Disruptive Physician Behavior: Use and Misuse of the Label

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ABSTRACT: Beginning in 2009, The Joint Commission (TJC) requires medical leaders to address disruptive behaviors in accreditation organizations and this includes addressing disruptive physician behaviors. The Federation of State Medical Boards (FSMB) has acknowledged the importance of addressing disruptive physician behavior as reflected in the 2000 Report of the Special Committee on Professional Conduct and Ethics and in the 2011 Policy on Physician Impairment. This article provides in-depth information about disruptive physician behavior, including discussion of the causes and contributing factors, strategies to manage such behavior, formulation of medical staff policies, and appropriate and inappropriate use of the *disruptive* label. Although not a diagnosis, the disruptive label is useful in screening for disruptive physician behaviors. However, the disruptive label should not be applied to physicians just because they present controversial ideas or offer criticism of the medical system.

Introduction

Beginning in 2009, The Joint Commission (TJC) created a new Leadership standard (LD.03.01.01)[1] that addresses disruptive and inappropriate behaviors in two of its elements of performance:

- EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.
- EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

TJC also provides 11 suggested actions to serve as guidelines for organizations to address disruptive and inappropriate behaviors. One of the suggested actions states: "Hold all team members accountable for modeling desirable behaviors, and enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment." This means that physicians are to be given no exception or special status. This provision is important in light of a finding from a study conducted by the American College of Physician Executives in which a significant number of respondents agreed 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."[2]

The Federation of State Medical Boards (FSMB) has acknowledged the importance of addressing disruptive physician behavior, as reflected in the 2000 Report of the Special Committee on Professional Conduct and Ethics[3] and in the 2011 Policy on Physician Impairment.[4]

This article provides in-depth information about disruptive physician behavior, including discussion of the causes and contributing factors, strategies to manage such behavior, construction of medical staff policies, appropriate and inappropriate use of the *disruptive* label, and prevention. Although not a diagnosis, the disruptive label is useful in screening for disruptive physician behaviors. However, the term "disruptive" should not be used to label physicians who present controversial ideas or who offer criticism of the medical system.

DISRUPTIVE PHYSICIAN BEHAVIOR CONSISTS OF A PRACTICE PATTERN OF PERSONALITY TRAITS THAT INTERFERES WITH THE PHYSICIAN'S EFFECTIVE CLINICAL PERFORMANCE...THE DISRUPTIVE BEHAVIORS NEGATIVELY IMPACT THE PERSONS WITH WHOM THE PHYSICIAN INTERACTS.

Definition

Disruptive physician behavior consists of a practice pattern of personality traits that interferes with the physician's effective clinical performance. Manifestations are behavioral (see Table 1).

The disruptive behaviors negatively impact the persons with whom the physician interacts. The behaviors include inappropriate anger or resentment,

inappropriate words or actions directed toward another person, and inappropriate responses to patients' needs or staff requests.[5] The behaviors can be expressed *directly* to patients or *indirectly* through impeding the health care delivery team, or they may *potentially* compromise the quality of care of patients. The behaviors can be overtly aggressive, such as yelling, cursing, or throwing objects. Or, they can be indirectly passive-aggressive, such as sarcasm, "joking" at someone else's expense, or giving them the "cold shoulder." The disruptive physician may avoid direct expressions and, instead, resort to more disguised expressions, especially when put on notice by a medical executive committee. Insidious behaviors are more difficult to explicate, making it difficult for others to render complaints and for victims to defend themselves. When called to task, the disruptive physician can argue that the behavior in question is a matter of interpretation, the physician meant no harm, and the recipient is overly sensitive and reading things into what was said. The whole matter was just a simple "misunderstanding."

Table 1
Disruptive Behaviors

Aggressive behaviors:
- Yelling
- Foul and abusive language
- Threatening gestures
- Public criticism of coworkers
- Insults and shaming others
- Intimidation
- Invading one's space
- Slamming down objects
- Physically aggressive or assaultive behavior

Passive-aggressive behaviors:
- Hostile avoidance or the "cold shoulder" treatment
- Intentional miscommunication
- Unavailability for professional matters, e.g., not answering pages or delays in doing so
- Speaking in a low or muffled voice
- Condescending language or tone
- Impatience with questions
- Malicious gossip
- Racial, gender, sexual, or religious slurs or "jokes"
- "Jokes" about a person's personal appearance, e.g., fat, skinny, short, ugly
- Sarcasm
- Implied threats, especially retribution for making complaints

Horty cites case law that defines disruptive behavior as conduct that "disrupts the operation of the hospital, affects the ability of others to get their jobs done, creates a 'hostile work environment' for hospital employees or other physicians on the medical staff, or begins to interfere with the physician's own ability to practice competently."[6] In its model medical staff Code of Conduct, the American Medical Association (AMA) offers definitions of the terms *inappropriate behavior* and *disruptive behavior*, as well as *appropriate behavior* (see Table 2).[7]

