The Behaviorally Disruptive Physician

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It is difficult, if not impossible, to read a newspaper or watch the evening news without recognizing the degree to which violence permeates our world. Violence in the medical workplace does occur on a regular and continuing basis, and we often overlook its more subtle manifestations and its effects upon those around us.

Physicians can consciously or unconsciously be perpetrators of disruptive behavior in the medical workplace, actions that are felt by others to represent anger, intimidation, and the threat of harm to others. We often fail to see the more subtle manifestations of our conduct, and the ways in which our thoughts, words and actions affect another. A pattern of such behavior may emerge in some physicians which has not been responsive to feedback from others, and attempts at corrective action may continue over time. The inherent problem is that of abuse of power and position for personal gain or to avoid blame or responsibility for adverse outcomes. An individual may create a reputation of being difficult to deal with or moody and others soon learn how to work around them without arousing their ire or reactions. For the purposes of this discussion, we will refer to them as behaviorally disruptive physicians.

The expression of anger in the workplace by physicians is manifested in a variety of disruptive and maladaptive behaviors that tend to persist or reassert themselves over time. They are briefly summarized in Table I. A given problem physician will possess their own characteristic pattern of behaviors that result in conflict and concern in the hospital or office. Anger may be expressed with subtlety and persistence, or with sudden explosive dramatic outbursts. These actions may directly or indirectly affect the care given to patients. A great deal of time is consumed in adjusting to this individual, attempting to control them, and in efforts to assist those who feel injured.

Disruptive and Maladaptive Behaviors

TABLE I. Common behaviors in disruptive physicians

Inappropriate anger or resentments

- intimidation
- abusive language
- blames or shames others for possible adverse outcomes
- unnecessary sarcasm or cynicism
- threats of violence, retribution, or litigation

Inappropriate words or actions directed toward another person

- sexual comments or innuendoes
- sexual harassment
- seductive, aggressive, or assaultive behavior
- racial, ethnic, or socioeconomic slurs
- lack of regard for personal comfort and dignity of others

Inappropriate response to patient needs or staff requests

- late or unsuitable replies to pages or calls
- unprofessional demeanor or conduct
- uncooperative, defiant approach to problems
- rigid, inflexible responses to requests for assistance or cooperation

There are a variety of factors that can lead to such behavior by any professional in any medical establishment on occasion. Many professionals have experienced similar behavior in their homes during childhood and adolescence. Many others have directly suffered from abuse of power and position during their medical education or training. Indeed, some of the behavior that is no longer accepted was considered outrageous, but tolerated in the not too distant past. Numerous articles have appeared in the medical literature in recent years documenting the frequency and prevalence of medical student and medical resident abuse. Negative role modeling, particularly the use of public humiliation as a socialized and necessary element of medical training, is often used to justify current behavior. Physicians experience a great deal of pressure from peers and the public to meet exacting performance expectations. When something goes wrong, when a perfect result or outcome is in jeopardy, then blame is anticipated and expected. If we do not want to accept the blame, then we are prone to place it on others. In the long journey from high school to practicing physician, many sacrifices are required. Often we do not have as much time for the development of interpersonal skills as other students. Medical training has not historically provided education and experience in supervisory or team building, conflict resolution or effective leadership. We learn as we go, often from the mistakes we make along the way, unaware of or personal in-vulnerabilities or lack of sophistication.

The medical workplace is the stage upon which numerous human dramas are played. Many tragic scenes occur wherein suffering, conflict, and death with their medical and psychological consequences are experienced each day. In this highly charged environment there is a constant demand for faultless performance and flawless decision-making. Over time, we develop a hardening, a ritualized suppression of feelings in order to cope with the demands and stress. In the process we

can become insensitive to the needs, feelings, and sensibilities of patients, peers, and coworkers while developing an emotional armoring against the criticism, barbs and comments of others. Our ability to utilize healthy adaptive mechanisms such as humor, altruism, sublimation and rationalization can be overcome. Each of us carries inherent personal vulnerabilities and weaknesses. Mechanisms that one utilized earlier I life may no longer be appropriate or effective. Our own image of ourselves may become distorted through denial, our compulsion with perfection, our obsession with being right, and our narcissistic defenses. We may lose the ability to see oneself as other people see us, becoming susceptible to a heroic fall, a metaphoric death due to the sin of hubris, or false pride.

