

Management of disruptive behaviour in physicians:

a staged, rehabilitative approach

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A recent Physician Health column reviewed the nature and causes of disruptive physician behaviour, and outlined a broad strategy for addressing this kind of problem.¹ The following article offers intervention suggestions based on a growing understanding of this issue, and evolving Physician Health Program (PHP) experience managing these cases.

What follows is a fictitious, but representative, account describing a typical referral to the PHP concerning behaviour of a physician who is found by co-workers to be disruptive.

Case study

The doctor, an anesthetist, has been on staff at the hospital for several years. His work is excellent, as he has a strong focus on exemplary patient care and the attention to detail required to ensure favourable clinical outcomes.

Unfortunately, however, there have been a series of incidents over the past two years that involve colleagues and co-workers who are now documenting these incidents and registering formal complaints when, in past, they were inclined to let things go.

The incidents are varied, but include episodes of the doctor sharply criticizing operating room nurses because he believes they are not sufficiently knowledgeable or skilled to meet his high standards.

His criticism is sometimes characterized by the use of profanity — usu-

ally in front of others. On more than one occasion, the doctor has shoved a nurse aside to perform a procedure himself, or reposition the patient.

The nurses feel on edge when working with him. Some have refused to work again with the doctor, and this is creating staffing and morale problems in the operating suite.

The nursing supervisor has spoken to the doctor and has been dismissed by him as someone who is defending her staff rather than advocating for improved patient care. In fact, now the doctor feels the nursing supervisor is “out to get” him.

The chief of anesthesia has also spoken to the doctor on a collegial basis on several occasions, even suggesting anger management training. But there has been no more formal approach to these concerns, and the pattern of objectionable behaviour has not changed. In fact, the doctor, while respecting his chief as an individual and a clinician, has only scorn for his perceived ineffectual administrative capabilities, and failure to understand that he is only trying to

improve the quality of patient care.

Increasingly, the doctor believes his chief to be a “pawn” for a hospital administration more interested in fiscal issues than quality health-care delivery.

When this doctor is interviewed in the PHP office, it is clear that he is very upset by being singled out and feels victimized. He might acknowledge that there can be times when his behaviour is upsetting to others, but that is mostly due to their sensitivities, for which he can't be responsible.

In truth, he is genuinely unaware of the impact of his behaviour on others.

Case management

How might this case, and others like it, be successfully managed? Could the situation have been improved earlier?

Following is a suggested range of practical strategies for managing types of behavioural disruption at a variety of stages, short of the formal, administrative approach. The focus here is upon behaviour that tends to be chronic and not obviously caused by an

acute problem or a readily apparent psychiatric or substance use disorder.

What is disruptive physician behaviour?

While disruptive physician behaviour has been described in many ways, one working definition is:²

"A physician with disruptive behaviour is one who cannot, or will not, function well with others to the extent that his or her behaviour, by words or actions, interferes or has the potential to interfere with quality health care delivery."

As examples, Pfifferling suggests a range of unreasonable behaviours that can be considered disruptive, reproduced in Table 1 below.³

Table 1: Unreasonable Behaviour

- Fails to comply with practice standards.
- Shames others for negative outcomes.
- Uses foul, abusive language.
- Arbitrarily sidesteps policies.
- Acts in ways that could be perceived as sexual harassment.
- Threatens associates with retribution, litigation or violence.
- Criticizes staff in front of others.
- Is disrespectful or discourteous a majority of the time.
- Relies on intimidation to get his or her way.
- Communicates indirectly about clinical decision-making.

A three-stage clinical response strategy is recommended in order to assist with the recognition of disruptive behaviour and devise management protocols.

Level One: Early-Stage Response

The best time to respond to problematic behaviour — in simplest terms, behaviour that would not be tolerated in other work settings — is the very first time it is observed.

Another way to recognize this kind of behaviour is to codify acceptable behaviour as a point of reference.

Therefore, every hospital and patient care institution should have a Code of Conduct.

- *Code of Conduct*

A Code of Conduct can be a simple statement. The Sotiles offer this as an example:⁴

"To satisfy our mission, all members of the medical and health staff will treat patients, staff and fellow physicians in a dignified manner that conveys respect for the abilities of each other and a willingness to work as a team. Behaviour that is deemed to be disruptive to promoting an atmosphere of collegiality, co-operation, and professionalism will not be tolerated."

