

A SYSTEMS APPROACH TO DISRUPTIVE BEHAVIOR IN PHYSICIANS: A CASE STUDY

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ABSTRACT

Disruptive behavior in a medical setting has been defined as objectionable or offensive interpersonal behavior that leads to disruptions of professional activities in the workplace. The most frequent approaches to disruptive professionals have largely focused exclusively on the identified physician. This focus has been found to be ineffective for a number of reasons, in particular because of the recurrence of the behavior after a period of time. A new conceptualization of disruptive behavior is offered in this paper. The authors argue such behavior is often instrumental — that is to say the behavior is goal oriented and accomplishes a result sought by the disruptive individual. Starting from this conceptualization, a case is reviewed.

The case is analyzed, first to demonstrate the effect of the disruption on team functioning. A significant disruption in team communication is demonstrated through an analysis of the clinical team's social network. Significant role confusion is found among support professionals in the clinical team. The case is then analyzed to determine the instrumentality (usefulness) of the behavior to the disruptive physician. A system-based intervention is developed and the disruptive behavior is reduced.

The authors argue disruptive behavior presents a significant risk to patient safety. They also argue regulatory authorities have a duty to reduce this risk and understanding the impact of this behavior on the team, and the delivery of health care services, will allow authorities to effectively intervene and reduce or eliminate the behavior and its safety risk.

BACKGROUND: DISRUPTIVE PHYSICIANS

It has been estimated about three percent of physicians exhibit disruptive behavior based on interviews with physicians and other health care professionals¹; however,

a state physician health program has reported up to 70 percent of the physicians referred are for problems that could be classified as “disruptive” behavior.²

Disruptive behavior is generally defined as:

1. sexual harassment involving employees or patients
2. racial or ethnic slurs
3. intimidation and abusive language
4. inappropriate criticism, sarcasm or cynicism
5. late or unsuitable replies to calls
6. threats of violence, retribution, or inappropriate use of litigation or threats of litigation³

In the past, hospital administrators, nurses, employees and even patients and their families have often been remarkably tolerant of this aberrant physician behavior. Criticism has frequently been muted through fear of losing “high producers” or through rationalizations that “high strung” behavior merely reflects high stress in an overworked doctor. Indeed, patients can view a physician who reacts with loud anger or heightened criticism toward hospital staff as an advocate. There is increasing awareness of the importance of team communication in the delivery of quality patient care.⁴ Disruptive behavior reduces communication between members of the health care team and negatively impacts cooperative patient management. There are a number of other costs associated with disruptive physician behavior, including decreased staff morale, decreased job satisfaction, increased staff turnover and increased time spent in investigations and counseling. Pfifferling⁵ estimates the cost of a disruptive physician to be \$150,000.

In 2001, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) implemented stan-

dards that direct health care organizations to manage the impact of disruptive physicians through their required physician health program. Traditionally, most hospital well-being committees dealt with substance abuse, but now these programs address and manage a wider range of problems, including disruptive behavior. As a result, hospitals and state physician health programs treat the disruptive behavior in the same manner as other physician health issues, whether that disruptive behavior is primarily due to a psychiatric diagnosis or to other issues.

More recently, the use of physician “Codes of Conduct” to allow medical staffs to take a privileging action against physicians who display disruptive behavior has been recommended by hospital counsel. This approach frames the impact of disruptive behavior on a health care team as a patient safety issue. In addition the Federation of State Medical Boards (FSMB) altered its guidelines to: “Accordingly, the Committee proposes amending the *Essentials* to strengthen Federation policy regarding boards’ ability to discipline physicians whose behavioral interactions with physicians, hospital personnel, patients, family members, or others creates an environment hostile to the delivery of quality health care or otherwise interferes with patient care.”⁶

Our data supports a view of disruptive behavior in physicians that indicates the behavior has both a mental health component and an “intentional” component, i.e., there are situations in which the disruptive behavior accomplishes certain goals within the system where the physician operates. In terms of the mental health component, Neff⁷ reports in his sample of physicians initially reported for disruptive behavior that the incidence rate of psychiatric illness is quite high. Neff further reports the physicians met criteria for both Axis I disorders (primarily mood disorder and/or active chemical dependence) as well as Axis II disorders (primarily narcissistic and obsessive/compulsive traits). The determination of the presence/absence and diagnosis of Axis I and Axis II disorders frequently involves a comprehensive assessment involving psychiatric and psychological assessment (including testing) urine toxicology screens, physical examination and record review with collateral information. In order to gain an understanding of the origin and instrumentality of the behavior, additional data must be collected. The use of specific data regarding the observed behaviors, the impact of the behavior on members of the health care team, diagnostic data, and patient management and outcome data are all used to develop a clear picture of the

disruptive physician within a clinical microsystem,⁸ and the parameters of a successful solution.

