The Disruptive Physician
A Quality of Professional Life Factor

by John-Henry Pfifferling, PhD

ENHANCING THE QUALITY of life for health professionals has never been more urgent. Disruptive behavior directly affects the wellbeing of physician executives and their colleagues. Recently, I gave two presentations on the disruptive physician to risk management professionals. One meeting was in the Midwest and the other in the Northwest. At each meeting, I asked the audience to raise their hands if they had to deal with a “disruptive” physician in the last year. Of the 200-plus attendees, virtually all raised their hands.

- Is this phenomenon increasing in prevalence?
- Are behaviors that were traditionally tolerated, no longer accepted?
- Are staff and peers more assertive?
- Are employment lawyers persuasively educating staff about “hostile work environments,” and, in turn, are staff more committed to conflict resolution or litigation?
- Is the explosive growth of group practice, hospital employed physicians, and managed care an aggravating factor in further disruption?
- Has the medical culture changed and become less tolerant of disrespectful and angry behavior?

This article explores some of the costs associated with the disruptive physician phenomenon. Medical leaders need to understand that attending to quality of professional life issues includes dealing with the insidious costs and stress associated with the necessarily subjective domain of “disruptive” physician behavior.

KEY CONCEPTS

- **The Disruptive Physician**
- **Professional Well-Being**
- **Quality of Professional Life Issues**
- **Defining Reasonable and Competent Interpersonal Behavior**
- **Preventing Hostile Work Environments**
- **Conflict Resolution**

Medical leaders need to understand that attending to quality of professional life issues includes dealing with the insidious costs and stress associated with disruptive physician behavior. The disruptive physician or professional undermines practice morale, heightens turnover in the organization, steals from productive activities, increases the risks for ineffective or substandard practice, and causes distress among colleagues. Physician executives need to help reduce or prevent this behavior and develop accepted systems in which to manage, confront, and rehabilitate the person labeled “disruptive.” Suggested strategies to consider in developing a system include: (1) Defining reasonable and competent interpersonal behavior; (2) educating in interpersonal skills; (3) evaluating interpersonal skills; (4) developing disruptive policy; and (5) assessing, confronting, and rehabilitating.

Profile of a disruptive physician

A typical fictionalized case from the Center for Professional WellBeing often includes the following description:

“We have seen this pattern of abusive outbursts for five to ten years. His outbursts are unreasonable, intimidating, and often out of proportion to the nature of the incident. Not only are staff the recipients of the outbursts, but often patients or their family members hear or witness the scene. We have counseled him. The executive committee has told him to tone down. We have sat him down and listened to his anger at staff or peers who, he says, can’t

follow orders or just don't care. His medical care is usually superb. He is one of the busiest physicians in his specialty. We are particularly worried that staff will not call him late at night for fear of being ridiculed or screamed at. We are losing staff and we are worried about being sued. For years we have tried to pacify him and we are tired of dealing with him. We are prepared to take his privileges away, even if it means a protracted lawsuit."

Does this description sound familiar? Years of abuse and manipulation often occur prior to the development of a formal policy or even use of an outside assessment or confrontation.

Does the person appear not to fit into a neat "impaired physician" category and is he or she usually very busy, technically competent, and, perhaps, even the expert in a particular clinical domain? On the other hand, is a disruptive physician impaired and can this form of impairment be eliminated from the medical staff by appropriate use of clear bylaw language?[1]

Disruptive physicians may only occasionally have incidents or there may be a pattern of habitual disregard for the dignity of others, particularly those with less status or power. If a pattern of habitual disruption is identified and is associated with patient harm, the practice, medical staff, and/or hospital may be held liable. Whatever the cause of the behavior—emulating a bullying style from residency mentors, impatience because of perfectionism or stress syndromes, cultural differences in interpersonal communication, psychiatric, personality, or addictive disease—others feel transgression.