What Is Not Pure Disruptive Behavior

A single episode of disruptive behavior does not render a physician a disruptive physician. Human beings are complex creatures. No one is perfect. Expecting absolute harmony is unrealistic. The disruptive behavior label should not be applied to the physician who has an occasional bad day or an occasional reaction that

Table 2
American Medical Association Definition of Terms

- **Inappropriate behavior** means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as "disruptive behavior."
- **Disruptive behavior** means any abusive conduct, including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.
- **Appropriate behavior** means any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized medical staff, or to engage in professional practice, including practice that may be in competition with the hospital. Appropriate behavior is not subject to discipline under these bylaws.

is out of character for that individual. Instead, the disruptive label should refer to a pattern of seriously inappropriate behavior that is deep-seated and habitual. That having been said, single occurrences that are egregious still need to be addressed by medical staffs even if they are not part of a pattern.

The Challenge of Addressing Behavioral Issues

Addressing behavioral issues is challenging. Failure to address disruptive behaviors can result in irreparable harm to patients and staff. Despite challenges inherent in doing so, it is important to establish guidelines to define both positive/desired behaviors as well as negative/unacceptable behaviors. As of January 10, 2009, TJC requires medical leaders to address disruptive behaviors or "behaviors that undermine a culture of safety."[1]

Both within the profession and in health care settings, times have changed; disruptive behaviors are no longer acceptable. No longer can physicians act autocratically as god-like figures. Arrogant, demeaning behaviors create a hostile workplace. Today's physician must be capable of functioning as one part of a larger system of health care delivery. This is in keeping with TJC standards and with core competency requirements established by the American College of Graduate Medical Education (see Table 3).[8]

Competent bedside manner that respects patients and their needs, as well as professionalism toward coworkers of every status, is necessary for a well-functioning work environment. This is in keeping with the AMA Code of Medical Ethics regarding collegiality (see Table 4).[9]

Table 4
AMA Medical Ethics Regarding Collegiality

- Responsibility to other health professionals
- Respect the rights of colleagues and other health professionals
- Make relevant information available to colleagues
- Expose physicians deficient in character or competence
- Avoid engaging in conduct that undermines the public's confidence in the profession
- Facilitate remedial action for deficiencies

Defining appropriate/good and inappropriate/bad behavior involves making value judgments. What is acceptable behavior in one setting may not be in another. For example, although ad hominem verbal attacks are to be discouraged, allowing heated debates among physicians in closed staff meetings may be appropriate — while having such debates in front of patients is inappropriate.

Human communication involves individual perceptions and feelings. Dealing in the realm of subjectivity is challenging. When it comes to creating medical staff policies and procedures, it is important to get it right. The stakes may be high in terms of the impact of disruptive behavior on patient care. There are risks to the complainant in terms of potential retaliation. There are risks to the physician in terms of potential damage to reputation and viability of career, especially if the complaint is a false one.

Table 3
Positive Physician Behaviors

The American College of Graduate Medical Education (ACGME) has promulgated requirements for residency programs that include interpersonal skills. Among these core competencies are the following:

- Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
- Interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and other health professionals
- Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds
- Systems-based practice, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care

Failure to take into consideration the subjective aspect of human communication is to ignore a significant aspect of relating. Common sense, supported by research, shows that a significant component of spoken communication is nonverbal. Body language is a powerful means of communication. It is not simply the words spoken but also the associated facial expressions, gestures, eye contact, body posture, and intonation that convey meaning behind the literal words. Depending on the style of communication, the same words can convey acceptance, appreciation, and understanding or conversely rejection, humiliation, and disparagement.[10]

The issue is made more complex by the fact that, although the disruptive behavior is part of a deep-seated pattern, its expression can vary depending on circumstances. Disruptive physicians can thrive when they are in control. In settings that are compatible with the physicians' likes and needs, they can function quite well, especially where there are no external constraints on them. In positions of power, they can resort to intimidating tactics to accomplish their agendas. Problems arise when disruptive physicians are faced with circumstances that require flexibility to consider the needs of others. They have difficulty collaborating and compromising. Self-centered and inflexible, they resort to rigid defenses. When asked to explain their behavior, disruptive physicians defend the behavior as justified. From their viewpoint, the problem is the negative circumstance that prompted the display of disruptive behavior.

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One can refer to theories with greater ease than making determinations about real-life situations. Some disruptive behaviors are obviously inappropriate. But what about subtler cases? Addressing insidious behaviors can be challenging. Medical staff leaders tasked with making determinations about what behavior is appropriate and what is not must be wary of their own tendencies, on the one hand, to be overly moralistic and punitive or, on the other hand, to be overly permissive. Medical staff leaders must be careful not to back down when confronted by an intimidating disruptive physician who refuses to be accountable for inappropriate behaviors or threatens legal retribution. Having empathy for all parties concerned, including the perpetrator, can be challenging for medical staff leaders when involved with specific cases that spark strong emotions.

