
A Plan for Identification, Treatment, and Remediation of Disruptive Behaviors in Physicians

WILLIAM H. SWIGGART, CHARLENE M. DEWEY,
GERALD B. HICKSON, A.J. REID FINLAYSON, AND
WILLIAM A. SPICKARD JR.

SUMMARY • Physicians exhibiting a pattern of disruptive conduct represent a small portion of all healthcare professionals. Available evidence demonstrates, however, that their behaviors can result in increased workplace stress; contribute to poor workplace environments; contribute to dysfunctional teams; reduce quality of care for patients and families; and increase risk of litigation for hospitals and institutions. Our experience at Vanderbilt reveals that both internal and external factors play a role in a physician's behavior and ability to cope with workplace stresses. We have gained valuable insight into various means of indentifying, assessing, treating, and remediating physicians exhibiting unprofessional behavior. The vast majority of healthcare team members conduct themselves professionally and without complaint. This paper will demonstrate how to address those rare individuals who exhibit disruptive and/or unprofessional behavior.

William H. Swiggart, MS, LPC/MHSP, is an assistant in medicine and co-director of the Center for Professional Health at Vanderbilt University Medical Center in Nashville, Tennessee. Charlene M. Dewey, MD, M.Ed., FACP is an associate professor of medical education and administration and an associate professor of medicine at Vanderbilt University Medical Center. Gerald B. Hickson, MD, is associate dean for clinical affairs and the director of the Center for Patient and Professional Advocacy at Vanderbilt University Medical Center. A.J. Reid Finlayson, MD is an assistant professor in the Department of Psychiatry and the medical director of the Vanderbilt Comprehensive Assessment Program. William A. Spickard Jr., MD is professor of medicine emeritus in the Department of Medicine at Vanderbilt.

INTRODUCTION

Unprofessional conduct may exist at any level within the healthcare system.

Epstein and colleagues (2002) built a definition of professional competence as "the habitual and judicious use of communication, knowledge, technical skills, and reflection in daily practice for the

*Without leadership
commitment, abusive
behaviors will not be
addressed*

benefit of the individual and community being served." In contrast, unprofessional behavior can be described as a lapse in professionalism during

a single event, or during recurrent events (Ginsburg et al 2000; Stern 2006). Figure 1 demonstrates the range of disruptive behaviors often exhibited.

A pattern of disruptive behavior may be precipitated by external and/or internal factors. External factors include challenges the physician faces in the work environment. Internal factors, such as psychiatric disorders or substance abuse, can significantly affect a physician's behavior and his or her ability to cope with external factors

(see Table 1). These factors can produce the "perfect storm," damaging finances, relationships, and patient care.

Research reveals that many, if not most, professionals are never associated with any episodes of alleged or actual non-professional conduct; in fact, only a relatively small number of physicians (4-6 percent) attract more complaints than their average peer (Pichert et al. 2008; Hickson et al. 2007; Hickson et al. 2002). Disruptive behaviors are often reinforced within the "clinical microsystem." A systems approach can help reduce disruptive behaviors while addressing the system issues that reinforce the same behaviors (Williams et al. 2004).

MANDATES TO IDENTIFYING DISRUPTIVE BEHAVIORS

The AMA Code of Ethics states, "A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception,

