ON TARGET

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*Instituting a disruptive conduct policy for medical staff.*

A healthy work environment is one that promotes interaction and communication among all professionals, a positive and strong working relationship between the nurse manager and physician director, and activities such as joint patient care rounds, shared clinical protocols, and joint teaching of physicians and nurses. There are situations when a physician’s unacceptable conduct leads to a disruptive environment for patients, staff, and fellow physicians. This article describes the steps taken in one institution to establish structures and systems to communicate behaviors that are unacceptable and a policy to be followed should disruptive behavior be encountered. Having systems and structures in place assists in promoting a healthy work environment. Children’s Hospital of Philadelphia, University of Pennsylvania School of Nursing, 40 Guardian Drive, Philadelphia, PA 19104, USA. barnstnr@nursing.upenn.edu

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*The disruptive-abusive physician: a new look at an old problem.*
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*A process for objective review of physician performance.*

How do you objectively evaluate physicians at reappointment. How do you establish a common ground for the evaluation process that still acknowledges acceptable differences in performance? Perhaps one physician has some difficulty with documentation and attendance at meetings, but has no quality problems clinically. Another physician may have good documentation and meeting attendance, but has some quality problems. Another physician has a behavior pattern that is disruptive, a few documentation problems, but excellent quality. Yet another physician is a marginal practitioner with major problems in several areas, including quality. Reappointment of these physicians might be extremely difficult, especially if the credentials committee is recently appointed and not familiar with the details of the performance data.

**Hershey N.**
*A different perspective on quality.*

Evaluation of physicians in the credentialing processes of hospitals has generally been viewed as focused upon whether the physicians will provide services to patients at the appropriate level of professional performance and will not engage in disruptive behavior at the institution. Three measures — exclusive contracting, medical staff planning, and exclusive credentialing — have been employed, singly or in combination, at many hospitals to restrict or to deny medical staff appointments and clinical privileges to professionally qualified and competent physicians. Because the hospitals have articulated links, when employing these restrictive measures in making credentialing decisions, to the public’s interest in their being able to provide good quality services to the communities they serve, the hospitals have usually been successful in litigation brought by physicians who have been denied staff appointment or specific clinical privileges.
Disruptive physicians in the OR direct threat to patient care.

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Diagnosis and therapy for the disruptive physician.

A disruptive physician can alienate staff, drive away patients, and even land your organization in a lawsuit. Consider some practical advice on how to identify and deal with disruptive physicians.

Wolfson Children’s Hospital, Jacksonville, Fla., USA.
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Linney BJ.
Confronting the disruptive physician.

Ignoring disruptive behavior is no longer an option in today’s changing health care environment. Competition and managed care have caused more organizations to deal with the disruptive physician, rather than look the other way as many did in years past. But it’s not an easy task, possibly the toughest of your management career. How should you confront a disruptive physician? By having clearly stated expectations for physician behavior and policies in place for dealing with problem physicians, organizations have a context from which to address the situation.

Lowes R.
Taming the disruptive doctor.


Pfifferling JH.
The disruptive physician. A quality of professional life factor.
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.
Center and Society for Professional Well-Being, Durham, NC, USA.

Pfifferling JH.
Managing the unmanageable: the disruptive physician.

Purtell DJ.
How to deal with the disruptive physician.
Hospital medical staffs are beginning to deal with the sensitive problem of the disruptive physician. Courts in 11 states already have allowed hospitals to dismiss physicians who display unprofessional behavior. Hospitals and medical staffs, however, must be careful to document a correlation between a physician’s disruptive behavior and interference with patient care.

Rosenstein AH.
Original research: nurse-physician relationships: impact on nurse satisfaction and retention.
The worsening state of the nation’s nursing shortage has drawn attention to the need for more effective ways to recruit and retain nurses. For this reason, VHA West Coast (a regional division of VHA, Inc., a national network of community-owned hospitals and health care systems) conducted the targeting nurses, physicians, and executives in a large network of hospitals. VHA designed the survey to assess how these disparate groups viewed nurse-physician relationships, disruptive physician behavior, the institutional response to such behavior, and how such behavior affected nurse satisfaction, morale, and retention. An analysis of the first 1,200 responses from nurses, physicians, and hospital executives suggests that daily interactions between nurses and physicians strongly influence nurses’ morale. All respondents were very concerned with the significance of nurse-physician relationships and the atmosphere they create. And although all respondents saw a direct link between disruptive physician behavior and nurse satisfaction and retention, the groups differed in their beliefs about responsibility, barriers to progress, and potential solutions. The findings suggest that the quality of nurse-physician relationships must be addressed as facilities seek to improve nurse recruitment and retention. A survey shows that relations with physicians greatly affect nurses’ job satisfaction and morale. Disruptive behavior on the part of physicians is a chief issue.
VHA West Coast in Pleasanton, CA. USA. arosenst@vha.com

Trunkey Donald D, Botney R., Assessing Competency: A Tale of Two Professions, JACS 2001; 192 (3) 385-95.
Poll Results: Doctors’ Disruptive Behavior Disturbs Physician Leaders

Survey reveals ongoing problems with physicians yelling at nurses, refusing to carry out tasks and showing a severe lack of respect for others

By David O. Weber

They’re out there... browbeating nurses and pharmacists, dressing down hapless staff, belittling patients to their faces, swearing at the tops of their voices, muttering ominous threats, dripping sarcasm and snide innuendo, slouching in late day after day, raging, sulking, hurling surgical instruments, blowing off appointments, sabotaging meetings, sneering at administrators, insulting their colleagues, refusing to answer pages, addling their judgment with drink or drugs, breaching sexual boundaries, “climbing into bed with an overdose patient in the ICU”... oh yes, you name it, no matter how outrageous, one of them is pretty sure to have done it... because....

They’re out there: The Problem Docs.

More than 95 percent of physician executives who responded to a recent survey by the American College of Physician Executives reported encountering these disturbing, disruptive and potentially dangerous behaviors on a regular basis.

In fact, one in three of the more than 1,600 survey respondents said they observe “problems with physician behavior” either weekly (14 percent) or monthly (18 percent). And an unfortunate 3.4 percent reported daily breaches of the institutional peace by a problem doc.

Generally speaking, problems with physician behavior occur within my organization:

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Response Percent</th>
<th>Response Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once or twice a year</td>
<td>17%</td>
<td>276</td>
</tr>
<tr>
<td>3 to 5 times a year</td>
<td>24.1%</td>
<td>392</td>
</tr>
<tr>
<td>More than 5 times a year</td>
<td>9%</td>
<td>309</td>
</tr>
<tr>
<td>Monthly</td>
<td>18.1%</td>
<td>294</td>
</tr>
<tr>
<td>Weekly</td>
<td>14.1%</td>
<td>230</td>
</tr>
<tr>
<td>Daily</td>
<td>3.4%</td>
<td>56</td>
</tr>
<tr>
<td>Never</td>
<td>4.3%</td>
<td>70</td>
</tr>
<tr>
<td><strong>Total Respondents</strong></td>
<td><strong>1627</strong></td>
<td></td>
</tr>
<tr>
<td>(skipped this question)</td>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>

©ACPE 2004 Physician Behavior Survey
“This is the most difficult aspect of being a physician executive,” commented a respondent. “I find it really distasteful to have to counsel a ‘renegade’ physician.”

**From overt to subvert**

Every one of the transgressions listed above was mentioned specifically as having been witnessed by respondents to the survey.

To be sure, they agreed, in general terms it is simply “disrespect” that is the most common form of physician misbehavior roiling their organizations. Disrespectfulness among doctors, which covers a multitude of sins, was cited as a source of problems by almost 83 percent of respondents, and chronicled in more unpleasant nitty-gritty in their comments.

More than half of those surveyed—51 percent—said “refusal to complete tasks or carry out duties” was another typical ignition point. Forty-one percent cited “yelling” and 37 percent “insults.” Only 9 percent agreed that “physical abuse (including throwing items)” is a typical occurrence. But almost 14 percent described “other,” less readily classifiable, bad behaviors—like the outrageous ICU incident.

Paradoxically, the graver the offense, the easier it may be to deal with. As the medical director of an 8,000-physician network health plan observed, “egregious behaviors (sexual misconduct, criminal behavior, fraud and other unprofessional behavior)... are often grounds for suspension or termination.”

Substance abuse, which might readily explain a serious lapse in conduct—and at least carries a clear-cut course of corrective action—accounts for no more than 10 percent of the physician behavior problems in their organizations, the respondents overwhelmingly reported.

Almost half said alcohol or drugs played no part whatsoever in the problems they’ve encountered. Just 5 percent said addictions are linked to more than a tenth of occurrences.

No, it’s the nagging, grating, low-level stuff that a preponderance of physician executives said gives them heartburn.

“Physician disruptive behavior can range from overt to subvert,” wrote one. “The subvert behavior is the hardest to deal with because the offenders oftentimes have well devised excuses/explanations that make it very hard to [take] action.”
When a problem with physician behavior arises, it MOST OFTEN involves conflict between a physician and:

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Another physician</td>
<td>14.7%</td>
<td>229</td>
</tr>
<tr>
<td>A nurse or nurses, physician assistants, etc.</td>
<td>56.5%</td>
<td>878</td>
</tr>
<tr>
<td>Members of the administration</td>
<td>14.5%</td>
<td>226</td>
</tr>
<tr>
<td>A patient or patients</td>
<td>14.2%</td>
<td>221</td>
</tr>
<tr>
<td><strong>Total Respondents</strong></td>
<td><strong>1554</strong></td>
<td></td>
</tr>
<tr>
<td>(skipped this question)</td>
<td></td>
<td>81</td>
</tr>
</tbody>
</table>

The executives strongly agreed that it is really just a few bad apples who are to blame. Fully 70 percent of survey respondents reported that “physician behavior problems at my organization nearly always involve the same [people] over and over again.” Fewer than 30 percent reported that problems “crop up among various physicians from time to time with no clear pattern.”

A good summation was provided in this extended comment:

“We most physicians are emotionally well-developed and find a way to be kind and respectful even in times of great stress. In other words, they behave as doctors should behave, and they do so always and throughout their careers.

“I think significant behavior issues fall into two categories. First is the category of one-time offenders in the setting of unusual stress. These people are generally ashamed of their behavior after they settle down, and they rarely repeat.

“Second is the far more troublesome category of people who repeatedly violate many boundaries, including workplace rules and ordinary social norms. They are, over the course of time, globally disruptive. Some repeaters suffer alcoholism, depression, dysthymia, etc. However, many, if not most, [have] diagnosable personality disorders.

“We have a horrible track record in our own profession of even recognizing physicians with personality disorders, much less...
dealing effectively with them. In fact, amazingly, we make excuses for them like, ‘He’s such a good doctor; his patients love him!’ or ‘He just has a surgical personality.’ My personal favorite excuse for abuse is, ‘He holds others to his own high standards!’ When I see that one on a reference, the application goes into the garbage can.”

Concluded the writer: “Every physician executive should have a refresher course on the psychopathology of personality disorders and on dealing with disruptive physicians.”

**Blunt criticism**

Hospitals and physician practices are hierarchical settings; those at the top of the hierarchy—and indeed those who are alphas in the sub-hierarchies—have often felt a need to parade their status.

Haughtiness, intimidation and self-indulgent outbursts, especially but not exclusively among doctors, have always featured prominently in the history of medicine.

As one respondent observed, “Physicians too often feel they are above rules, regulations, behavioral standards and other day-to-day social etiquette, as they feel they are a privileged class.”

And so, not surprisingly, those below them on the totem pole—nurses, physician assistants and other supporting members of the health care cast, at least from the physician’s perspective—are most likely to bear the brunt of a problem doc’s wrath, according to the survey.

Well over half of respondents said problematic interpersonal conflicts that involve a physician most often have a coworker with less professional clout on the receiving end.

Only 14 percent of respondents said the arguments and fights break out among doctors.

Indeed, clashes with those who assist them, either clinically or administratively, account for the majority of physician behavior problems. Frustration and a sense of vulnerability “due to changes within the organization” are the primary rub according to 26 percent. Almost the same percentage identified refusal to “embrace teamwork” as the principal issue.

Only 4 percent of respondents attributed significant problems to “turf battles among physicians.” (Eight percent listed “other” causes as foremost and those ran the gamut from “miscalculation” of the clinical diagnosis to the straightforward description of the problem such as: “He’s a jerk.”)

In fact, the physician executives who took part in the survey were surprisingly blunt in their assessments of their peers.

“Lots of arrogant, immature snobs [are] practicing medicine,” wrote one.

“Some people never reach adulthood,” suggested another. “Unfortunately, many of them are physicians who, when under stress, behave as adolescents.”

“Sometimes in dealing with my docs,” mourned a weary respondent, “I am reminded of what Caligula said: ‘Would that the citizens of Rome had one neck, that I might hang them all!’”

Not that survey respondents were totally lacking in sympathy for the small minority of their professional colleagues who succumb to pressures or provocations by venting inner demons.

“In my experience,” wrote one, “most are reasonable people, deficient in interpersonal and emotional intelligence competencies and under tremendous stress.”

**Enough to test a saint**

Several respondents suggested that physician comportment in general is much better these days. Others disagreed.

“The problem seems to be worsening,” wrote one, synthesizing the bleaker view, “as many docs are asked to do more with fewer resources and they tend to lash out at anyone within striking distance. As finances get tighter there seems to be a larger disconnect between docs and administration as well.”

“This has been a chronic problem that is acutely getting much worse,” agreed another. “The stress of our jobs (I am a surgeon) is increasing due to the decrease in reimbursement for professional activities, increasing regulatory requirements and severe financial constraints placed upon the hospitals in which we must practice.”

Agreed a third: “Economic pressures (malpractice premiums, etc.) that threaten their very ability to stay in practice have made the docs more irritable and short-tempered than I have ever seen before.”

Again and again, survey respondents outlined backdrops to physician misbehavior that test even the saintliest among them:

- “This is a difficult time for physicians with flat or declining income, rising expectations, rising office overhead, and diminished autonomy. Professionalism has sagged. Physicians are depressed about their loss of control and enormously frustrated by the complexity of the health care system. They bristle at the need for regulatory oversight and have a great deal of difficulty with any non-physicians mandating any kind of activity or behavior, clinical or otherwise. Their frustration boils over all too easily.”

- “In our organization, most problems with physician behavior seem to stem from stress and frustration, either with dealing with difficult patients (pain management patients demanding drugs, patients with mental illnesses), or dealing with the
frustrations of working in a bureaucratic organization with limited resources."

- “There is also the issue of employees (often nurses) having very little ‘resiliency’ and immediately complaining to administration about relatively minor physician behavior problems that human beings should be able to work out among themselves.”

- “All my docs are voluntary physicians in a community hospital. I have noticed over the past few years a decreasing willingness to support the hospital or even feel part of it, and reluctance to be a part of a team seems to be growing. I suspect a lot of this is due to the hits that physicians are taking in society in general, from Medicare, MCOs and the trial bar, and the hospital is the easiest and closest place for them to act out. Since the hospital has some empty beds, it is difficult to be extremely aggressive with some physicians whose behavior is episodically problematic. Also, with the nursing shortage and many per diem and agency nurses, physicians don’t have the same bonds with nursing, team building is difficult and often seen as ‘not worth it’ and nurses themselves are only acting as ‘task doers’ rather than professionals involved as part of a team. So the professional environment breaks down on all sides.”

**Breaking the code**

If in some mythical Golden Age physicians were accountable to no one but Asclepius, the Greek god of medicine and healing, it’s obvious those days are long since past. More than 70 percent of the organizations represented by respondents to the survey—primarily hospitals, large group practices, health care systems and academic medical centers—adopted a written code of behavior that physicians must adhere to. Eighty percent said they established a formal disciplinary process to be followed when doctors are accused of violating behavioral norms.

Nearly 90 percent of the physician executives who answered the ACPE survey reported that they are responsible for investigating complaints about physician behavior in their organizations. Two-thirds are charged with enforcing behavior policies and almost three-quarters personally coach doctors who get into trouble. Almost unanimously they expressed gratitude for black-and-white rules and disciplinary procedures to govern physician misconduct—or lamented their lack.

“A three-stage disruptive MD policy, used by the chief of staff when patient care is not at risk, enables our credentials committee to take action. It is worth its weight in gold!” exclaimed one.

“We tie maintaining privileges to performance and behavior,” reported a second. “Disruptive physicians who will not learn to be civil and professional ‘voluntarily relinquish their privileges.’ Performance and behavioral expectations are clearly defined and
If you answered “Yes” to having a behavior code, do you think it is enforced:

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uniformly</td>
<td>46.3%</td>
<td>505</td>
</tr>
<tr>
<td>Selectively</td>
<td>46.4%</td>
<td>506</td>
</tr>
<tr>
<td>Not at all</td>
<td>7.2%</td>
<td>79</td>
</tr>
</tbody>
</table>

Total Respondents 1090
(skipped this question) 539

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physicians sign at initial credentialing and at each reappointment that they have read and will comply with these expectations.”

Summarized a third: “One of our biggest institutional problems was that our previous policy had too many ‘options’ and side channels which would allow the chair to stop the process, stall indefinitely, or repeatedly give final warnings over and over and over…. Once they were removed, the process became more rigid, but freed the chair from being accused of showing favoritism. Options lead to inconsistency, and set dangerous precedents. A rigid policy actually protects the chair by removing his discretion and avoiding complaints of not being equally strict.”

