

Educational Program of the AMA Section on Medical Schools

Presentation Summaries

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Introductory Remarks

Ronald Franks, MD

Chair, Section on Medical Schools

Dealing with disruptive physicians can consume 25 percent or more of our time. Hoping that this problem will solve itself will not work. There are interventions that have been shown to be successful and you are about to learn a great deal of useful information about these methods.

Behavioral Impairment in Physicians

Disruptive Behavior: Impact on the Learning Environment, Career Choice, and Residency Selection

Session Moderator/First Speaker

Peter "Jeff" Fabri, MD

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Over the next two days, we will look at the issue of disruptive physicians from a variety of perspectives: first from the point of view of a medical student and a resident physician and then from a physician and his wife who have personally grappled with the problem. We will hear from the director of a ground-breaking treatment program and gain insights into psychological and legal concerns from experts at the University of South Florida College of Medicine (USF-COM), which has started its own efforts to prevent and treat disruptive behavior.

The profession is really just beginning to recognize this as a significant problem. A 2004 survey by the American Society of Physician Executives found that 10 percent of physicians are disruptive at least part of the time, and 2 to 3 percent use disruptive behavior as their normal mode. Many of them are unaware of what they are doing.

This behavior creates a great many problems for the teaching institution. The literature shows that disruption is an important factor in nurse turnover, patient dissatisfaction and student abuse. Disruptive faculty create negative role models for medical students. Disruptive and impaired physicians increase the risk of medical error. Some people have even said that if you take a list of patient complaints, a list of malpractice complaints and a survey of an individual's behavioral characteristics, they'll be the same.

It takes guts to tackle this problem, but it has to be done. An organized program can identify high-risk individuals so that their behavior can be changed. The University of South Florida College of Medicine took on this issue about one and a half years ago. As the associate dean for graduate medical education, Dr. Fabri was seeing one new resident a week for behavioral problems. When he talked with these residents, it became clear to him that they were simply mimicking their role models, the faculty.

A few faculty at the University of South Florida College of Medicine visited the Center for Professional Health at Vanderbilt University Medical Center and convinced the dean that the school needed a program like Vanderbilt's. The overwhelming majority of physicians who go through the Vanderbilt program to deal with disruptive behavior come out converted, better, functional. It has

been shown that these physicians can change. The fact that somebody has gotten to age 50 does not mean they cannot go back and learn new behaviors.

Disruptive behavior has to do with incomplete competence in emotional intelligence, a concept that was described in the 1995 book of the same name by Daniel Goleman. According to Goleman, emotional intelligence has five basic ingredients: self-awareness, self-regulation, motivation, empathy and social skills. He expands that list to 24 specific characteristics. Dr. Fabri applied the list to his specialty of surgery as well as looked at the typical academic surgeon. He or she probably has eight of the characteristics: self-confidence, trustworthiness, conscientiousness, innovation, achievement drive, commitment, influence and leadership. Dr. Fabri then looked at the characteristics that an academic surgeon typically does not have. He noted that the list was twice as long. The characteristics are accurate self-assessment, emotional awareness, self-control, adaptability, optimism, understanding others, developing others, service orientation, leveraging diversity, political awareness, communication, conflict management, operating as a change catalyst, building bonds, collaborating/cooperating and building team capabilities.

The Dr. Fabri remarked that when physicians do well on the list it is largely by accident — not because they planned it by encouraging these characteristics in their teaching. Medical education focuses on knowledge and skills. Medical students are selected because they do well on multiple choice exams. That is, they are good with rote memory. Resident physicians then are promoted largely on the basis of technical skills. Physicians are autonomous, isolated heroes. But what kind of model is that? When one goes to work, the real issue is not whether one can remember Krebs's cycle; it's whether one can adapt to new information, new knowledge, new interrelationships, and whether one can work in a team.