When it finally becomes necessary to take action and begin the process of coming to terms with a disruptive physician, be aware that the process is seldom easily or quickly completed. Initial steps involve the use of conflict resolution at the hospital or clinic level, using senior practice partners and appropriate administrative personnel. In many cases this approach will be successful. However in others, initial strategies that seek modification of behavior and corrective action will seem effective for short periods of time. Some professionals will return to old patterns of disruptive behavior and the concerned parties in the hospital or clinic will finally come to the conclusion that more intensive measures are necessary, and will require the use of additional leverage and the help of outside resources.

The following outline depicts the most effective means for accomplishing the task of confronting the disruptive professional under such circumstances.

CONFRONTATION

1.Rarely will disruptive professionals independently seek help. They characteristically lack insight into the nature or severity of their problematic behavior. Following aggressive intervention and assessment, the majority develop at least partial insight.

2. When it is necessary to proceed to confrontation, utilize a diverse team and choose a neutral meeting site. Request each team member to specifically describe the problem behavior and its impact upon others. Emphasize the seriousness of the situation.

3. Determine in advance acceptable outcomes from the confrontation. Identify the types of resources available. Decide whether an independent assessment is needed and the specialized components that will be required. Consider what treatment or therapy is acceptable in lieu of assessment. Seek acknowledgment of the problem behavior by the physician and responsibility to take corrective action. Offer assistance in obtaining help and make recommendations upon acceptable outcomes. Disclose what providers of assessment or treatment are acceptable. Identify any financial assistance or other support the professional can expect.

THE BOTTOM LINES

4.Carefully review the alternatives that will be exercised if the professional refuses to comply with the recommendations. Review state and federal requirements. Reveal the team's bottom lines only if the professional will not commit to an acceptable course of action in a reasonable period of time. Emphasize potential loss of privileges, liability insurance, or termination of employment or contract. Outline precisely due process provisions that are operable through organization bylaws or policies. Indicate when reports to state professional health program, state licensure board or national practitioner data bank may be made. Do not threaten actions you are not prepared to take.

REHABILITATION AND RE-ENTRY

5. If the confrontation is successful, identify a peer to serve as a liaison and mentor in the process. Monitor progress in implementation of the agreed upon action plan. Develop clear rehabilitation goals. When appropriate, emphasize a plan for return to active practice when goals are met.

6. Prior to professional re-entry or within a short period of time after information is obtained from assessment and/or treatment [with the physician's written authorization], establish realistic re-entry expectations and conduct boundaries. Utilize peer monitoring and, if necessary, supervision in practice. Encourage or require continuing education in arrears of weakness. Construct a clear and precise re-entry behavioral contract which specifies the consequences for failure to comply. Within the contract identify a mechanism for future conflict resolution. Provide dignity and support for the professional as well as the workplace staff.

Independent assessment by professionals who are not associated with the hospital or clinic provides the most objective information. When the professionals that do such evaluation indicate at the outset that they will not be involved in any therapy or treatment of the referred party, then an additional conflict of interest is avoided. In our experience, disruptive professionals who have serious problems and have not responded to conservative measures are most effectively evaluated by a multi-disciplinary team of professionals that provide comprehensive and definitive evaluation for mental disorders, addictive disease, and covert medical illnesses. The time away from professional responsibilities as well as the time and expense of such a process can be therapeutic in and of itself. Reports should approach forensic standards, and evaluators must be prepared to represent and defend their work in the future if bottom lines need to be exercised.