

Recognition and management of the behaviourally disruptive physician



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The Physician Health Program (PHP) phone rings and a department head or chief of staff asks: “Can you tell me how to find an anger management program?” Without hearing any other details, it’s likely that the caller is trying to cope with a behaviourally disruptive physician on the hospital staff. Few other medical staff issues can be more sensitive or vexing.

Since the inception of the PHP in 1995, 24 of 657 cases (nearly four per cent) have fallen into this category. More than half were referred to the PHP in 2000, representing over eight per cent of all cases last year.

While the vast majority of physicians behave professionally, mindful of the feelings of others, some abuse the power bestowed upon them by their position, and develop reputations of being angry, moody, or difficult to deal with. Who are these physicians and why does this happen?

Most everyone in the medical profession knows, or has known, such a person. They are the academic staff physicians that medical students and residents prefer to avoid. They are the surgeons (nearly half the PHP cases represent surgical specialties) no one wants to assist. Community physicians shield their patients from these clinicians when they are on-call, even if it means delaying treatment or sending them elsewhere. They are the attending physicians no nurse or colleague wants to call after hours. Sometimes, even patients are reluctant to be treated by them.

Forms of disruptive behaviour

The disruptive doctor’s behaviour may be long-standing and legendary. Conversely, it might be more recent in onset, and the subject of quiet concern. Anger may be expressed in sudden and unpredictable outbursts, or subtly, with persistent verbal abuse that undermines the confidence and respect of co-workers.

Much time and effort is spent responding to the damage, complaints and morale problems generated by the offending behaviour — behaviour that has been uncomfortably tolerated and accepted, even though patient care, directly or indirectly, may have been adversely affected.

Inappropriate expression of anger or frustration may result in the use of abusive language in front of patients. Co-workers or trainees may feel belittled, blamed for possible adverse patient outcomes, or even personally threatened. Objects, especially surgical instruments, may be thrown and damaged, risking injury to others. Nurses, female colleagues, residents and medical students have reported feeling sexually harassed.

Disruptive behaviour may simply take the form of lack of co-operation with others. Replies to pages may be late or ignored. Committee or other hospital duties may be neglected — with haughty contempt or passive-aggressive avoidance. Approach to patient care might be excessively controlling, overly rigid and rejecting of collegial input, opinion and advice. Contrary positions taken by colleagues or superiors may cause resentment, resulting in the threat of retribution, litigation, or even violence.

Causes of disruptive physician behaviour

There are a variety of causes and conditions for physician disruptive behaviour. An important initial consideration is to accept disruptive behaviour as just that: a way of acting based on personal experience, habit, internal discomfort or illness. The behaviour is experienced as maladaptive by others, although seldom by the physicians themselves. It can’t be understood apart from the physician’s personal and professional context, and thus merits full

clinical evaluation. Then, and only then, can the conditions and diagnoses of which the behaviour is symptomatic be known and ameliorated.

Disruptive behaviour that is relatively recent in onset may simply be a reaction to a recent life stress. The stress may come from the professional realm, such as a lawsuit or regulatory action, or from one's personal life, such as family illness, divorce or bereavement. Sleep deprivation, fatigue, financial difficulties and a variety of adjustment problems may also contribute to the behaviour observed.

A variety of psychiatric disorders may be responsible for the problematic behaviour and, if unrecognized or poorly understood, will persist if left untreated. These include substance abuse and dependence, mood disorders (especially bipolar illness) and, less often, anxiety and delusional disorders.

Organic brain disorders, such as dementia of all kinds and delirium, must be included in the differential diagnosis. Recent or past cerebral trauma must also be considered in

this category. Behavioural deterioration may also be secondary to distress related to a medical condition, especially when the condition is inadequately treated, as can happen to physicians who delay good medical care by failing to consult a personal physician, or by treating themselves.