Of all the skills that involve emotional intelligence, working within teams is one of the most important. Dr. Fabri mentioned he was standing in a long line at a bank once, and this man walked up and said, "Excuse me, I'm a doctor," and went to the front of the line. Physicians need to see themselves as members of a team. When Dr. Fabri was in surgery training, his attending would say, "Do what I tell you and don't think, or you'll weaken the team." But that's not real teamwork. What is teamwork? Do we want a group of individuals who are each trying to outperform the other? A group of people that know what they do very, very well, but they don't really talk to each other? Or are we looking for a group of individuals who are fluid, can adapt to change, can pass the ball back and forth to each other and pick up for each other's weaknesses?

Dr. Fabri asked how many of the audience remembered the 1986 book, "All I Really Know I Learned in Kindergarten," by Robert Fulgum. He believed that the simple rules in the book could help set the framework for the Section's discussions on disruptive physicians, "Share everything; play fair; don't hit people; put things back where you found them; clean up your own mess; don't take things that aren't yours; say you're sorry when you hurt somebody; live a balanced life; learn some and think some; and draw, paint, sing, dance, play and work every day some. When you get out in the world, watch out for traffic, hold hands and stick together."

We need to develop programs to nurture, sustain and reward these behaviors. The University of South Florida College of Medicine has instituted a system of portfolios for fourth-year medical students. It has a list of things that the faculty expect the students to do in the fourth year, over and above the curriculum. The portfolio for the fourth-year medical students includes professionalism, teamwork, handling stress, self-development, attendance and punctuality, compassion and self-motivation.

There is a lot of disruptive behavior going on but it can be unlearned. You can get a good start by identifying “poster children” whose behavior is clearly outside the norm. If you can fix them and bring them back “with a new religion,” they will help move your program forward.

The USF-COM has a structured program to identify and manage disruptive physicians. All of the department chairs and residency program directors are required to attend half-day sessions on this topic and new resident physicians and all of medical faculty deal with the topic in orientation. Faculty can call a hotline at any hour, receive a callback from a professional within five minutes and get whatever kind of help they need. They are also working on ways to define behavioral boundaries and are introducing clear consequences for those who cross them. Confidentiality of program participants is also an issue. Florida has a new constitutional amendment that limits confidentiality, but they have found ways to protect the confidentiality of participants.

It is important to have a team of senior administrative people shepherding this program through. The dean at USF-COM has bought into the plan; they have educated the chairs and program directors; they’ve educated the residents. They identified who their constituents are. It’s going to take a lot of momentum and continued commitment for this to work, but they are not going to let the ball drop.

Speaker

Hannah Zimmerman

Medical Student

University of Missouri - Kansas City School of Medicine

When medical students are exposed to disruptive behavior, it definitely influences how excited they are about coming in every day and what specialties they choose. They are influenced by how their attendings behave. Students who decide against a specialty often say, “I don’t want to be like that trauma attending or that cardiologist or OB-GYN.”

As a member of the Liaison Committee on Medical Education this past year, Ms. Zimmerman has had an opportunity to gather a few stories about disruptive behavior from medical students. The following are a few of the stories she gathered, minus the names of the students and the programs.

A trauma surgery rotation had a patient with multiple gunshot wounds who had a J-tube that was always falling out and needed to be re sewn by the intern. When this happened yet again, the attending grabbed the intern by the collar, slammed him up against the wall, cursed him and said, “Put the J-tube back in right now.” Based on this incident, one medical student decided he would never choose surgery as his specialty. He said he felt scared to go in every day on rounds. He felt that he had to come in early and prepare perfect presentations on patient care because he was so afraid of this attending.

On a colorectal surgery rotation, a medical student was holding a retractor for a surgeon who suddenly became exasperated and said, “What the ‘F’ are you doing? Please leave the OR!” The student was uncertain of what to do and who to talk to. The student ultimately reported the incident to his chief resident, but the response was, “That’s just the way that attending is.”

On an internal medicine rotation, the attending would be very critical of just one medical student, even when it had to do with a patient he had not been assigned. The attending would say, “That wasn’t thorough enough,” or “We need more of this or that.” Citing this experience, the student said he would never choose internal medicine.

Students on a neurology rotation had the utmost respect for the attending's knowledge base, but not his bedside manner. On rounds, when patients tried to talk to him, he would address the team and ignore the patient. One day, the attending asked a severely injured patient to communicate with his fingers. When the patient took some time to raise his finger, the attending said, "With guys like this, sometimes you've got to keep asking the question." Three of the students said they would not choose neurology because of this physician's lack of compassion.