FIGURE 1: SPECTRUM OF DISRUPTIVE BEHAVIORS IN PHYSICIANS

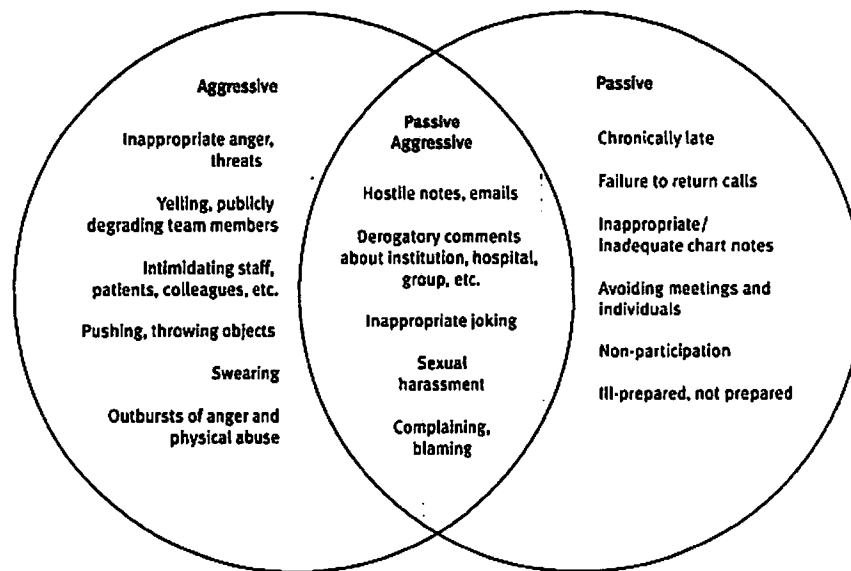


TABLE 1: FACTORS INFLUENCING DISRUPTIVE BEHAVIORS

External Factors	Internal Factors
<p>High system demands and low system support</p> <p>Disruptive behavior is reinforced by the system</p> <ul style="list-style-type: none"> • Bully doc gets preferential operating time • Masking ineffective managers • Failure to act <p>The system fails to provide physician with complaints and/or feedback</p> <p>Life-cycle events (i.e. death in the family, children leaving home, divorce, etc.)</p>	<p>Alcohol and drug addiction</p> <p>Compulsive behavior around sexual acting out, compulsive gambling, eating, working, etc.</p> <p>Little or no training in conflict resolution, leadership skills, communication, and teaching skills</p> <p>Psychiatric disorders</p> <ul style="list-style-type: none"> • Narcissistic personality disorder • Depression/bipolar • Dementia, etc.

to appropriate entities" (Principles of Medical Ethics, AMA 2009). This code of ethics empowers physicians to become overseers of the ethical practice of medicine and encourages action to protect our standards of professionalism. Leaders in healthcare, as well as colleagues, staff, employees, and patients and their families, should all report disruptive behaviors and elevate patient care and staff satisfaction within the systems in which they work or are treated (Hickson et al. 2007).

The July 9th, 2008 sentinel event alert by The Joint Commission focused attention on this topic, stating, "To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team" (The Joint Commission 2008). The Joint Commission identifies a link between patient care and disruptive behaviors, solidifying the role of the healthcare system and those in leadership positions to take action and implement safeguards for the "whistle blower" and develop means for addressing disruptive behavior head on (Harkreader 2008).

"The most effective surveillance tools for detecting unprofessional behavior are the eyes and ears of patients, visitors, and healthcare team members" (Hickson et al. 2007). Without leadership commitment, abusive behaviors will not be addressed. A lack of consequences enables recurrent patterns to develop. Leadership's responsibility is to create and maintain an environment that addresses such behaviors (Hickson et al. 2007).

IMPORTANCE OF IDENTIFYING, TREATING, AND REMEDIATING

Significant consequences exist because of disruptive behaviors. These include detrimental effects on physician wellbeing, professional stature, patient care outcomes, the working environment for the healthcare team, and nursing retention (Samenow et al. 2007).

The identification of disruptive behaviors in physicians, or any member of the healthcare team, is something all members

of the healthcare leadership team should address. Treating and remediating these physicians has its challenges, but it can be beneficial. Table 2 provides a list of infrastructures that are necessary to adequately address unprofessional behaviors (Hickson et al. 2007).

It is important to document a pattern of misconduct, even when the behavior is considered mild or simply uncharacteristic

It is important to document a pattern of misconduct, even when the behavior is considered mild or simply uncharacteristic (e.g. the sleep-deprived physician who speaks abruptly to a nurse). Obvious breaches in profession-

alism such as sexual misconduct, showing up for work intoxicated, violence, or repetitive behaviors such as consistently using profanity or harassing team members should prompt immediate action. Evidence shows that appropriate interventions can reduce complaints and defer/prevent future events, including lawsuits (Pichert et al. 2008; Hickson et al. 2002). For the past decade, the Vanderbilt University School of Medicine has taken significant steps to identify,

evaluate, and treat/remediate disruptive physicians.

This article focuses on three Vanderbilt programs that address the disruptive physician using a case vignette. The vignette is not based on one individual. It is a composite of real behaviors and activities encountered with several physicians from around the country. The case highlights various points of entry, existing resources, underlying causes for disruptive behaviors, and possible outcomes and benefits from implementing a comprehensive program that addresses the disruptive behavior in this physician.