Halting the epidemic

It is time to define reasonable professional behavior—and educate those with behavioral deficits or handicaps so that the epidemic does not continue. If educational or coaching interventions do not stop the behavior, then it is appropriate to further assess the subject physician with a comprehensive, multidisciplinary evaluation. Beyond assessment, corrective actions need to be identified and a local monitor selected to help in rehabilitation and reentry. Research and data should be collected on interventions. As yet, there is almost no literature on outcomes and agreed upon protocols for successful remediation.

Each staff or organization needs to be reasonably definite in establishing the type of behavior that is and is not acceptable. Local risk management staff, attorneys, and representatives of the medical staff need to set standards that are reasonably clear. The standards also need to define disruptive conduct, which has an adverse impact upon probable or real patient care.

Different states may already have definitions of how much proof of patient harm is required to show deficient quality of care. Check with your legal counsel to determine the language appropriate for validation of proof between behavior and patient care harm as medical bylaws are established. According to the American Medical Association's Office of the General

Counsel, disruptive behavior needs to be dealt with when it affects or may affect quality of care. The General Counsel's office believes that judging what is and is not quality of care is the primary responsibility of the medical staff. Hospitals, of course, can determine employee policy regarding disruptive behavior, but ought not to engage in physician peer review responsibilities. As more and more physicians become employees of hospitals, new definitions of peer review may arise.

Preventing Disruptive Behavior

- Define interpersonal behavior
- Educate in interpersonal skills
- Evaluate interpersonal skills
- Develop disruptive policy
- Assess, confront, rehabilitate

—John-Henry Pfifferling, PhD

The costs of a "disruptive" physician

The disruptive physician or professional undermines practice morale, heightens turnover in the organization, steals from productive activities, increases the risks for ineffective or substandard practice, and causes distress among colleagues. Distress is particularly prevalent among medical executives and administration staff who are supposed to cooperate with each other and clinical peers. Definitions of disruptive behavior vary, but usually include some indication of behavior felt by others to "represent anger, intimidation, and the threat of harm to others."[2]

Reports of cases commonly describe physicians or staff who are uncooperative, disregard informal or formal attributes of professional conduct, and are rigid in cooperatively problem-solving. An entire class of behaviors is associated with inappropriate sexual comments, sexual harassment, and seductive or assaultive actions. Still other cases indicate behavior where racial comments or disregard for dignity of others is observed.

Consequences to staff

How do staff behave around a disruptive physician or colleague? They tend to withhold information for fear of being belittled or criticized. They cover up the physician's mistakes so they won't have to ask for help or be the scapegoat. They take little interest in suggesting different ways of approaching or creatively resolving a patient care issue for fear of being considered arrogant. Their self-esteem is reduced as a result of not receiving positive feedback and believing that the criticism indicates they practice incompetently. To reduce or deflect harassment, they may imply or shift blame to someone else. In a cascading fashion, the entire team becomes more isolated, defensive, or dysfunctional. Individuals leave the practice or department, often blaming administration for a cover up. They may describe the department to acquaintances as dangerous or inadequate.

What are the costs to the practice of these staff problems? If recruiting a new staff member averages $30-50,000, how many members have left over the years because no one would take action? How many cases of harassment are waiting to occur, and at what cost? How many creative staff members have not joined the department because they heard about the problem doctor? How much time have the medical director or others spent deliberating, worrying, and/or placating the situation?

Staff

- Withhold information
- Cover up
- Reduced initiative
- Reduced morale
- Reduced self-esteem
- Interstaff blaming and dysfunction
- Harassment and lawsuits stemming from anger
- Increased turnover
- Decreased commitment to public relations for the organization

Consequences to peers

As a physician executive, how much of your time is spent in dealing with disruptive behavior complaints? Is the disruptive physician an aggravating factor in chronic fatigue risk? Is your medical staff often psychologically absent from meetings or discussions, so they do not have to deal with the style or behavior of the disruptive physician? Are they there, but get paged quickly, and are they more reticent than in the past?

How many physicians have left or are looking for other positions as a result of the subject physician? Is there a palpable impact on creativity because the discomfort level is so high with the subject physician around? Physicians, just like other staff, withhold information (perhaps, even crucial) from the disruptive physician so that they are not shamed or belittled. When colleagues are directly meeting, correcting, or even covering up as a result of the disruptive physician, they are not productive. All of these factors have a direct impact on income and productivity.

