In this model, each doctor is trained to function independently rather than collaboratively.

But treatment of patients is rapidly shifting from individual doctors making autonomous decisions to teams that include multiple physician and non-physician members who coordinate care as a group. The group, not the individual doctor, is increasingly accountable for the quality of that care. (And team members will increasingly sink or swim financially based on their ability to collaborate effectively.)

For this model to succeed, however, feedback is essential. Yet physicians are not acculturated to give and receive feedback. When a colleague is alcoholic, clinically depressed, anger-prone, or erratic in behavior, there is no politically correct way to intervene—until, that is, the inevitable but preventable catastrophe that everyone knew was in the offing finally makes it impossible not to intercede.

This reticence to speak up needs to end. For teams to work, disruptive conduct by any member must to be addressed with far greater swiftness, decisiveness, and skill than is now generally the case. That starts with feedback. Medical culture must evolve so that it becomes permissible to offer it.

Evaluation and Remediation of Problem Doctors

A number of organizations exist to assess disruptive physicians and offer coaching, counseling, workshops, seminars, and psychotherapy with the goal of behavior modification and reintegration into the workplace (see *Where to Seek Help* on page 20). Some are private consulting firms. Others are universities and hospitals. Still others are state-funded entities.

At Phil's behest, for example, Tom contacted a private firm specializing in the assessment and remediation of disruptive physicians. Three well-validated personality assessment tests, plus an in-depth clinical interview, were then used to develop a comprehensive psychological profile of Tom and clarify the nature of his problems (see *The Evaluation Process* on page 22). Tom took two of the tests online in a monitored setting. Monitoring was about to become a big part of his life.

Tom was initially resistant to the evaluation process. But it slowly began to sink in that his career was on the line. He could participate or not, but he would have to live with the consequences of non-participation. That would very likely mean he would, yet again, need to find another job. Once he understood the seriousness of his situation, he quickly became engaged in the process.

The clinical interview was revealing. Tom had always excelled in school and at sports. He did everything well. His parents were supportive; he was never criticized by them, even though he was criticized by others.

Breezing through medical school, Tom encountered his first problems during his residency. He found it difficult to follow the rules, preferring to do it "my way," raising serious questions in the eyes of others about his fitness for a medical career.

He took a year off to find himself, traveling and doing locums work. There were fewer rules. He experienced greater freedom from supervision. Ultimately,

Where to Seek Help

A number of organizations—consulting firms, universities, hospitals, and state-run entities—offer assessment and remediation services for disruptive physicians. Here is a sampling:

Anderson & Anderson
Offers a 12-hour coaching program with six months of aftercare for disruptive physicians.

Location: Brentwood, California
Phone: (310) 207-3591
Website: *www.andersonservices.com*
Email: *Georgeanderson@aol.com*

Center for Professional Health
Offers a three-day continuing medical education (CME) course for "distressed" physicians.

Location: Vanderbilt University Medical Center, Nashville, Tennessee
Phone: (615) 936-0678
Website: *www.mc.vanderbilt.edu*
Email: *cph@vanderbilt.edu*

Federation of State Physician Health Programs
Serves as an education resource on physician impairment for physician health programs (PHPs), which exist in all 50 states to help physicians address chemical dependency and mental health issues. Includes a directory of PHPs nationwide.

Location: Chicago, Illinois
Phone: (518) 439-0626
Website: *www.fsphp.org*
Email: *doughj@albmed.org*

Physician Assessment and Clinical Education Program
Offers a three-day CME "Anger Management for Healthcare Professionals Program," as well as assessment and monitoring services.

Location: University of California, San Diego
Phone: (619) 543-6770
Website: *www.paceprogram.ucsd.edu*
Email: *upace@ucsd.edu*

Physicians Development Program
Offers "People Skills" and "Physician Workplace" programs for problem doctors.

Location: Miami, Florida
Phone: (305) 285-8900, ext. 575
Website: *www.physiciansdevelopmentprogram.com*
Email: *info@pdpflorida.com*

Pine Grove Behavioral Health and Addiction Services
Offers a "Professional Enhancement Program" for professionals with addictive illness, disruptive behavior, boundary violations, personality disorders, interpersonal difficulties, and vocational issues.