DISRUPTIVE PHYSICIAN VIGNETTE

Background

Dr. Jane Doe is a 35-year-old obstetrician. She is a member of a hospital-based practice. She was fired from one residency training program and had to transfer to another program, where she had trouble with fellow residents. She married during her third year of residency training, but was divorced shortly after the birth of her

TABLE 2: INFRASTRUCTURE FOR ADDRESSING UNPROFESSIONAL BEHAVIORS

- Leadership commitment
- Supportive institutional policies
- Surveillance tools to capture patient and staff allegations
- A model to guide graduated interventions
- A process for reviewing allegations
- Multi-level professional/leadership training
- Resources to help disruptive colleagues
- Resources to help disruptive staff and patients

only child, who is now 15. She admits to feeling socially inept and wants to change. She wants to be socially respected but feels she must talk loudly to get things done. She becomes demanding in crisis situations and is abusive to staff when she gets frustrated. She ignores hospital communication guidelines. She has had four complaints from staff who felt disrespected by her sarcastic comments in front of patients. She has a pattern of becoming emotionally distraught and unable to control her temper, including slamming doors, and on occasion throwing things.

Identification through Patient and/or Family Complaints

In this case, the institution is aware of Dr. Doe's disruptive behaviors due to patient and staff complaints via the Center for Patient and Professional Advocacy. This is an important route for information about abusive physicians to reach leadership. This Vanderbilt program embodies eight elements critical to identifying disruptive conduct. The elements have been included in The Joint Commission Sentinel Alert #40, July 9, 2008, "Behaviors that undermine a culture of safety" (The Joint Commission 2008).

All new team members (physicians and staff) are introduced to the Vanderbilt Credo, a set of institutional values. Such values and associated policies addressing non-professional conduct are of limited value if the organization does not have eyes and ears to quickly identify disruptive behaviors and provide an opportunity for fair and early feedback to the party involved.

Dr. Doe's patients are informed through signage, videos, and staff that whenever the organization fails to meet their expectations, hospital leadership wants to hear from them. Patients and

families report their concerns, suggestions, or complaints to advocates of the Office of Patient Affairs. Staff and faculty can document observed episodes of unprofessional conduct through an electronic event reporting system, anonymously if they'd like. There is a defined process for reviewing all such complaints.

After the complaint was reviewed, Dr. Doe was told that an observation had been documented. This made her aware that the organization has eyes and ears. Periodic analyses of the surveillance databases showed that Dr. Doe attracted more than her fair share of complaints.

The hospital has a committee consisting of physician peers trained to conduct "awareness" interventions. A committee member wrote a letter to Dr. Doe requesting a meeting. Dr. Doe was reminded of the collective commitment to professionalism, and she was told about the high number of complaints about her in the database. She was encouraged to review the data and reflect on ways to address the recorded complaints/observations. Dr. Doe was also reminded of the institution's policy that if the professional is unable or unwilling to address the causes of the complaints (as based on continued surveillance), an authority figure will be brought into the process to develop a plan to address the problem and determine the consequences of failure. In this case, Dr. Doe received several "informal" interventions and two "awareness" interventions, but she was unmoved. Dr. Doe's authority figure was then involved.

Initial Evaluation and Referral

Dr. Doe came to her program director's attention after the peer message and surveillance system revealed that she continued to attract patient and staff complaints. Often complaints of disruptive behavior

L
E
A
T
U
R
E

will not reach the level of a department chair for quite some time, as colleagues and peers tend to ignore the behavior and complain to mid-level leadership or peers first. Vanderbilt provides all department chairs access to both the patient complaint data as well as faculty and staff complaints.

During the discussion with her chair, Dr. Doe raised her voice and stormed out of the chair's office. Given Dr. Doe's failure to comply, the chair mandated an assessment from the Vanderbilt Comprehensive Assessment Program for Professionals (VCAP). Vanderbilt also has a Faculty and Physician Wellness Program (FPWP) that accepts both self-referrals and mandatory referrals.

Comprehensive Assessments

The Vanderbilt Comprehensive Assessment Program for Professionals (VCAP) is a multidisciplinary program developed in

2002 to assess fitness for duty for a variety of professionals, including lawyers, physicians, athletes, business executives, and entertainers. Comprehensive assessments are patterned upon the American Psychiatric Association (APA) guidelines for fitness-for-duty evaluations. These evaluations consist of a series of interviews by a multidisciplinary team of experienced professionals, including psychiatrists, addiction specialists, psy-

chologists, social workers and specialized nurses. Extensive collateral history is also gathered from others who are affected by the behavior.

The Vanderbilt Comprehensive Assessment Program for Professionals (VCAP) is a multidisciplinary program developed in 2002 to assess fitness for duty for a variety of professionals, including lawyers, physicians, athletes, business executives, and entertainers

Dr. Doe was referred to VCAP for a comprehensive assessment, and she consented to collateral contact with family members, hospital staff, peers, and hospital administration. Detailed inquiry of her social history focused upon her family, using a family genogram to depict individual family members, addiction issues, and relationships. She also was given a complete psychiatric evaluation, including assessment of addictions, psychiatric testing, evaluation of psychodynamic conflicts, analysis of her ability to meet life's challenges, examination of sexual health and boundary issues, and a spiritual health assessment (without denominational bias). Optional neuropsychological testing is administered if indicated, but Dr. Doe showed no evidence of cognitive problems. Referral for specialized investigation and testing at the Vanderbilt University Medical Center is available when needed for other co-morbid disease processes.