Several respondents credited ACPE continuing education courses for opening their eyes to the need for such policies. “Your course, ‘Managing Physician Performance,’ helped me understand the importance of developing and enforcing standards for physician behavior,” wrote one. “Since we have done that more consistently, we have less nursing staff turnover and higher employee satisfaction.”

Nevertheless, there are still a number of organizations where doctors have adamantly and successfully blocked implementation of a formal behavior policy, the survey found. Two physician executives reported that they had actually been ousted from their jobs for trying to overcome that obstinacy.

“Medical staff protect physicians,” observed one of them “Three attempts to initiate [a] disruptive physician policy were met with stonewalling…. [and my] attempt to… involve [the] board of directors [in] developing an ethics committee were dismissed—as was I (without cause).”

Said another: “The organization I was with until 1/2004 did not have a physician nor employee harassment policy. The word ‘on the street’ was: if we had a policy, we’d have to enforce it. I believe I was fired because I tried to hold [a] small group of physicians—who represented substantial revenue to the hospital—accountable for their behavior.”

Survey respondents were remarkably divided in their perceptions of the evenhandedness of enforcement of physician codes of conduct.

Forty-six percent said the rules are invoked uniformly, no matter the status of the offending doctor; the same percentage said application is selective. Some 7 percent said the codes of conduct are not enforced at all.

At the same time, 61 percent disagreed that “physicians in my organization who generate high amounts of revenue are treated more leniently when it comes to behavior problems than those who bring in less revenue.” Nevertheless, favoritism was a recurrent theme in the comments:

- “Nothing ever happens to the most abusive physicians, because they bring in too much money.”
- “The worse offenders are the ones in power and [with] friends on our Board of Directors.”
- “The surgeons are permitted to act out more because they generate more money and there is the perception that ‘this is just how surgeons behave.’”
- “There is… a two-tier system, the high earners and the rest of us…. The analogy I like to use is Animal Farm: ‘Some walk upright, the rest of us crawl!!!’”

Summarized one executive: “Bad behavior on the part of physicians is the single biggest impediment to improvement of our work environment, improved quality of care and better fiscal integrity. My organization consistently avoids placing any constraints on bad-behaving physicians who are either academically accomplished, big
That minority viewpoint was expressed in the comment: “Because it is easy and RNs (and other paramedical personnel) are encouraged to report perceived behavior problems, many physicians now feel victimized. They feel even more pressured to explain their actions because of the perception that it is not ‘politically correct’ to side with the physician.”

**Tailoring the punishment**

All but a handful of the survey-takers reported that within the last two years they’d given a problem doc a good talking to. (The precise terminology used was “met with a physician to discuss their behavior problem[s];” 94.5 percent said they’d had to do that.)

Two-thirds issued a written warning. Just over half ordered a doctor to seek counseling. About a third each had either terminated a physician or, at the other extreme and in all candor, “tried to ignore a problem and didn’t take any action.”

More than 100 other punitive recourses were listed—suspension of privileges, probation, report to

---

**Physicians in my organization generally are:**

<table>
<thead>
<tr>
<th>Response Description</th>
<th>Response Percent</th>
<th>Response Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treated exactly the same as other employees when a behavior problem is reported</td>
<td>27.6%</td>
<td>426</td>
</tr>
<tr>
<td>Treated more leniently than other employees because of their professional stature</td>
<td>63.2%</td>
<td>977</td>
</tr>
<tr>
<td>Treated more harshly and held to a higher standard of behavior than other employees</td>
<td>9.2%</td>
<td>143</td>
</tr>
</tbody>
</table>

**Total Respondents**: 1546

(skipped this question)
the state licensing board, enforced leave of absence, practice restrictions, even legal action.

In a few cases problem docs were fined or threatened with a fine, or had their salaries reduced. But overall, only 17 percent of respondents said their organizations had any direct links between physician compensation and appropriate behavior.

How effective were the interventions in this grab bag?

About a quarter each of respondents judged that their organizations’ attempts to correct physician misbehavior were successful either 26-50 percent of the time or 51-75 percent of the time. A particularly skillful 14 percent claimed a 75-100 percent success rate. At the opposite end of the spectrum, six percent of respondents doubted their organizations had curbed a problem doc’s worst tendencies more than 5 percent of the time—at best.

But as a great many of the physician executives who commented on the survey emphasized, improper conduct can range from a momentary burst of pique to habitual and flagrant malfeasance. And the settings in which disruptions occur vary enormously.

“Three to five [incidents per year] is a different metric for small offices than for large organizations,” pointed out one respondent.

Explained another: “[Hospital] physicians often are treated differently (including more leniently) not because of their professional status but because they are private volunteers (medical staff members) and NOT employees. Medical staff bylaws are not the same as employee HR policies…. The medical staff is more akin to a PTA (volunteers) working with employees (teachers and principal) for the good of students (patients). Disciplining PTA parents for poor performance is different—different rules/fewer options/etc.—than disciplining the teachers.”

Interestingly, only one respondent to the survey admitted to having once been a problem doc himself.

### Attempts to intervene and correct physician behavior at my organization are successful:

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% - 5% of the time</td>
<td>6.1%</td>
<td>92</td>
</tr>
<tr>
<td>6% - 10% of the time</td>
<td>11.3%</td>
<td>172</td>
</tr>
<tr>
<td>11% - 25% of the time</td>
<td>18%</td>
<td>274</td>
</tr>
<tr>
<td>26% - 50% of the time</td>
<td>25.3%</td>
<td>385</td>
</tr>
<tr>
<td>51% - 75% of the time</td>
<td>25.5%</td>
<td>388</td>
</tr>
<tr>
<td>75% - 100% of the time</td>
<td>13.8%</td>
<td>209</td>
</tr>
</tbody>
</table>

**Total Respondents** | 1520

(skipped this question) | 115
“Being a physician executive has not made me immune,” he wrote. “I was fortunate to have had my own issues addressed with great professionalism and with sensitivity by two of my colleagues… and I appreciated the clarity with which they established parameters of performance balanced by their wish to see me through my difficulties.

“In all of my dealings with colleagues since that intervention,” he continued, “I have tried very hard to adopt a similar posture. I can honestly say that I have become a more effective leader since I have identified the source of my own prior personal poor behavior, and I feel that I owe my professional career to the patience of these two supervisory colleagues. I have learned from them not to tolerate inappropriate actions from any physician, but rather to attempt vigorously to get those physicians to understand themselves better and to take the necessary steps to carry themselves more professionally.”

Yes, they’re out there, those problem docs. But they’re not all lost causes. As one respondent put it, the troubles with disruptive behavior were much worse in the past. “Behaviors that would have been covered up or tolerated 15 years ago would not last five minutes now! …Things are improving!”

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Voices of dissent

Just two of the 1,627 members of the American College of Physician Executives who responded to the online survey on physician behavior problems took bitter exception to its very premise.

One said: “Physicians are not perfect, never have been, never will be. ACPE is becoming part of the problem, NOT part of the solution. ACPE has become a pawn and its rhetoric has become a tool to be wielded and abused against high-quality physicians (and ultimately patients) by corporate practitioners and even criminals who have invaded health care.”

The other offered a more extended critique: “I do not think that this is a valid survey because it focuses only on the behavior of the physician…. The hospital setting is literally a Pandora’s Box of personalities who will at one time or another affect the physician’s patient…. If their behavior is obtuse, critical, professionally immature and this behavior is encouraged or not checked by the administration, then the care of the patient will be compromised. The physician will not be able to practice to his ability and his behavior toward the staff may be affected….

“Perhaps,” the writer continued, “there should be trained and professionally licensed behavioral psychologists strategically set on the turf who can identify problems in a positive way to ensure that the personnel are mutually supportive in the interest of the patient. Perhaps they should be on the floor when the patient rings for an hour for a bedpan, or when the dietary aide removes the untouched tray from the sick patient before he has had any assistance in eating it. The hospital is full of cruelties that should be corrected and monitored. Administrators cannot correct them from their wood-paneled offices. [They] have to be there! Do you not think that these omissions affect the spirit, if not the behavior, of the physician caring for that patient? When the physician is terminated, who will feed the patient in that hospital?

“Let’s all be Human if not Divine, and let’s have communion,” she urged. “Let’s solve our problems the old fashioned way. Let’s all talk and be civil. This focus on physician behavior is wrong, unrealistic and biased…. I believe there is no such thing as a disruptive physician; rather there is disruption within the hospital. This campaign against the physician must be halted….”

—David O. Weber

NEW BOOK ON DISRUPTIVE BEHAVIOR

Want even more information about how to deal with disruptive behavior by physicians?

Be sure to check out a new book published by The Greely Company:
A Practical Guide to Preventing and Solving Disruptive Physician Behavior.

Book includes:
- Behavior and conduct policies
- Incident report policies
- Case scenarios
- Insightful advice on how to prevent or solve disruptive behaviors
For Safety’s Sake

Disruptive Behavior Must Be Tamed

By David O. Weber
Most Physician Behavior Problems

Many physician executives who participated in the ACPE survey observed that problem docs cost their organizations significant amounts of money by driving away scarce personnel. Younger nurses especially do not tolerate this kind of behavior, and readily exit the system when faced with it," warned one. (Recruiting and training a single medical/surgical RN replacement costs $46,000 at a minimum, the VHA estimates, and studies indicate 20 percent of nursing turnover in hospitals is attributable to clashes with doctors. But killing patients is the most serious potential problem of ineptitude in interpersonal relations, and many ACPE survey respondents made a point of that. “We view [physician behavior] as a safety issue,” as one put it. “An employee who is intimidated may be reluctant to question an order or action when by doing so an error might be avoided.”

In the wake of its survey, the ISMP has sketched out a tentative map for changing the “culture of intimidation” in health care. Suggested steps include:

- Establishing a diverse steering committee drawn from all levels of the organization—top to bottom—to explore and define intimidation. The ISMP proposes a simple one: “not being treated with respect, or any behavior, no matter how small, that causes another to doubt their self-worth.”

- Establishing a conflict resolution process. One facet might be a “two-party for resolution”—used in other industries where safety is a paramount concern—under which any question that is not answered must be posed again, and if still not answered must automatically be referred to a third party for resolution.

- Encouraging confidential reporting.

- Enforcing zero tolerance, but confronting offenders with “data, authority and compassion” rather than punishment.

- Providing ongoing education and training.

- Rewarding outstanding examples of collaborative teamwork.

And, of course, as always: Leading by example.

Half the respondents to the ISMP survey said they had felt pressured into dispensing or giving a drug when they harbored serious doubts about its safety.
Managing Unmanageable Physicians

Leadership, stewardship and disruptive behavior

By Timothy Keogh, PhD and William Martin, MPH, PsyD

One of the more alarming and stressful challenges physician executives face is how to deal with disruptive behavior. Regardless of the type of organization or location, physician executives are accountable for managing disruptive behavior and the associated consequences of this behavior ranging from patient outcomes to minimizing legal risk exposure.

There is no magic bullet. There is no panacea. On the other hand, there are concrete ways to decrease the prevalence of disruptive behavior while at the same time tackling the issue head-on for the benefit of all stakeholders, including the physician who is displaying the disruptive behavior.

Role, rights and responsibilities

Former President Harry Truman is often quoted for saying, “The buck stops here.” This statement applies to every physician executive. At the end of the day, the physician executive is responsible and will be held accountable for both the prevention and expeditious resolution of disruptive behavior by physicians.

Physician executives should position themselves to take the lead in dealing with disruptive behavior, especially as state medical boards and other non-physician health care executives, including CEOs and CNOs, are increasingly taking matters into their own hands.

The ability to minimize and effectively manage disruptive behavior must be built on a foundation of supporting policies, procedures, processes and structures. The absence of this infrastructure places physician executives in the heat of battle without the proper equipment to carry out their responsibilities.

Moreover, the absence of a supporting infrastructure subtly signals to the physician demonstrating disruptive behavior that this will be handled on a case-by-case basis as an individual personnel matter.

This approach decreases objectivity and increases the risk of favoring some doctors and not others. In short, physician executives must assert the right to be properly equipped before being held accountable for any outcomes.

Given the role of physician executives as managers and organizational stewards, they must be prepared to carry forth the following responsibilities efficiently, effectively and ethically:

- Distribute, communicate and educate every employee in the organization on the appropriate policies and procedures on disruptive behavior.
- Consult with internal and external experts in law, behavior change and impaired physicians as necessary.
- Monitor all investigations and cases of disruptive behavior to comply with both the letter and spirit of the law.
- Review all allegations and complaints seeking to identify patterns in order to minimize disruptive behavior.
- Update all policies and procedures.

The overwhelming majority of physician executives are accountable for patient outcomes, patient safety and patient satisfaction at both the individual and the aggregate levels.

To that end, any behavior that detracts from patient outcomes, patient safety and patient satisfaction must be addressed. In addition, all managers, including physician...
executives, are held accountable for providing a safe working environment, according to the Occupational Safety and Health Act (OSHA) and a “discrimination-free work environment” according to Title VII of the Civil Rights Act, as well as other statutes at the federal and state levels. Also, every organization and each profession has its own set of internal accountabilities.

It is clear that physician leaders will be held accountable for their organization’s vision, mission, values, code of conduct and bylaws, as well as for the standards of proper conduct within the profession of medicine. In short, accountability is more than a set of external statutes and rules. Accountability mandates a call to deliberate action on the part of the physician executive.

Taking action

One of the more challenging tasks facing physician leaders is to know when to intervene and when to sit back and monitor from a distance.

The bad news is that no formula or algorithm exists. However, there are relatively clear signposts that suggest the need to take action. What are these signposts? A useful framework is what we refer to as The Ripple Effect of Executive Action. How does The Ripple Effect of Executive Action work?

1. Identify all individuals, patients and processes that are impacted by the disruptive behavior. The greater the number of individuals impacted, the greater the call to action.

2. Highlight the probable risks to all individuals impacted. The greater the risks, the greater the call to action.

3. Conduct a cost-benefit analysis of acting versus doing nothing. The greater the benefits of acting versus doing nothing, the greater the call to action.

4. Select a way to intervene either through coaching, mediating, referring or disciplining.

In deciding when to act and when to sit back, physician executives need to think about two important leadership questions:

1. What do I unknowingly communicate to others?

2. How can I make sure that I am understood?

Most of us don’t have an accurate answer to the first question. Do people listen to you because of your position and your authority in the organization, or do they listen to you because of the clarity of your statements, the incisiveness of your thinking and the helpfulness of your suggestions?

Most people believe they are listened to because of the latter reasons. But the actual answer may be a combination of the two.

Taking deliberate action begins with deciding to act based on your analysis of The Ripple Effect of Executive Action, then asking...
**Now Hear This**

**Good listening and communication skills are key to dealing with behavior problems**

Listeners may be influenced just as much by the way you say things as by what you say. Your style of communication may be more obvious to others than you may think.

When people listen to you, whether they are your colleagues, your staff, your boss or the disruptive physician, they are listening to the words you use, but they are also reading the nonverbal signals you are sending. The tone of your voice, the way you set your eyebrows, the distance of your chin from your chest as you speak and the decibel level at which you speak are all data points your listeners intuitively use to gather meaning.

Those listening to you are probably only vaguely aware that they are monitoring these non-verbal signals, but the signals convey a cumulative message that adds as much as 55 percent to the meaning of your words.

In dealing with a disruptive physician, it is crucial for you to have some insight into your personal communication—both verbal and non-verbal styles. Physician executives are often better at analyzing the behavior of others than they are at analyzing their own behavior.

It is particularly important to understand how your behavior changes when you are tired, hurried or stressed. These internal conditions become obvious to others from your facial expressions, your tone of voice, the volume you use, the brevity of your comments and a range of attributes that are readily apparent to others, but may be less apparent to you.

Some common communication blind spots we frequently notice in others are:

- Cutting people off before they are finished speaking
- Taking too long of a turn when speaking to someone and not letting them get a word in
- Multi-tasking when we should be listening to someone

It is critical that physician executives demonstrate and model a non-judgmental way of listening and making sense of what they have heard in order to select the best approach to resolving disruptive physician behavior.

So the answer to question #1, “What do I unknowingly communicate to others?” is complex and needs some personal insight.

To answer question #2, “How can I make sure that I am understood?” One practical way is to make sure that the listener is “formatted.”

Formatting the listener is an aspect of being listener-centered. It is a check to make sure that you and your listener are on the same page. Just as you cannot copy a

Continued…
• Communicate in a way that they understand
• Tell the truth fast and hard
• Ignite their competitive strivings

This does not suggest that all physicians displaying disruptive behavior are alpha males or alpha females. However, when dealing with an alpha personality, here are some suggestions:
• Avoid social talk—Skip the preliminaries. As a matter of fact, alpha types tend to avoid people at work who use a lot of social preliminaries. Too much chitchat makes them crazy. With alphas, a little conversation goes a long way.
• Skip the details—The alpha type is highlight-oriented rather than detail-oriented. Too many details tend to complicate their ability to use their strength, which is quick decision making.
• Bring something to hand over—Use structure in the form of bullet points or a chart, a graph or a table. Alpha types want information they can use right away. They are readily persuaded by data that are presented visually.
• Include steps—Because taking action is a strong point for alpha types, play to their strengths by suggesting a few steps that can be taken right away.