Magnitude of the Problem

Sound data are lacking for the incidence of disruptive physician behavior. Analyzing information from several sources, Leape and Fromson[11] state, "Our best estimate is that 3 percent to 5 percent of physicians present with a problem of disruptive behavior." According to a 2004 survey of physician executives, more than 95 percent reported regularly encountering disruptive physician behaviors, and 70 percent reported that the disruptive behaviors nearly always involved the same physicians. Disruptive physician behaviors most commonly involved conflict with a nurse or other allied health care staff. Nearly 80 percent of the respondents said that disruptive physician behavior is under-reported because of victim fear of reprisal or is only reported when a serious violation occurs.[12]

In surveys of health care professionals, nurses perceive many physicians as displaying disruptive behaviors. Physicians, when evaluating themselves, are less likely to perceive such problems. Why the difference? One reason is that systemic institutional factors can play a role in selecting for and teaching disruptive behaviors. Abusers often have a past history of having been abused themselves. Although not intended, medical training by its very nature can serve to encourage disruptive physician behavior among those who already have personalities that are so inclined. Studies show that many medical students and house staff experience abuse during their training. Abuse is described as "belittling" or "humiliation" by "malignant" and "egotistical" attending physicians. Some students identify with abusive authority figures who served as role models during training, especially when abuse is common among superiors and condoned by the institution.[13,14,15] Those who survive their hazing experiences can identify with those in power who previously abused them. (In psychological parlance, this is referred to as "identification with the aggressor.") Having achieved full status as physicians, some physicians, having paid their dues, feel entitled to re-enact abuse on others. As Eckenfels and colleagues warn,

"Today's abused student is tomorrow's source of social control as a resident or attending physician."[16]

Causes and Contributing Factors

Disruptive behavior can be manifestations of Axis I psychiatric clinical conditions, or of Axis II personality disorders, or of an occasional incident not stemming from underlying psychopathology. Clarifying these distinctions is important in managing the physician and argues for expert professional evaluation.

Pure disruptive behavior as defined in this article is not caused by substance abuse or an Axis I psychiatric clinical condition such as depression or bipolar disorder. Pure disruptive behavior arises from the physician's personality or basic character. Typical personality disorder diagnoses among disruptive physicians include paranoid, narcissistic, passive-aggressive, and borderline types that can occur as mixed types (see Table 5).

Other Contributing Factors

Many different types of factors can result in interpersonal conflicts. Gender, ethnicity, culture, religion and social factors can contribute to interpersonal conflicts. Differing values and perceptions may result in conflicts. Maladaptive personality or character traits can lead to conflicts. It is the latter that is at issue with pure disruptive physician behavior.

External stressors can provoke disruptive behaviors in physicians predisposed to such behavior. The more external stress — personal or professional — the greater the risk that the physician will express disruptive behaviors. Functioning as a physician places demands on coping skills that are psychologically draining. Krizek writes that the nature of surgical training and the rigors of practicing surgery are impairing.[17]

Psychological Dynamics

In some settings, the disruptive physician's behavior can be adaptive. However, because of inflexibility,

Table 5
Differential Diagnosis Associated with Disruptive Behavior

Axis I (symptoms disorders):

- Bipolar Disorder
- Depressive Disorders
- Substance Use Disorders
- Attention Deficit Disorder
- Intermittent Explosive Disorder
- Circadian Rhythm Disorder
- Dementia

Axis II (personality disorders):

- Paranoid (pattern of distrust and suspiciousness; such that other's motives are interpreted as malevolent)
- Narcissistic (pattern of grandiosity, need for admiration and lack of empathy)
- Passive-aggressive (pattern of negativistic attitudes and passive resistance to demands for adequate performance in social and occupational situations)
- Borderline (pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity)

Table 6
Personality Traits Associated with Disruptive Physicians

Positive traits:

- Highly-skilled
- Well-read
- Intelligent
- Articulate
- Hard-working
- Heavy admitters
- Confident
- Persevering
- High-achieving

Problem traits:

- Arrogant
- Intimidating
- Controlling; insistence of having things their way
- Inflexible, uncompromising
- Self-centered; exaggerated sense of self-importance
- Entitlement
- Un-empathic
- Rationalizing to justify their behavior
- Blame others
- Create upset and distress in others; viewed as difficult by others
- Denial; lacks self-awareness, insight, accurate self-appraisal
- Lacking in remorse; incapable of genuine apologizing
- Failure to self-correct behavior
- Resist help
- Vindictive
- Litigious

the same personality traits are maladaptive across a broad variety of settings (see Table 6). Disruptive physicians lack closeness in relationships, lack empathy for others, and lack insight about their problem behaviors. They denigrate and resist mental health treatment.

