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The Case of the Verbally Abusive Physician

John B. Schorling, MD, MPH |November 25, 2009

The Case

Dr. Smith is a 43-year-old general surgeon at an academic medical center. Outside the operating room (OR) he gets along well with others and has positive patient satisfaction scores. He is one of the most productive surgeons in his department and his patient outcomes are excellent. In the OR, however, he is known as a demanding but highly skilled surgeon with a quick temper who frequently yells at nurses and support staff for not being quick enough to follow his directions. Several nurses have complained informally about his use of demeaning language, and the chair of his department met with him once to encourage him to "tone it down" in the OR. One day, on arriving in the OR for his first case, he finds the patient not yet ready and demands to see the charge nurse. When he is told that she is busy, he storms out of the room, yelling, "I can't work in this place with you #!* idiots! If anyone else here cared about the patient, she'd be in the room by now. Call me when you figure out how to do your jobs." When this is reported to the charge nurse, she files a formal complaint against him under the institution's Standards for Professional Behavior Policy.

As a result of the formal complaint, the surgeon is required to meet with the medical director of the OR and the administrator to review the circumstances. At this meeting, the surgeon states that he understands that swearing in the OR is inappropriate and he apologizes. He agrees not to use such language again. However, he believes that the OR is understaffed and that it is not possible for him to provide the necessary quality of care without adequate staff to get his patients in the room on time. The administrator acknowledges the current difficulties with staffing but says that she is doing all she can to fill positions, and that the shortage is affecting everyone equally.

Several weeks after meeting with the medical director and the administrator, Dr. Smith is in the middle of performing surgery when a new nurse hands him the wrong instrument. He immediately starts swearing and berating her, saying that she is incompetent, has no place in an OR, and ought to find another profession. The nurse apologizes, and they finish the operation without further incident. Both the anesthesiologist and another nurse are present at the time of the outburst. The nurse who was berated fills out another report documenting Dr. Smith's behavior.

Commentary

Disruptive behavior has gained increasing attention as healthcare organizations strive to create a culture of safety and reduce medical errors. Disruptive behavior by a physician has been defined by the Federation of State Medical Boards as "aberrant behavior manifested through personal interaction with physicians, hospital personnel, health care professionals, patients, family members, or others, which interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care.[1]" This can include behavior ranging from active verbal abuse and physical threats and actions to more passive actions, such as refusing to perform assigned or expected tasks.[2] In response to recent surveys documenting the prevalence of disruptive behaviors and their potential impact on patient care, The Joint Commission issued a new Leadership standard that became effective January 1, 2009 that addresses disruptive and inappropriate behaviors. This states that "the hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors" and "leaders create and implement a process for managing disruptive and inappropriate behaviors.[2]"

Prevalence of the Problem

Disruptive behaviors, unfortunately, are not uncommon. In a survey conducted in 2004, 79% of physician executives indicated that problems with physician behavior occurred within their organizations more than 3-5 times a year. Disrespect was the most common behavior noted (83%), but refusal to complete tasks, yelling, and insults were also common. Overall, 70% indicated that physician behavior problems nearly always involve the same physicians, and

56% said that most problems involved conflicts between physicians and staff members.[3]

Rosenstein and O'Daniel have conducted a series of surveys among VHA hospitals, a national alliance of more than 1400 not-for-profit hospitals.[4-7] In their most recent study, a total of 77% of respondents had witnessed disruptive behavior among physicians, including 88% of nurses and 51% of physicians.[7] General surgeons were most frequently identified as likely to exhibit disruptive behavior (26%), followed by neurosurgeons (20%), cardiovascular surgeons (13%), and orthopaedic surgeons (10%). Nurses were noted to demonstrate disruptive behavior by 65% of respondents -- 73% by other nurses and 48% by physicians.