A SYSTEMS VIEW OF DISRUPTIVE BEHAVIOR

The authors take a systems view of disruptive behavior in physicians: The behavior is exhibited in a clinical microsystem, and the behavior gains some reward (or at least a response or result that is viewed as a reward by the index physician) for the physician, i.e., these behaviors must be instrumental for the physician or they would ultimately cease.⁹ The instrumentality might be a surgeon getting the operating room suite he prefers, the hospitalist getting undisturbed rest because nurses avoid him, the intensivist never having to deal with the family of a patient, or even a gain that can only be understood within the setting of the disruptive physician’s own psychiatric disorder. The disruptive behavior, while seen as dysfunctional by hospital administration or others, serves a purpose for the physician, even in cases where there is an underlying psychiatric diagnosis. Taking a systems view of this behavior allows the issues surrounding the physician’s disruptive behavior to be clearly presented, and allows the system to concentrate on changing not only the behavior of the index physician, but the response of the clinical system that enables the disruptive behavior. This helps to ensure that the behavior ceases and does not return. It is vitally important the clinical system change in order to keep the improvements in physician behavior. Consistent monitoring and reinforcement of appropriate behaviors are critical to ensure that change is lasting.

A systems approach to disruptive behavior involves gathering and using a great deal of physician data, including background data and 360-degree surveys (see L. Harmon for another example of their application with disruptive cases).¹⁰ The main goal of this use of data is to understand the physician’s behavior in terms of preceding events, and consequences for the physician, the hospital, staff and patients. In addition, our criteria for success are a solution that will:

- i. Reduce level of disruptive behavior
- ii. Deal with issues related to patient safety
- iii. Create a good possibility that behavior will not recur

THE DISRUPTIVE PHYSICIAN IN PRACTICE: A SCENARIO

A large community hospital that is a member of a large multi-hospital system was experiencing serious issues with one of its most active surgeons. The surgeon had a

history of inappropriate behavior, including angry outbursts with nursing staff, manipulating the surgical schedule, inappropriate response to hospital calls, poor documentation and other nonclinical issues. There was a general feeling the index physician used abrasive tone and language. Some clinical issues, including case selection, ICU rounding and bed use, and concerns about intraoperative times, were also identified.

Based on the history outlined above, the medical staff of the hospital decided to explore taking adverse action against the physician. In doing so, they concentrated on concerns about surgical case selection and postsurgical patient management. The medical staff engaged an outside evaluator to review the cases, preparing for a fair hearing process in the hospital. The result of the review was inconclusive: Some minor problems with care were noted, but none seemed serious enough for a privileging action. The review did not address the behavior problems, such as surgical case scheduling issues and intensive care bed manipulation — and some of those problems were not limited to the index physician. The medical staff decided, rather than take a privileging action that might not address the issues, an intense effort would be made to work with the physician and the surgery programs in the hospital to develop a solution that addressed behavior issues, improved staff/physician relations and protected patient safety. The hospital and the medical staff wanted to know, however, if their relationship with this high-producing physician, who was a leader of a specialty surgical program, could be salvaged and the concerns addressed. The hospital and the medical staff brought in an outside consultant to address this problem.

A thorough review of issues surrounding the specialty surgery department and the index physician was undertaken. The data collection was extensive and included reports from the medical staff executive committee and the physician well-being committee; incident reports; interviews with a number of physicians, nurses, nursing supervisors, respiratory technicians, medical staff and hospital executives, the index physician and medical staff legal counsel. Existing medical staff rules were reviewed. Using specific tools, assessment data were gathered on staff emotional states, staff communications and affiliation patterns.

Based on this information, the index physician's behavior was categorized along four continuums. The goal of the classification system is to gain a better understanding of

the antecedents and consequences of the behavior; the motivation behind the behavior; the physician's interpersonal and communication approach; and, to what extent the behavior is under their control. The analysis of antecedents and consequences assesses whether the behavior is related to work issues (equipment, staffing, patient care, etc.) versus interpersonal ones (dating, personality conflict, sexual overtones, etc.). The motivation analysis assesses whether the system is poorly designed or the individual is unable/unwilling to conform to an otherwise workable system. Data were also gathered to determine whether the physician possesses the necessary skill sets to interact appropriately. Finally, data were gathered to determine if the behavior is caused by a mental status issue or is intentional, albeit inappropriate.