Even with these suggestions, results don’t always come right away. Ludeman and Erlandson suggest that those who use the coaching approach should be patient. “Changes in behavior typically begin to show in three to six months as the client harvests low-hanging fruit from our initial coaching effects. Sustained change takes about a year. But the goal of coaching is to change the entire team dynamic, not simply to treat the alpha as an individual problem.”

If physician executives can find success when coaching alphas, then coaching other types will be a lot less challenging and distressing.

Mediation is a form of conflict management that is typically used in situations where both parties agree to seek the counsel of a neutral third party who will serve as a guide to assist in reaching a mutually satisfying agreement to resolve specific issues.

Physician executives can play the role of a mediators in certain cases involving disruptive behavior. However, the following conditions must be firmly established prior to assuming this role:
• Both parties must voluntarily agree to participate.
• Both parties must demonstrate earnest efforts toward achieving a mutually satisfying agreement.
• Both parties must attempt to resolve the clearly defined issues using this process alone.
• The physician executive must be able to consistently act as a neutral third party and take ownership for the process and not for the outcome of the process, which belongs to the two parties.

Referring is another option. Similar to what happens in the clinical practice of medicine, referring is not a public declaration of incompetence or lack of caring, but recognition that the patient requires a resource that cannot be provided by the practicing clinician.

This same logic applies to managerial situations. Do not risk attempting to be the Renaissance person as a physician executive.

Depending on the assistance required, some potential experts for referral are human resource professionals, executive coaches both for document onto a disk or CD unless the disk or CD is first formatted, you cannot copy or place your words in the listener’s head unless you provide clear verbal guidelines to focus the conversation.

In other words, don’t assume anything. When it comes to unambiguous communication, the listener needs structure. Before you begin your conversation with the disruptive physician, collect any data that shows the gap between the expected performance of your organization and the physician’s actual performance. Base your conversation on that data.

The importance of providing a suitable, conversational format for the listener was shown in an experiment to discover how frequently speakers use formatting.

Linguists Charlotte Linde and William Labov conducted an experiment called the New York City Apartment Experiment. They set up an office in New York City as if they were census takers and asked volunteers to describe the layout of their apartments. They found that 97 percent of the subjects described their apartments in a room-by-room fashion as if they were taking the listener on a mental walking tour through the apartment without regard for how the listener was able to visualize the layout of the rooms.

For the speaker, this mental walking tour was an efficient way to visualize and describe all of the apartment’s rooms. For the listener, however, it was quite difficult to visualize the layout. Having never actually seen the apartment, the listener had no context and the speaker did not give any structure to describe the layout of the apartment.
the disruptive physician and/or the physician executive, mediators, mental health professionals and attorneys. Regardless of the setting, it is often wise to seek the advice of legal counsel to mitigate legal risks.

As is true with any consultation, it is important to keep the lines of communication open and to collaborate in the assessment, intervention and evaluation stages of this process.

It is particularly important in managerial situations that issues related to confidentiality, conditional employment and other legal matters be clearly identified prior to establishing a relationship with any referral source. It is also important to clarify who the client is because the client may be different from the individual who is paying the referral bill.

**Disciplining** is the consequential process when coaching, mediating and referring fail to yield expected results, or for those situations in which the single behavior is so egregious that discipline is the first response.

Disciplining is not to be associated with punishing. They are not the same. In fact, disciplining is a more tailored coaching process in which the physician executive clearly spells out the range of consequences—both positive for demonstrating the expected behavior and negative for continuing the disruptive behavior.

A key success factor when disciplining is to make certain that the physician executive has access to consequences. For example, when coaching and mediating have failed to work, the physician executive may find that the physician displaying disruptive behavior did an end run to neutralize all consequences that the physician executive was about to initiate.

To avoid this problem and ensure access to consequences, go to your boss and other key stakeholders in the power hierarchy prior to disciplining to make sure that you can impose specific consequences.

In the end, preventing and managing disruptive behavior is directly proportional to your organization’s underlying performance management system and associated policies and procedures.

Physician executives dealing with disruptive behavior should be able to clarify their roles and responsibilities and act accordingly, being careful to act as stewards of organizational resources rather than “lone wolves” against other lone wolves.

Managing disruptive behavior is one of the most stressful and challenging tasks that any physician executive faces, but the rewards of directly addressing this behavior when it first occurs reaps many dividends for patients, for staff and for fellow physicians.

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**By Timothy Keogh, PhD and William Martin, MPH, PsyD**

**Reference:**


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**Reference:**

Aretha Franklin captured the attention of audiences worldwide with her smash hit R-E-S-P-E-C-T. Embedded in the lyrics of this song is a leadership maxim: Find out what it means to me.

The Queen of Soul is telling listeners, including physician leaders, that respect is individually defined. The challenge for physician executives is to find out how each of their direct reports, colleagues and patients defines respect. Then, they must act accordingly.

Consider this case

A physician assistant who reports to one of your physicians at a clinic approaches you for the third time in a month with a complaint. “I know that you must be tired of me coming to you about Doctor X but I am sick and tired of Doctor X not respecting me. Doctor X has no respect for me or anybody else in this clinic.”

In this case, Aretha Franklin’s lyrics should be the prompt for your response. “In order for me to address this very important issue, it is critical for me to understand what you mean when you say Doctor X does not respect you. Can you give me some examples of when people at work respect you and when they don’t respect you so that I can fully understand this from your perspective?”

At this point, most people will share stories with you or list a number of characteristics that demonstrate respect or the lack of it. Based on that information, you have the behavioral expressions of respect for this individual. Now you are more fully prepared to approach Doctor X with some tailored behaviors that will signal a greater show of respect.

Another way that physician executives approach the challenge of respect is to shape the organizational culture to show that respect is a cornerstone of that culture. Lynn Sharp Paine, author of Value Shift, shares the following perspective of culture shaping:

“Managers talk about values as essential for encouraging cooperation, inspiring commitment, nurturing creativity and innovation, and energizing the organization’s members about a positive self image. They seek ideals like respect, honesty, and fair dealing as the building blocks of a high-performance culture . . . [Employees] want to be respected, treated fairly, and recognized for their contributions. They prefer colleagues who are trustworthy and who can be counted on to keep their promises.”

Moreover, the benefits of taking action will accrue to the group and to the organization and shape the culture for the benefit of the patient.

Reference:

Disruptive Behavior and the Law

By Susan Lapenta, JD

Hospitals and other health care entities have a duty to provide an environment where care can be delivered to patients in a safe and effective manner. Fulfilling this duty can be complicated, if not outright compromised, by a single physician whose disruptive actions divert energy, resources and attention away from patient care.

The American Medical Association defines disruptive conduct as “personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively.” According to the AMA, disruptive conduct “includes but is not limited to conduct that interferes with one’s ability to work with other members of the health care team.”

Interestingly, the disruptive physician is often described as bright, charismatic, charming and engaging. In the same breath, the disruptive physician is often described as controlling, tenacious, unpredictable, threatening and intimidating.

It is not uncommon for others in the community (including people who have been repeatedly victimized) to rate the disruptive physician as among the most competent in his or her specialty. These seemingly contradictory traits are probably one of the reasons the physician is able to continue engaging in unacceptable behavior for so long.

In an attempt to deal with problem behavior, many medical staffs adopt a code of conduct. It is helpful for the code of conduct to expressly state that all staff members “must treat others with respect, courtesy and dignity and conduct themselves in a professional and cooperative manner.” The code of conduct should also identify the types of behaviors that are considered unacceptable.

Each institution has great latitude in setting its own standards of conduct. A well-defined code of conduct is one mechanism for communicating expectations about behavior. Medical staff and hospital leaders can refer to the code of conduct when concerns are raised about a physician’s behavior.

IN THIS ARTICLE...

Review the procedural and legal steps you should take to effectively deal with physicians with behavior problems.

Start with collegial intervention

Rarely does a single episode of inappropriate conduct result in action being taken against a physician. With a truly disruptive physician, leadership is more often faced with chronic complaints from employees, other physicians, and even patients. Even then, meaningful action often does not occur until there is a significant event like the resignation of a key employee, an adverse clinical outcome or worse.

Although medical staff bylaws (and credentialing policies) contain an investigation process that can be used to address disruptive conduct, it is preferable to start with, and exhaust, less formal mechanisms first.

A progression from informal review to formal investigation helps establish a record that will reflect all of the various steps taken to resolve the inappropriate conduct before professional review action is imposed.

The first step in dealing with disruptive conduct should be collegial intervention. Collegial intervention involves medical staff or hospital leaders meeting with the physician in question. Collegial intervention is not intended to address immediate issues but is a means to determine whether intervention is necessary. If collegial intervention is not successful, it is often helpful to include the vice president of medical affairs, the chief
executive officer and maybe even
the chair of the board.

The goals of collegial interven-
tion are to:

1. Inform the physician of the
   nature of the concern raised
2. Explain what conduct is accept-
able and what conduct is not
   (reference the code of conduct to
   help communicate this message)
3. Advise the physician of the con-
   sequences if concerns are raised
   and confirmed in the future

The outcome of collegial inter-
vention might be a letter of guid-
ance or counsel. If complaints con-
tinue to be received, the result of
the collegial intervention might be
a letter of warning or a letter of
reprimand. Some bylaws or policies
even allow for the imposition of a
short-term suspension by medical
staff or hospital leaders.

Another very effective tool in
dealing with a disruptive physician
is imposing specific conditions of
practice. The conditions of practice
become a personalized code of
conduct for the disruptive physician
and outline requirements that the
physician must satisfy if he or she
wishes to continue to exercise
privileges at the hospital.

**Adopt code of conduct**

In drafting this personalized
code of conduct it is important to
be both very specific and all-
compassing. If the conditions are
not explicit, this physician will like-
ly take advantage of the vagueness.
Restating the requirement to abide
by all medical staff and hospital
bylaws, policies, rules, regulations
and procedures can be useful.

The conditions of practice
should also put in place a mecha-
nism for monitoring the physician's
activities and should outline conse-
quences if the physician fails to
meet the required standards. This
approach is effective because it
defines, in clear and concise terms,
what is expected of the physician
and the consequences if these
expectations are not satisfied.

Another key element of the
conditions of practice is to define
the scope of any future hearing
should there be a breach. The hear-
ing should be limited to whether
the conditions of practice were vi-
olated, not on the long-standing his-
tory or pattern of disruption that led
to their imposition.

Limiting the scope of the hear-
ing through the conditions of prac-
tice will make the hearing much
more manageable. At the same
time, the hearing will afford physi-
cians an opportunity to demonstrate
that they met the conditions.

**Don’t forget to document**

It is imperative that any action
taken against a disruptive physi-
cian be documented. Documentation is
especially important since leaders of
the medical staff are likely to
change. Without documentation,
there is no institutional memory of
previous attempts to change the
physician’s behavior. The documenta-
tion should include:

- Date and time of the incident
- A factual description of the
  questionable behavior and
  circumstances that precipitated it
- Names of witnesses
- Consequences of the behavior as
  it relates to patient care or
  hospital operations
- Any action taken to remedy or
  intervene in the behavior

All documentation should be
kept in a central place, typically the
physician’s credentials or quality
file. The physician should have an
opportunity to see any documenta-
tion that is created and to respond
to it. A secret or private file creates
both legal and practical problems
and should be avoided.

The bad news about dealing
with disruptive physicians is that
they are more likely than any other physician to file a lawsuit against those involved in imposing the disciplinary action. The good news is that courts all around the country have recognized the authority of a hospital to take action against physicians for reasons related to inappropriate behavior.

Additionally, the Health Care Quality Improvement Act of 1986 provides substantial protection in the form of immunity to peer reviewers when professional review action “is based on the ... professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients).”

In numerous cases, courts dismissed actions brought by physicians who had been subject to a suspension or restriction of privileges based on their behavior. Even prior to the adoption of HCQIA, courts routinely upheld the decisions of hospitals to take disciplinary action against physicians based on bad conduct.

As strong as the immunity under the HCQIA is, it is not absolute.

In Clark v. Columbia/HCA Infor. Services, Inc., 25 P.3d 215 (Nev. 2001), the Nevada Supreme Court refused to grant immunity, finding that the hospital’s revocation of privileges was in retaliation for the physician’s whistleblowing activity (the physician had written letters to the Joint Commission on Accreditation of Healthcare Organizations and the state board expressing concerns over quality of care).

This whistleblower defense is likely to be exploited by the disruptive physician, so it is imperative that medical staff and hospital leaders fully and carefully review all quality-of-care concerns, including those raised by the disruptive physician.

References:
1. AMA Code of Medical Ethics, E-9.045 Physicians with Disruptive Behavior.
2. In a study conducted by VHA West Coast, respondents saw a direct link between disruptive physician behavior and nurse satisfaction and retention. The survey also found that 92.5 percent of the respondents said that they had witnessed or experienced disruptive behavior by physicians. Cited most frequently was yelling, raising the voice, disrespect, condescension, berating colleagues or patients, and use of abusive language. Rosenstein AH. “Nurse-Physician Relationships: Impact on Nurse Satisfaction and Retention.” American Journal of Nursing, June 2002.
Doctors Doing Drugs and Drinking

Some physicians with substance abuse problems are protected by family and friends

By Monique Fields

Editor’s note: Names of the doctors interviewed for this article who freely talked about their past substance abuse problems are being kept confidential in order to protect their privacy.

As a director of pharmacy at a California hospital, Dr. Kevin stole Vicodin, Percocet, Demerol and morphine. He used them to get high, and there was no way for his colleagues to detect his abuse of his authority.

Dr. Kevin’s deceit was an inside job. He knew that when drugs reached their expiration date they would be good for another six months to a year. When 10 pills came back from the hospital floor, he logged in that five came back. If anyone ever checked, they would find the inventory of the five pills and never miss the five he put in his pocket.

He exploited a sad reality.

A hospital’s accountability doesn’t work when the abuser is one of its very own. Pharmaceutical paperwork where Dr. Kevin worked required two signatures. As the supervisor, Dr. Kevin was always the last to sign off on such transactions. Even when confronted about his erratic behavior, he had a solid alibi. No drugs were missing and hospital records proved it.

“They actually would have never caught me until I died,” Dr. Kevin says.

The reason: Physicians tend to be better at hiding their addictions, drug treatment experts say.

That may correspond with the findings of ACPE’s Physician Behavior survey where the vast majority of respondents indicated that substance abuse was behind bad behavior in only 10 percent or less of the cases. Several survey participants noted, however, that it’s often difficult to determine if a doctor has a problem with drugs or drinking.

What’s more is that family and colleagues help doctors keep alcohol and drug abuse out of sight. Family and colleagues look the other way when seeing troublesome behavior, failing to report it. As a result, the disease gets a head start, sometimes making treatment more complex and difficult.

The delay getting treatment is just putting off the inevitable, says Warren Pendergast, MD, associate medical director for the North Carolina Physician Health Program, one of more than 40 treatment programs nationwide specially designed for medical professionals.

“The problem is going to come out eventually,” he says.

That’s what happened to Dr. Kevin.

One of his supervisors knew he was doing something, but he couldn’t prove it. The supervisor watched as Dr.
Kevin couldn’t keep his mind focused on his job and noticed when he fell asleep at the counter. The supervisor didn’t smell alcohol and cast that possibility aside. He also says he knew Dr. Kevin wasn’t taking anything from the pharmacy because he had checked all of the records. Dr. Kevin laughed at those words, knowing he had duped his supervisor. In the end, it would be the first of six such confrontations.

**Longtime habit**

By the time Dr. Kevin started stealing drugs from hospitals, he had been abusing alcohol and drugs for years. He started drinking alcohol to fit in when he was 16. He quickly graduated to marijuana and then to opiates and tranquilizers. He used the drugs to kill the fear, the fear of the unknown. He didn’t feel comfortable in his own skin until he had some alcohol or drugs in his system. On top of that, he chose a field where he would have unfettered access.

That’s the primary difference when it comes to doctors and other abusers. Colleagues don’t believe doctors would put their careers in jeopardy. For their part, doctors also have garnered a significant amount of respect by the time they walk through hospital doors and begin practicing medicine.

Or as Pendergast puts it: “People just don’t think of doctors getting sick.”

Dr. Kevin, though, was sick. He flunked out of his first treatment program, going on a five-day binge of valium, amphetamines and cocaine just days before he was set to graduate. The second time around he lasted 88 days. When he finally confronted his addiction, he freed himself of alcohol and drugs for more than two years.

But it only took one sleeping pill for him to relapse. One tiny, 0.25 milligram Halcion. That one pill set off a chain reaction that left Dr. Kevin so high he couldn’t pick himself off the floor when he needed to urinate. Like most abusers, Dr. Kevin was in denial.

A recovering addict has at least one sponsor, a mentor of sorts who has experienced some of the same challenges. When Dr. Kevin's sponsor moved to another city, he convinced himself that he could be his own sponsor.