Ms. Zimmerman said she also had a lot of positive stories from her own rotations. On her surgery rotation, she was asked to list the three strap muscles, but could only think of two. The attending said, "Just take your time and think." To her, that encouragement was a solidifying moment. The attending was patient with her. His attitude had a lot to do with why she picked surgery to be her specialty.

Another example she shared was from her pediatric cardiology rotation. Every attending wanted to make sure the students learned what they needed to know. When they critiqued her, it was always done in an encouraging manner; it was never belittling. They took the time with the students on rounds to really teach them and the students didn't feel threatened.

Medical students do talk to each other about their attendings and they have a lot of stories. Attendings' behavior may be improving, but the negative things are still there. This behavior definitely does influence a student's specialty choice as well as how excited he/she may be to come in that day.

Speaker

Douglas "Che" Miller, MD

Resident Physician

University of Oklahoma Health Sciences Center

Dr. Miller also shared some stories and added a disclaimer, "Anything that I mention may or may not have come from my institution."

He said that he would shine some light on this subject from a different view. He grew up with a disruptive father. It was difficult, but it gave him the opportunity to understand a few facets of human behavior. He believes disruptive behavior comes from a real benevolent cause. His perception is that it actually is due to physicians' frustration when they are advocating on behalf of their patients. Physicians often have conflicts with hospital staff or junior colleagues when making a point on the patient's behalf. But the demands of medicine have changed and this behavior is no longer tolerated. Residents have to figure out how not to learn this behavior in an environment where it happens all around them.

Dr. Miller said that he wanted to be a surgeon since he was very young and that he is starting his chief resident's year in general surgery shortly. He said that he knows the field is saturated with doctors who exhibit disruptive behavior and has wondered why that is. One can speculate that general surgeons exhibit disruptive behavior because their work demands immediate action. They say, in effect, "I would tell you this very nicely if I could, but I can't because we have got to do this right now." This urgency sometimes leads them to become short with staff and other physicians. The staff nurses may make excuses for the surgeon. They'll say, "This is a stressful job, just bear with him" or "He's a very nice person deep down." And quite frequently, it's true. Many, if not most of these physicians, are good doctors who are knowledgeable and respected. The difficulty has become how to handle them.

As a resident physician, Dr. Miller said he has seen disruptive behavior. Often after an episode, the senior resident or faculty member says, "I'm sorry, I didn't mean that. You did a great job in there." But the resident still feels awkward. One resident was told he was "too stupid to run a suction device." That really hurt the resident. If residents don't do it right, it's because they don't know how to yet. Dr. Miller equated residents to puppy dogs – they are very loyal and very forgiving if you apologize to him/her. Sincerely, deep down, the resident physicians want to do what's right. Residents would very quickly respond if they were told how to do something. It's difficult in surgery because often enough there is no time for explanations.

Residents are in an awkward position. They are students but they are also teachers. Senior residents will teach junior-level residents and medical students. Whenever faculty or senior residents insult a junior resident, it jeopardizes their credibility in front of the medical students they are teaching. It makes it difficult to regain that credibility.

Residents are disruptive when they are fatigued, stressed, and not able to perform. Most importantly, they have a lot of pride and they don't like being proved wrong. But, in fact, junior-level residents are wrong much more often than their faculty or senior residents.

Residents may also engage in sexual harassment and other sexually inappropriate behavior. They are probably more guilty of that than anybody else because they are the same age as many on staff at the hospital. Basically, you have a group of young, nice-looking men mixing with a group of young female nurses. This means resident physicians need to be educated about inappropriate behavior.

One thing that is important is that residents are malleable and it's a good time to intervene during training. This is one of the last great chances to teach them that their behavior is inappropriate before they go on to become a practicing physician.