Alternately, the Code of Conduct can be a more comprehensive document addressing such values as respect, honesty, integrity, accountability, confidentiality and more. Pfifferling suggests listing reasonable expectations as well as unreasonable behaviour (see Table 2 below).⁵

Table 2: Reasonable Expectations

- Complies with practice standards.
- Uses conflict resolution skills in managing disagreements.
- Addresses concerns about clinical judgments with associates directly and privately.
- Communicates with others clearly and directly, displaying respect for their dignity.
- Participates in regular behavioural feedback.
- Supports policies promoting co-operation and teamwork.
- Is open to constructive criticism.

A Code prepared through consultation and consensus can be a powerful tool in defining the limits of acceptable behaviour, especially if all doctors indicate an acceptance of the Code upon receipt of hospital privileges or employment. The Code helps create a culture of respect and collegiality, offering guiding principles for all who work in the institution.

While the Code may simply represent common sense and decency, the absence of such a Code can hinder the approach to managing disruptive behaviour in physicians.

- *Initial response*

With a Code of Conduct that applies equally to all in place, any physician behaving in a way that is not compatible with the Code should be approached as soon as that behaviour is first observed.

Whether a colleague, department head, or another person in a position of authority, the intent is to draw to the doctor's attention the instance of problematic behaviour. Anyone is entitled to a "bad day," but if others are affected, it is reasonable to talk to the doctor about it.

It is not necessary to diagnose the problem. It is sufficient to bring the issue into the doctor's awareness, along with the impact of the behaviour upon others, and request a behaviour change. This can be done while offering support, acknowledging the many ways the doctor is valued in the institution. If the doctor has any personal problems or issues he or she would like to address, helpful resources can be suggested.

Listening to the doctor's concerns, if any, and responding appropriately when valid and important issues are raised is constructive, but this sort of discussion would be better addressed at another meeting. The purpose of this conversation is to emphasize the disruptive nature of the doctor's behaviour, whatever the circumstances and context in which the behaviour is encountered.

It is suggested that the physician leader conducting this interview prepare carefully by reviewing the details of any complaints thoroughly, anticipate the doctor's reactions, as well as his or her own. A skilled leader will offer an empathetic and supportive understanding of the doctor's perspectives, without becoming emotionally engaged or drawn off point.

An interview designed to provide effective feedback should remain focused on behaviour, which can be changed, and not personality structure, which cannot.

This meeting, even if informal, should be not be excessively delayed, nor should it be conducted in the middle of a crisis, or at a time when

the participants' energy is low.

This interaction may or may not involve documentation, as it can be very informal. Also, follow-up can be arranged informally as well — perhaps a quick chat after a few days or weeks.

Positive behavioural changes should be acknowledged. If further, minor and sporadic episodes occur, the process can be repeated — up to a point. Little more should be required.

If the behaviour subsides, then the issue is resolved.

Level Two: Later-Stage Response

Problem behaviour secondary to an acute upset in a doctor's life will likely resolve after an informal, concerned approach, if not spontaneously.

Problem behaviour that persists and is accompanied by clear signs of substance abuse, or a psychiatric disorder, demands a structured intervention as soon as possible because these disorders will likely worsen without assessment and treatment.⁶

Problem behaviour due to unrecognized substance use disorders or psychiatric disorders, or entrenched predisposing characterologic and personality styles (e.g., narcissistic, obsessive-compulsive, avoidant traits) will likely return. Again, it is not necessary for the physician leader positioned to respond in these cases to know the exact etiology for the troublesome behaviour, but it is necessary to take action.

• *Suggested first steps*

It is suggested that the ideal individual (or individuals) to take responsibility for managing such a case is a physician leader in a position of responsibility, rather than a colleague without such authority.

Recurring incidents must be documented and investigated. When valid concerns are reported, those making the reports must be assured that they will be supported and their concerns dealt with in a fair, effective and timely manner.

A meeting with the doctor must be planned once the documentation has

been received and validated. Because it is essential that the process be fair and impartial, it is recommended that hospital or institutional legal counsel be consulted prior to meeting with the doctor.