Pure disruptive behavior is motivated by the physician's need for power and control in relationships. Disruptive physicians seek to control others through intimidation. They are not team players. Invitations to act collegially meet with rebuffs. Disruptive physicians rebel against limits that are set on them. The DSM-IV description of Passive-Aggressive Personality Disorder is apt: "These individuals habitually resent, oppose, and resist demands to function at a level expected by others."[18] Disruptive physicians, while dominating others, resent others dominating them. Ironically, the repeated disruptive behaviors ultimately provoke others in positions of authority into scrutinizing and regulating the disruptive physician's behavior. This results in the very domination the disruptive physician detests.

Complicating matters is the fact that one cannot rely on collaboration from the disruptive physician to arrive at a reasonable consensus position about the occurrence of inappropriate behaviors and even less about how to remedy problems. The disruptive physician has no appreciation of the inappropriateness of the behavior. In fact, the opposite is true: The disruptive physician views the behaviors as justified and others as deserving of harsh treatment. There are no pangs of conscience that suggest reconsideration and change; an internal corrective feedback mechanism is absent in the disruptive physician. Disruptive physicians do not collaborate in problem solving to improve their behavior. They disparage and resist mental health approaches. Effective management requires the imposition of strict external controls, which disruptive physicians vehemently resist. They view remediation as punishment. They feel victimized when prevented from victimizing others.

Impact on the Workplace

Disruptive physician behaviors can have a devastating and widespread impact on the health care system. A single physician can create a hostile workplace environment. Demoralization of staff and lawsuits are not uncommon. According to TJC, "Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments" (see Table 7). Accordingly, TJC requires medical systems to create "a code of conduct that defines acceptable, disruptive, and inappropriate behaviors" and to "create and implement a process of managing disruptive and inappropriate behaviors."[1] In order to implement TJC requirements, medical staffs and health care organizations must collect information and analyze complaint information to determine if there are trends or patterns that suggest disruptive behavior and the need for intervention.

TJC suggests proactive, rather than passive, actions to develop an organizational process to uncover information. Specific suggestions include:

- Soliciting and integrating substantial input from an inter-professional team, including representation of medical and nursing staff, administrators and other employees.
- Developing and implementing a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior.
- Including ombudsman services and patient advocates, both of which provide important feedback from patients and families that may experience intimidating or disruptive behavior from health professionals.
- Monitoring system effectiveness through regular surveys, focus groups and coworker evaluations.[1]

Why Bother to Assist Disruptive Physicians?

Oftentimes, disruptive physicians are successful and accomplished practitioners, who profess high standards of patient care and clinical practice. Aside from their interpersonal problems, they are

Table 7
Impact of Disruptive Behavior

- Lowered staff morale
- Increased turnover of staff
- Negative reputation of the health care system
- Undermined team effectiveness
- Poor patient satisfaction
- Diminished patient care: medical errors, adverse elements
- Increased cost of care
- Lawsuits

valuable members of the medical group because of their knowledge and technical expertise. Whenever possible, efforts should be expended to assist them so that they behave appropriately and can be valuable contributors in the health care setting. Invoking discipline with no option for assistance automatically creates an adversarial relationship in which the physician becomes invested in justifying the disruptive behaviors. A program of assistance allows for constructive change to the benefit of the individual physician, patients, and members of the health care delivery system. There is a win-win result for all parties when a program of assistance is successful.

Strategies to Manage Disruptive Behavior

Keys to success in changing disruptive behavior involve a program of management that is intensive, multimodal, and long-term. "Tough love" is the key phrase/byword. Constructive change in disruptive physicians comes through requiring adherence to expected behaviors while providing educational and other supports to teach the physician new coping skills for achieving the desired behaviors (see Table 8). Expectations should be explicitly crafted into a behavioral management contract to improve functioning and reduce acting out on the part of the physician.

Trying to talk the physician out of being angry is not realistic and is counterproductive. The problem is not in having angry feelings. It is the manner in which the angry feelings are expressed, and whether this expression is disruptive or not. A goal of management is to teach ways of expressing the feelings in order to achieve the desired end rather than expressing them inappropriately with all the problems that subsequently ensue.