At the same time, Dr. Kevin’s job was keeping him awake at night. He had been charged with completing a pharmaceutical report for the Joint Commission on the Accreditation of Hospitals, covering three years. But Dr. Kevin only had been at the hospital for two years. He spent his time fabricating information for the third year of the report. When a doctor suggested he take a sleeping pill to alleviate his bouts of guilt, Dr. Kevin’s support system wasn’t there. He took the sleeping pill. Then he went to get 100 more.

“To whom it may concern,” he prayed, as he lay on the floor that day. “Help me or let me die.”

By that time, Dr. Kevin had failed and succeeded in treatment. He had friends who knew how to help him. He turned to them, and one let him get sober at his home. That friend also gave Dr. Kevin an ultimatum—tell an administrator at the hospital about his drug abuse. Dr. Kevin obliged, turning himself in one day in December 1992.

“If I hadn’t turned myself in,” says Dr. Kevin, “I don’t think I would be alive today.”

Dr. Kevin, 47, survived, but his career didn’t. His license was suspended for four years and he never returned to a pharmacy. Today, he is a courier, traveling the globe as he helps transports equipment. He has been sober for nearly 12 years.

Dr. Kevin’s addiction could have taken a blow much sooner. His enablers were his family, his colleagues. No one stepped up and confronted him. They feared for his life and said nothing.

‘Quiet’ addiction

There are more like him, more doctors who exhibited the tell-tale signs of abuse.

But for reasons that astound some professionals, doctors are
often allowed to quietly consign themselves to addiction.

Like Dr. Kevin, Dr. Bob took his first sip of beer at age 16. When he took his last drink, some 44 years had passed. He didn’t lose his job or his family, but he severely limited his achievement in medicine.

In the end, he drank every day, getting drunk on the weekends. What he got in return was a pair of shaky hands, tremors so powerful he couldn’t control them. Dr. Bob, too embarrassed for colleagues to see his hand tremors, took himself out of the operating room. He even applied for and received administrative duties, casting aside years of medical training as an obstetrician/gynecologist so that he could continue to drink.

He compensated for his drinking in any way that he could. His memory lapses, for example, were so profound he wrote notes to himself, particularly at night.

“In all those years, I never saw a patient (while I was) drunk,” Dr. Bob says. “I was never in the operating room drunk. But I was certainly hung over seeing patients.” When confronted by family or colleagues, he was embarrassed, professed his guilt, promised to cut back. And he did, if only for a short time.

But soon the cravings would return, and Dr. Bob turned to the bottles he had hidden everywhere. He had bottles stashed in his car, in his briefcase, in all corners of the house. He drank on the way to work. He had a glass of wine with dinner. His wife went to bed and he stayed up to drink.

“It was so gradual and so insidious,” says Dr. Bob, now in retirement.

“My motivation was suffering. I was becoming more and more isolated.” He was passed over for a promotion, in part, because of his drinking. He left a job where he was an administrator for an HMO and went to work for a California county health department, again severely limiting his growth as a medical professional.

There, he was in a meeting one morning when a colleague smelled alcohol on his breath. The colleague suggested he seek treatment, but stopped short of reporting him to the medical board, primarily because he wasn’t seeing patients at the time. He knew he had a problem, but he didn’t want to seek treatment too soon. He didn’t want to quit. He also was scared treatment wouldn’t work. If the treatment failed, he knew there was nowhere to turn. So, he didn’t go. But the idea has been planted in his head.

The fellow doctor checked up on him periodically, prodding him for answers about his treatment. He finally went to meetings, but only to manage his drinking. He figured he would cut back on his drinking, not stop. But he couldn’t fight the cravings. He talked himself into having one last drink. He argued with himself that day, but he trusted his drunk self more than his sober self.

A few days later, though, his wife, who had talked to him about his drinking, smelled the alcohol. Busted for the last time and knowing he couldn’t stop drinking on his own, Dr. Bob went to a 12-step program.

“There was no hope for me,” he says. “I could not stop.” He hasn’t had a drink since that day his wife smelled the familiar odor on his breath. That was six years ago. But Dr. Bob lamented that his drinking was tolerated at work. He called for help on more than one occasion:

• There was the time he talked with his doctor about possible liver damage and the doctor missed the clue.

At the North Carolina Physician Health Program, one of more than 40 treatment programs nationwide for doctors, the number of physicians assessed each year has steadily increased over the last 16 years. In 1988, the program assessed 26 physicians with some sort of substance abuse or behavior problem. Ten years later in 1998, they assessed 65, and, in 2003—the last year for which statistics are available—they assessed 138 physicians. (The program assesses physicians and, if necessary, refers them to appropriate treatment programs.)

Here’s a look at the types of problems the NCPHP has assessed and numbers of cases they’ve handled:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>2003</th>
<th>Total in Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aging</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Alcohol</td>
<td>25</td>
<td>368</td>
</tr>
<tr>
<td>Amphetamine/Stimulant</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Barbiturate</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>Dual Diagnosis</td>
<td>10</td>
<td>63</td>
</tr>
<tr>
<td>Marijuana</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Opioids/Analgesics</td>
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<td>152</td>
</tr>
<tr>
<td>Polydrug</td>
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<td>143</td>
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<tr>
<td>Psychiatric Disorder</td>
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<td>178</td>
</tr>
<tr>
<td>Sexual Misconduct</td>
<td>7</td>
<td>102</td>
</tr>
<tr>
<td>Other</td>
<td>26</td>
<td>211</td>
</tr>
<tr>
<td>Unsubstantiated</td>
<td>26</td>
<td>116</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>138</strong></td>
<td><strong>1389</strong></td>
</tr>
</tbody>
</table>

At the North Carolina Physician Health Program, one of more than 40 treatment programs nationwide for doctors, the number of physicians assessed each year has steadily increased over the last 16 years. In 1988, the program assessed 26 physicians with some sort of substance abuse or behavior problem. Ten years later in 1998, they assessed 65, and, in 2003—the last year for which statistics are available—they assessed 138 physicians. (The program assesses physicians and, if necessary, refers them to appropriate treatment programs.)
• There was the time another doctor asked leading questions about his drinking. “You probably drink socially, right?” Dr. Bob recalls. “Taking a history like that is worthless,” he says.

**Difficult diagnosis**

If alcohol and drug abuse are complex diseases, diagnosing and treating doctors who suffer from them is even more so. Dr. Bob has developed his own theories about why such behavior is tolerated, especially when the risks are so high.

“I think (doctors) are in denial about the role of alcohol in their own lives,” he says. “They’re afraid to deal with their own (addiction) and that makes it easy for them not to deal with others.”

If someone had confronted him, turned him into a supervisor and threatened to go further, Dr. Bob says he would have sought treatment sooner. “I should have been reported.”

Instead, he got warnings not to let it happen again. The colleague who finally confronted him wouldn’t let him off so easy.

“When I am honest with myself, I was jeopardizing patient care,” he says. “I was not as attentive as I should have been and just getting by. Mostly I was giving 200 percent effort to behave normally.”

The lack of normal behavior is a tip off of sorts. Another abuser, Dr. Robert, for example, scheduled his drinking around his work. He didn’t have clinics for Friday afternoons, leaving time to prepare for his weekend binges. He also didn’t schedule surgeries on Monday mornings, giving himself time to recuperate from the previous weekend’s drinking.

Other odd behavior: Dr. Robert turned over his medical duties to others because he was incapacitated. He didn’t show up for work at the scheduled time and made rounds after midnight.

“My job began to suffer,” Dr. Robert says. “I worked hard to protect my right to drink. I performed as well as I could. I volunteered for the tough assignments. I tried to be as good as I could so that people wouldn’t fuss with me about my drinking.”

A simple rotation saved his life.

Dr. Robert, a general surgeon at a west coast Naval hospital, was required to spend some time in a visiting doctor program at the hospital’s treatment facility for addicts. Dr. Robert knew he was sick, confessed he should be the patient, not the doctor. He was sent home to gather his belongings. Soon he was a drug treatment patient in his own hospital.

Dr. Robert, now 64, doesn’t suggest anyone do what he did. But the lack of anonymity forced him to get real with himself, his drinking and his colleagues. He has been sober for 25 years. He knows his colleagues allowed his disease to progress so that he could retain his career.

Experts say such enablers aren’t really helping.

“The professional consequences get worse,” says Pendergast. “The addiction continues. By the time it’s detected, it’s worse. Sometimes there is a sense of needing to get negative drug screenings and not to get treatment.”

Doctors also are confident, almost bullying those who question their behavior. “You can test me every day,” is a phrase Pendergast has heard countless times while trying to help doctors.

The ramifications of reporting a doctor, especially a superior, sometimes have far reaching effects, particularly for clinics and some specialties.

“If you do report your boss, he may go away and the clinic will suffer,” Pendergast says. Such thinking, though, is short-sighted.

The medical profession is more accepting of doctors who seek treatment. A number of programs are in place and allow colleagues to refer a doctor to treatment without putting his job in jeopardy.

Educating doctors about how to make referrals and what making a referral means will slowly change the secrecy of alcohol and drug abuse among doctors, says Marsha Epstein, MD, a service planning medical director in Los Angeles.

Epstein has successfully referred doctors to Alcoholics Anonymous. She recommends that physician executives who have a physician with alcohol or drug problems be referred to AA or another appropriate agency. Physicians executives might also consider attending an open AA meeting or an Al-anon meeting to learn more about substance abuse.

“You can’t make them go. But some of them are going to go just by your doing that.”

Another, more personal strategy brings similar results. Epstein says doctors are moved when they hear the stories of recovering doctors who share their experiences and show others through their stories that there is hope.

“When you hear somebody tell their story, it’s so inspiring.”

**Monique Fields** is a journalist for the St. Petersburg Times in St. Petersburg, Fla., and also an accomplished freelance writer. She can be reached through her Web site at www.moniquefields.com
The average medical man is an educated gentleman, a delightful companion, a man of parts, and many such are our best friends. But doctors, when associated in corporate matters, are oftentimes too self-seeking. With an eye out for their profession, they are inclined to be aggressive, and naturally, under such conditions are not a gracious, peaceful, easily cooperative body of men.

—George H.M. Rowe, MD, Association of Hospital Superintendents, 1902

Agnes Miller, RN, an excellent staff nurse on 3-North, has a problem.

Dr. William Smith’s patient in room 322 has suddenly developed a serious post-operative complication that requires immediate transfer to the intensive care unit. Miller does not have the authority to order the transfer, Smith cannot be reached, and the surgeon covering for him is in surgery and cannot call back for three hours.

Miller calls VPMA Dr. John Ames, who has no clinical practice, but is available to help nurses with physician issues. "Get the patient to ICU, now," Ames orders.

Smith returns, picks up his phone messages and learns that his patient has been transferred to the ICU without his prior consent. He immediately goes to the ICU and angrily writes two orders:

“Transfer this patient to the care of Dr. Ames!”
“Cardiology consult STAT.”

Smith then takes Miller aside and tells her that if this ever happens again he will see that she is fired.

The vice president of nursing tells Ames about the angry record entry and the insult to Miller. Ames is surprised because Smith is an excellent surgeon. In addition, although Smith frequently disagrees with management, he is an articulate and often helpful dissenting voice, not a troublemaker.

Ames orders the offensive entry purged from the record, gets the whole story from Miller and decides on a strategy for confronting Smith.

First, he contacts the chief of surgery, explains, and says, “May I borrow your authority? I would like to handle this.” The chief of surgery is more than happy to stay out of the matter altogether.

Ames then allows an overnight cooling off period. The next day he calls the operating room and leaves a message for Smith, asking him to come by between cases.

When the two meet, Smith immediately says, “John, I guess this is about that childish, idiotic thing I did on 3 North yesterday. I have already apologized to the nurses.” Ames reads the situation quickly and decides that no further action is necessary.

“Dr. Smith, here is what I want to tell you in no uncertain terms. I don’t mind you transferring patients to me, but don’t you ever order a cardiology consult on one of my patients again. Do you have time for lunch?”

Impatience and frustration

Does this incident sound familiar? Situations like it are commonplace and it is time for physician executives to pay attention to these bursts of anger and arrogance from physicians who are physically and mentally intact, and whose emotions are ordinarily under control.

Outrageous incidents like alcohol or drug abuse or a physical altercation are much easier to handle than these more subtle, infrequent behavior problems that crop up among physicians.

By temperament, by training, by inference (doctors order nurses), and because of their unique God-like importance to sick and injured people, physicians are famous for assuming that impatience, frustration and disrespect are acceptable characteristics.
They are not.
Physicians find several features of today’s health care system frustrating. Forty percent of practicing physicians in one survey feel that they are “plagued by bureaucracy, loss of autonomy, diminished prestige and deep personal dissatisfaction.” And 40 percent say they would not enter the medical profession if they were deciding on a career today.¹

Physician frustrations with managed care include heavy paperwork, restrictions on referring patients to colleagues and being urged to design diagnostic workups according to cost instead of patient need.

Physicians are also frustrated with multi-layered management bureaucracy in their organizations. In the ACPE Physician Behavior Survey, respondents report that nearly 52 percent of problems with physician behavior involve refusal to complete tasks or carry out duties. Presumably, this means in part, that physicians do not meet expectations of executives and managers who assign organizational duties. What are we expecting of practicing physicians and how are we expressing our expectations?

In the ACPE poll, nearly 83 percent of respondents reported that physician behavior problems involved disrespect, and 56 percent of problems involved conflict with a nurse or physician’s assistant.

Conflict with nurses is sometimes an expression of disrespect. Nursing advocates justifiably ask for the three R’s: respect, recognition, and reward.² In one sense that means economic respect and is a plea for adequate pay for nurses. Other times nurses resent the fact that physicians feel superior to nurses. Since most nurses are women and most physicians are men, gender issues also come into play in doctor/nurse working relationships.

Some physician disrespect for nurses is actually a manifestation of resentment and insecurity. Doctors must increasingly share the health care stage with nurses and some doctors don’t like that at all.

**Ethics of it all**

Physicians who display impatience, frustration or disrespect are abandoning their professional ethics. Most professional organizations have written codes of ethics, all of which require some version of competence, dependability, respect, courtesy and diligent effort.

For physicians, part of the professional ethic is putting patients’ needs ahead of other considerations. A physician abandoning the professional medical ethic by behaving unprofessionally is ironic, because the same physician might be loudly critical of managed care for abandoning that part of the professional medical ethic that requires putting patients ahead of profit.

In a 1937 code of behavior for interns and residents in training, doctors were encouraged to develop desirable personal habits and attitudes including the following:

- Make promises sparingly and keep them faithfully.
If we continue to treat physicians like spoiled children then some of them will continue to act like spoiled children.

- Praise good work done regardless of who did it. If criticism is warranted, criticize helpfully, never spitefully.
- Preserve an open mind on all debatable questions. Discuss, but don’t argue. It is a mark of a superior mind to disagree and yet be friendly.
- Pay no attention to ill-natured remarks about you. Simply live so nobody will believe them. Disordered nerves and poor digestion are common causes of backbiting.3

In the ACPE survey, nearly 72 percent of respondents reported having a written code of behavior in their organization. Unfortunately, written codes of personal behavior resemble prominently posted, altruistically worded codes of business ethics. That is, they are nice window dressing but actually have little impact.

Reporting instances of physician misbehavior is an important issue. There is a fine line between demonstrating support for employees, patients and the medical staff on one hand, and on the other hand carefully distinguishing trustworthy reports from tattling, spying and carrying out personal vendettas.

In the ACPE poll, 29 percent of respondents indicated that behavioral problems were under-reported because of fear the physician would retaliate. Sixty-three percent of respondents reported that physicians were treated more leniently than employees because of their professional stature.

In these two matters, the ethical ball is in management’s court. If we continue to treat physicians like spoiled children then some of them will continue to act like spoiled children. Expectations of professional behavior should be made clear, although not used as organizational threats.

They should apply to anyone involved with patient care from telephone operators to prima donna practitioners. If you have not yet tried it, you will be amazed to find that such insistence on professionalism wins respect, not ridicule, from those physicians whose opinions really matter to you.4

The manner of handling instances of misbehavior must fit the nature of the offense. The true story that opens this column exposes the mistaken belief that management must always take a hard line. Indeed, as a consultant I have encountered situations where a reasonable physician was turned into a behavior problem because he was badly managed by organizational authorities.

In the ACPE poll, talking to the offender was part of the strategy 94 percent of the time. Handling disruptive incidents without causing escalated disruption requires imaginative application of analytical observation skills and productive interaction techniques.

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References
Physician compensation is a sensitive issue that should be approached with caution and objectivity.

Physician practices usually attempt to distribute funds in a fair manner. However, at times, unequal distribution occurs and, if unintentional and unintended consequences result and are not addressed in a timely manner, they will have a divisive impact on the practice.

Physician compensation review should be a standard, recurring task by the practice, preferably coincident with the group's annual operational and financial planning process.

Compensation tends to be the most contentious and divisive issue within a physician practice as factors such as resource consumption, staffing, personal lifestyle, practice habits, physician specialty, payer mix and quality all have to be taken into consideration.

Additionally, as the sole producers of revenue, physicians not only desire to maximize their incomes, but they need to generate sufficient funds to ensure that the practice remains viable and that the necessary investments are made in staff, physician recruitment, training, information systems, equipment and facilities.