These conditions combine in a significant number of cases, but probably not the majority. Summer et al, of the Alabama Physicians Recovery Network, reported that in 10 of 32 cases of disruptive physician behaviour, primary clinical impression came from the above-mentioned categories.¹ It is interesting that they also report that chemical dependence or abuse was subsequently revealed as a contributing factor in 19 of the cases.

It is likely true that problematic personality styles and attitudes play a role in many instances of disruptive behaviour. In the Alabama report, fully 21 of the 32 evaluated physicians were deemed to have personality disorders, leading the authors to conclude: "Personality disorders appear to contribute to the majority of referrals with disruptive behaviour."

Most often observed in physicians are narcissistic and obsessive/compulsive traits and disorders. Other personality problems, including dependent, avoidant, histrionic, and borderline traits and disorders, are also observed, though less often.

These physicians behave in ways consistent with life-long maladaptive patterns. It is unusual for such a physician to experience insight as to how his or her behaviour affects others. It therefore falls to administrators, regulators and others in positions of responsibility to determine when and how remedial action should be taken.

Management of disruptive behaviour

Sometimes, a friendly and concerned approach to a colleague whose behaviour is problematic might be helpful. This is especially true when the behaviour is of recent onset and related to life stresses or reversals. When the disruptive behaviour has been part of a long-standing pattern, or when there is a condition characterized by denial, lack of insight or even impairment, rejection by the physician when approached is likely.

Once a decision has been made that a physician's behaviour should no longer be tolerated, two kinds of action should be planned: administrative management and clinical evaluation.

This process is well described by Gendel in *The Handbook of Physician Health*, published by the American Medical Association.² An intervention can be conducted following a format similar to that described in a previous "Physician Health" column.³

Individuals in positions of authority must confront the doctor with documented concerns in a compassionate but firm manner, with a goal of ending the behaviour immediately.

Acknowledgement of the behavioural problem by the physician should be sought, along with his or her responsibility to take corrective action.

Acceptable outcomes should be defined. Any support required to reach these outcomes (possibly including cost of assessment and/or treatment) should be offered.

Contingencies which may affect a doctor's privileges or involve the regulatory authorities must be seriously considered if the doctor is not compliant with the process. The intervention team must not bluff in this regard. Then, the doctor should be referred for a comprehensive clinical evaluation performed objectively and expertly in third-party fashion.

Consultation with legal counsel and other experts is a good idea prior to intervening. Similarly, the doctor should have an opportunity to consult legal counsel — who may assist in resolving everyone's concerns without acrimony, threat of litigation, or legal action.

It is very helpful if an institution has policies in place that define disruptive behaviour and a process to confront and resolve it. Any condition diagnosed should receive appropriate treatment, aftercare and clinical monitoring when necessary.

When other disorders are ruled out, even personality disorders should be treated with psychotherapy or behav-

oural interventions designed to rectify the disruptive behaviour in a lasting way.

Administrative management in the form of monitoring and ongoing accountability to the institution concerned may be indicated. This is true even when no formal diagnosis is reached, or when personality problems prove to be resistant to any clinical intervention.

Conclusion

Vaillant et al⁴ have described some of the personality traits of physicians and their vulnerabilities. Despite tendencies toward obsessive, controlling behaviour, self-doubt, and a powerful sense of responsibility for patient care — even at the expense of self-care — most physicians cope very well with the myriad of demands placed upon them in an ever-changing and highly stressed practice environment. Even so, occasionally, but not rarely, a physician's behaviour becomes disruptive to others in his or her environment.

In most cases of disruptive physician behaviour, the underlying cause is not immediately apparent. Disruptive behaviour may appear virtually the same in different cases, but can be caused by entirely different conditions. Left alone, many may suffer. Timely, firm administrative management, coupled with expert clinical evaluation, can reveal physician problems that are treatable.

In the end, tensions ease, staff morale and patient care improve, and the physician can continue to function as a valued member of the health-care team with dignity and respect.

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