Dr. Jeff Fabri: He also shared a disclaimer with the audience. He said it was not planned that the two previous speakers would be surgeons; they were selected by their peers. Dr. Fabri said from his perspective as an associate dean for GME that the surgeons aren't the worst behaved; they're just the most visible. In fact, some of the most disturbing stories he has heard about disruptive physicians do not involve surgeons at all. In one case, a Vietnamese resident in a non-surgical specialty was in a morbidity and mortality conference, explaining a case that had gone wrong. A senior attending said, "You son of a bitch, if you ever do that again, I'll slit your throat." Three weeks later, the resident committed suicide.

Reactor

*Anderson Spickard Jr., MD
Director
The Center for Professional Health
Vanderbilt University Medical Center*

Dr. Spickard said that the behavior in the stories that were just mentioned, he thought had pretty much disappeared. In the old days there was leadership by intimidation, but that won't work any more. He said that exhaustion leads to disruptive behavior. Disruptive physicians say things in a weak moment but do not realize how important and powerful they are. One key factor is working long hours. All of us make mistakes when we are tired. You need to have at least seven hours of sleep each night or "the wheels come off."

There is a great deal of truth about the importance of emotional intelligence. Some people are born with emotional intelligence. There are surgeons who have the positive aspects of emotional intelligence, but people can also be trained in it. Companies that soar tend to be those where the CEOs do their work in atmospheres where emotional intelligence is high.

All of us have our moments, said Dr. Spickard. He recently was reminded by a nurse with whom he worked many years ago that once he had thrown a chart the entire length of the room because she hadn't gotten a complete blood count done. He said that he couldn't remember doing that, but most likely behaved that way.

Some of the disruptive physicians can be the best doctors anyone has ever seen. They tend to be narcissistic, but if they have no narcissistic remorse, then they will be a hard case to work with. The narcissistic person can explain every action – why they are not finishing their charts on time, why they're not coming to rounds or to clinic, or why a wound was screwed up by the nurses. They say, "It's the system's fault; it's not my fault." If they've got this narcissistic focus in their lives, with no narcissistic remorse, they are very tough to deal with. Glen Gabbard, MD, a professor at the Menninger School of Psychiatry at Baylor College of Medicine in Houston, says that if you have a little window of narcissistic remorse, you can deal with a person. And that's what Dr. Spickard has found as well. If the physician questions just a little bit, "Well, maybe it's not just them who screwed up; maybe I've got some responsibility for this" then we can work with them. They need to take some responsibility for their actions.

The Joint Commission on Accreditation of Healthcare Organizations requires hospitals to have a comprehensive physician wellness program. Vanderbilt has 140 physicians attending their wellness program. Ninety percent of them are self-referred; 10 percent were required to come. The disruptive physician tends to be younger than those with substance abuse problems and, so far, they are mostly surgeons or other interventionalists. Confidentiality is ensured for the participants and they work in small groups with therapists. Some of these doctors need to have a five-day evaluation, which costs about \$5,000 to \$6,000. Among other things, it looks back into the family of origin. Disruptive doctors tend to come from families who neglected them, who were rigid and distant. For example, the child came home with an A-minus and the parent wanted an A. As adults, these doctors do not have a hook into emotional concerns.

In the past two or three weeks, a half dozen physicians have come to Vanderbilt for the second of three visits for disruptive behavior. Dr. Spickard said that he has been thrilled to see that with some guidance, people can change. Their spouses go from being scared and overwhelmed to saying, "Well, maybe it will work out." Of the 10 who have completed 360-degree evaluations with a full survey, eight have had major changes in their behavior for the better. But it's hard work – harder even than dealing with substance abusers.

You've got to start early with preventive efforts. Medical schools need some way of helping disruptive students before they get into residency training and perpetuating the cycle. Schools need a physician wellness program which says this behavior is not tolerated and has clear policies on what is egregious and what kind of help the disruptive individual should get. But education is not going to be enough. You also need a program that can take care of the people who are the outliers.

Question and Answer Session

Lars Larsen, MD
Associate Dean, Academic & Faculty Development
The Brody School of Medical at East Carolina University

Expectations of physicians' behavior are undergoing a sea of change, especially within the boards of trustees of hospitals. Boards are no longer taking the view that physicians are very special people who have to be treated in special ways. They expect the hospital to treat its physicians in the same way a corporation treats its employees. It's a very businesslike approach. Young doctors have to understand that disruptive behavior will affect recredentialing. At Brody, all disruptive episodes are thoroughly investigated, filed away and then taken into account when recredentialing comes around.