Here’s a look at two typical compensation models:

- **Private Practice Model**—Physicians who have experienced the dynamics of private practice are very familiar with productivity-based compensation. A private practice physician's compensation is limited only by his/her ability to generate and collect revenue, and control expenses. Successful private practitioners are constantly trying to raise revenues and reduce expenses in order to increase their personal incomes. While enjoying unparalleled freedom to direct all aspects of their practices, private practitioners are also exposed to all of the risks associated with owning a business. If revenues decline or expenses increase, the physician’s compensation will immediately decrease.

- **Employment-Based Salary Model**—With the rise of large group and hospital-owned practices, increasing numbers of physicians have become employees in an effort to achieve a degree of income stability. Traditional compensation models for employed physicians include a high base salary that provides the physician with income stability, but may reduce the incentive to contain costs or strive for high productivity.

**Legal issues**

Anti-kickback statutes and Stark regulations prohibit physicians from referring Medicare or Medicaid patients for the delivery of a range of designated health services to entities with which they have a financial relationship.

Included in the list of designated health services are clinical laboratory services, radiology services, inpatient and outpatient hospital services and several other services. Recently promulgated regulations may increase scrutiny of compensation arrangements within physician groups.

A violation of the Stark Law may result in severe financial penalties that could include fines, loss of Medicare and Medicaid reimbursement and exclusion from participation in those programs. Fortunately, the Stark Law provides for several exceptions including an exception for compensation arrangements that meet certain standards.

To qualify for an exception, a compensation arrangement must, among other things, be consistent with fair market value, promote financial viability of the organization and further the legitimate business purposes of the parties.

The challenge in designing a physician compensation system is to balance the various countervailing forces. The desire to provide physicians with a degree of compensation stability, and reward high productivity and quality, must be balanced with the need for organizational viability and compliance with federal regulations including appropriate documentation and coding.

**The basics**

The primary objective of a physician compensation plan is to ensure that physicians act as if they have a personal investment and financial stake in the success of the medical group. This is obvious for private practice groups. In employed and/or salaried situations, it is easy
to lose perspective between productivity, overhead expenses, collections and compensation.

Subject to certain constraints, physicians should be compensated from a pool that remains after all expenses of the business are paid. The amount available for distribution should be allocated based on a combination of individual productivity, consumption of practice expenses, certain quality and collaborative benchmarks and rewarding group behavior.

Although there are a lot of inputs into distributing income from the practice’s operating margin, the group should strive to keep the formula as simple as possible. At a minimum, the following components should be factored into developing the compensation formula and calculating the distribution of the operating margin.

- **Attract and retain quality physicians**
The compensation model must provide for a level of income that is competitive in the market in order to attract and retain quality physicians.

- **Provide personal and organizational incentives**
The compensation model must provide incentives that reward physicians based on their individual level of performance. In addition, the model must provide incentives for contributing to the high performance of the organization as a whole.

- **Promote organizational viability**
The compensation model must promote the viability of the group by encouraging the efficient utilization of resources such as staff, supplies and physical space. The model must also ensure that physician compensation is appropriate and not considered excessive according to legal and regulatory guidelines.

- **Promote quality service and clinical quality**
The compensation model must distinguish excellence in customer service and provide mechanisms to recognize and promote high clinical quality.

- **Evolve with industry trends**
The compensation model must be flexible enough to evolve and adapt to changes in managed care penetration, market rates of pay, and demand for services without needing to be completely redesigned.

- **Simple to understand**
The compensation model must be based on simple, easy-to-understand principles. The components of the model must be straightforward and physicians must be able to understand which components they can directly impact in order to affect their compensation.

- **Base compensation**
Although many practices operate purely on a productivity-based compensation system, there are many instances when a base salary or floor makes sense for the practice. Examples include calculation of pay for time off, regular pay to meet personal expenses, new physician recruits and employed physicians. The base should be set at 40 to 60 percent of a physician’s total compensation. The actual distribution of compensation of under the “base salary” method is only sustainable in the long run if the practice generates sufficient operating margin to support established salary levels.

- **Production compensation**
Production compensation should represent a significant portion of the compensation model to ensure that each physician has the incentive to generate a high level of volume. This component generally accounts for at least half of a physician’s compensation and, under some models, represents the entire physician’s compensation. Calculation methodologies include use of RVUs, collections, work time, adjustments for payer mix and direct allocation of practice resources.

- **Service quality compensation**
In order to offer some balance to a productivity-based compensation model, service/quality should be factored into the calculation. Reserving between 10 and 15 percent for this component will offer sufficient incentive for a physician to pay attention to patient satisfaction.
Evaluating Your Compensation Plan

Every compensation plan should be reviewed annually. It is important for the group to determine if market conditions, reimbursement levels and increasing expenses allow the current methodology to remain sustainable. This requires a detailed financial and operational analysis of the practice.

An effective starting point to determine if your plan is meeting its intended goals and objectives is to perform a Strengths, Opportunities, Weaknesses and Threats (SWOT) analysis of the compensation formula. Following are some ideas that a group can use to perform its own analysis.

Strengths
1. Ability to earn better-than-average compensation
2. Incorporates productivity, resource/expense management and quality into the formula
3. Cooperative, open and collaborative relationship between administration and physicians
4. Formula is not overly complex and can be readily modeled against changes in market conditions

Opportunities
1. Adjust formula to allow for some sharing of risk for financial performance
2. Demonstrate success in achieving high patient satisfaction to influence reimbursement levels
3. Maintain competitive compensation to allow for continued growth and attraction of high quality physicians

Weaknesses
1. Minimal downside risk for physicians on guaranteed salary
2. Substantial rewards possible for poor expense management
3. Poorer performing physicians have the ability to gain excess compensation from quality and satisfaction components

Threats
1. Difficulty in maintaining compensation pool at desired level due to increasing industry-wide expense structure
2. Maintaining high revenues and manageable expenses in a primary care based group
3. Potential for reimbursement backlash if insurance costs continue to increase at an accelerating rate

• Cost containment
The cost containment component is based on how effectively the practice manages non-physician costs. This component should have a 5 to 10 percent impact on each individual physician’s compensation. Without an emphasis on cost containment and expense management, it is possible for a physician to create an unacceptable level of expenses in proportion to the revenues generated.

The compensation plan should be reviewed frequently to ensure that its intended objectives are met and revisions are made to ensure the distribution methodology is not adversely impacting individual physicians and the practice as a whole. A regular review of the plan will likely result in perceived winners and losers. The practice’s ability to address compensation issues and move forward in a collaborative manner plays a significant role in determining the dynamics and strength of the group.

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Survey highlights

The survey asked about the types of disruptive behavior witnessed or experienced. The most frequent responses included:

- Disrespect
- Berating colleagues

What were the issues or events that precipitated disruptive behavior?

Nurses felt that the most common circumstances involved placing calls to physicians to clarify physician orders. Physicians indicated that orders not being carried out correctly or in a timely manner were the biggest problems.

The survey found that disruptive outbursts occurred most frequently in operating rooms, medical-surgical units, intensive care units, emergency departments and obstetrics areas.

When asked about disruptive behavior by physician specialty, general surgery ranked number one, followed by cardiology and cardiovascular surgery, neurology and neurosurgery, orthopedics, obstetrics and anesthesiology.

Another survey question asked how serious an issue disruptive physician behavior was at the hospital. The overall response to this question was 6.77 on a scale of 1-10, with 10 being extremely serious.

When asked how important a factor disruptive behavior is for nurse satisfaction and morale, the total group response was 8.01—the highest score in the survey.

Nearly 37 percent of the survey participants indicated that nurses were leaving their hospitals as a result of disruptive behavior. Of those who responded positively, the average number of nurses reported leaving per year was 2.5.
About 44 percent of the participants indicated that barriers to reporting disruptive behavior existed. The most common barriers included:

- Fear of retaliation
- The fact that nothing ever changes
- Lack of confidentiality
- Lack of administrative support
- Physician lack of awareness or unwillingness to change

Survey participants also suggested ways to improve the working relationship between nurses and physicians.

Nurses want more opportunities for collaboration and communication, closely followed by the need for education and training for nurses and physicians with programs that foster improved working relationships. Also mentioned was the desire to hold open forums and group discussions.

Physicians listed increased education and training and more opportunities for collaboration as their top recommendations, followed by the need to foster more open forums and group discussions to improve relationships.

Both physicians and nurses said it was only a few physicians who gave the rest of the physicians a bad reputation. They also agreed that disruptive behavior is a two-way street, with nurses sometimes guilty of exhibiting disruptive behaviors toward physicians.

**Roots of the problem**

One of the key findings in the survey is that perceptions differ dramatically between physicians, nurses and executives when it comes to the causes, responsibilities, barriers and solutions surrounding physician-nurse relationships.

Some of the contributing factors—such as individual personalities, training, gender biases, historical behaviors and environmental forces—may not be easy to alter. Other factors like cultural tolerance, leadership support and the development of appropriate policies, roles and responsibilities that set behavioral expectations can be changed.

For physicians, many of their behaviors are molded in medical school. Throughout their medical training,
physicians learn to think on their own and take responsibility for their actions. This self-preservation fosters autonomy, independence and an autocratic, domineering behavior pattern that is the antithesis of team building and collaboration.

This also sets up a tiered hierarchal model of care that establishes a subservient role for nurses. While medical training does little to nurture the development of certain “people skills,” the problem is further accentuated by the lack of formal training in management and leadership skills.

Another factor influencing physicians is increasing external pressures such as:

- Lower compensation
- Demands for greater accountability and productivity
- Governmental oversight
- Managed care restrictions
- Consumerism
- Increasing liability risks

As a result, many physicians feel demoralized and harbor a victim mentality. All of these issues may increase their predilection for disruptive behavior.

The working environment influences nurses’ behaviors and perceptions, as well. Their stressors include time demands, irregular schedules, shifting roles and historically inadequate levels of compensation. Nurses, like physicians, also are trained in a hierarchical system. Once again, this model is antiquated.

Administration also plays a significant role, with administrators often creating a hospital culture that has a powerful impact on the nurse-physician relationship. Attitudes, tolerance, equality, receptiveness and staff interactions help mold the culture. In many organizations, inadequate time and resources are dedicated to leading and refining the culture.

If clear behavioral expectations based on shared values are not implemented by the administration, then individuals resort to their own “natural” behaviors that can result in disruptive outbursts.

One key to success is to have physicians, nurses and administrative leaders come together to set acceptable behavior expectations by implementing a zero-tolerance policy for abusive physician behavior. But, as the survey showed, policies alone may not necessarily ensure proper behavior.

Collaboration will only fully evolve when shared goals pertaining to patient care and professional values are revealed and discussed openly among physicians and nurses. This cultural change requires informed and courageous leaders who exemplify respect, commitment and partnership based on shared core values.

Improving the relationships

Given the enormous complexity of the problem, the approach to improving physician-nurse relationships must come from several different perspectives.

Issues related to scheduling, staffing, workload requirements, job responsibilities, job benefits and amenities all need to be addressed, but nothing impacts a nurse more than feeling valued and respected for the type of patient care they provide.

Their day-to-day duties and peer interactions have a strong influence over their perceptions and attitudes about their job. Relationships with physicians are one of the factors influencing this perception.

Some ways to increase physician awareness and sensitivity to this issue is with lectures and newsletters. But the greatest success comes when a
physician champion embraces the issue and spreads the word to colleagues.

Another step is to create opportunities for communication among physicians and nurses. This can be done through informal meetings and discussions (during rounds or phone contacts) or more formally through projects, meetings or committee work where physicians and nurses can come together.

More formal educational opportunities will help, too. Programs focused on team building, joint collaboration, conflict management, time management, stress management and even something as simple as phone etiquette for both physicians and nurses, have proven very successful for improving lines of communication.

Of course, a strong, consistent, well-enforced code of conduct that outlines appropriate behavior for staff and physicians is critical to success. The ideal policy should emphasize the right of all employees to enjoy a harassment-free working environment.

Those who do not follow appropriate behavior guidelines must be approached and counseled by a designated group of peers who are trained and prepared to offer specific recommendations. The team must insist that the physician get help.

The process needs to be consistent, but at the same time it needs to be flexible. A single explosive episode from a temporarily overworked physician during summer vacations should have a different response than a physician with a long history of unprovoked abusive behavior.

The intervention team must emphasize that they are most interested in changing the behavior so that the physician can continue to function—not in ending the physician’s career.

For those individuals who are unable or unwilling to improve their behavior, the organization must be ready to take appropriate actions. More severe or repeated cases may require counseling or specific education programs. Immediate suspension of privileges must always be an option when faced with recalcitrance from a physician whose behavior directly endangers either staff or patients.

Obviously, health care is not the only industry with problem personalities. Disruptive behavior in any organization destroys the morale of the workers, negatively affects product/service quality and drives away talented employees.

JCAHO Standards Help Address Disruptive Physician Behavior

Michael D. Youssi, MD, MHA

A medical staff’s ability to tackle the challenges of disruptive physician behavior may be related to its compliance with accreditation standards of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO).

IN THIS ARTICLE...

Doctors, Nurses and Disruptive Behavior

In this article…

A hospital’s medical staff is charged with assuring that patients receive quality medical care. But disruptive physician behavior can destabilize patient care at many levels.

• At the governance level, it can trigger painful disciplinary action by the governing body.
• At the physician level, it can strain referral, coverage, leadership and peer review activities.
• For nurses, it can severely compromise nurse-physician communication, diminish morale and contribute to the nursing shortage.
• For patients, the very quality of medical care we pledge to assure is threatened.
• And for the disruptive physician, it can bring unwanted scrutiny, befuddlement, loss of stature and remorse.

Standards set by the Joint Commission for Accreditation of Healthcare Organizations can help medical staffs deal with disruptive physician behavior in a fair, organized fashion. The standards impact medical staff bylaws and rules and regulations, executive committee structure and function, departmental leadership and the credentialing and performance improvement processes.

Organization and bylaws standards

These standards specify the mutual responsibilities and accountabilities that exist between the governing body and the medical staff on the one hand, and between the medical staff and its members on the other.

Bylaws provide for the orderly conduct of medical staff business and empower the medical executive committee to act on the medical staff’s behalf in bringing recommendations to the governing body.

In matters of appointment to the medical staff and delineation of clinical privileges, the medical staff is accountable to the governing body. Importantly, the final credentialing decisions rest with the governing body.

This, in effect, creates a firewall that clearly places responsibility for effectively dealing with disruptive physician behavior in the medical staff’s lap.

Should a physician’s disruptive behavior reflect a health problem, the JCAHO standards go further to require the medical staff to implement a process to identify and manage the individual physician’s health-related matters. In some cases, disruptive behavior may be reasonably interpreted to require anger and/or stress management or formal behavioral counseling and monitoring.

Medical executive committee standards

The medical executive committee is accountable for recommending, for the governing body’s approval, six pivotal actions that help identify any physician with disruptive behavior:

1. Establishing mechanisms and criteria for reviewing credentials
2. Considering individuals for medical staff membership
3. Delineating clinical privileges
4. Ensuring participation of the medical staff in process improvement
5. Establishing ways for medical staff membership to be terminated
6. Creating a fair-hearing process
These standards for accreditation empower the medical staff leadership to act on behalf of the governing body and the community to preserve the quality of patient care provided by credentialed physicians.

**Department chair leadership standards**

JCAHO standards require that the department director/chair is responsible for all clinical and administrative activities of the department and continuing surveillance of the professional performance of all department members.

This gives the director/chair the opportunity to get to know the individual members of the department and become aware of any problems with disruptive behavior.

Additionally, the department director/chair is responsible for recommending continued medical staff membership for each member of the department. This responsibility may become a flashpoint when dealing with disruptive physician behavior. It is also one reason to fairly and fully address behavior issues up front and manage the behavior formally and comprehensively.

JCAHO standards stipulate that each clinical department makes recommendations to the medical staff about the criteria for clinical privileges in that department.

These criteria must pertain to competence and ability and are above and beyond those criteria set by the medical staff in general and could include results of appropriate performance improvement activities.

It is wise to imbed specific language in the department’s credentialing and orienting processes to prevent and mitigate problems involving disruptive behavior.

**Credentialing standards**

JCAHO standards address, in specific detail, essential components of the processes of credentialing, appointment/reappointment and granting/revoking of clinical privileges. Here are some that target disruptive physician behavior:

1. Authority of the medical staff to define the information to be provided for consideration for membership or privileges
2. Information provided from monitoring professional performance, judgment and clinical/technical skills
3. Information required from peers
4. A requirement to submit any reasonable evidence of current ability to perform privileges that may be requested
5. A requirement for applicants to consent to the inspection of records and documents pertinent to competence and ability to perform

**Standards aid physician executives**

As the article by Alan Rosenstein (Disruptive Physician Behavior Contributes To Nursing Shortage page 8) shows, disruptive behavior by a physician poses a serious challenge to physicians in leadership positions. Equipping physician leaders to deal with the issue is a step in the right direction.

At least in the hospital setting, JCAHO standards do give physician executives a blueprint for an empowered, professional and respectful approach to confronting and managing disruptive physician behavior.