Peers

- Chronic fatigue/complaints
- Psychological and illness absenteeism
- Incomplete and dysfunctional communication leading to inadequate teamwork
- Dumping on staff and patients
- Premature turnover
- Reduced creativity and innovative problem-solving
- Heightened risk and litigation as a result of partner liability
- Increased paperwork and problem colleague meetings (tremendous time drain)
- Lawsuit fears and anxiety (as a result of threats from "disruptive" physician)
- Withholding information from disruptive physician due to anxiety about outbursts
- Corrective or cover-up activities leading to a loss of incomeproducing time
- Sabotage

Consequences to Administrators

Both clinical and nonclinical administrators expend time and have increased fatigue from worrying about staff lawsuits. Schedules may get changed to protect people from intimidating behavior. How many administrative staff have left because of an inability to change or fire the disruptive physician? How much time and money is used in the confrontation process? How much time and energy is spent monitoring the physician in the rehabilitative phase?

Administrators

- Increased risk of staff/employee lawsuits
- Increased time counseling disgruntled staff, peers, and patients/family members
- Wasted time protecting staff from involvement with disruptive physician
- Dramatic increase in administrator turnover (as a result of not dealing with the target physician)
- Increased psychosomatic risk
- Increased time spent putting out fires and reactive public relations
- Increased time spent unnecessarily recruiting as a result of turnover surrounding the disruptive physician
- Expensive adversarial processes
- Increased time spent with sexual harassment issues
- Conflict management time spent with all affected people
- Increased expenses attempting to satisfy the unrealistic demands of the disruptive individual
- Time, energy, and expenses engaged in the confrontation process
- Time, energy and expenses spent in rehabilitation process

Consequences to the disruptive physician

Rarely does anyone explain in advance to the medical staff some of the consequences of being a disruptive physician. If the behavior continues, then the physician may lose his or her privileges, employment, or ability to practice medicine. Certainly, disgruntled patients, staff, or even peers may initiate lawsuits. The disruptive physician becomes isolated from feedback and support. Colleagues may not pitch in when asked for help because the physician is seen as a "jerk." Disruptive physicians not only stress those around them, but often suffer from stress syndromes themselves. When they look for other employment, the normal support from peers and administration is not available. Finally, their increased legal risks and costs are a major problem.

It is time to define reasonable professional behavior—and educate those with behavioral deficits or handicaps so that the epidemic does not continue.

Disruptive physician

- Potential loss of privileges, employment
- Increased risk of lawsuits from disgruntled patients/family
- Isolation from colleagues
- Increased work because colleagues will not assist
- Difficulty finding other employment
- Increased legal costs (defending allegations)
- Heightened personal morbidity risk
- Decreased social network
- Alienation from administration and its support

Aggregating the costs

Aggregating the costs of the disruptive physician problem is an eye opener and may persuade medical staff to more formally define behaviors that are considered professional, and which, if transgressed, result in sanctions. Real and estimated costs can be collected by medical administration. The costs can be used to convince recalcitrant peers to cooperate in a confrontation. They can be used to convince colleagues to establish a set of defined standards, sanctioned in some legal way, as to expected behavior. Procedures, with due process parameters, can be developed so that a system is in place. Building a system reduces the ad hoc nature of cases and begins to reduce the fear that the medical executive will be the target of personal attacks by the subject physician.

Each facility and executive needs to collect data on the cost items listed for staff, peers, administrators, and the target physician. The multiple possible costs to patients and family members are a related but separate topic. Untoward harm to patients can accrue as a result of decrements in professionalism associated with maladaptive adaptation to the disruptive physician. Practitioners may omit, duplicate, and deliver suboptimal care because of fears in a perceived toxic environment. The disruptive professional directly affects physician satisfaction and needs to be managed in order to promote a healthier work environment. Not only do we need to measure patient satisfaction and use the information appropriately, but also we need to measure physician satisfaction and intervene to promote wellbeing.