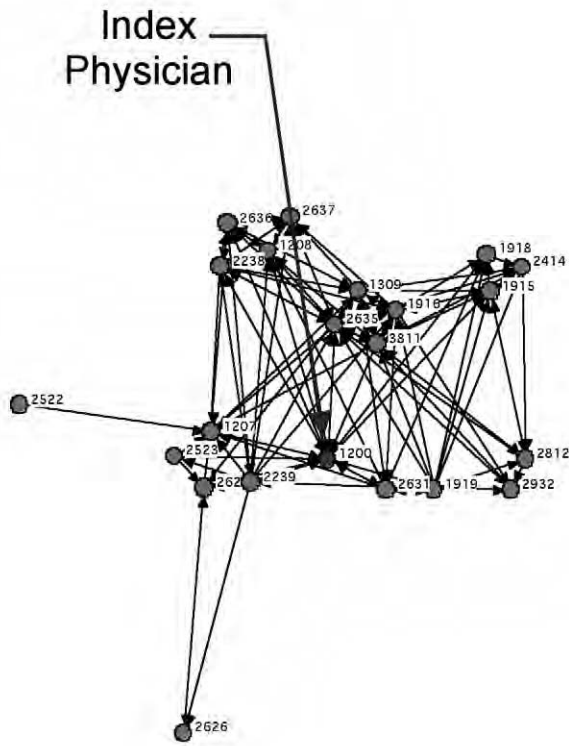
In this specific case, the antecedents of the index physician's behavior were work related (based on patient handling and documentation, and interpersonally corrosive to morale but not personally abusive or inappropriate), derived from system issues, indicated performance failures (practice and management rather than competence), and were based on the physician's intentions (the behaviors more likely resulted from desire to maintain practice volume, rather than mental status issues).

This profile suggests that there is a good chance of success using a system intervention. [Although not called for in this case, if Axis I and/or Axis II disorders contribute to the disruptive problem they must be treated to have a positive outcome to the case. In many cases such problems must be dealt with prior to a systems intervention of this type.] In the case described here, the physician is attempting, albeit inappropriately, to address perceived problems in the hospital system. It also suggests, if appropriately motivated, the physician has the skills to conduct communications in an appropriate and acceptable manner. This is a profile that provides hope for change on the part of the index physician if the community remains supportive.

Using the data gathered in this process, it was determined that:

- The index physician's role was central to the hospital and community, but he was becoming increasingly isolated from peers and distanced from his colleagues (based on quantitative criteria, a graphic representation of social-workplace isolation for this case is provided in Figure 1 [this is a social network diagram where the distance between points can be interpreted as the degree of isolation]).

Figure 1: Isolation of the Index Physician



- His use of support personnel was different and in some ways more extensive than other surgeons and contributed to a sense of role confusion among support professionals (based on a normed test of role clarity, Figure 2). For example, the index physician became angry if too many questions were asked, but also became angry if decisions were made that were different than those he would make. He asked his “trusted” nurses to practice very nearly outside their scope of practice.

Clearly, the quality of care provided by the hospital to the index physician’s patients could be impacted by these behaviors – social isolation reduces communications, key to success in a modern medical facility.^{4,11}

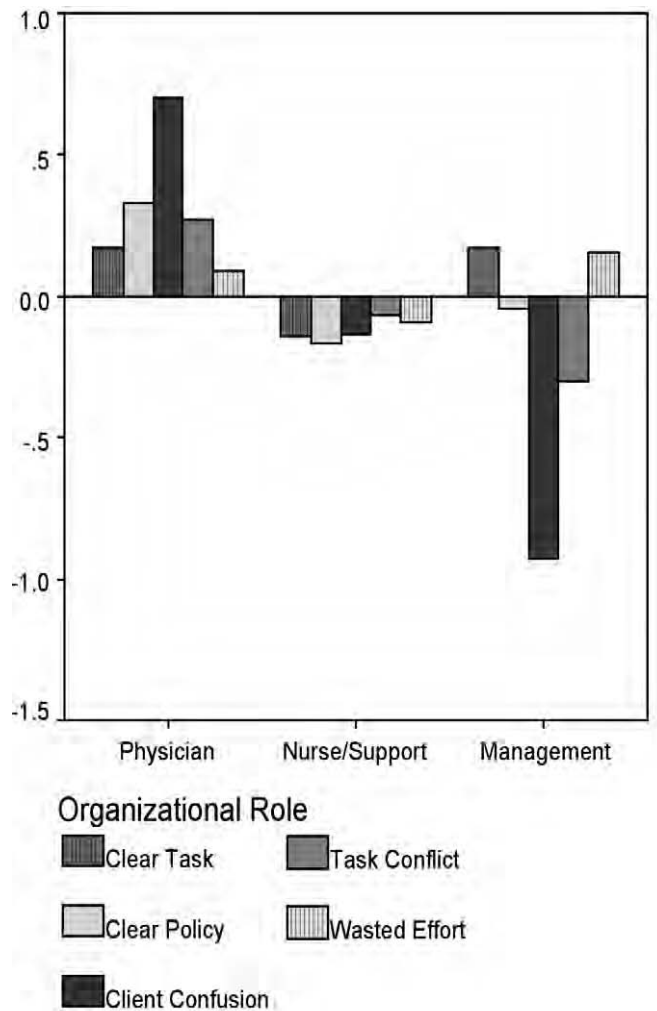
The review also uncovered other important findings relevant to the operation of this hospital department, including concerns that were shared by a number of physicians and clinical staff. In reviewing these issues with hospital management and staff, as well as the medical staff, it became clear that there was merit in some of the index physician’s concerns. However, his strategies for resolving these concerns were often less than fully analyzed and his approach to implementation and often even to raising the issues was frequently abrasive.