Michael Reichgott, MD
Associate Dean for Clinical Affairs and Graduate Medical Education
Albert Einstein College of Medicine at Yeshiva University

The student and resident speakers had two different approaches. One was about the faculty's educational skills and some examples of where they need work. The other was an apologia consisting of all the reasons why it's OK to act out – because we have stressful lives, work hard, do difficult things.

A question for Dr. Spickard: Are you using the transtheoretical model, the “readiness for behavior change” approach developed by James O. Prochaska, PhD?

Dr. Anderson Spickard: Yes, we use that model in particular when educating physicians on how to deal with the disruptive patient or the alcoholic patient.

Stuart Gitlow, MD
Assistant Clinical Professor of Psychiatry
Mount Sinai School of Medicine

Not all behavior that is labeled disruptive is bad. Many years ago, as a second-year resident, I had a very difficult night at the hospital. After just a half hour of sleep, my pager went off at 5:45 am. As it turned out, it was a mock code. I must have yelled something, turned around and went back to sleep. The next day, I found out that I had been reported as a disruptive physician. My group of residents was really quite disruptive. We did many things like what I did that night, and we got called before the program's disciplinary tribunal fairly often for issues that were not as egregious as battering a young doctor, but more typically the sort of responses you might expect when you are not getting any sleep. As I look back, residents in my program tended to be individualistic; they were not part of the homogenized crowd. They were also the ones who ended up on the front covers of their medical journals or chair of their departments or otherwise standing out as leaders in their fields.

My question: How can we balance the ideal of individualism with the team approach that is coming into favor right now?

Hannah Zimmerman: I always ask myself if my mom would be proud of my behavior. At the end of my third year I was on post-call and I think I had used more expletives in one day than in my whole life. My mother said to me, “If you ever behave like this again, don't tell anyone I am your mother.”

Dr. Jeff Fabri: Goleman's point is that people who grew up in the 1970s and 1980s were tolerated if they acted out. Today those people are not tolerated. They get into their job and within a year they are gone. People used to do everything they could to keep these physicians on staff, but now, in some cases, a cardiovascular surgeon is more expendable than an experienced CCU nurse, because nurses are in short supply.

Erica Frank, MD
Vice Chair for Academic Affairs of the Department of Family and Preventive Medicine
Emory University School of Medicine

People who have been harassed in training are less likely to say they like being a doctor. In a survey of medical students and residents, 40 percent said they felt harassed and 89 percent said they felt belittled. But of those who strongly agreed that they were glad to be doctors, only 15 percent said they were harassed; of those who strongly disagreed, 58 percent had been harassed.

Jane C.K. Fitch, MD
Chair of the Department of Anesthesiology
University of Oklahoma Health Science Center

It is widely thought that disruptive behavior is created in medical school. But my experience is that it has nothing to do with that. I used to be a nurse and observed the medical students who were a problem. They came in disruptive and they left disruptive.

Dr. Anderson Spickard: I am always asked, "When did the disruptive behavior start?" There is not enough evidence to know for sure. But, bottom line, it is possible to change behavior.

Michael M. Miller, MD
Wisconsin Delegate to the American Medical Association
Director of Behavioral Services at Meriter Hospital, Madison, WI

The problem has to do with acculturation. We can be acculturated by good parents or we can be acculturated to act boorishly. These skills are teachable but we also need to revamp the medical student selection process. I heard excuses of behavior from the panel – quite a bit from the resident and even a bit from Dr. Spickard when he said that disruptive behavior is influenced by "the heat of the moment." In the corporate world, "the heat of the moment" is not an excusing factor. Taking a worst-case scenario, massacres by soldiers are "in the heat of the moment."