Referral to a single anger-management course will not change a long-standing pattern of disruptive behavior that arises because of a personality disorder. Successful management of disruptive physician behavior begins with an in-depth Comprehensive Fitness-for-Duty Evaluation, which should include

Table 8
Elements of a Program of Remediation

Remediation should be tailored to the needs of the individual physician based on psychiatric evaluation. Examples of program elements include the following:

Training sessions:

- Communication skills training:
  - Anger management
  - Negotiation and conflict resolution
  - Sensitivity training
  - Self-assertiveness training
  - Team building
- Impulse control training

Treatment options:

- Focused psychotherapy
- Use of psychotropic medications for select cases
- Professionally led assistance groups for physicians with disruptive behavior
- Behavioral coaching

Ongoing assessment:

- Assessment utilizing the 360-degree tool
- Periodic psychiatric re-evaluation to adjust the participant's contract based on progress or recurrences of negative behaviors; determinations about danger to patients and coworkers, suitability to practice and limitations that may require practice restrictions (temporary or permanent) or need to terminate well-being committee assistance as ineffective and refer to medical executive committee for discipline

Oversight program resources:

- Participation in physician wellbeing committee
- Participation in state physician assistance program

medical, chemical, and social evaluation in addition to psychiatric evaluation with personality assessment.[19] The front-end professional evaluation serves as a guide to developing a program of remediation and monitoring and as a benchmark against which to measure future change. A program of remediation and monitoring should be codified into a tightly crafted contract. Expect that the disruptive physician will search for loopholes to slip through. As such, contracts should always be open to revision, based on experience. Vague contracts invite recurrences of inappropriate behavior and a process of protracted negotiations. Medical staffs can become frustrated and worn down by disruptive physicians, who have boundless energy to avoid closure that would result in accountability for their problem behaviors. Of surprise to most medical staffs is the fact that professional evaluations yielding individualized remediation programs can produce amazingly positive results when they are carefully conducted and there is a good follow-through process, supported by a monitoring program.[20]

The goal of remediation is improved behavioral functioning. Psychological insight, which rarely occurs, would be a bonus. Educational and other remedies that teach the physician positive coping skills are useful. However, they must be applied over a number of years in order to prevent recurrences of disruptive behaviors. Remediation involves a learning curve over time. Expect some recurrences of problem behavior. Improvement consists of fewer occurrences that are less egregious in nature. A brief crash-course may give false hope to a medical staff, while allowing the physician to "get it over with" quickly. With remediation requirements completed quickly, the physician resumes an out-of-sight, out-of-mind mentality and reverts back to disruptive behaviors.

Understanding the psychological underpinnings of disruptive behavior should not serve to excuse disruptive physicians from responsibility for the behavior. In a program of assistance, disruptive physicians must be held accountable for any recurrences of disruptive behavior. Learning to be accountable for creating problems is part of a growth process.

Because disruptive physicians lack internal motivation to improve behavior, it is the threat of external consequences that incentivizes compliance with behavioral expectations. Imposition of sanctions meets with opposition from the disruptive physician, and medical staffs must be prepared for a fight. Fierce adversaries, disruptive physicians are confident they will prevail and triumph in legal proceedings. Prone to be litigious, many disruptive physicians are self-educated in the law. Some even have law degrees. Black and white legalistic thinking appeals to them. The prospect of proving others wrong and making them pay appeals to the mentality of the disruptive physician.

Effective monitoring takes genuine commitment on the part of a medical staff. There must be long-term follow-through in order to change deeply imbedded behavior patterns. Sometimes monitoring is best accomplished by referral to an external professional monitoring agency that is experienced in dealing evenhandedly with the resistances of this population and guarantees impartiality to the physician. For some physicians with hardcore resistance to constructive change, there is no easy way out for medical staffs. Ignoring the behavior, hoping it will go away, only serves to enable continuation of it. Early intervention is best. Allowing one physician to engage in disruptive behavior serves to encourage others to express similar behaviors, and the whole system can become dysfunctional.

CONSTRUCTIVE CHANGE IN DISRUPTIVE PHYSICIANS COMES THROUGH REQUIRING ADHERENCE TO EXPECTED BEHAVIORS WHILE PROVIDING EDUCATIONAL AND OTHER SUPPORTS TO TEACH THE PHYSICIAN NEW COPING SKILLS.

At all stages of intervention, treatment, and monitoring, physician due process rights should be respected. If assistance from a well-being committee fails and a process of reasonable "progressive discipline" fails, termination can be considered. Such cases must be reported to the medical board which may result in action against the physician's license if the board determines that complaints are valid.

Construction of Medical Staff Policies

In accordance with TJC, medical staffs and hospitals must develop behavioral standards. Medical staff bylaws, policies and procedures should be consistent with hospital regulations and with the federal, state, and local laws. Behavioral expectations should be reinforced through initial medical staff privilege screening, re-credentialing, and periodic education of the medical staff. Systems

should be established to identify problem physicians. Disruptive physician behavior can be identified utilizing patient complaints and surveys, peer assessments, and 360-degree reviews that utilize feedback from coworkers, including physician peers, nursing staff, and administrators.

In developing bylaws, medical staffs must define appropriate and disruptive behaviors. Where does one draw the line between acceptable versus unacceptable behaviors? On the one hand, care should be taken not to be overly restrictive which can be unrealistic in terms of human behavior. Doing so can have a chilling effect on open communication. On the other hand, being too lax and ignoring inappropriate behavior can create problems. Doing so can enable the perpetrator to persist in expressing unacceptable behavior and serve as a role model for others to do likewise. What to include and what to exclude can be a difficult balancing act.