Location: Hattiesburg, Mississippi
Phone: (888) 574-4673
Website: *www.pinegrovetreatment.com*
Email: *phemphill@forrestgeneral.com*

Professional Assessment Services & Solutions (PASS)
Offers intensive outpatient assessment, consultation, and treatment services for disruptive physicians.

Location: Scottsdale, Arizona
Phone: (602) 370-0303
Website: *www.passusa.org*
Email: *info@passusua.org*

Professional Renewal Center
Offers a three-day CME program for distressed physicians, assessment, monitoring, and more.

Location: Lawrence, Kansas
Phone: (877) 978-4772
Website: *www.prckansas.org*
Email: *eherrman@prckansas.org*

though, he returned and finished his residency. Finding a job was never a challenge. Tom was articulate, initially personable, and clearly bright. He had worked in several different emergency departments and urgent care centers before moving to his present job, always leaving when he found himself at odds with management.

As part of his evaluation, Tom was asked to choose six coworkers to offer feedback on his behavior. Phil was also asked to choose six respondents who knew Tom. The purpose was to let Tom see himself through the eyes

The Evaluation Process

When a disruptive physician is sent for psychological evaluation, what is involved? While every assessment organization has its own way of doing things, three assessment instruments are in common use: a 360° Peer-Feedback Survey Instrument, the Minnesota Multiphasic Personality Instrument 2 (MMPI-2), and the Hogan Development Survey (HDS). In addition, there is an in-depth clinical interview. Each offers different kinds of information about the doctor under review..

The 360° Survey

The term "360° appraisal" originated in the business world and refers to *full circle* feedback from bosses, peers, more junior colleagues, and often customers. This approach evolved as the limitations of the more traditional top-down approach to evaluation became apparent—namely, that it was perceived as potentially unfair, biased, limited to one person's perspective, and often de-motivating. Because the 360° method overcomes such problems, it has been introduced in some hospitals, where it is typically used to provide feedback to residents.

In the case of a disruptive physician, a 360° Survey is used to collect data from medical colleagues, nurses, technicians, administrative staff, and others who interact regularly with the doctor being assessed. Using multiple sources to appraise physicians on multiple dimensions of functionality improves the objectivity and impact of the feedback. It is, furthermore, more difficult to discount the views of substantial groups of colleagues and subordinates than the views of just one or two.

MMPI-2

MMPI-2 is the oldest comprehensive psychological test designed to assess psychopathology. A self-report test, it has been standardized on thousands of subjects and provides objective indications of significant psychological disorders. It is designed to measure enduring characteristics—the relatively stable components of personality—more than the short-term fluctuations that vary with situational distress.

MMPI-2 not only measures psychopathology; it includes indices of validity that allow the interpreter to make assessments about the subject's test-taking biases. Those assessments include whether an individual is capable of understanding the test items, answering randomly, or attempting to minimize or amplify his symptoms. The current edition of the MMPI-2 includes several new scales that not only increase its validity but also provide better data for identifying serious psychopathology.

HDS

Based on well-validated research from the Center for Creative Leadership, an education and research organization, HDS is a self-report survey on factors leading to "derailment," causing an apparently successful career to go off-track.

In contrast to MMPI-2, which seeks to identify disabling psychopathology, HDS identifies the less-obvious personality disorders, the more subtle idiosyncrasies that end up becoming dysfunctional over time, particularly when the external controls on an individual's behavior diminish.

These dysfunctional behaviors typically are caused by people's distorted beliefs about how others will treat them, beliefs that negatively impact a person's career and life satisfaction. Such individuals are often are unaware that their perceptions are distorted or that their behavior has any negative impact. HDS is thus a very useful instrument for bringing these issues into the awareness that is an essential precursor for behavior change.

