

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS[□]

CEJA Report 2-A-00

Subject: Physicians With Disruptive Behavior¹

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Presented to: Reference Committee on Amendments to Constitution and Bylaws
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1 Introduction

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3 Resolution 9 (A-99), “Addressing the Disruptive Physician,” instructed the AMA to identify and
4 study behavior by physicians that is disruptive to patient care, define the term ‘disruptive
5 physician,’ and disseminate guidelines for managing the disruptive physician. The resolution
6 was forwarded to the Council on Ethical and Judicial Affairs.

7 8 Provisions of the Code that refer to behavior

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10 The importance of respect among all health professionals as a means of ensuring good patient
11 care is at the very foundation of the ethics advocated by the American Medical Association. The
12 preamble to the Principles of Medical Ethics included in the Code of Medical Ethics clearly
13 states: “As a member of this profession, a physician must recognize responsibility not only to
14 patients, but also to society, *to other health professionals*, and to self” (emphasis added). Many
15 of the seven Principles at least indirectly address various aspects of this notion of professional
16 responsibility. Principle II refers to honest dealings among colleagues and adds an obligation to
17 expose “physicians deficient in character or competence.” Principle IV requires physicians to
18 respect the rights of colleagues and other health professionals, in addition to those of patients.
19 Principle V partly refers to the obligation to make relevant information available to colleagues, as
20 well as to obtain consultation and use talents of other health professionals when indicated.
21 Together, these brief statements clearly depict medical care as an endeavor built on collegiality
22 and the mutual respect of all those involved in patient care.

23
24 Conversely, deficiencies in this collaborative effort are viewed critically throughout the Code,
25 and several Opinions address these concerns directly. Opinion 9.031, “Reporting Impaired,
26 Incompetent, or Unethical Colleagues,” provides a broad frame for “intervention” when
27 inappropriate physician behavior constitutes a threat to patient care. Although the Opinion
28 emphasizes reporting, it implies that institutions where medical care is provided should have in
29 place mechanisms “to assess the potential impact” of such behavior and “to facilitate remedial
30 action.” Opinion 9.04, “Discipline and Medicine,” addresses incompetence, corruption, dishonest
31 or unethical conduct that poses a real or potential threat to patients and undermines the public’s
32 confidence in the profession. Opinion 9.10, “Peer Review” refers to various entities that
33 “scrutinize physicians’ professional conduct,” to ensure that a physician’s exercise of medical
34 judgment meets professional standards of competent care.

[□] Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on
Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended,
except to clarify the meaning of the report and only with the concurrence of the Council.

Defining “disruptive behavior”

The Code already addresses a few forms of conduct that could lead to disruptions in the delivery of care, such as substance abuse (Opinion 8.15), disputes between supervisors and trainees (Opinion 9.055), and sexual harassment and exploitation between supervisors and trainees (Opinion 3.08). This report is limited to the conduct of individual physicians and does not refer to physicians acting as a collective, which is considered separately in Opinion 9.025, “Collective Action and Patient Advocacy.”

In fact, disruptive behavior may be viewed along a spectrum. Although there is no agreed-upon definition, and the term “disruptive” is sometimes interchanged with the term “abusive,”² it generally refers to a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care.³ Such behavior may be expressed verbally by using foul or threatening language, or through non-verbal behavior such as personal habits, for example facial expressions or manners. It may affect the broader operations of an institution, or relate more narrowly to one’s ability to work with others, such as unwillingness to work with or inability to relate to other staff in ways that affect patient care. In addition, it may have negative effects on the learning environment of an educational institution—by modeling inappropriate behaviors for students and residents, and by impairing their ability to achieve clinical skills. Behavior that tends to cause distress among other staff and affect overall morale within the work environment, undermining productivity and possibly leading to high staff turnover or even resulting in ineffective or substandard care would fall within the definition of disruptive behavior.⁴ However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.

In some instances, disruptive behavior may be the manifestation of an underlying condition that requires special attention. Disruptive behavior, such as aggressiveness, intrusiveness, and hyperactivity, or irritability and argumentativeness can be the effects of stress, substance abuse or withdrawal, or dementia. Also of concern are other psychiatric illnesses or organic disorders that affect physicians in ways that cause disruption within the medical care environment.

Intervention

Whether the disruptive behavior is the manifestation of an underlying pathology or not, it is important that it be addressed. In some instances, processes that already are established for grievances or for dealing with impaired workers may be expanded or may serve as models to address disruptive physicians. Policies can help ensure that the intervention process is a fair and objective one, as provided for in Opinion 9.05, “Due Process.”

In developing institutional policies, it is also important to recognize that the same behavior in different environments may not result in the same degree of disruption. Policies, therefore, should be crafted carefully, keeping in mind the characteristics of the setting where they will be applied. Finally, as was emphasized in Opinion 4.07, “Staff Privileges” policies should make clear that interventions should be guided by the welfare and best interest of patients, rather than based on personal friendships and dislikes, antagonisms, jurisdictional disagreements or competitiveness among members of the staff.