We all have our flash points when we can lose our temper, but that is no excuse. I know that the times when I am at my worst, when my mom wouldn't like what I was doing, are when I have been on call too much. For me, one of the classics is that a nurse will call and I will be irritated. I am thinking, "It's one more blankety-blank call; one more intrusion on my personal life and my family life." My family may be vocally complaining and I know that their complaints are valid. I am focusing solely on my experience, which is, "You're bothering me and getting in the way of my family life. I try to lead a balanced life and I just came back from a 20-mile bike ride. As I am taking care of myself, you're bothering me." But the fact is, they're just asking a question. The caller just has a job to do; they're faced with things in their nursing practice act. They have to ask certain questions, whether it's 8 at night or 2 in the morning. If they need remediation on how to make a phone call, that can be addressed through professional education. But at that moment, when I'm snapping at them and saying, "Why the hell did you call me," or something like that, it creates something that they'll remember for years. Even though for me it was just one moment of my life,

they will remember it for years. My expression of anger doesn't get the phone call done quicker; it doesn't solve the patient problem. I really think the basic empathic act, realizing where somebody is coming from, is important for all of us. This kind of behavior doesn't apply only to phone calls; it can apply to all sorts of things. We bitch and moan when we're offended but it goes with the territory. When we're there to be available to somebody, they need to call.

Dr. Douglas Miller: One of the things the Governing Council of the Resident and Fellow Section is closely looking at is the impact of the 80-hour workweek. One side-effect is that faculty work longer hours to make up for the limits. If they're a bit more irritated, we have to excuse that as residents. We kind of brought this on ourselves. The residents and the medical students brought this issue forward in the AMA and other places and now we have our 80 hours. But now we're upset that faculty don't have the time to teach us and are maybe a bit more irritated than before. So we have to excuse that as residents.

As faculty, you're smarter than me; you're a whole lot more suave than I am. The person in my program who has taught me the very most is possibly the quietest. We residents have nicknamed him "Dad." He's so influential. I'm not afraid of him yelling. I'm not afraid of him being disruptive. I don't want him to be disappointed in me. I want to make sure I have all of my ducks in a row so that he won't be disappointed in me. How do you make that happen? You live an ice-cold, perfect example as a physician. I never see him do anything inappropriate and there is no person I want to be more like. I take that approach with my medical students. If I want them to be like me, then I have to do a decent job.

Dr. Jeff Fabri: Systems or processes can contribute to disruptive behavior. In the area of quality assurance, we've all learned that complications and errors do not usually come from bad people. We know that if you find the systems and processes that facilitate these errors and complications, you make much greater progress than simply going after a bad apple. I believe we can identify situations that are part of the educational process, such as excessive fatigue, that contribute to disruptive behavior and make substantial improvements. I don't think we're trying to excuse the behavior. I think we're trying to identify the things we can fix.

Carlyle H. Chan, MD
Former Program Director for Psychiatry
Medical College of Wisconsin Affiliated Hospitals

When I was in medical school, I had a professor who got some enjoyment from taking students into a locker room and mercilessly grilling and humiliating them. I remember a friend from another medical school had a very similar experience. We decided that there were three places in society where such people could function - Marine boot camp, the prison system, and gross anatomy faculty.

We know that people who are abusers were abused themselves early on. That is a form of role-modeling but there are also some characterological aspects of behavior that come into play, and those are much more difficult to unravel. When I was a training director, I knew that disruptive behavior did not start when students entered the residency program. It was actually going on in various stages during medical school. One of the warning signs that I used as a training director was how residents treated the administrative staff. That gives you some inkling of what is going on. My question is how can we do more early recognition and intervention?

Dr. Anderson Spickard: Patient complaints are a good indicator for monitoring practicing physicians, and we are developing a software program to identify the units that have difficulties with residents. The ideal is to identify problems early, but I don't think we should be selecting medical students on the basis of the traits of emotional intelligence because we don't know enough yet.

Hannah Zimmerman: Peer evaluations by students about students could help show who needs early intervention. You'll often hear students say about their peers, "I wouldn't send a patient to that person when they get to be a doctor." Students would welcome the process but they would want it to be anonymous.

Frederick Schiavone, MD
Associate Dean for Graduate Medical Education
State University of New York-Stony Brook

I applaud your program of training the chairs and the program directors in how to deal with disruptive physicians. We've used that model many times for lots of different types of educational efforts – teaching the competencies, for example. But my great concern is how do you take this message out to the 1,200 or 1,500 physicians who make up a school's clinical faculty?