At the meeting, the documented concerns should be revealed to the doctor so that he or she might become aware of how his or her behaviour (focus on behaviour rather than the individual) has affected co-workers or others and, therefore, has potentially had an adverse impact upon patient care.

Of course, the doctor might have important perspectives about the incidents to offer (indeed may have already done so) and these should be heard. Still, in that there has been a pattern of troublesome incidents and behaviour, the doctor needs to hear that corrective action must be taken, even while continuing to support the doctor as an individual and a contributor to the community.

At this stage, the doctor should be directed to attend an appropriate assessment designed to analyze the circumstances and nature of the

problem, be it personal, family, systemic, or a combination of these. The doctor should be reassured that the ultimate purpose of the assessment is to identify any underlying factors that might be causing distress and which can impact upon patient care.

Physician leaders who undertake to manage these kinds of issues must be informed about the range of assessment resources that exist and how to access them. These are usually third-party services requiring direct payment, therefore a funding formula must be achieved in advance.

Following such an assessment, a rational course of action can be suggested. Physician leaders are cautioned against prescribing any specific course of corrective intervention (e.g., an anger management course) in the absence of an appropriate assessment and consequent recommendations.

The doctor should be provided with suggested resources to accomplish the assessment, and should be made aware at the outset that he or she will receive a full copy of the report, and that some form of summary of the assessment containing

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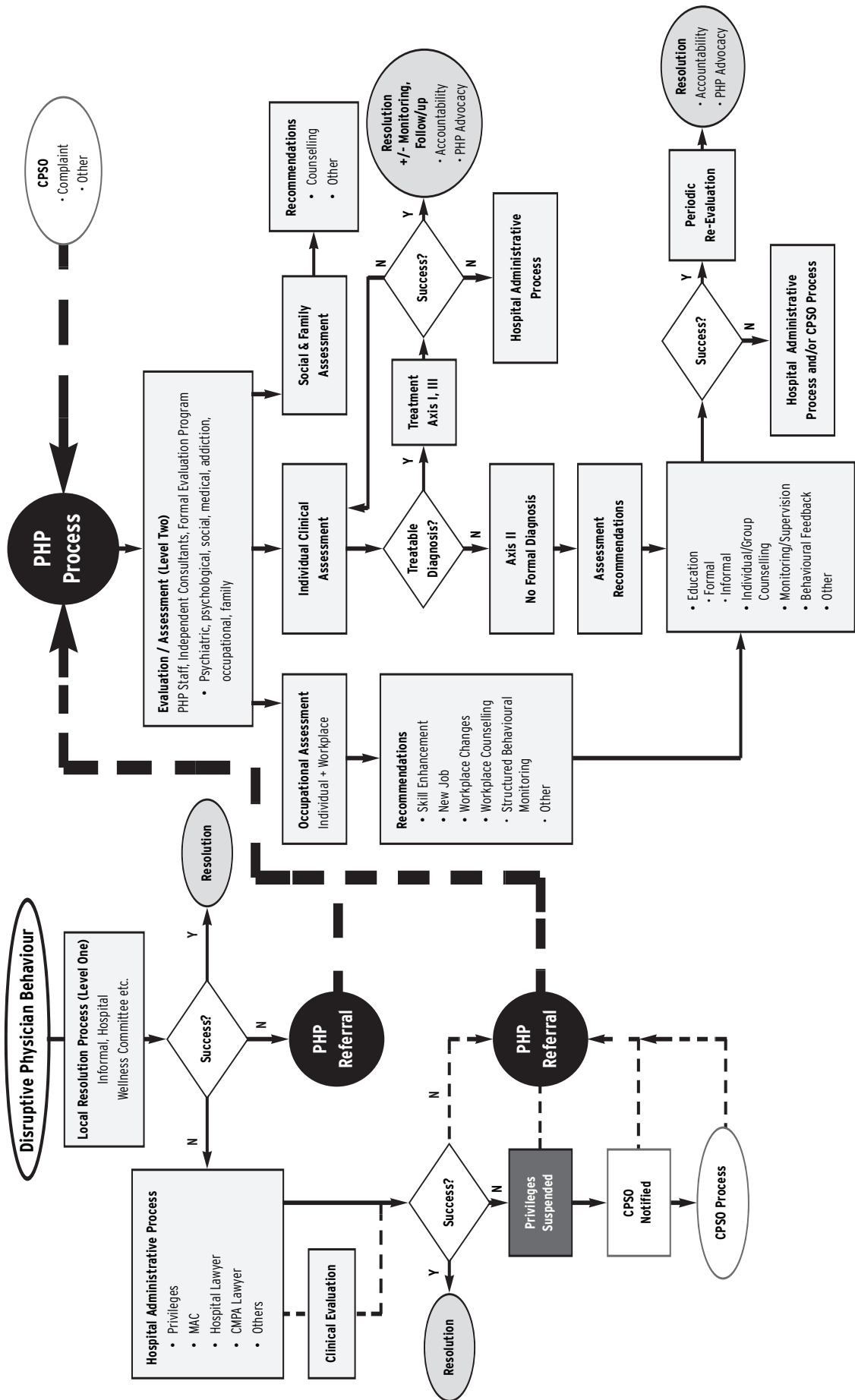
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Managing Disruptive Behaviour - Process Flowchart