Elements of a Policy on Disruptive Behavior

The principal objectives of the policy should be aimed at ensuring high standards of patient care and preserving a professional work environment. Policies should include a definition of

1 disruptive behavior or categories of disruptive behavior that will trigger intervention. They
 2 should provide a channel through which disruptive behavior can be reported and appropriately
 3 recorded. A single incident may not be sufficient for action, but each individual report may help
 4 identify a pattern that requires intervention. Policies should establish a clear review or
 5 verification process. They also should establish a process to notify a disruptive physician that a
 6 report has been made, and provide the physician with an opportunity to respond to the report.
 7 Furthermore, they should include means of monitoring whether a disruptive physician's conduct
 8 improves. Proposed corrective actions should be commensurate with the behavior. Policies,
 9 therefore, should allow for self-correction, as well as structured rehabilitation. Institutions should
 10 consider whether the reporting requirements of Opinion 9.031, "Reporting Impaired,
 11 Incompetent, or Unethical Colleagues" apply in particular cases. Suspension of responsibilities
 12 or privileges should be a mechanism of final resort if the behavior persists despite attempts to
 13 intervene. In addition, policies should establish which individuals will be involved in the various
 14 stages of the process (from reviewing reports to notifying physicians and monitoring conduct
 15 after intervention), and should provide guidelines for confidentiality. Finally, policies should
 16 ensure that individuals who report disruptive physicians are duly protected.

17 Conclusion

19 Behavior that disrupts the delivery of care has many facets. It may be verbal or physical, may be
 20 targeted at colleagues or patients. Since disruptive behavior ultimately can result in substandard
 21 patient care, it is important for institutions to have policies in place that will facilitate prompt and
 22 fair intervention. The Council on Ethical and Judicial Affairs previously provided detailed
 23 guidelines on reporting impaired, incompetent, or unethical conduct. Institutional processes that
 24 already have been established to address these matters may be expanded or similar ones
 25 developed to address disruptive physicians. Such a process should include an opportunity for the
 26 disruptive physician to respond to such claims and, where appropriate, to alter his or her behavior
 27 without further action. Policies also should allow for self-correction, as well as structured
 28 rehabilitation. In addition, policies should establish proper means of monitoring changes in
 29 behavior. If disruptive behavior does not improve or when patient care is jeopardized, it may be
 30 necessary for responsibilities to be removed or privileges suspended.

32 Recommendations

34 For the foregoing reasons, the Council recommends that the following be adopted and that the
 35 remainder of this report be filed:
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37 This report is limited to the conduct of individual physicians and does not refer to physicians
 38 acting as a collective, which is considered separately in Opinion 9.025, "Collective Action
 39 and Patient Advocacy."
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 42 (1) Personal conduct, whether verbal or physical, that affects or that potentially may affect
 43 patient care negatively constitutes disruptive behavior. (This includes but is not limited to
 44 conduct that interferes with one's ability to work with other members of the health care
 45 team.) However, criticism that is offered in good faith with the aim of improving patient
 46 care should not be construed as disruptive behavior.
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48 (2) Each medical staff should develop and adopt bylaw provisions or policies for
 49 intervening in situations where a physician's behavior is identified as disruptive. The
 50 medical staff bylaw provisions or policies should contain procedural safeguards that

1 protect due process. Physicians exhibiting disruptive behavior should be referred to a
2 medical staff wellness – or equivalent -committee.
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4 (3) In developing policies that address physicians with disruptive behavior, attention
5 should be paid to the following elements:
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- 7 (a) Clearly stating principal objectives in terms that ensure high standards of
8 patient care and promote a professional practice and work environment.
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- 10 (b) Describing the behavior or types of behavior that will prompt intervention.
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- 12 (c) Providing a channel through which disruptive behavior can be reported and
13 appropriately recorded. A single incident may not be sufficient for action,
14 but each individual report may help identify a pattern that requires
15 intervention.
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- 17 (d) Establishing a process to review or verify reports of disruptive behavior.
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- 19 (e) Establishing a process to notify a physician whose behavior is disruptive that
20 a report has been made, and providing the physician with an opportunity to
21 respond to the report.
22
- 23 (f) Including means of monitoring whether a disruptive physician’s conduct
24 improves after intervention.
25
- 26 (g) Providing for evaluative and corrective actions that are commensurate with
27 the behavior, such as self-correction and structured rehabilitation.
28 Suspension of responsibilities or privileges should be a mechanism of final
29 resort. Additionally, institutions should consider whether the reporting
30 requirements of Opinion 9.031, “Reporting Impaired, Incompetent, or
31 Unethical Colleagues” apply in particular cases.
32
- 33 (h) Identifying which individuals will be involved in the various stages of the
34 process, from reviewing reports to notifying physicians and monitoring
35 conduct after intervention.
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- 37 (i) Providing clear guidelines for the protection of confidentiality.
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- 39 (j) Ensuring that individuals who report disruptive physicians are duly protected.

REFERENCES

¹ In developing this report, the Council contacted the AMA's Governing Councils of the Resident and Fellow Section and the Organized Medical Staff Section, as well as the American Psychiatric Association, the Federation of Medical State Boards, and the American College of Legal Medicine.

² Benzer DG, Miller MM. The Disruptive – Abusive Physician: A New Look at an Old Problem. *Wisconsin Med J.* 1995;94:455-459.

³ Lang DA. *The Disabled Physician: Problem Solving Strategies for the Medical Staff.* AHA, Chicago, Ill., 1989.

⁴ Pffifferling J-H. Managing the Unmanageable: The Disruptive Physician. *Family Practice Management.* 1997; Nov/Dec:77-92.