I'd like to add that the media is working against us by emphasizing some really bad behavior by physicians. The TV show "House" has some of the most egregious behavior that I've ever seen.

What types of programs are there to prevent disruptive behavior, other than selecting out individuals when they throw a piece of chalk down the hall or stab someone in the chest? In the egregious cases, any mother can make the diagnosis of disruptive behavior. But how do we capture the culture change that needs to be done?

Dr. Jeff Fabri: We don't have the final answer but we spend a lot of time thinking about this. We think that we can have some traction in solving this problem – not tomorrow, but maybe in the near future – if we can identify and remediate a handful of "poster children" who will come back with clearly changed behavior. We need to put together a meaningful physician wellness program that is continually reminding the faculty that we care about them and that we're there to help them.

Liz Hay
Second-year Medical Student
University of Indiana Medical School

The ideal is zero tolerance but we all know that isn't realistic. When do you say enough is enough and send a disruptive person into rehabilitation?

Dr. Jeff Fabri: Institutions have to define some boundaries. The boundaries we establish at the USF-COM may not be the same that your school establishes in Indianapolis, but you have to have boundaries. A lot of disruptive physicians are totally unaware of what they're doing. As they begin to change and come back to work, I think you will begin to see a secondary and tertiary affect in the form of better faculty behavior. But you have got to start making an effort and it has got to have teeth.

Dr. Spickart: Unless you deal with disruptive physicians where they are, using people who understand them, they will go get a "geographic cure." That is, they think things are going to be better if they go to another place to work, but they only take their same behavior to the new place. A

lot of residents fill a slot at another place because they got kicked out of where they were. In the same way, a faculty member can go here, there and yonder, still untreated for his or her problem. The move could have the effect of uplifting their spirits but it won't change their underlying behavior problem.

Dr. Jeff Fabri: Leadership may be willing to overlook the problem because these physicians often bring in a lot of money. But at the USF-COM, we got a commitment from the dean that if we identify disruptive physicians, he will require them to go to a training program.

Melissa Behringer, MD
Assistant Professor of Family Medicine
University of Alabama-Birmingham, Huntsville Campus

I see male physicians doing things that the nursing staff tosses aside, saying "They are male," while female physicians like me can be dealt with more harshly by female nurses. There is an issue of gender differential in terms of expectation behavior.

I use colored ink in my pens for everything except truly official documents. I do this because it is then more difficult for patients to forge my prescriptions. One day I was on rounds with my residents, and a unit clerk comes waving an order sheet and saying, "Dr. Behringer, this is unacceptable!" I took a deep breath and said, "OK." I took the order sheet and I reread it line by line. My units were correct. There were no unapproved abbreviations. It said exactly what I wanted it to say. I said, "What's wrong?" She said, "You can't write in this ink." I asked her where in the medical records instructions and bylaws did it say that I have to write in blue or black ink. Then she sent me to the charge nurse and we went through exactly the same conversation. I had residents and students around me and I was trying not to show disruptive behavior. Finally the charge nurse said, "I can't deal with you, I'm going to have to call the chief of staff." Sure enough, I got a page that afternoon. He and I discussed why it happened and he asked me to make some adjustments, and that's fine. He said, "I know you are not one of my problem physicians." And I laughed and said, "That tells me exactly how the nurse presented the problem to you." Correcting is one thing, but doing it like the nurse did to me is not appropriate. I don't think the nurses would come at any male physician that way. I would like to hear some discussion on this gender differential, because I think woman physicians do have to deal with it.

Gary Onady, MD, PhD
Associate Professor of Internal Medicine and Pediatrics
Boonshoft School of Medicine, Wright State University

Here is a method of encouraging teamwork that has worked for me. We have instituted team-based learning over the last several years. I have noted in observations of physicians working in teams that isolation causes frustration and dysfunctional behavior. The associate dean of academic affairs at our institution had implemented an evaluation component. Students are evaluating their own peers. At the first day of orientation, we have the students go through an exercise in which they learn the importance of feedback, evaluation and teamwork. Then they choose how much a part of their grade that is going to be. We were shocked to see that many of them chose it as a huge part of their grade. This was the first year we did this. I've never heard such positive evaluations. I'm hoping that this kind of process can continue to be instilled and developed as students go through all four years.