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ACPE offers an excellent course on how to manage disruptive physician behavior. To bring the course to your organization for an OnSite Educational Program call 800/562-8088 or visit www.acpe.org/onsite for more information.
CHAPTER 4

Understanding and Managing Physicians with Disruptive Behavior

By Kent E. Neff, MD

INTRODUCTION

Overview

Early identification of and intervention with the physician with disruptive behavior create more constructive options. Yet the common practice is to do “too little, too late” and to become involved in an adversarial process. Clarity of communication is essential, but there is often confusion about what the problem is. Physicians with disruptive behavior often complain, correctly, that no one really told them how serious the problem was until they were threatened with suspension. Knowledge of consequences is more important in determining behavior than knowledge of antecedents. But usually much more energy is spent trying to figure out why the physician does what he or she does rather than in devising appropriate consequences for the problem behavior. Finally, most physicians can hear feedback about their behavior when it is presented in a respectful manner by concerned colleagues, but this is not usually how it is done. Why is this so?

Disruptive behavior in physicians is not a new problem, but only recently has it received significant attention. Many factors are involved, including a shift in how professionals such as physicians are viewed, increasing empowerment of employees, and new laws covering sexual harassment/hostile work environments. Whereas inappropriate behavior from physicians historically was ignored or excused, such “enabling” behavior by colleagues and health care executives now carries markedly increased risk. In the current environment, failing to deal effectively with such behavior can result in significant losses of productivity and money.

There has been a tendency to excuse disruptive behavior when the physician is seen as clinically competent. Politically powerful physicians, high producers, physicians who respond with anger or launch a counterattack, and clinical “stars” in particular have avoided confrontation about their behavior. The attitudes and experience of physician leaders and the culture in which the problematic behavior occurs are important factors...
affecting whether or not disruptive behavior will be addressed. In the past, the negative consequences of taking no action regarding this behavior were often minimal for the medical staff, the hospital, and the physician. In today’s complex and volatile health care environment, that is no longer the case. Omnipresent pressures for increased productivity and collaborative working relationships and concerns about a hostile working environment/sexual harassment have made it imperative that all physicians be confronted about behavior that is considered disruptive.

Intervening with these physicians is not easy. More often than not, executives and managers still tend to look the other way until the problems become urgent. We do “too little, too late.” By the time an intervention is done, everyone is upset with the physician, and the situation has become adversarial. Effective communication has stopped, and people have chosen sides. Options have become more limited, and the chances of a positive outcome have been reduced. The medical director or administrator can become an unwitting lightning rod for frustrations that should be directed elsewhere. Trust suffers, and it becomes more difficult to work collaboratively. Experience has now shown that these difficult issues can be addressed constructively, resulting in a “gain-gain” outcome in many cases. The framework, strategies, and methods for doing so are the topics of this chapter.

Definition of Disruptive Behavior
The following definition is a good starting point: “An aberrant style of personal interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to interfere with the process of delivering good care.”

In essence, any behavior that could reasonably interfere with patient care, communication, morale, the functioning of the health care team, etc., could be considered disruptive. This could include language; personal habits, such as cleanliness; manner; or style.

Examples of disruptive behavior may include:

- Profane or disrespectful language
- Demeaning behavior, i.e., referring to hospital staff as “stupid”
- Sexual comments or innuendo
- Inappropriate touching, sexual or otherwise
- Racial or ethnically oriented jokes
- Outbursts of anger
- Throwing instruments or charts
- Criticizing hospital staff in front of patients or other staff
- Negative comments about another physician’s care
- Boundary violations with staff or patients
- Comments that undermine a patient’s trust in a physician or the hospital
• Inappropriate chart notes, e.g., criticizing a patient’s hospital treatment
• Unethical or dishonest behavior
• Difficulty in working collaboratively with others
• Failure to respond to repeated calls
• Inappropriate arguments with patients, families
• Poor response to corrective action

Legal Considerations
Concerns about legal action are often cited as reasons not to take action in a case of disruptive behavior. However, greater liability occurs by not taking action rather than by taking appropriate disciplinary action, as long as it is done in the correct manner. Documentation is critically important. There is well-established support in case law for dealing firmly and decisively with physicians whose behavior is disruptive.

Obviously, involving legal counsel at appropriate points in the process of managing these physicians is necessary and prudent. However, responding in a formal, legalistic manner is very threatening to physicians and may create an unnecessary adversarial relationship. The physician is likely to respond defensively, often through his or her own attorney. Meaningful dialogue is blocked. There are often more constructive ways to get the physician’s attention early in the process.

An appropriate balance needs to be struck. If the actions of the medical director are based only on legal concerns, some constructive options may be missed. Animosity, polarization, and a poor outcome are more likely to result when this occurs. Establishing and maintaining respectful dialogue, attempting to work collaboratively with the physician, and avoiding formal adversarial actions as long as there are other reasonable options available are strongly recommended. Experience shows that much can be done before it is necessary to invoke a formal adversarial process. Establishing and maintaining a dialogue-based process as long as possible can avoid many pitfalls.

The Importance of Addressing Disruptive Behavior
Disruptive behavior must be addressed promptly for two reasons. The first is that the behavior itself can adversely affect patient care, either directly or indirectly. The behavior may put the patient at risk or lead to a poor outcome. Such behavior can directly affect the members of the health care team and their ability to work collaboratively. This behavior also may increase the risk of malpractice and of harassment claims and litigation.

The second reason is that disruptive behavior may be a sign of an illness or a condition that might affect clinical performance. Disruptive behavior and clinical performance problems may share the same roots. The first or the only sign that a physician’s clinical performance may be at risk may be an episode of disruptive behavior. Given the autonomous nature of medical practice, such observable behavioral signs occur only infrequently and must be investigated. The following example is illustrative:
A dedicated but demanding young surgeon who was a superb clinician was noted to be increasingly irritable in the operating room during difficult cases. This behavior began to escalate, and he had several outbursts of verbally abusive behavior toward nurses. One day, during a period of great frustration, he struck a nurse.

The incident was immediately reported to the Vice President for Medical Affairs. After a prompt investigation, the physician was suspended and sent for assessment. He was found to be under extraordinary personal stress and to be quite depressed. At a clinical level, he was considered not safe to practice until his depression had been adequately treated. The physician was most cooperative and was relieved to receive some help. A brief medical leave of absence, antidepressants, and psychotherapy were recommended and agreed to by the physician. Colleagues and the hospital were very supportive. His prognosis was considered excellent.

His clinical performance remained intact throughout this period. But the assessment demonstrated that his clinical performance was at great risk. It is likely that his problems might never have been discovered had the behavior not been identified as disruptive and an intervention done promptly. A more serious problem may well have been averted by prompt, decisive, corrective action.

Disruptive behavior should be reframed as a serious liability and patient safety issue. Intervention should be considered an opportunity to help a physician in personal difficulty, ideally before his clinical performance is at risk. Taking this view facilitates more appropriate responses, and the task becomes less onerous.

Managing the Problem Versus Responding to Crises
What generally resulted from this historical laissez-faire approach was an unorganized, case-by-case “crisis” method of dealing with problems. There was no systematized, written, proactive approach designed to minimize liability and increase the chances for a positive outcome. While sometimes a good formal process was spelled out in the medical staff bylaws, carefully crafted procedures for identifying, intervening with, evaluating, supporting, and monitoring these physicians were usually missing. Barriers to setting up such procedures included a lack of appreciation of the extent and importance of the problem, a sense that “it could not happen here in our fine institution or with our excellent physicians,” wanting to avoid a “witch hunt,” concern about legal liability, and not knowing how to proceed.

All medical organizations, regardless of size or type, should expect these problems to occur and should plan for them in advance by establishing good procedures. The failure to do so only increases potential liability for the institution and the likelihood of losing valuable physician resources.
Reframing the Behavior and Taking a Positive Approach

Effective management of physicians with disruptive behavior is an art born of common sense, compassion, respect, and good planning. These difficult issues can be viewed as a problem or as an opportunity. It is best to take a positive, proactive stance rather than approaching it from a negative, confrontational point of view. Emphasize the positive side, promoting respect and harmony in the workplace. Managing physician behavior is a process, not an event. It starts with dialogue, building trust, and placing emphasis on the problem behavior, not the person. Consider the following example:

An internist in his 50s, upset over an adverse action of the Peer Review Committee, became verbally abusive and disruptive at a medical staff meeting. A highly productive and competent physician, he had become increasingly uncooperative in the hospital’s effort to partner with physicians. The hospital CEO and medical staff president were spending considerable time fielding numerous written complaints from this physician. Concerned about what to do, the hospital administrator retained a consultant.

The physician in question was found to be dedicated to good patient care and highly concerned about his patients. His style was rigid and uncompromising, and he had limited interpersonal skills. He was having great difficulty in adjusting to recent changes in the health care environment and was becoming increasingly disenchanted and isolated. A leader in the hospital, he felt that he was no longer appreciated.

The consultant recommended to the administrator that he meet regularly with the physician and attempt to reestablish a relationship and to build trust. Long frustrated with this physician’s behavior, he was initially quite resistant to this suggestion. But he did begin to meet with him for lunch regularly. There was a subsequent reduction in the doctor’s disruptive behavior. While problems with this physician were far from resolved, the stage was set for more productive communication and interaction with him.

Instances of disruptive behavior are grossly underreported. The frequency and the severity of such events are much greater than is generally appreciated. An effective strategy for addressing disruptive behavior must create an environment in which early reporting is encouraged and supported. The threshold for tolerance of inappropriate, disrespectful behavior must be lowered. These changes can best be accomplished through positive, reasonable, nonpunitive means. Collaboration by many different professionals in the organization is necessary. A punitive attitude or response toward either the person reporting the incident or the physician will sabotage efforts to address this problem more constructively.

The Credentialing Fallacy

A second shift involves moving from a static concept of fitness for practice to a dynamic model that takes into account changes over time. Traditionally, it was considered that, once a physician was appropriately credentialed, he or she was safe to practice.
This was eventually referred to as the “credentialing fallacy.” In essence, physicians were divided into two camps: good doctors and marginal doctors. Inadequate attention was paid to the fact that any physician, even a highly competent one, could be adversely affected by many factors, resulting in substandard clinical performance. In essence, any physician, given the right circumstances, has the potential to become impaired in his or her practice. Neither competence nor good intentions fully protect a physician from this possibility.

The new approach involves tracking more than just competence. The bottom line is not just what the physician knows, but what he or she does with patients, i.e., his or her clinical performance. Ensuring safety to practice is a dynamic process that is affected by behavioral, emotional, and physical factors. Clinical performance should be periodically reassessed, particularly if signs of problems arise. In the case of both disruptive behavior and clinical performance problems, psychological, addictive, and medical conditions may be associated and/or causative. It is usually appropriate to search for them under these circumstances. If such potentially impairing conditions are present, insisting upon treatment and documenting that there has been sufficient resolution to allow safe practice are recommended.

**Understanding the Factors Associated with Disruptive Behavior**

The key to successfully managing physicians with disruptive behavior is to intervene in a manner that is likely to get the physician’s attention and to motivate him or her to work with you in making appropriate changes. Therefore, trying to understand how the situation is perceived by the physician is important in devising good strategies. The disruptive behavior indicates that there is a behavioral problem, but it usually gives little information about what is behind the behavior. While there is often some correlation between the severity of the disruptive behavior and the severity of the causative condition, relatively benign but still disruptive behavior may be the only sign that the physician is seriously impaired. Developing a clear understanding of common causative or contributing factors is necessary. It is also helpful to understand common personality attributes and common experiences of physicians, as these have implications for how to intervene effectively.

**The Current Health Care Environment**

The current volatile, “pressure-cooker” health care environment is extremely stressful for physicians. It is perceived as highly threatening. Physicians are losing their much-valued autonomy. They are working harder and making less. Practicing medicine is not nearly as satisfying as previously for many physicians. At times, the medical environment can be demeaning and/or downright abusive to physicians. This threatens the already fragile self-esteem of many physicians. Anxiety is increasing. There is a sense that they have sustained many professional losses in the past few years. Many physicians feel a sense of powerlessness and confusion and are overwhelmed by the current realities in medicine.
This is important to understand. The unique characteristics of today’s health care industry are especially difficult for physicians to accept and manage. They often lack the basic personal, interpersonal, and organizational skills to cope effectively with these new realities. Their fears and apprehensions are reality-based.

Acknowledging to the physician with disruptive behavior that you appreciate the harsh, unforgiving nature of the current health care environment is often helpful. But it is important to continue to insist that the physician change his or her responses to these stressors, i.e., his or her behavior, despite the perceived unfairness of it all.

**Organizational Issues**

The organizational culture determines the extent to which disruptive behavior will be identified as a problem and how it will be managed. Most health care organizations' cultures, regardless of type or size, present problems in this area. For example, there is usually a lack of adequate accountability for physician behavior. Problem behavior is frequently ignored until it escalates and becomes chronic, leaving fewer nonadversarial options for the medical executive. The threshold for tolerance of disruptive behavior is usually much too high. Left unaddressed, disruptive behavior often spreads to other colleagues and staff. The following example of a health care system with two hospitals and a conjoint medical staff is illustrative:

*One of the two hospitals had a serious and escalating problem with a variety of disruptive behaviors by physicians in operating rooms. Both anesthesiologists and surgeons were involved. The problem became so severe that a consultant was engaged to assist in managing it.*

*The behavior of several physicians was identified as particularly egregious. Two physicians were identified as having such serious clinical performance deficiencies as to be considered impaired; possible impairment was noted in a third physician. Two of the physicians were promptly suspended by the medical staff on the basis of their clinical performance problems. There was a noticeable reduction in the level of disruptive behavior by other physicians after these actions were taken.*

*The behavior of several other physicians was also determined to be disruptive, but no formal standard for behavior existed. Because of concerns that taking action without an objective standard in place would be perceived as autocratic by the medical staff, it was decided to develop the standard first, before taking any further action. The Principles of Partnership (Appendix 1, page 66) was used as the initial draft and was approved by both the medical staff and hospital administration. Once this document was in place, a program for managing the disruptive behavior was implemented successfully.*

*The second hospital, located in the same city, did not have problems of similar severity in its operating rooms, despite the fact that the two hospitals had conjoint medical staffs.*
A final point is that the initial phases of introducing more accountability for physician behavior are the most difficult. Once appropriate limits have been successfully set with a physician or two, it gets easier. This is particularly true when the approach is supportive and constructive as well as firm.

**Personal Factors Common to Physicians**

Physicians as a group tend to be quite autonomous, a characteristic often cited as an important reason for choosing medicine as a profession. They tend to be highly inner-directed and are sensitive when criticized. Their high intelligence can complicate matters by helping them develop effective defenses against changing their behavior. Many are perfectionistic and detail oriented, often having difficulty seeing the bigger picture. Because they see their intentions as good, they are offended when someone suggests otherwise by criticizing their behavior. Physicians have such a strong bond to their profession, and so much of their affirmation is obtained through their work, that professional criticism of any kind may result in feelings of devastation. Physicians often perceive not only that they have done something wrong, but also that they are bad doctors or bad persons. They may become overly defensive, making it difficult to work with them. In professional liability litigation cases, these factors may contribute to physicians' feeling so devastated that they cannot ably assist in their own defense.

**Medical Education and Training**

The hard work and delayed gratification necessary to gain admission to medical school often mean that the entering medical student may be less socially experienced than his or her nonmedical peers. Regardless, medical school is a powerfully influential experience. Technical considerations take precedence over interpersonal ones. The physician is trained to seek perfection. The belief that he or she cannot make a mistake, that "good" physicians' do not make mistakes, creates barriers to self-examination. If the physician comes from an abusive background or one in which self-affirmation came primarily from high achievement, there may be a synergistic effect.

In addition, medical school and residency may negatively affect self-esteem. At times the two environments can be downright abusive, again being synergistic with vulnerable physicians. Faculty may provide distant, impersonal, negative models in terms of doctor-patient interaction and treatment of nurses and staff. It is not surprising that the practicing physician, when under stress, may exhibit similar demeaning and abusive behavior. The following example is illustrative:

*A gifted internist in his 40s became increasingly irritable and argumentative with clinic staff. Very demanding of himself and others, and a perfectionist, he began to have outbursts of verbally abusive behavior toward staff when he was under stress. This escalated to the point that he had several verbal altercations of a similar nature with several patients. An intervention was done, and he was referred for a comprehensive assessment.*
He did not have a psychiatric disorder, but he did come from an abusive family. This pattern of abuse continued in medical school and residency. He could remember times when he had been verbally abused and even physically assaulted in residency. Despite his impeccable clinical performance, he had poor self-esteem and low self-confidence. He responded well to outpatient psychotherapy and training in communication skills. Follow-up for several years yielded no further recurrences of the disruptive behavior.

Developmental Issues
Unresolved developmental issues are frequently associated with physicians whose behavior becomes disruptive. Childhoods characterized by neglect and/or abuse are common in these physicians. Often the harshness of the past was not recognized by the physician. Sometimes the past trauma has been so overwhelming that it resulted in post-traumatic stress disorder. These emotional scars may contribute to a wide variety of clinical psychiatric disorders, problematic personality traits, personality disorders, or future behavioral difficulties unaccompanied by a psychiatric diagnosis. Low self-confidence and self-esteem often result. Intellectually gifted, many future physicians find affirmation in academic or other accomplishments, but languish in their emotional development. Medical school and training only exacerbate these problems. This sets the stage for future difficulties in interpersonal relationships and communication under stress. The present harsh environment in medicine may be particularly difficult for these physicians. Not infrequently, there is a clear connection between the nature of the childhood experience and behavioral problems in practice. Consider the following example:

An excellent internist in her 30s was rude and demeaning to both nurses and patients. The problem was worse in the emergency department, where she was quite resistant to seeing certain kinds of patients, especially those who were not particularly ill at the time of their visit. She avoided ED call whenever possible. Her partners in the medical group intervened and referred her for assessment as a condition of remaining in the group.