Defining reasonable and competent behavior

Each medical staff needs to develop objective standards and conduct so that cooperation and delivery of care is not disrupted by intimidation, harassment, disrespect, fear, and threats of violence or litigation. Enforcement of these standards needs to be fair and reasonable, not arbitrary and capricious. For example, a policy that listed "hypercritical" behavior as a standard for labeling someone disruptive would be too ambiguous. The criteria could be used to discriminate against critics or someone out of favor.

It is best to invite participation in the process from all those capable of being sanctioned. A core group needs to be responsible for developing the standards and the process in which disruptive behavior is embedded. A trigger chart of

interpersonal expectations that can be articulated, more clearly defined, and used to develop behavioral standards follows.

All members of the medical and health staff are expected to routinely behave in ways that support the delivery of cost-effective, quality patient care. Behaviors that promote cooperation and teamwork are a priority.

Interpersonal expectations

- Respond to pages in a timely and suitable manner
- Respond to patient and staff requests appropriately
- Refrain from shaming others for negative outcomes
- Treat others with courtesy and respect
- Refrain from sexual innuendoes and sexual harassment
- Refrain from using abusive language, including repetitive sarcasm
- Cooperate and communicate with other providers, displaying regard for their dignity
- Respect patients' autonomy, confidentiality, and welfare
- Refrain from racial or ethnic slurs
- Refrain from threats of violence, retribution, or litigation
- Refrain from actions that are reasonably felt by others to represent intimidation
- Refrain from snide, cynical remarks
- Address concerns about clinical judgments with associates directly
- Refrain from favoritism or sidestepping rules
- Refrain from criticizing staff in front of others
- Refrain from foul language, shouting, and rudeness
- Use conflict management skills in managing disagreements
- Encourage clear communication

Practice expectations

- Seek and obtain appropriate consultation
- Arrange for appropriate coverage when not available
- Complete patient records within an established time frame
- Disclose potential conflicts of interest
- Assist in the identification of colleagues who may be in need of assistance
- Address dissatisfaction with policies through appropriate grievance channels
- Participate in clinical outcome reviews
- Maintain professional skills and knowledge and participate in CME
- Comply with the practice standards updating policy
- Refrain from "fraudulent" scientific practices

Adding practice expectations helps move the organization from a negative mindset to a more organized, healthy model. What is it that you expect from professionals? What can they expect from the practice? What are the rights, obligations, and principles of the practice? What will the practice do to support professionalism? A healthy practice can reframe the negativity of the disruptive individual to develop and nurture cohesion and cooperation.

Physician executives need to develop a working consensus on defining reasonable and competent interpersonal behavior to prevent or reduce disruptive behavior. Step one is to identify and communicate practice expectations and step two is to implement a mechanism for focusing on the interpersonal aspects. What do you expect in cooperative and communicative behavior among physicians, associates, staff, and between practice members and patients? Veltman even describes a case where the inability to work with others in a harmonious environment by itself is enough to deny continuing privileges.[1] In this situation, the physician's incessant and unfair criticisms broke down nursing staff morale.

What mechanism or instrument will you use to collect data in this area and what educational strategies will you use to enhance interpersonal communication? In evaluating peers, what performance appraisal or feedback methods will you use? How will you orient physicians as to expectations and will the department or practice provide resources for both training and remediation? A final step in dealing with the disruptive physician is implementing an intervention policy based on assessment, confrontation, and rehabilitation.

Implementing an intervention policy

When a physician's behavior affects other people's ability to deliver quality patient care, he or she must be confronted. Action should also be taken when harassment is perceived to be so potent as to constrain other people's ability to practice. We must confront when the subject's professionalism is constrained or impaired or when allegations of injury to staff, peers, or employees are presented.