The Clinical Interview

The clinical interview includes a review of a physician's family background, early history, education, and work history, including problems encountered with work, marriage, and family. If coworker feedback is part of the assessment, it would be discussed at this time, as would the results of assessment tests; any critical items identified by test protocols would be examined in some depth. Based on these findings and the doctor's response to them, therapeutic recommendations would then be offered.

of others. Naturally, he chose people he believed understood and empathized with him.

No matter. The results were unanimous. All 12 respondents found much of Tom's behavior unacceptable, and there was an enormous gap between Tom's self-ratings, all highly positive, and those of the respondents, whose comments were not only quite negative, there was no discernable difference among them. Everyone felt that Tom was a bully and jerk!

Tom was shocked.

Tom was also given a comprehensive psychological test designed to assess psychopathology. The results showed no evidence of serious mental illness, although there was a strong suggestion of anti-social attitudes and behaviors. A self-report survey was also revealing. Tom's scores indicated that he had a narcissistic personality with a high degree of suppressed anger.

This feedback, interestingly, did not come as news.

"I've often wondered if I was a narcissist," Tom reflected. "My wife certainly won't be surprised to learn that she's been right about me all along."

The results of his evaluation were sobering. Tom enjoyed his clinical work and the lifestyle of an emergency and urgent care physician. The prospect of being forced to leave yet another job because of his anger management issues was disconcerting to him. He needed a reality check. He got one. Discussing a treatment regime was then no longer out of the question.

Phil received a report summarizing the findings. It is standard practice to keep the medical director, lead physician, or whoever refers a disruptive doctor for evaluation in the loop. A doctor under evaluation consents to this at the outset of the process.

The firm that assessed Tom then assigned him an affiliated psychotherapist, who would work with him for a period of two years. The therapist would also monitor Tom and send the assessment firm regular reports on his progress, which in turn would be summarized for Phil. Tom agreed to all this.

By the end of the first year, however, Tom was no longer "The Terror." He didn't suddenly become warm and cuddly, but least he now was able to maintain a professional demeanor with his coworkers. The outbursts ceased. Continuing follow-up provided both the guidance and feedback he needed to develop the necessary auto-control system that led to a successful outcome.

The Role of the Physician Leader

Disruptive physicians are often about two problem doctors, not one. The first is Tom, or someone like him. Then there's Phil. By putting off dealing with Tom, Phil was, in effect, his enabler. Why did he ignore repeated staff complaints? Why did people have to threaten to quit before he would act?

The Joint Commission's mandate is explicit: disruptive physicians should be dealt with decisively and in a timely manner. Every healthcare executive knows this—or should. Yet Phil's procrastination seems to be the rule rather than the exception with doctors with supervisory oversight of other doctors.

By doing, eventually, what he *should* have done—paying attention to staff complaints, then referring Tom for assessment and treatment—Phil never had to deal with the question of what *must* be done. But what if a disruptive physician refuses treatment, or refuses to acknowledge the validity of his assessment, or refuses to be monitored? What if he agrees to everything but his behavior doesn't change—or change enough?

In any of these events, there would be little or no alternative to terminating the doctor for cause. Not to do so would expose the center to litigation and potential serious financial risk. If the staffers who threatened to quit en masse had actually done so, it would have been disastrous for clinic, and morale among the staffers who remained would surely have been jeopardized. In addition, the center's reputation in the community would likely be harmed as word unpreventably spread.

Quality care, especially patient safety, necessitates that all caregivers behave in a professional manner, especially when engaged in direct patient care. This requirement is especially true for physicians, who tend to be viewed by non-physician staffers as team captains and setters of standards.

Healthcare organizations need to have unambiguous, clearly written policies and standards that clarify the meaning of "professional demeanor." Explicit expectations about being on time, manner of dress, answering calls—behaviors that in the "good old days" never needed to be mentioned—can no longer be assumed; they must be spelled out.

Physician executives with direct supervisory authority over other doctors must insist that these standards be met, and be ready to step in as enforcers of appropriate behavior before members of the center staff are driven to the point where they must threaten to quit. It may not be easy (see *Medical Culture's Feedback Problem* on page 19), but to allow a problem doctor to go unchecked is a dereliction of duty to all concerned: patients, staff, and the center itself. ■

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