She did not have a clinical psychiatric disorder, but the roots of her behavioral problems could be traced directly to her experience in her family of origin. Her father was a medical practitioner and was the dominant presence in the family. Expectations were very high, and the physician and her siblings were expected to carry on despite illness or adversity. One was not considered “ill” unless essentially bedridden. The physician had internalized this family attitude toward illness, developing a pejorative attitude toward the “worried well.”

The physician began outpatient psychotherapy and did well. Her practice partners made some adjustments in her ED call schedule to reduce her exposure there for a time. In return, she took call on another service. The rude, abusive behavior stopped.
Psychiatric Disorders
A wide variety of psychiatric disorders are commonly associated with physicians whose behavior becomes disruptive. The disorders may be causative or contributory. The most common disorder seen in this group of physicians is major depressive disorder. Alcohol and drug dependence are also seen frequently, as would be expected. Bipolar disorder is surprisingly common and may be so severe as to produce impairment in practice. Other psychiatric illnesses, such as obsessive compulsive disorder, may also occur in this group of physicians. The number of accumulated losses, both personal and professional, may be significant and is commonly ignored by the physician and his or her colleagues. Unresolved grief is frequently a contributing factor to the physician's problems. Doctors in certain specialties, such as oncology, experience numerous losses in conjunction with their practices and are particularly prone to "burnout."

Personality disorders may also be present (less than a third of cases). When present, they may be a very important contributor to the pattern of disruptive behavior. These are usually compatible with continued practice once the physician is able to change his or her problem behavior. Prominent personality traits that are not so severe as to reach the level of a disorder are common and are also major contributors to disruptive behavior patterns. With timely intervention, treatment of any underlying conditions, good follow-up, and monitoring, it appears that most of these physicians can be safely returned to practice. In many cases, even partial resolution is sufficient to allow return to practice, as long as there are no current concerns about patient safety and there is appropriate monitoring.

Physical Illness
Physical illness is generally overlooked as a cause of or contributing factor to disruptive behavior in physicians. It is often minimized or ignored by both the physician and his or her colleagues. Physicians with disruptive behavior frequently have not had regular medical examinations. Many physical illnesses can lead to actual impairment in practice if left unchecked. The possibility that the physician is simply a sick physician should always be kept in mind. A medical history and physical examination should be part of any comprehensive assessment of a physician with disruptive behavior. Evaluating physicians should be informed about the full scope of the doctor's behavioral problems, as well as any other concerns of the referent.

Examples of physical illnesses that have been associated with disruptive behavior are sleep disorders, multiple sclerosis, diabetes mellitus, and Parkinson's disease. The relationship of these disorders and other medical illnesses to disruptive behavior may be direct, as in cognitive problems directly caused by the illness, or indirect, as in a physician recently diagnosed with Parkinson's disease who was unable to perform his medical duties because of fatigue and preoccupation with his diagnosis and its potential catastrophic effect on his life.

Litigation Stress
Dr. Sara Charles, in her groundbreaking work on litigation stress in physicians, identified
a number of serious sequelae to the professional liability litigation process, including significant anger, depression, and physical illness. These and other consequences of professional liability claims can affect a physician’s behavior to the point that it becomes disruptive or the physician becomes impaired in his or her practice. A number of approaches have been used in attempts to mitigate the stress of this common occurrence, with varying results. Litigation stress and its consequences continue to be a significant problem. It is all too frequently minimized by the sued physician and colleagues. Litigation stress should always be considered a potential contributor to disruptive behavior. If present, it needs to be directly addressed in a supportive, collegial manner, concurrent with efforts directed at changing disruptive behavior.

**Establishing a Formal Behavioral Standard**

Most health care organizations have carefully articulated mission statements. In contrast, very few have written behavioral standards, particularly ones that apply to physicians. This creates significant problems when a suspected case of disruptive behavior arises. With no preexisting standard, the initial determination of whether the behavior is truly disruptive becomes much more difficult. Also, the lack of a formal standard makes it more likely that there will be inconsistencies in the type and severity of behavior that is considered disruptive.

Establishing a clear, reasonable, fair, and firm behavioral standard is the first step toward long-term success in managing disruptive behavior in physicians. The process of drafting and approving such a standard can be a good opportunity for educating the medical staff and others about the importance of respectful behavior. An open process of discussion allows concerns and fears of physicians to surface and be allayed. Most physicians will support a document they consider reasonable and fair. Medical staff approval should not be difficult. *The Principles of Partnership* (see Appendix 1, page 66) has been used as the starting draft in numerous hospitals/health care organizations. Each medical staff can make appropriate modifications as it sees fit. Some medical staffs have incorporated the Principles into their bylaws; others have required that the behavioral standard be signed at initial credentialing and whenever privileges are renewed.

An ideal approach is to have the medical group or other health care organization develop a parallel *Principles* for its employees, resulting in the same standard for everyone. At the very least, behavioral standards for physicians and other employees should be very similar and compatible. Physicians are not the only professional group to present with disruptive behavior. For example, nurses may also exhibit such behavior.

**Guiding Principles for Managing Physicians with Disruptive Behavior**

Successful management of physicians with disruptive behavior is a collaborative task. While the actual intervention with the physician usually falls on the shoulders of the physician executive or the administrator, many people from different disciplines may contribute to the process. Physicians are not at all the most important source of information in most
cases. Nurses, office staff, department managers, and others who work closely with the physician or under the physician’s direction usually are much better reservoirs of useful information. These professionals must be included in the process. Doing so involves risk on both sides. Establishing mutual trust is a prerequisite for this process to work.

While physicians cannot manage these colleagues without involvement from other groups, physicians are almost always the most effective intervenors with their colleagues. The physician-to-physician approach is usually much better received by the physician being confronted. Responsibility for management of physicians with disruptive behavior should be assumed by physicians whenever possible. Of course, this should involve close collaboration with administration and/or the board of directors as appropriate. Because division of responsibilities varies in organizations, delegation of this responsibility may parallel established organizational policies and procedures. Physicians should be the primary intervenors, but involvement of a member of the administrative team or board may be prudent under some circumstances. The timing of such involvement may be critical. The unique aspects of each situation should dictate these decisions. Involving family members often carries great risks, because unknown, problematic dynamics may take precedence and sabotage intervention efforts. Both spouses and practice partners may have difficulty maintaining confidentiality, also a serious problem. It is usually better to avoid these potential problems and not involve family in the intervention. Close personal associates of the physician should not be involved if, for any reason, there is concern about their behavior in the planned intervention process.

Managing these physicians is not an event; it is a process, akin to the difference between managing acute and chronic illness. Different principles are involved. This process will be more effective when it involves careful planning and thoughtful, ongoing dialogue rather than being simply a response to crises as they occur. The following guiding principles may be useful:

**Respectful and Safe for All Concerned**

Disruptive behavior is usually disrespectful behavior. Effective management involves ensuring that this behavior stops while more respectful behavior from everyone is proactively encouraged. Practicing respectful behavior at all times engenders trust and collaboration and models proper behavior. The physician in question, whose self-esteem is usually low, will respond much more positively if approached in a dignified, respectful manner. Nurses and others who might be involved at some point in the process should also be treated with great respect. Being respectful does not imply weakness or lack of resolve.

Being respectful includes extending common courtesies and using appropriate social skills. Judgmental or emotionally charged words should be avoided. Care should be taken to separate objective data from opinions.
Confidential at All Stages
Maintaining confidentiality in hospitals and medical groups is usually a difficult task. But keeping everything in this process fully confidential at all stages is absolutely essential for success. Leaks of information not only potentially sabotage intervention and resolution processes, but also create considerable legal and economic liability potential. It is nearly impossible to create trust in a process that is not confidential.

Maintaining full confidentiality also allows one to work informally in the organization and get reports of problem behavior earlier. In many cases, no one will come forward unless there are assurances that the source will be kept confidential. These requests should be honored. The physician executive doing the intervention should be fully convinced that the behavior is documented and inappropriate. This personal conviction and the objective data should be communicated to the physician, taking the focus off any specific individual who might have written an incident report. Experience shows that it is not necessary to reveal the original source of such information.

Timely and Prompt
Timeliness of investigation and intervention is critical to maximize the chances of a successful outcome. Just as in certain medical situations, there is a "golden period" for intervention that helps ensure a good result. Often, the physician knows that he or she was out of line and feels bad after a disruptive episode. Right after the event, the physician may be able to recognize the problem and be more amenable to doing something about it. Prompt attention to the matter is also reassuring to staff, who often wonder whether or not the medical staff will even address the problem. In cases in which a proper investigation cannot be completed quickly enough, a meeting with the physician to inform him or her that you are aware of the incident, are looking into it, and will meet with him or her later may tip the scales in your favor and make a subsequent intervention easier.

Planned Carefully and Managed at Every Stage
Every action taken should fit into a carefully crafted plan. Actions contemplated should be examined beforehand for their potential effects and consequences. Meetings and interventions should be orchestrated as much as possible. Specific tasks should be assigned, e.g., who should say what and when. Intervention meetings need to be rehearsed in advance. Set a list of potential goals and acceptable outcomes for the meeting. Plan for certain contingencies that may arise. Set dates or deadlines for certain phases of the process when appropriate. Keep the process moving along. Significant delays usually work against you.

Fair and Supportive in Orientation
Fairness and a genuine willingness to assist the physician to correct the problem are also essential elements of a successful process. Maintaining this attitude may be especially difficult when the physician’s behavior is egregious or the physician has failed
to change despite repeated admonishment. Experience shows that these physicians can and do change their behavior when approached and when appropriate help is given. Colleagues and hospital staff members will accept and even support firm action if they see that the physician is being treated fairly and is being given a reasonable chance to change.

Based on Objective Data Presented in Nonjudgmental Terms

Information about disruptive incidents is often subjective and judgmental. When this is the case, making accurate assessments of the problem and good judgments about potential actions may be very difficult. Presenting the problem behavior to the doctor in this form is likely only to antagonize him or her and thwart effective communication. The problem behavior should be carefully described in objective, observable, nonjudgmental terms. Specific times, dates, and details should be included when possible. The quality of the subsequent intervention can be only as good as the quality of the data. Presentation of objective, detailed data, free of impugned motives, offers leverage in influencing the physician to change. Well-documented, objective data also may protect you from liability at a later time.

“Hard” on the Problem Behavior, “Soft” on the Physician

This concept is taken from mediation theory and is the sine qua non of a successful intervention. In other words, separate the physician from the problem behavior. The behavior, not the doctor, is the problem. That is why the term “physician with disruptive behavior” is preferable to “disruptive physician.”

Most physicians with disruptive behavior have good intentions. It is always necessary to acknowledge the physician’s value at the beginning of the meeting. Give specifics about what it is about him or her that is good and appreciated. The message should be: “You are a good and valued physician. It is your behavior that is the problem.” Such statements, delivered in a respectful manner by meaningful colleagues, maximize the chance that the physician will be able to hear your concerns about his or her behavior. Failure to emphasize up front that the physician has value, especially given the personality profiles of physicians with disruptive behavior, is likely to have disastrous consequences for communication with that physician.

Incremental, with Graded Responses and Consequences Appropriate to the Situation

The ideal process is incremental, with the physician executive making graded responses appropriate to the severity of the behavior, to whether it is the first infraction or a repetitive problem, to the potential consequences to patient care, to the extent of potential legal liability, and so on. Responding in this manner is often difficult, because reporting is late and the intervention is done when the situation has escalated into a crisis. Earlier reporting and prompt investigation increase the opportunity for appropriate, graded actions. Some physicians will respond well to a clear statement of concern by colleagues.
Knowledge of consequences is more important in influencing behavior than knowledge of antecedents. Clear consequences for behaving inappropriately are often lacking. In these situations, the physician has little incentive to change. Adding appropriate consequences—again, matching the severity of the potential disruption—gives the physician some incentive and the physician executive some leverage. A common example of this phenomenon occurs around medical records. Some physicians will simply not complete their charts until they are threatened with suspension. A smaller number will do nothing until they actually are suspended. Some, of course, won’t complete them under almost any circumstances. When this happens, the primary focus should shift to examining the past behavior of the medical staff and organization in terms of what the real consequences of noncompliance have been, how consistently they have been applied, and whether there really is a willingness to set firm limits and enforce them. The disruptive physician will often readily sense whether or not his colleagues are serious about the matter at hand. A small but important subset will do nothing meaningful until they are convinced they have to. Such self-examination should always be part of the process when the medical staff, for example, begins to get tougher about disruptive behavior by physicians.

**Kept “Informal” and Nonadversarial as Long as Possible**

While the bylaws of the organization usually outline a series of actions and protect the physician through due process, the goal is to remain out of the formal bylaws process for as long as possible. The most effective process is to keep the dialogue going, maintaining an “informal” stance free of rigid legal constraints. Most problems involving disruptive behavior can be resolved at this level. If the bylaws are invoked, the battle is to some extent lost. Obviously, this escalation cannot always be avoided. By following the other principles outlined, the physician executive can increase the likelihood of a successful intervention without going through cumbersome due process.

**Involve Careful, Ongoing Follow-Up and Monitoring of the Physician**

Because disruptive behavior tends to be caused by chronic conditions or acute exacerbations of chronic conditions, careful follow-up and monitoring are essential. The prognosis for successful sustained change is helped by good monitoring. It reminds the doctor that he or she is being observed. Lapses in behavior may be picked up promptly and a full relapse averted. Adjustments to treatment or remediation can be made. Staff and colleagues are reassured. It protects the organization, because potential liability is reduced. Paradoxically, it can protect the physician as well by providing benchmarks indicating that he or she is doing well. Far too little attention is paid to this critical function. All physicians who need to be confronted about disruptive behavior should have some form of monitoring. The type, time frame, and nature of the monitoring and of regular feedback should be appropriate to the situation. The same rules of intervention apply: feedback should be respectful, objective, and balanced, with both positive and negative observations.
Evaluation, Monitoring, and Follow Up

Outside Evaluation as a Resource
In order to determine whether or not the physician is safe to continue practicing, or what the likelihood is of a recurrence of the disruptive behavior, the medical executive often needs more information than is available at the time of intervention. In these cases, referring the physician for a third-party evaluation is strongly recommended. Such assessments can be very helpful, both to the referring individuals and to the physician with disruptive behavior.

An outside evaluation should usually be more than just a standard medical or psychiatric examination. Frequently what is needed is a “fitness for duty” evaluation. The experienced evaluator or evaluation team can often gain access to more information than is available to the medical executive. They are not constrained by the adversarial nature of the relationship that has often developed. The assessor should have specific expertise relevant to the problem being assessed. There may be substantial advantages to a multidisciplinary team assessment rather than a single-party evaluation, because a single evaluator, no matter how skilled, can be misled much more easily than a team. The evaluators should always receive all relevant information about the physician’s problem behavior. The credibility of an evaluation done without this information should be called into question. Inadequate or incomplete evaluations may create new problems by creating a false sense of security about the physician’s fitness to practice, or by giving the physician leverage in resisting further oversight by colleagues.

Guidelines for Evaluations
The following guidelines may be useful to consider:

- Decide what kind of evaluation is indicated.
  - Be very specific about what you want.
  - Request references from the proposed evaluators, and contact them regarding outcomes and satisfaction.
  - Select the potential evaluators according to qualifications and experience specific to the assessments you want.
  - Use evaluators with good experience in dealing with physicians whenever possible.

- Tell the physician which evaluator to consult, or let him or her select from a list of evaluators whom you consider to be qualified.
  - Do not let the physician select his or her own evaluator.
  - Disqualify any close friends or associates of the physician being evaluated.

- Use someone outside the group or organization when possible and appropriate.
- Make sure that the evaluator does not have biases against what you are doing or against your organization.
• Contact the evaluator yourself and tell him or her the purpose of the evaluation and what you expect.
  ▶ Be very specific.

• Furnish the evaluator with all relevant information regarding the physician’s behavior, staff observations, and other objective data.
  ▶ Never allow the physician to be evaluated without the assessor knowing the full picture and why you are concerned.
  ▶ Ask the evaluator to review the information before seeing the physician.

• Always request some screening for alcohol and drug problems.
  ▶ Make sure the evaluator understands how addiction presents in physicians.
  ▶ Request a full addiction evaluation when indicated. This usually requires a separate evaluation. Use a physician skilled in the evaluation of physicians.

• Always include a medical history and physical examination.

• Allow the evaluator to see the physician as many times as necessary to complete the evaluation. Encourage multiple evaluation visits.
  ▶ Several encounters may give a clearer picture of the problems.
  ▶ Request that the evaluator interview the spouse when alcohol or drug problems are suspected.

• Involve the state Physician Health Program when addiction is suspected. Some state PHPs also assist with disruptive behavior problems.