THE DISRUPTIVE PHYSICIAN LABEL CAN BE MISUSED IN SEVERAL WAYS... THE LABEL SHOULD NOT BE APPLIED TO PHYSICIANS WHOSE DISRUPTIVE BEHAVIORS ARE SYMPTOMS OF A PSYCHIATRIC CLINICAL CONDITION

Medical staff bylaws should include a due process component because false accusations can be made. Complaints should not be considered valid without a complaint verification process. Bylaws should include an appeals process with an option for a fair hearing.

Also, physicians should be permitted an avenue to report individuals whom they perceive to be incompetent. Typically, nursing administrations provide a process for nurses to submit complaints, including complaints about physicians. Medical staffs should formalize a similar process for physicians to lodge complaints. Periodically, individual complaints should be reviewed collectively to uncover patterns in the system that can be constructively addressed.

Resources are available to guide medical staffs in developing bylaws. Pfifferling[21] provides guidelines for developing an equitable system for managing disruptive behavior. The policy guidelines can assist medical staffs to ensure that policies address such key areas as behavioral expectations, method of confrontation, grievance process, assessment, treatment, sanctions and work re-entry. The College of Physicians and Surgeons of Ontario, Canada[22] provides a *Guidebook for Managing Disruptive Physician Behaviour* that includes a "Sample Code of Conduct" and a "Sample Complaints Procedure" that can be adapted by medical staffs in developing bylaws. The American Medical Association's detailed "Code of Conduct"[7] can serve to guide medical staffs in developing policies and procedures that are consistent with TJC standards. The California Medical Association (CMA) has developed sample guidelines for developing medical staff bylaws regarding a physician code of conduct.

The CMA has expressed concern that the 2009 Joint Commission Leadership Standard allows hospitals, as opposed to medical staffs, to define disruptive behavior. According to the CMA, California law does not condone this type of hospital control over the self-governing medical staff: "Medical staffs, not hospitals, determine when, under what circumstances, and how disruptive behavior should be managed."[23]

TJC suggests, but does not require, that leaders "Conduct all interventions…with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies."[1] That would include Axis I psychiatric conditions. But does this include disruptive behavior caused exclusively by Axis II personality disorders? Some medical staffs may choose to invoke discipline without an option for assistance to disruptive physicians whose behavior is rooted in a personality disorder. The AMA and the CMA both recommend assistance as an option. Medical staffs that wish to create an assistance option for physicians with disruptive behavior should create a policy and procedure for referral for professional psychiatric evaluation to determine the root cause and to determine if an assistance approach is feasible. Medical staffs may refer the disruptive physician to their state physician health program to develop and oversee a program of assistance and monitoring. Referral to the state medical board will be required in cases in which a physician declines assistance and the behavior poses a danger to patient care. Some physicians may be more inclined to accept assistance knowing that they face potential discipline with referral to the medical board.

Given the complexities of crafting bylaws, medical staffs should seek counsel from an experienced health-law attorney. In crafting bylaws regarding

disruptive behavior, medical staffs can also benefit from consultation with a psychiatrist experienced in evaluating and managing disruptive behavior. Likewise, in addressing specific cases that come before the medical staff, consultation with a health-law attorney as well as a psychiatrist experienced in behavioral issues can help avoid pitfalls (see Table 9).

Appropriate vs. Inappropriate Use of the Disruptive Label

The disruptive physician label can be misused in several ways. The label is not a diagnosis. The label should not be applied to physicians whose disruptive behaviors are symptoms of a psychiatric clinical condition (Axis I psychiatric disorder). A number of psychiatric conditions can present with symptoms that include agitated, angry and inappropriate behaviors. For example, Axis I psychiatric disorders such as Bipolar Disorder, Depression and Substance Use Disorders can present with symptoms of agitation, mania, poor judgment, and poor impulse control that present as disruptive behaviors. Medical staff committees should not diagnose conditions. Instead, committees should act in a case management or oversight capacity and refer the physician to appropriate resources. Referral for professional evaluation can establish whether diagnosable psychiatric conditions are present. When Axis I psychiatric disorders are present, such individuals should be assisted by physician well-being committees in accordance with TJC standards for assisting impaired physicians.[24] Treatment can alleviate the disruptive symptoms and allow the physician to return to normal baseline functioning.

Anyone can have a bad day. The disruptive label should not be applied to a physician who has a one-time or occasional disruptive episode that is otherwise out of character for the physician. Pure disruptive behavior is rooted in personality; it is deep-seated and pervasive.