Based on these findings and conclusions, the consulting team proposed a path to resolution to the hospital and medical executive staffs. This path is one that directly and aggressively involved the index physician in developing a solution to these issues. It also includes requirements for sophisticated data development and analysis prior to implementation; an outside expert moderator of the process; and, accountability of the index physician and others on the medical staff in the implementation of the final solution. Finally, the approach recommended by the team requires built-in reinforcement and punishment for appropriate and inappropriate responses respectively.

SYSTEM APPROACH AND IMPLEMENTATION

In this program effort, our approach was to undertake three core, loosely sequential, efforts: data development, strategy formulation and implementation. These efforts are generally undertaken with a working group including the index physician, hospital clinical staff who are mem-

Figure 2: Negative measures of role clarity for nursing staff (a negative score for management is expected as their role is split between staff and managerial concerns.)



bers of the clinical microsystem, medical staff and hospital or medical board leaders.

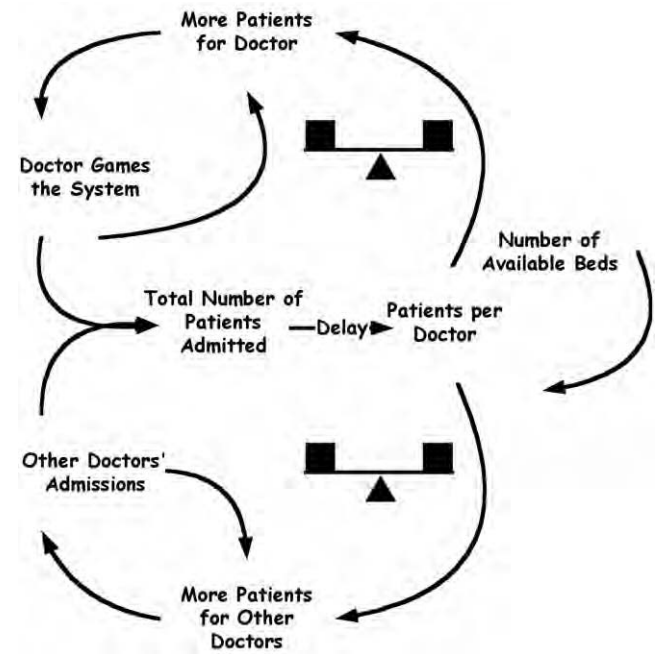
In data development, the working group develops an understanding of the best clinical practice of hospitals and physicians in settings similar to those of the index physician and their hospital. This effort, commonly referred to as benchmarking, provides a basis of judgment. In addition to data that may already be available, we request the working group be involved in the development of its own data to cause the appropriate acceptance of the findings by the members of the working group. The data we develop will include clinical and efficiency parameters, legal and compliance parameters and reinforcement structure parameters.

In strategy development, the working group develops the approach to resolving the issues for the index physician and the hospital or board within the understandings developed in data development. This effort sets goals, objectives, standards, and reinforcement and punishment policies in an effort to improve the way the index physician interacts with pertinent clinical systems. Figure 3 presents an analysis loosely based on Senge¹² of one of the underlying causes of the behavioral difficulties in this case: a shortage of surgical intensive care unit (SICU) beds, causing competition among surgeons. Because the working group develops these approaches and responses, there is a high level of acceptance and compliance by the group members. The effort in this case included interviews with all involved parties to develop performance measures, reviewing structures and arrangements to provide incentives for all parties to meet these performance goals and a written plan for goals, structure and ongoing monitoring from which agreements can be developed.