**Comprehensive, Multidisciplinary Team Assessment**
In recent years, comprehensive assessment by a multidisciplinary team has gained increasing acceptance as a useful resource in the armamentarium for managing physicians with disruptive behavior. These assessments usually last from two to four days—more commonly, the latter. While not necessary in all cases, these assessments may offer great advantages. Physicians are difficult to evaluate because of their high intelligence, education, skills, and position. Identification with the subject of the evaluation can also be a problem for the evaluator. Many physicians have difficulty being assertive with colleagues in these delicate relationships. Individual evaluators are often unable to influence the physician to take ownership of behavioral problems. A comprehensive team can often overcome these obstacles, empower the physician, and get him or her to see the team’s perspective and take ownership of the problem behavior.

Examples of situations in which this kind of assessment should be considered include:

• Clinical performance problems
• Complex cases
• Disputed, conflicted cases, e.g., where the physician resists evaluation or denies that there is a problem
• Suspected alcoholism or other chemical dependency
• Diagnostic dilemmas
• Chronic relapsing of an addicted doctor or dual diagnosis cases
• High-stakes cases, e.g., a high producer or high-profile physician
• Politically sensitive cases, e.g., a medical staff leader
• High-liability cases, e.g., hostile work environment or threat of litigation
• Sexual harassment cases
• Cases in which licensure or hospital privileges are at risk
• Suspected cases of sexual impropriety or boundary violations
• Chronic cases of disruptive behavior unresponsive to intervention

Separation of Evaluation and Treatment
Most team assessment programs have arisen from existing addiction programs whose primary role has been to evaluate and treat addicted people. Many treatment programs have excellent assessment programs that are quite effective, particularly when the referral and the potential diagnosis are accepted by the physician. However, caution should be exercised in using this option, especially when there is initial resistance on the part of the doctor. In these cases, and perhaps in most cases, full separation of the evaluation and the treatment components is recommended. It is usually safer and less subject to criticism. If a conflict of interest on the part of the assessment team is perceived, additional liability may be created for the referent. The credibility and the impartiality of the assessment team are of paramount importance. Physicians being assessed have often commented that they feel safer and are more willing to disclose sensitive information when the assessment is completely separate from any recommended treatment.

There have been a number of contentious lawsuits around these issues in recent years. The threat of legal action would be expected to increase if the concerns of the physician are not addressed promptly or if the physician is forced into accepting a diagnosis or treatment that is not based on unbiased, objective criteria. The referring organization and individuals could become included in these legal actions. State Physician Health Programs can be very helpful in these difficult, conflicted cases.

State Physician Health Programs (PHPs)
No discussion of this type would be complete without mentioning the important role of state Physician Health Programs. They have done pioneer work in educating, identifying, evaluating, referring, and monitoring physicians with alcoholism and drug dependency. Most states have some kind of program. The scope of available services varies considerably from state to state, as would be expected. Regardless, PHPs are an important resource for the physician executive. Their considerable experience and broader perspective regarding the management of the addicted physician improves the outcome and may also
reduce liability. A confidential referral of chemically dependent physicians to the state PHP is strongly recommended. Each medical executive should be aware of the state PHP and should know how to access and use its services.

Over the past few years, the role of many PHPs has been broadened and expanded to meet new areas of need. Disruptive behavior is now being addressed by some PHPs. Given the mission of most programs to serve physicians throughout the state, it is likely that more PHPs will offer some services for physicians with disruptive behavior.

**Hospital or Group Physician Health Committees (PHCs)**

An increasing number of medical groups and hospitals have established their own committees to assist in managing these physicians. In California some years ago, hospitals were mandated to establish and maintain these committees. Establishing such a committee can be very helpful and can serve as the focal point for education and physician awareness building. It is recommended that all hospitals and medical groups of more than a few physicians consider establishing a PHC.

**Monitoring and Follow Up**

Monitoring the progress of physicians with problem behavior has long been observed to improve the prognosis for maintaining appropriate behavior and remaining safe to practice. The monitoring process can also provide ongoing support to these physicians, as well as frequent reminders of the need to follow recommendations. For these reasons, all physicians with disruptive behavior should be monitored in some manner. The type and degree of monitoring will, of course, vary, depending on the disruptive behaviors and what is behind them. This is another reason why it is so important to understand what has been causing the behavior. In order to be most effective, both the behavior and compliance with the recommendations for treatment should be monitored. This is routinely done with alcoholic physicians, whose abstinence and active participation in a personal recovery program are both monitored by PHPs.

The lack of good monitoring is often the weakest link in the chain of management of these physicians. Monitoring is often poorly organized, too informal, not started promptly, discontinued too quickly, and done in a punitive manner. The group or hospital PHC can be very helpful in implementing a better monitoring program.

Treatment or other recommended activities should be monitored. Do not take the physician's word that things are going well. This presents a dilemma regarding confidentiality, which is necessary for most treatment to be effective. Also, the physician has a right to confidentiality in the therapy process. Two approaches may be helpful. The first is to ask any treatment provider to keep all information confidential except the physician's participation in the therapy (i.e., whether the physician is attending as requested by the therapist and is complying with the treatment, and whether the therapist considers the physician safe to practice). The second option is to use an "administrative" clinician in
addition to the treating clinician. The administrative clinician could periodically do a separate evaluation of the physician’s status and progress, including making a determination as to whether the physician is safe to practice. This would constitute an independent medical examination (IME), and the full results would be reported to the physician executive. This would remove the treating clinician from any conflict of interest and fully protect confidentiality of sensitive information.

Some guidelines for monitoring are:

- Start the planning process for monitoring early.
- Explain to the physician why you are doing it.
  - State that it is for the physician’s benefit as much as for yours, as it creates a good “track record” for him or her.
- Identify an appropriate monitor who understands the problem and will be seen as fair and reasonable.
- Schedule frequent meetings at first (weekly, in many cases).
  - Short meetings are fine; frequency is more important than length.
- Balance positive and negative feedback.
  - Start with the positive first, as in an intervention.
- Use objective descriptions of current behavior.
- Commend the physician for his or her progress.
- Remember that you are shaping behavior and that the physician will not do it all correctly at first.
- Consider writing periodic letters to the physician documenting his or her status and progress, or summarize your meetings in brief letters to the physician.
- Remember that positive feedback is more influential than negative feedback in changing behavior.
- View the monitoring process as an integral part of the management process.
- Use monitoring meetings as an opportunity to maintain dialogue with the physician and to provide ongoing support.

Finally, two problematic types of behaviors present fairly frequently and pose significant problems for the physician executive. First, it is not uncommon for a physician with disruptive behavior to emit similar behavior during intervention meetings regarding that behavior. How should colleagues respond? Remember that it is essential to keep these meetings under control at all times. The physician should first be reminded that his or her behavior is inappropriate and unacceptable in the meeting and should be asked to stop. If the physician does not stop in a reasonable time, the meeting should be immediately terminated. A follow-up meeting should be rescheduled at a time set by the physician in charge. Once the meeting has been terminated, it is usually best not to continue
the meeting at that time, even if the physician agrees to control his or her behavior. The physician should be told clearly that this is another example of unacceptable behavior. The behavior at that meeting then becomes an additional problem in its own right. Having some time to think about this event may serve to change the physician’s perspective on his or her behavior.

The second common behavior is when the physician either threatens or carries out retribution (usually to those whom he or she thinks reported the behavior). This may be either verbal or nonverbal, active or passive. This behavior is patently unacceptable, and the physician should be told so immediately. For physicians whom the leadership suspects may act in this manner, warning him or her in advance is usually a good idea. Again, this becomes a problem in its own right and may well be cause for suspension.

**REFERENCES**


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APPENDIX 1:

Principles of Partnership

PREAMBLE

The Physicians and the Hospital/Health System Staff (Staff) recognize their considerable interdependence in the rapidly changing health care environment. They acknowledge that their success in competing in the marketplace and their ability jointly to deliver high-quality health care depend in large part upon their ability to communicate well, collaborate effectively, and work as a team to optimize and monitor outcomes.

Physicians and Staff further acknowledge that there are many participants in the process of effective health care, including patients, their families, health system staff, allied health professionals, and others, and that working harmoniously with them is a necessary aspect of modern health care. Both parties affirm that everyone, both recipients and providers of care, must be treated in a dignified, respectful manner at all times in order for their mutual goal of high-quality health care to be accomplished.

Physicians and Staff further affirm that it is their mutual responsibility to work together in an ongoing, positive, dynamic process that requires frequent, continual communication and feedback. Both agree to devote the necessary time and resources toward achieving these goals and maintaining a positive, collaborative relationship between them and with other providers and recipients of care.

Principles

In order to accomplish these goals, Physicians and Staff agree to the following principles and guidelines and to work collaboratively to promote them in the organization and in the community.

1. Respectful Treatment

All members of the health care provider team (physicians, hospital staff, vendors, contract personnel, etc.) and all direct and indirect recipients of health care (patients, their families, visitors, etc.) shall be treated in a respectful, dignified manner at all times. Language, nonverbal behavior and gestures, attitudes, etc. shall reflect this respect and dignity of the individual and affirm his/her value to the process of effective, efficient health care.
2. **Language**

Physicians and Staff agree not to use language that is profane, vulgar, sexually suggestive or explicit, intimidating, degrading, or racially/ethnically/religiously slurring in any professional setting related to the hospital and the care of its patients.

3. **Behavior**

The parties agree to refrain from any behavior that is deemed to be intimidating or harassing, sexually or otherwise, including but not limited to unwanted touching, sexual touching, sexually oriented or degrading jokes or comments, requests for sexual favors, obscene gestures, physical throwing of objects, or making inappropriate comments regarding physicians, hospital staff, other providers, or patients.

4. **Confidentiality**

Physicians and Staff agree to maintain complete confidentiality of patient care information at all times, in a manner consistent with generally accepted principles of medical confidentiality. The parties further recognize that physicians and hospital staff have the right to have certain personal and performance problems and concerns about competence dealt within a confidential manner in a private setting. Physicians and Staff agree to maintain this confidentiality and to seek proper, professional, objective arenas in which to deal with these issues.

5. **Feedback**

Physicians and Staff agree to give all parties prompt, direct, constructive feedback when concerns or disagreements arise. The parties recognize the necessity of describing such behavior in objective, behavioral terms and that such feedback should be given directly to the person(s) involved through appropriate channel, in a confidential, private setting.

6. **Clarification of Roles**

Physicians and Staff agree that the delivery of health care involves a complex, dynamic set of roles and responsibilities and that clarity and agreement on these roles and responsibilities is necessary. Both parties agree to work together to achieve and maintain clarity and agreement on these roles and to support each other in the carrying out of these responsibilities.
APPENDIX 2:
Managing Physicians with Disruptive Behavior-
Checklist of Steps

Step I: Make Rapid Initial Assessment

- Examine each report of disruptive behavior immediately; triage and get additional information if situation looks serious or urgent.
- Maintain confidentiality at all times; insist upon it from everyone.
- Make an initial determination: Is immediate action needed?
  - Patient care affected or potential for same too great?
  - Physician too distressed or out of control to be safe?
  - Serious effects upon staff, others?
  - Unacceptable legal liability?
- If “yes” to any of the above, shorten the time frame of the steps below.
  - Consider immediate action when patients or others at risk.
  - Intervene at the level of your data.
    - The initial action need not be definitive; by taking initial action you do not give up your right to take additional actions later.
- Consider a very prompt meeting with the doctor.
  - Inform physician of your initial concerns; tell him or her you will meet again soon.
  - Communicate seriousness and urgency to the physician.
  - Use this meeting as an opportunity to get the physician’s attention.
    - “Golden period” for intervention.
  - Consider immediate suspension in egregious cases.
- Involve hospital/group PHC and state PHP when appropriate (e.g., when alcohol or drug addiction is suspected or when physician might be ill or needs support).

Step II: Collect Additional Data and Complete Investigation

- Maintain confidentiality.
- Establish time frame for completion of the investigation.
  - In days, not weeks.
- Get information from multiple sources when possible.
• Consult nurses, other staff (usually best sources of information).
• Involve physicians as appropriate (not usually best sources).

• Collect objective data regarding behavior, not opinions such as what is “wrong” with him or her.
• Review incident reports and other documentation of the past behavior.
• Search for any evidence of problematic alcohol or drug use.

**Step III: Assess Clinical Performance**

• Assess routinely in all cases; may be brief in some excellent performers.
• Review for any clinical performance problems, documented or suspected.
  ▶ Check with QA, UR, risk management, clinical department.
  ▶ Look for any recent change or deterioration in performance.

• Include quality of communication, relationships with patients, staff, others.
• Evaluate physician’s workload. I.e., is workload too great to maintain quality?
• If evidence of clinical performance problems, refer to appropriate department or committee for investigation and action.
  ▶ Do not delay—clinical performance problem takes precedence.
  ▶ Do not allow clinical performance problems to be lost in the controversy about a disruptive behavior problem.

**Step IV: Define the Behavioral Problems**

• Write them down in clear, detailed language.
  ▶ Make sure you understand the problems and have adequate data to proceed.

• Use behavioral descriptions to describe the physician’s actions.
  ▶ Use objective, nonjudgmental, respectful language.
  ▶ Include date, time, witnesses, etc.
  ▶ Always refer to the behavior, not the person.
  ▶ Eliminate emotionally charged words.
  ▶ Do not impugn motives (assume good intentions).
  ▶ Put in form that could be reviewed by the physician, his or her attorney, etc.

**Step V: Determine Whether the Behavior Requires Action**

• Decide whether or not the behavior is disruptive and why.
  ▶ Ensure you are comfortable with any decision before it is finalized.

• Make decision promptly, and prepare to follow quickly with appropriate action.
• Take some action in almost all cases if the behavior is truly disruptive.
May be only to inform physician of your concerns and warn him or her to avoid similar behavior in the future.

- “We don’t want you to get into any trouble.”

- Make sure the specific action fits the infraction and level of the data.
- Do not take any action with which you do not agree or that you do not support.

**Step VI: Plan and Rehearse Intervention Meeting**

- Use a group (two-four, usually) of people who are significant to the physician to intervene.
  - Use only physicians, unless there is a good reason to involve others.
  - Balance group when possible so physician will not feel railroaded.
    - Consider including a colleague whom the physician would see as supportive (as long as the physician agrees with need to take action).

- Make sure the intervention team agrees with the assessment of the problem and the need to take this action.

- Determine the following in advance:
  - Goals of the meeting.
  - Outcomes that are acceptable.
  - Who should attend the meeting and who will lead.
  - Roles of those participating.
  - Where the meeting will take place (based on what you want to communicate to the physician).
  - When meeting should be held.
  - How long, approximately (set upper limit, e.g., 1 to 1-1/2 hours).

- Rehearse beforehand.
  - Decide who will say what, and in what order.
  - Ask everyone to write down what they will say and bring it to the meeting.
  - Chairman should have a practiced response to diversions.
    - “I know you are concerned about the quality of nursing on the unit. We can set up a separate meeting to talk about that. Right now we are here to talk about your behavior.”
  - Take enough time to get it right; good preparation is key to success.

- Decide consequences before the meeting.

**Step VII: Take Action**

- Thank physician for coming to the meeting.
- Always act in a respectful manner.
• Explain the purpose of the meeting.
• Assume miscommunication will occur.
  ▶ Paraphrase frequently.
• Ask the physician to hear you out first.
  ▶ “We called this meeting to discuss some concerns with you. We want you to hear us out first, then you will get a chance to respond. OK?” (get the physician’s agreement).
• Start by communicating the physician’s value and worth.
  ▶ “Dr. Smith, you are a valuable member of this medical staff. We know that you have a strong commitment to your patients.”
  ▶ Elaborate with more examples, statements of value, and positive regard.
• Then state your concerns about his behavior.
  ▶ Focus on defining problem behaviors.
  ▶ Give several examples of problem behavior if possible.
  ▶ Deal with the problem behavior; do not make diagnoses.
  ▶ Do not impugn motives; assume that the physician has good intentions.
  ▶ Label behavior as “unacceptable” and explain why.
• Empathize with physician but remain firm that behavior must change.
• Do not get angry or accusative with the physician.
• If relevant, indicate that no retribution will be tolerated.
• At the end of the meeting, summarize and plan the next steps.
• Tell the physician the consequences of no behavior change.
• Maintain control; stop the meeting if it starts to get out of control.
  ▶ Do not permit the physician to be abusive in the meeting.
• Remember the power of the written word.
  ▶ Write a summary letter of the meeting to the physician.
  ▶ Ask the physician to acknowledge that the summary is accurate.

Step VIII: Follow Up and Monitor Progress

• Always monitor the situation and have follow up meetings.
  ▶ Good monitoring improves the chances for maintaining positive change.
• Regular, frequent follow-up meetings are usually best.
  ▶ Meetings can be short; frequency is more important than length.
  ▶ Initial meeting frequency = every one to four weeks; err on frequent side.
• Do the following in the meetings.
  ▶ Tailor follow up to the nature and severity of the problems.
Balance positive and negative feedback.
- Tell the physician when things are getting better.
- Remember that positive feedback is more powerful than negative feedback in influencing behavior.
- Summarize and agree on next steps, if any.
- Confirm next meeting date.
- Always encourage the physician.
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