The label "disruptive" should not be used to silence physicians who criticize the health care system. When physician voice is ignored, patient care suffers. The CMA has prepared a statement cautioning medical staffs to guard against vague codes of conduct. Physicians should not be labeled "disruptive" if they violate onerous and overbroad codes of conduct designed to squelch medical advocacy or target competitors.[25] In a similar vein, the AMA advises, "Criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior."[26] Furthermore, judgments about a physician's behavior should be fair and unbiased, "not based on personal friendships, dislikes, antagonisms, jurisdictional disagreements or competitiveness among members of the staff."[27] Individual whistleblowers with good ideas, even when well presented, may be falsely labeled disruptive as a tactic to silence them.

Although disruptive physicians can be right, a good message can be destroyed by a bad delivery. Unfortunately, key issues become lost because of poor delivery. The focus becomes the objectionable delivery rather than the issues that caused the physician to express anger. In today's world, physicians must learn appropriate ways of expressing complaints. A good system provides a mechanism for physicians to express complaints. Failure to include physician voice creates fertile ground for disruptive behaviors.

What Can be Done to Prevent Disruptive Behavior?

Consistent with recommendations from TJC, preventive approaches require a proactive stance to uncover existing or ongoing problem physicians. Sensitizing medical staffs to the issues requires regular educational sessions. Recommendations offered in Table 9 of this article address systems issues. For example, medical staffs can require applicants to endorse their compliance with a behavioral policy during the initial application and credentialing process, and subsequently as part of recredentialling.

As part of the application process for medical staff privileges, applicants can be screened for unprofessional behavior. Medical staffs can solicit, from those individuals who write letters of reference, information about unprofessional behavior. To simplify matters, letters of reference can be appended with checklist forms. For example, has the applicant manifested undesirable behaviors (as listed in Table 1 of this article)? Conversely, questions can be asked about positive behaviors. For example, does the applicant possess the core competences as defined by the ACGME (as listed in Table 3 of this article)?

Can prevention of disruptive behavior be applied to the medical school application process? There is accumulating evidence that performance in medical school and beyond is related to personality.[28] Five factors of personality have been identified as important to success. "Agreeableness" has been

identified as one of the "big five personality factors." As such, some medical schools are utilizing instruments such as the "multiple mini interview" (MMI) to assess character of students in the application process. Some MMI stations aim to assess behaviors that evidence whether or not an applicant is caring, empathic and collaborative. In addition, should education of students in training include learning modules to teach skill sets that promote desired behaviors? Further research could be done to determine how effective such efforts may be in reducing the incidence of disruptive physician behaviors.

Summary

Physicians, like all human beings, manifest with a wide range of behaviors and means of relating to others stemming from their individual personalities and environmental influences. Anyone can have an occasional expression of

Table 9

Elements of a Policy to Manage Disruptive Physician Behavior

Behavioral standards and identification of disruptive behavior:

- Definition of disruptive behavior
- Definition of desired behavior
- Endorsement of behavioral policy during initial credentialing and also subsequent re-credentialing
- Mechanism for identifying disruptive behavior
- Mechanism for reporting complaints and concerns about disruptive behavior

Infrastructures for addressing incidents:

- Review or verification process to ascertain the validity of each complaint
- Process to notify the physician of a complaint
- Mechanism for conducting interventions
- Process for making referrals to a well-being committee for assistance in terms of case management and oversight
- Process for making referrals for psychiatric evaluations to determine fitness for duty, diagnosis, recommendations for treatment, and monitoring plan
- Model corrective action plans/contracts commensurate with the behavior
- Monitoring system to determine whether disruptive physician behavior recurs or improves
- Process for disciplinary actions in cases not appropriate for remediation (suspensions, termination, loss of clinical privileges, reporting to professional licensure bodies)
- Understanding of who will be involved at various stages of the process
- Guidelines for confidentiality
- Protection of the physician's due process rights under the law
- Protection against retaliation for individuals who file complaints

Systems issues to include the voices of all stakeholders:

- Organizational process that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees
- Skills-based training and coaching for all leaders and managers in relationship-building, collaborative practice (including skills for giving feedback on unprofessional behavior) and conflict resolution
- With the goal of making systemic improvements so as to reduce occurrences,
  - develop a mechanism for analyzing complaint data with regard to patterns and trends within a system
  - develop a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients
- Mechanism for physicians to report complaints about coworkers
- Mechanism for physicians to report complaints about the health care system

Primary prevention:

- Ongoing education of the medical staff regarding acceptable and disruptive behaviors and resources to obtain assistance

inappropriate behavior. The disruptive physician differs from peer physicians in the sense that manifestations of inappropriate behavior represent an ongoing pattern that is pervasive, deep-seated, and resistant to change. Expected behavioral standards have been established by the professional organizations and, when incorporated in medical staff policy, may prevent and/or redress disruptive physician incidents. When pervasive violations of behavioral and interpersonal norms persist and medical staff attempts to mediate are met with physician resistance, denial, and even aggressive responses, consideration should be given to referral for in-depth professional evaluation of the physician. The feasibility of offering assistance should be considered before automatically invoking discipline. The goal of professional evaluation is to determine a diagnosis, identify contributing causes, and formulate a specific treatment and monitoring plan for the individual physician. In all cases, a balanced, respectful, and compassionate perspective toward both perpetrators and their targets should guide the work of medical staff committees. The disruptive label should not be applied to physicians just because they present controversial ideas or who offer criticism of the medical system. ■