Confrontation can be accomplished in several ways. An initial informal

Managing Physicians with Disruptive Behavior

The American College of Physician Executives is offering an online course on "Managing Physicians with Disruptive Behavior." This is an interactive course where participants explore case studies to gain a better understanding of several common types of disruptive behaviors exhibited by physicians. The facilitator, Kent Neff, MD, is Director of the Professional Assessment Program at Abbott Northwestern Hospital in Minneapolis, Minnesota. At the course's conclusion, participants will have an improved ability to recognize, evaluate, and formulate strategies for more effective management of physicians with these behaviors. The 1999 course dates are April 25 - June 7, September 7 - October 18, and November 15 - December 30. For additional information, please contact Susan Quinn at 800/562-8088 or via email at squinn@acpe.org.

assessment can be completed with the assistance of an outside individual or team interested in changing the ground rules—outside leverage is used to begin a corrective process in this approach. Such an assessment can occur on-site or off site. The model commonly employed at the Center for Professional Well-Being is visiting the site and collecting a history to help the physician, or he or she agrees to visit us. We do not medically or psychologically assess the individual. We offer help or resources to correct some of the behavioral deficits, such as anger, conflict, and communication. We may recommend educational or medical/psychosocial assessment or treatment. In other cases we have recommended the use of local mediation, establishing a grievance policy, or even hiring outside practice management consultants.

Alternatively, the target physician can be sent to an assessment facility for a complete psychosocial workup, like the Professional Assessment Program at Abbott Northwestern Hospital in Minneapolis, Minnesota or the PhysiciansInCrisis Assessment Program at the Menninger Clinic in Topeka, Kansas. In addition, a trained confrontation team can be brought in from a State Physicians Assistance Program or can be developed locally for such situations.

Confrontation ground rules

There are some ground rules in the formal confrontation process. The following description is adapted from Richard Irons, MD.[2]

1. Confront with a trained team

The team members need to understand their roles in direct, clear communication. They describe the allegations/incidents of behavior. How did it disrupt others? What are the expected outcomes from the confrontation? Will outside assessment be used in the confrontation? Will any treatment substitute for an outside assessment?

2. What are the bottom lines?

What does refusal to receive assessment mean? What are the due process provisions? Are any outside reports necessary to authorities?

3. Rehabilitation and reentry

Which peers will serve as a monitor or a liaison? Are there clear rehabilitation goals? Is there a return to practice plan? Are there any changed boundaries that need defining (less call, supervision by whom?) What are the consequences if the subject fails to comply with a behavioral contract? If there are conflicts, who will be involved in conflict resolution?

4. Other considerations about assessment

Will outside assessors be involved in actual, ongoing therapy, when and if therapy is needed? Will a multidisciplinary team be involved in the assessment? What reports will be written about the subject? Who will receive the reports? Are any other individuals involved in long-term follow-up plans? Who will maintain resource information for the facility regarding treatment, assessment, guidance, career planning, and educational remediation?

Wider issues

It's not clear whether there are more disruptive physicians today than in the past. As demands for validating quality of care increase, external scrutiny will pressure executives to enforce professionalism. As groups increase in size and make commitments to corporate continuity, a decreased tolerance for disruptive behavior is expected. As physicians become more skilled in conflict resolution and communication skills, they will be more comfortable in establishing standards and in giving corrective feedback in the interpersonal domain.[3]

Medical training will teach and board examinations will assess communication skills, thus predisposing physicians to expect interpersonal feedback. Changes in how physicians practice also affect their stress and frustration levels. How can the managed care setting decrease or increase disruptive incidents? Managed care models may collect satisfaction data and, therefore, support interpersonal skill training and resources. On the other hand, managed care settings may constrain some physicians and engender value clashes, which are acted out as stress or anger.

If the managed care settings do not assess or promote quality of professional life interventions, we may see more disruptive behavior as frustration is taken out on practice members. As physicians join unions or similar organizations, there may even be adversarial consequences when they allege the lack of due process or arbitrary use of sanctions. Anxiety and stress in the practice of medicine associated with perceived lack of control could certainly trigger anger outbursts and disruptive acts. It behooves us to assess both individual and practice health factors so that respect, courtesy, and tolerance are prevalent. Some of the lessons learned from correcting disruptive behavior ought to encourage clear communication and increased education in anger and conflict management.

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