The findings and recommendations of Dr. Doe's evaluation were discussed in detail. In brief, she was found to have mood symptoms of cyclothymia, partially treated, and nicotine dependence. Personality testing confirmed problems in mood regulation. She was referred for cognitive behavioral therapy to manage her anger outbursts and for psychiatric treatment with appropriate medication recommendations for her mood disorder. She also was instructed to complete an educational program for disruptive physicians. The detailed report of her evaluation and recommendations was forwarded (with her permission) to her treatment professionals and a short summary (devoid of personal detail), including the diagnosis and treatment plan, was shared with her department head and chief of staff. She was found to be fit to practice.

Remediation and Education

The Center for Professional Health (CPH) offers three continuing medical education (CME) courses that deal with unprofessional behavior. The three available courses are Maintaining Proper Boundaries (Spickard et al. 2008; Swiggart, Starr et al. 2002); Prescribing Controlled Drugs (Swiggart, Spickard, and Dodd 2002); and the Program for Distressed Physicians (Samenow et al. 2008).

Dr. Doe contacted the CPH course director, who explained the scope of the program and completed a brief screening via a telephone interview. Dr. Doe explained that her behavior is often misinterpreted and that her goal is always to improve patient care. She said she is often hampered by "incompetent nurses and administrators only interested in the bottom line." The course requirements were explained. Dr. Doe admitted that she might have some rough edges and could use some improvement in communication skills.

Dr. Doe attended the three-day CME course that encompassed education, counseling, and experiential exercises. She became part of a small group of other physicians who provided accountability and support for the changes she was trying to make. She was able to learn specific skills in communication as well as conflict resolution with colleagues, staff, and patients. She identified specific triggers for emotional dysregulation and implemented prevention strategies. Through homework activities and feedback from course facilitators and co-participants, she developed a better understanding of the impact her behavior had on her patients, their care, and her colleagues. She was able to replace old behaviors with new strategies that were more successful. Dr. Doe participated in the three follow-up sessions that occurred at

one-month, three-month, and six-month intervals. She was able to practice the skills that she learned during the course and asked for feedback from colleagues and administrators. She was encouraged to stay in contact with the small group for support and accountability. The completed process took approximately seven months.

CONCLUSION

The experience at Vanderbilt in dealing with many distressed physicians with disruptive behaviors over the years sheds light on the importance of identifying, referring and treating disruptive physicians. Benefits include reduced malpractice claims, improved patient safety and quality of care, better team communications, system improvements that reduce reinforcement of behaviors, and remediation and changed behaviors of physicians. Some of the key lessons learned are listed below.

Lessons Learned

- Leadership support and buy-in is critical for identification and remediation of physicians with disruptive behaviors. Their commitment is vital to the success of any program implemented.
- Disruptive physicians often lack insight into the impact of their behavior on others.
- Feedback, monitoring, and educational interventions can be effective in changing disruptive behavior.
- Coaching physicians with disruptive behaviors has been successful in reducing lawsuits and increasing accountability to professional standards (Pichert et al. 2008).
- Most physicians responded very well to the small group experiential learning process. The role-play activities and

R
E
A
T
U
R
E

other skills practiced were perceived as being quite helpful (Samenow 2007). In certain situations, a job change is the best outcome for both the individual and the institution.

- Proper documentation is extremely helpful in planning educational interventions. Collateral history, although difficult and time consuming to obtain, may be invaluable for assisting the individual.
- State Physician Health Programs generally provide support and advocacy for physicians and are a good resource for those in leadership positions.
- The physician's and the institution's needs are not mutually exclusive and should be considered in concert.
- Patient complaints are a valuable source to identify disruptive behaviors and/or system errors that promulgate disruptive outcomes.

- If resources are available, many physicians may self-refer when addicted, under relational stress, burned out, or need help for psychological disorders.

The roots of behavior are complex. A combination of internal and external factors played a role in Dr. Doe's behavior. It is appropriate for healthcare leaders to identify disruptive behaviors and make appropriate referrals.

As we in healthcare continue to address the important issue of unprofessional and disruptive behaviors, we will gain additional insight through research and education on how to better identify, assess, and treat/remediate physicians.