About the author

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References

1. The Joint Commission. Behaviors that undermine a culture of safety. *Joint Commission Sentinel Event Alert*. 2008; issue 40.
2. Keogh T, Martin W, Managing unmanageable physicians. *Physician Executive*. 2004;18-22.
3. Federation of State Medical Boards. Report of the Special Committee on Professional Conduct and Ethics (Section III: Disruptive Behavior). 2000; 4-7.
4. Federation of State Medical Boards. Policy on Physician Impairment. Available at: www.fsmb.org/grpol_policydocs.html. Accessed July 21, 2011.
5. Dalco J. Disruptive Behavior. *Federation of State Physician Health Programs Physician Health News*. 1999; 3(2): 1-7.
6. Horty J. When conduct crosses the line. *Medical Staff Monthly*. 1998;1: 3.
7. Cohen B, Snelson E. Model Medical Staff Code of Conduct. American Medical Association. 2009.
8. ACGME. Core Competencies approved 09/28/99. Available at: http://www.acgme.org/outcome/comp/compmin.asp. Accessed May 17,/2010.
9. American Medical Association. Code of Medical Ethics Opinion 9.031. CEJA Report 2-A-00. 2000.
10. Mehrabian A. Silent messages: Implicit Communication of Emotions and Attitudes. Second edition. Belmont, CA: Wadsworth; 1981.
11. Leape LL, Fromson JA. Problem doctors: is there a system-level solution. *Ann Int Med*. 2006;144:104-115.
12. Weber DO. For safety's sake disruptive behavior must be tamed. *Physician Executive*. 2004; 17.
13. McMurray JE, Schwartz MD, Genero NP, Linzer M. The attractiveness of internal medicine: a qualitative analysis of the experiences of female and male medical students. *Ann Intern Med*. 1993; 119(8):812-818.
14. Daugherty SR, Baldwin DC, Rowley BD. Learning, satisfaction, and mistreatment during medical internship: a national survey of working conditions. *JAMA*. 1998; 279(15):1194-1199.
15. Elincki DM, Linger, B, Asch, E, et al. Multi-Institutional research examining student characteristics and student abuse. *Academic Med. October Supplement*. 1999; 74(10): S99-S101.
16. Eckenfels, EJ, Daugherty SR, Baldwin DC, et al. A socio-cultural framework for explaining perceptions of mistreatment and abuse in the professional socialization of future physicians. *Ann Behav Sci Med Educ.*, 1997; 4:11-8.
17. Krizek TJ. Ethics and Philosophy Lecture: Surgery… Is it an impairing profession? *J Am Coll of Surg*. 2002;194 (3): 352-366.
18. American Psychiatric Association. Passive-Aggressive Personality Disorder. Diagnostic and Statistical Manual of Mental Disorders. 4th ed.1994; 733-735.
19. Reynolds NT. A model comprehensive psychiatric fitness-for-duty evaluation. *Occupational Medicine: State of the Art Reviews*. 2002;17(1):105-118.
20. Reynolds NT, Tracy J. Case studies in evaluating and managing the disruptive physician. Presentation at the AMA 2000 International Conference on Physician Health. Seabrook Island, SC. 2000.
21. Pfifferling JH. Managing the unmanageable: the disruptive physician. *Family Practice Management*. 1997;4(10):76-8,83,87-92.
22. College of Physicians and Surgeons of Ontario. Guidebook for managing disruptive physician behavior. Available at: http://www.cpso.on.ca/uploadedFiles/policies/guidelines/office. Accessed 2008.
23. California Medical Association. Disruptive behavior involving member of the medical staff. CMA on-call document #1241. Available at: www.cmanet.org. Accessed July 7, 2010.
24. JCAHO Standard MS 2.6. Available at: http://www.jointcommission.org/standards_information/standards.aspx. Accessed September 24, 2011.
25. California Medical Association. Disruptive behavior involving member of the medical staff. CMA on-call document #1241. Available at: www.cmanet.org. Accessed July 7, 2010.
26. AMA. Medical Code of Ethics Opinion 9.045 – Physicians with disruptive behavior. Available at; http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion9045.page. Accessed Septemebr 24, 2011.
27. Physicians with disruptive behavior. Report of the Council on Ethical and Judicial Affairs AMA Report. 2000;2-A-00:2.
28. Griffin B, Wilson I. Association between the big five personality factors and multiple mini-interviews. *Adv in Health Sci Educ*. Published online July 13, 2011.