“need to know” details only will be returned to the physician leader at the completion of the process, with the doctor’s consent. The doctor will also receive a copy of this summary.

Confirmation from the assessment resource that the process has been initiated is helpful to assure a timely resolution.

Details of this plan should be committed to writing, and placed in the doctor’s file. A summary of the meeting and expectations can then be sent to the doctor in the form of a letter. A follow-up meeting with the doctor after a suitable interval (about three months) should be planned to assure the process remains active, and to gauge the doctor’s co-operation and progress.

Contingencies for non-compliance with this process, or unacceptable recurrence of offending behaviour, should be decided upon in advance and made clear to all concerned. At the extreme, this can mean suspension or termination of hospital privileges or employment (or activating a process toward that outcome), and / or a report to regulatory authorities, such as the College of Physicians and Surgeons of Ontario (CPSO) in this province. This is seldom required, but the clear knowledge that this contingency is possible can be leverage toward a favourable outcome.

At the beginning of this process, the doctor should be reminded that they can, and ought to, consult legal counsel of their own — again, for support and their assurance of a fair process

• *Assessment*

While expert assessment of the many dimensions of disruptive behaviour is not readily available everywhere, more resources are gradually being developed, and we are learning which resources to apply to any given case.

It is beyond the scope of this article to list and describe these services in detail, but a general description is appropriate.

Clinical assessment, focused on the individual, includes both psychiatric evaluation and psychological

testing employing a variety of validated instruments. These assessments are designed to identify any bona fide psychiatric or personality disorders, as well as personality styles and traits.

Other clinical assessments include evaluation of drug and alcohol use and general physical evaluation. Further clinical evaluations (e.g., neurological or neuropsychological) can be included if indicated.

Thorough assessments will include gathering and considering collateral information obtained through the review of relevant medical records, and interviewing others who know the doctor well.

Occupational assessment involves interviewing co-workers in the workplace to learn more about the nature of the problem behaviour, and, importantly, its setting. If systemic problems are revealed, with the co-operation of the workplace, helping interventions can be offered there as well.

An exciting innovation is the development of structured survey instruments which co-workers complete anonymously to encourage candid feedback. This intervention is designed to describe the doctor’s motivating and disruptive behaviours, and their impact on others across a variety of domains.

This kind of tool provides not only detailed, objective assessment of the behaviour patterns, but can be used to offer compelling feedback to increase the doctor’s self-awareness. By surveying the workplace in an ongoing manner, the doctor can utilize the feedback reports to gauge his or her progress.

Clearly, assessments will vary in sophistication and scope. The kinds of assessment resources will also vary, ranging from individual clinicians, such as psychiatrists and psychologists, to community-based clinicians who work in collaboration, to specialized assessment services that use a co-ordinated, multidisciplinary, “one stop” approach. No matter which service is selected, such clinicians and programs must be

expert at assessing behaviour in health professionals using an objective, forensic structure.

Selecting the most appropriate assessment resource can be as much a matter of art and experience as science.

• *Remediation and monitoring*

A comprehensive and useful assessment will suggest targeted helping interventions for the doctor in question. These can include education about effective communication, conflict resolution, self-awareness, management of anger, assertiveness training, and more.