Consequences

Disruptive behavior by physicians has a number of consequences. In an era when there is a shortage of nurses, such behavior has been cited as a significant factor contributing to nurse dissatisfaction and morale. In a survey conducted in 2001-2002 of 1200 nurses and physicians, 31% responded that they knew of a nurse who had left their hospital due to disruptive behavior, with an average of 2.4 leaving each year for this reason.[4] The same investigators studied the potential impact of disruptive behavior in the perioperative setting in an academic medical center and found that of 244 respondents, including physicians, nurses, and other employees, 46% stated that they were aware of a potential adverse event from disruptive behavior, and 62% indicated that it could have been serious, very serious, or extremely serious.[6]

In a recent survey of over 4500 participants (predominantly nurses and doctors) from 102 hospitals conducted from 2004 to 2007,[7] 94% responded that disruptive behavior sometimes, frequently, or constantly leads to stress and frustration; 89% noted reduced team collaboration; 91% noted reduced communication; and 99% indicated impaired nurse-physician relationships. Overall, 67% thought that disruptive behavior sometimes, frequently, or constantly leads to adverse events, with 71% of this group believing that such behavior led to errors and 51% to reduced patient safety. Overall, 18% were aware of a specific adverse event that occurred directly because of disruptive behavior. Because of these potential effects on patients and others, disruptive behavior also frequently violates principles of medical professionalism.[8] In summary, disruptive behavior can undermine morale, increase turnover, decrease efficiency, consume resources, and threaten patient safety.[9,10]

Underlying Predisposing Factors

Why do physicians engage in disruptive behavior? Despite the prevalence of such behavior, there has been little research on this topic. Physicians are certainly under increased stress from working in an environment of declining reimbursement that requires increased productivity just to stay even. In addition, an increased emphasis is placed on working in teams, which is not the way many physicians were trained. There is also more pressure to practice in specific ways, such as adhering to specific guidelines and pathways, that limit physician autonomy.

Stress, addiction, psychiatric disorders (especially mood), and personality disorders should certainly be considered.[1] Among 38 physicians referred to a specialized program for disruptive behavior, which is based on the Minnesota Multiphasic Personality Inventory®-2 (MMPI®-2), 16% were categorized as having high subjective distress, primarily due to depression and anxiety; 19% had characterological (personality) features; and 61% had normal profiles.[11] In some cases, substance use disorders may underlie disruptive behavior, although in the survey of physician executives discussed above, the respondents believed that less than 10% of episodes were due to substance abuse.[3]

Behaviorally disruptive physicians may rationalize their reactions as natural responses that are based on their commitment to their work and their unwillingness to compromise patient care, according to their perceptions, with the lower standards of others.[10] Although holding high standards is appropriate, the responses of these physicians are not because they may be adversely affecting the quality of care. Often underlying this stance are compulsive personality traits combined with a lack of emotional intelligence. Many physicians exhibit compulsive traits, especially what has been called the "compulsive triad" of self-doubt, guilt, and an exaggerated sense of self-importance.[12] Self-doubt often results from having excessively high personal standards -- common in many

physicians -- that are often so high that the standards are difficult (or impossible) to achieve. This inability to achieve their own high standards can lead physicians to doubt their self-worth. When something does not go well, such individuals tend to blame themselves -- often for things that are not within their control. Feelings of guilt follow and often lead to a renewed desire to increase control, which can be manifested as an exaggerated sense of self-importance. Given these high self-expectations, such physicians often impose equally high standards on others and react strongly if colleagues or staff fail to meet them, which these physicians may believe reflects poorly on themselves.

Among disruptive physicians, these traits may be coupled with low emotional intelligence, which refers to how well they understand and are able to regulate themselves (self-awareness and self-regulation). It also indicates their ability to read and respond appropriately to others (social awareness and relationship management).[13] In the business world, emotional intelligence has been found to be more predictive of success than IQ.

Not all physicians possess high levels of emotional intelligence, nor does their training foster it. Much of medicine is highly cognitive and is viewed as occurring external to the individual physician. Cultivating emotional intelligence requires introspection and an understanding of what one is feeling in the moment in order to respond appropriately. Lack of these skills can lead to "flooding," to an overwhelming emotional response to a situation over which an individual has little control.

Interventions

Ideally, institutions should develop comprehensive programs to deal with disruptive behavior, including both formal policies and procedures to make expectations and consequences explicit.[14] These should be widely disseminated to employees and physicians so that they are aware of them. Such approaches should include development of a code of conduct and a formal policy on acceptable behavior, as is now required by The Joint Commission. In addition, the institution should consider requiring all physicians to sign such a policy at the time when they are granted privileges and annually or when their privileges are renewed. Compliance with the policy should be monitored, ideally with not only active reporting but other tools as well, because underreporting is likely.[5] A standardized mechanism for investigating and documenting alleged episodes should include an assessment of potential underlying or contributing factors, such as stress, mood disorders, or burnout. Of note, these factors do not excuse disruptive behavior, and individuals still need to be accountable for their actions. Nonetheless, helping physicians confront these issues can often both reduce disruptive behavior and improve their well-being. Finally, responses to disruptive behavior should be "prompt, constructive, and sustained.[9]"

Techniques recommended for coaching "alpha males" (individuals, not just men despite the label, who are not happy unless they are "top dogs and calling the shots") may be useful for helping disruptive physicians.[15] These include the following:

- Presenting credible data concerning the behavioral issue in a straightforward fashion;
- Being clear about the consequences; and
- Offering alternatives that can produce the desired results.