Our final intervention design integrated the physician fully into the processes that presented a concern to the hospital. He is now directly involved in the management oversight of medical quality control of the surgical unit in which he participates. He is being directly rewarded for the efficacy of this critical quality control function. By involving him in the quality control function and by rewarding him for success in that endeavor, a positive behavior is substituted for the negative behavior. To maintain high-level quality measures, he can no longer “game” the admissions and discharges from the surgical intensive care unit. In addition, he has further incentive to maintain a high level of involvement with his postsurgical cases.

These interventions decrease the behaviors that led to

Figure 3: System analysis of the consequence of restricted SICU beds



stressful interactions between the disruptive physician and staff and the tension between the disruptive physician and his colleagues. To further monitor these behaviors the physician is also working with a behavioral coach. A steady improvement has been seen in this physician since the team began working with him and there has been no behavioral recurrence of disruption.

In implementation, the working group provides execution and transition management for their strategy. During this period, outside expert mediation continues for a period of time sufficient to ensure successful transition from an experimental trial to a standard procedure. There is approval by all parties, education and coaching to ensure everyone is given performance feedback, periodic performance review and “fine tuning” the strategy. The final set of solutions in this case involved adopting an approach that moved the index physician from the position as competitor with other members of the heart unit to one of ally and mentor. This allows the hospital and staff to focus not on the symptomatology of the problem — the physician’s approach to competition for scarce resources — but rather to a focus on the underlying problem itself: the scarce resource and appropriate and equitable methods for its allocation that are patient centered.

CONCLUSIONS

Not all engagements have resolutions as comfortable as this. But the case presented here does elucidate the basic

elements of all cases we have undertaken. First, in all cases the physician was employing behaviors that were unpleasant, abusive and not tolerable in today's working environment. In all cases the physician's own psychology and habitual behavior patterns contributed to the maladaptive behavior and some level of intervention — from coaching to intensive therapy — was necessary to provide a new set of appropriate behavioral responses. Second, in all cases the physician was achieving some goal by their behavior — in this case access for his patients in the SICU and a higher personal patient load, while in other cases his goal was a reduction in staff calls, preferred surgical times or teams, etc. In all cases the system did not respond correctly to the physician's inappropriate behavior — in this case the physician was rewarded with greater access to scarce resources, in other cases the physicians received preferential treatment, reduced night calls, optimum operating room start times, etc. In all cases the long-term solution included modifications to the operation of the clinical microsystem in which the physician was operating — in this case changes in surgical scheduling procedures — and each system required unique modifications.

LESSONS FOR HOSPITALS AND FOR STATE MEDICAL BOARDS

Identification of individual physicians who habitually exhibit disruptive behavior can be difficult for hospitals and state medical boards, and the risks of failing to identify disruptive providers have historically seemed low. However, over time, research has suggested failure to address disruptive physician behavior is associated with a number of negative outcomes. The importance of teamwork and communication to the delivery of quality medical care has been documented in the literature.^{4,11} Additionally, research also suggests disruptive physician behavior negatively impacts staff morale, nursing job satisfaction, and contributes to job turnover.¹⁵ Disruptive behavior commonly is a complex mix of long-term maladaptive behavior on the part of the index physician and hospital systems that respond inappropriately to behavior that is outside the norm. Separating truly disruptive patterns from merely demanding individuals or simple interpersonal conflict can strain systems designed under the expectation of professionalism on the part of system members.

Hospitals risk legal action when they fail to address disruptive behavior.¹³ In addition, routine communication problems or fear of addressing questions or concerns about care put patients at greater risk of poor care and

impacts the satisfaction and ability to practice of other providers in the system.¹⁴ Correlates of the disruptive behavior, such as isolation, entail a direct risk to patient safety and can be indicators of a loss of competence.¹⁵ Because of these implications for quality of care and patient safety, we believe licensing boards have a duty to address these problems in their licensees.

What to do? While hospitals have a stronger incentive to deal with the problem as they must experience the situation on a daily basis, intervention with disruptive physicians can be time consuming and difficult. The individual may have diagnoses of psychiatric conditions as well as years of habitual behavior patterns to overcome. Boards may have more leverage and better resources to deal with these problems in a meaningful way. The method described here allows boards to base their decisions on specific information about behaviors and the ways in which they impact the care of patients, and give boards and hospitals clear indicators of how behaviors can be changed. In addition, the process described above has wide acceptance with all participants, and clear accountability for all parties. In addressing these problems with good information, hospitals and boards can truly ensure that patients whose care is affected by a disruptive physician are protected, and improve the entire clinical microsystem in a measurable, accountable way.

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