Clinical interventions can include individual or group counseling or psychotherapy, and treatment of any psychiatric disorder identified. Sometimes lifestyle, family or occupational changes are indicated and can be facilitated. Personal coaching is a growing strategy in this regard. Of course, any substance abuse issues

OMA MEMBERSHIP

Advisory Service

The Ontario Medical Association provides a membership “advisory” service to assist physicians on issues relating to:

- medical/legal matters;
- billing disputes with respect to medical-legal reports and third-party billings/uninsured services;
- advice on Peer Assessment Program;
- medical records and confidentiality of patient records;
- patient disputes and doctor-patient miscommunication.

*Such inquiries should be directed to:
Dr. W. Michael Thoburn
Executive Director
Department of Professional Services
Ontario Medical Association
525 University Avenue, Suite 300
Toronto, Ontario M5G 2K7*

identified must also be addressed.

Systemic interventions can include counseling for co-workers about how to handle their feelings and communication with the doctor in question, facilitation of re-integration of the doctor to the workplace he or she has been away from, or other rehabilitation for troubled workplaces if appropriate and requested.

Monitoring can be relatively informal through the use of collegial mentors and interviews with department heads to more formal monitoring arranged by contract such as physician health programs offer.

Structured, anonymous surveys that provide feedback from co-workers can be incorporated into both rehabilitation and monitoring, and are a promising innovation in this area.

Level Three — Late Stage or Emergent Response

This category is used to describe cases where disruptive behaviour has created a crisis situation causing harm, or risk of imminent harm to others, including co-workers and patients. Examples include physical violence, obvious impairment, and persistent, marked verbal abuse which destroys morale and disrupts the health-care team.

These cases are urgent, if not emergent, and a prompt, suitable response for each is indicated. Considering the examples above, responses might include notifying police, immediate intervention, and hospitalization, or immediate suspension of privileges or employment, respectively.

Role of the Physician Health Program

The PHP can help at any stage of this complex process. This begins with offering advice and guidance to hospitals, colleagues and employers (as the doctors with behaviour of concern seldom call on their own behalf).

The PHP can conduct preliminary assessments then facilitate appropriate detailed assessments, treatment and education. The program is able to help structure monitored follow-up programs which might be indi-

cated. The PHP can also offer suggestions and examples for hospitals and institutions that are designing Codes of Conduct and policies to manage disruptive behaviour.

An algorithm (see Figure, p. 62) describing the management, from the perspective of the PHP, of disruptive physician behaviour is supplied. It also depicts how the PHP facilitated services are integrated and organized.

This algorithm suggests that a consequence of non-resolution of the problem behaviour is the involvement of the College of Physicians and Surgeons of Ontario.

Role of the College of Physicians and Surgeons of Ontario (CPSO)

The regulatory authorities — the CPSO — may become involved at any stage. The CPSO would become aware of such a case either due to a patient complaint, a report from the hospital or place of employment, or a complaint from some other source (the PHP does not make such reports to the CPSO, unless contractually agreed upon by a doctor being formally monitored).

Regardless of the source of the report, the CPSO will investigate such a matter and seek to have it resolved in a way that protects the public and, if possible, maintains the doctor's active registration. If all attempts at remediation fail, however, disciplinary action can be anticipated.

Conclusion

Disruptive behaviour in physicians is a challenging and costly phenomenon in our hospitals, health-care institutions and communities, and it is increasingly less accepted in our evolving medical culture.

If this problem is to be managed in a fair, objective and effective manner, hospitals and other institutions need to develop and implement Codes of Conduct, as well as policies based on the principles offered in this article.

These procedures must be applied consistently, without assuming causation when it is not readily appar-

ent, and without demanding specific remedial interventions before expert assessment is obtained.

Once appropriate helping interventions have been activated for the physician, and possibly the workplace as well, suitable follow-up, including formal monitoring in some cases, is valuable to sustain the gains that have been made, and prevent recurrence of problematic behaviour.

Effective management of problems in health-care teams teaches us a lot about the qualities of healthy and effective work environments. Institutions that learn these lessons value and actively encourage and support mutual respect, co-operation, and other qualities of effective teamwork.

In the end, valuable health resources are maintained, distress is relieved, and patients are well-served. Everyone wins.

OMR

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