A physician wellness program or other similar resource should be available to assist with determining the role of underlying factors -- for example, using a confidential assessment of stresses -- that can lead to recommendations for appropriate referrals. Formal assessments for mood disorders or substance abuse should be available, as well as supportive interventions to help deal with other issues, such as burnout, anger management, compulsive traits, and emotional intelligence. (Recognizing that these issues are common for physicians and that they often interfere with the ability to function optimally in modern healthcare environments can be a very useful starting point.) Resources that can be helpful include mentoring from a respected peer, professional coaching, referral to a therapist who is experienced in working with physicians, and stress reduction classes, especially with peers. (An example of a mindfulness-based stress reduction can be found at www.uvamindfulnesscenter.org) Continuing medical education

courses addressing disruptive behavior are also available.[16] Involvement in these and similar activities may not only reduce disruptive behavior of involved physicians, but also increase their overall well-being and satisfaction. Note that a physician wellness program can be very helpful in supporting physicians, but the role of such a program must be clearly separate from the processes for establishing the specific behavioral expectations and the consequences for failure to meet them.

Institutions also have a responsibility to create a positive, collaborative culture of safety. Simply identifying and dealing with those who display disruptive behavior are unlikely to be sufficient to make disruptive behavior uncommon. They should also invest in programs that can help all physicians develop the skills that they need to succeed in a rapidly changing environment where expectations are very different from those in the not-too-distant past (see examples at http://www.healthsystem.virginia.edu/internet/faculty-dev/wellness/home.cfm). The overall culture in many healthcare institutions needs to become more supportive so that positive, effective interactions become the norm. Formal training programs can help physician leaders develop the skills needed to model desired behaviors and to effectively mentor others. (Such a program is described at http://www.healthsystem.virginia.edu /internet/faculty-dev/LAM/home.cfm) A number of institutions have implemented programs that do not rely primarily on identifying and weeding out problems, but on identifying strengths and interactions that go well and focusing efforts on fostering them.[17,18] (For an example of such a program, also see http://appreciativeinquiry.virginia.edu)

Case Conclusion

According to hospital policy, after the second event of disruptive behavior, Dr. Smith is referred to his chair with a requirement for a formal response in 3 weeks. The chair refers him to the physician wellness program. There, Dr. Smith meets with a senior physician to review the complaints and the hospital policy. The physician wellness program is separate from the disciplinary process, but the disciplinary steps are reviewed here, including possible future referral of complaints to the Credentials Committee for formal action. Dr. Smith has no evidence of a mood or substance use disorder. He readily admits that he has very high standards for himself and others and has a hard time dealing with situations when these are not met. He would like to be able to respond better to others when he is under stress, because he knows that yelling is not contributing to optimal patient care. Also, he does not want to face further action. He also realizes that his behavior may ultimately limit him professionally, given the changing expectations in medicine. He asserts that the hospital should take some responsibility because of inadequate staffing in the OR, and he has some resentment for being disciplined because he has very high productivity with excellent outcomes. Nevertheless, he is very interested in improving his response to stress and his interpersonal skills, and he accepts a referral to a professional coach. With his consent, the plan, including specific behavioral expectations, is discussed with his chair, who concurs.

Dr. Smith actively engages with his professional coach, which he realizes is important for his further professional advancement. In particular, he works on improving his emotional intelligence and developing more appropriate and constructive ways of dealing with others who do not immediately perform up to his standards.

Following this program, several individuals in the OR comment spontaneously to his chair on his positive attitude, and there are no further complaints about his behavior.

Summary

Disruptive physician behavior remains common as the pressures facing doctors increase. However, such behavior undermines optimal patient care and the quest to create a culture of collaboration and patient safety in the healthcare setting. The most successful approaches to creating this culture will require not only disciplinary responses for those who act inappropriately, but will also combine proactive opportunities with positive organizational changes to help physicians gain the skills that they need to thrive in this new environment. When this happens, patients, coworkers, organizations, and physicians will all benefit.

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