The authors would like to express gratitude for the assistance of Diana Philips and Marine Ghulyan for their efforts in formatting

FOR MORE INFORMATION

For more information, please call or e-mail the following individuals:

Gerald Hickson, M.D. – Center for Patient and Professional Advocacy at Vanderbilt at 615-343-4500 or cppa@vanderbilt.edu

A.J. Reid Finlayson, M.D. – The Vanderbilt Comprehensive Assessment Program for Professionals at 615-322-4567 or vcap@vanderbilt.edu

William Swiggart, MS, LPC/MHSP – Center for Professional Health at 615-936-0678 or cph@vanderbilt.edu

Charlene M. Dewey, M.D., M.Ed, FACP – Chair, Faculty and Physician Wellness Committee at 615-936-0678 or cph@vanderbilt.edu

OTHER RESOURCES

Center for Patient and Professional Advocacy (CPPA)
www.mc.vanderbilt.edu/centers/cppa/index.html

Vanderbilt Comprehensive Assessment Program for Professionals
www.mc.vanderbilt.edu/root/vcap

Center for Professional Health (CPH)
www.mc.vanderbilt.edu/cph

and providing references for this manuscript. We applaud the Vanderbilt community and leadership for their continued support and effort in providing the resources for each of these programs described and for valuing their most prized possession—their faculty.

REFERENCES

- American Medical Association. 2009. "Principles of Medical Ethics." Online publication, accessed 2/3/09: www.ama-assn.org/ama/pub/physician-resources/medical-ethics/ama-code-medical-ethics/principles-medical-ethics.shtml
- Epstein, R. M., and E. M. Hundert. 2002. "Defining and Assessing Professional Competence." *JAMA* 287(2), 226-35.
- Ginsburg, S., G. Regehr, R. Hatala, N. McNaughton, A. Frohna, B. Hodges, L. Lingard, and D. Stern. 2000. "Context, Conflict, and Resolution: a New Conceptual Framework for Evaluating Professionalism." *Acad Med*, 75(10 Suppl), S6-S11.
- Harkreader, M. 2008. "Disruptive and Intimidating Behavior." *Nursing Perspectives*. Winter.
- Hickson, G. B., J. W. Pichert, L. E. Webb, and S. G. Gabbe. 2007. "A Complementary Approach to Promoting Professionalism: Identifying, Measuring, and Addressing Unprofessional Behaviors." *Acad Med* 82(11), 1040-1048.
- Hickson, G. B., C. F. Federspiel, J. W. Pichert, C. S. Miller, J. Gauld-Jaeger, and P. Bost. 2002. "Patient Complaints and Malpractice Risk." *JAMA* 287(22), 2951-2957.
- The Joint Commission. 2008. "Behaviors that Undermine a Culture of Safety." Online article; retrieved 2/2/2009: http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm
- Pichert, J. W., G. B. Hickson, I. N. Moore. 2008. "Using Patient Complaints to Promote Patient Safety: The Patient Advocacy Reporting System (PARS)." From, *Advances in Patient Safety: New Directions and Alternative Approaches*. Bethesda, MD: Agency for Healthcare Research and Quality.
- Samenow, C. P., W. Swiggart, J. Blackford, T. Fishel, D. Dodd, R. Neufeld and A. Spickard Jr. 2008. "A CME Course Aimed at Addressing Disruptive Physician Behavior." *Physician Exec* 34(1), 32-40.
- Samenow, C. P., A. Spickard Jr., W. Swiggart, J. Regan, and D. Barrett. 2007. "Consequence of Physician Disruptive Behavior." *Tenn Med* 100(11), 38-40.
- Spickard, W. A., W. H. Swiggart, G. Manley, C. P. Samenow, and D. T. Dodd. 2008. "A Continuing Medical Education Approach to Improve Sexual Boundaries of Physicians." *Bulletin of the Menninger Clinic* 72(1): 63-77.
- Stern, D. T. (editor) 2006. *Measuring Medical Professionalism*. New York: Oxford University Press.
- Swiggart, W., A. Spickard, Jr., and D. T. Dodd. 2002. "Lessons Learned from a CME Course in the Proper Prescribing of Controlled Drugs." *Tenn Med* 95(5), 192-3.
- Swiggart, W., K. Starr, R. Finlayson, A. Spickard. 2002. "Sexual Boundaries and Physicians: Overview and Educational Approach to the Problem." *Sexual Addiction & Compulsivity* 9: 139-48.
- Williams, M. V., B. W. Williams, and M. Speicher. 2004. "A Systems Approach to Disruptive Behavior in Physicians: A Case Study." *Journal of Med. Licensure & Discipline* 90(4): 18-24.

T
E
A
T
U
R
E