Michael M. Miller, MD
Wisconsin Delegate to the American Medical Association
Director of Behavioral Services at Meriter Hospital, Madison, WI

I'd like to suggest another team approach. Many years ago in my training, we residents formed a Tavistock group, which is a method of training people to work in groups and systems, developed by the London-based Tavistock Institute. Every week we got together and talked about where we were at, what it was like to be a resident and what it was like to interact with each other. A friend of mine is now doing this with football players in Madison, WI. Members of the group have to interact with each other, talk through issues and learn problem-solving with each other. If this approach were adopted as a requirement for completion of medical school, I think we would end up with a different culture of physicians.

Behavioral Impairment in Physicians **Disruptive Behavior: Impact on the Individual, Families, Colleagues and Licensure**

Speaker

An unnamed surgeon
Program Participant at The Center for Professional Health
Vanderbilt University Medical Center

The physician said he first realized he had a problem when his 5-year-old son vomited on a table at home. The physician was explaining to his son the finer points of addition and subtraction. He said he didn't raise his voice or swear, but in his mind, he was instructing an intern on just exactly how he should proceed. Then the son vomited and it was an incredible wake-up for the physician, but he pushed it aside because he didn't know what to do about it.

When the physician was a child, anger ruled his household. If you got mad about something, they were going to let you have your way. It worked well. People got out of your way. He didn't appreciate that people were avoiding him. At any rate, he didn't care. He didn't pay any attention to it until the day that his little boy threw up on the table.

The best month of the physician's life was when he was a fourth year medical student on his surgery rotation, working every other night on call – 36 hours on and 12 hours off, 120 hours a week. He loved surgery. He loved it because one doesn't have to worry, you don't have to think about anything else. He remembers blowing up at one of the attendings. The vice-chairman told him, "You know, son, there are some people who are smart enough that they can burn their bridges, but you're not one of them." That helped the physician modify his behavior, at least until he matched.

Every year in residency he was told he was fired and he did not know if he was going to finish until the very end. He said he had very minimal insight. To him, he was dealing with imperfect creatures and was trying to show them how to take care of patients. One of his chiefs would always stand up for him and say, "He never got mad about anything except for patient care." But his attendings knew there was a problem. When he was leaving residency, the chairman advised him, "When you get really mad about something, just walk out of the room, count to 10 and come back."

When someone is rude and demeaning, it angers people and they react. A lot of people who resented the physician's behavior when he was a resident wanted to get him fired. He never was actually fired,

because he never disrespected his bosses. It also helped that he had a lot of mentors whose good behavior he tried to emulate.

He finished residency and joined two general surgeons. He did 900 cases in his first year out. He and his wife had a child then. People would get mad, nurses would write letters, but people in authority would cover for him. They were glad he was there because he would take call every other night. He was just loving it. He was the busiest surgeon in town, doing 1,100 cases a year with no complications and no lawsuits – it was just the best. But he was incredibly unhappy and completely out of touch with his family. The physician said if you are suffering, it's easy to find something that you can do, like a hernia or a torachotomy, and just think about that all the time. You don't have to worry about emotions at all.

He started coaching soccer about six years ago and the kids didn't respond to the kind of coaching he had in high school, which was, "Give me 20 push-ups." He went to camps to learn how to be a soccer coach and how to talk to children. That helped a lot, but he didn't have coping mechanisms; he didn't understand anger. He was very good at blaming others because he really needed to be right.

Last year, he said some things that he shouldn't have and was compelled to enroll in the Center for Professional Health at Vanderbilt. It was a gift. He learned some things that he had never learned before. It helped him understand his anger. He completed the program in about six or seven months and now is working with a psychiatrist on a monthly basis.

He says he is a long way from where he wants to be but he now has some tools to use. He is trying to recognize anger distortions and solve the problem without saying rude or mean things. He knows now that what he says could crush somebody and make them feel terrible. He doesn't work as much now because work is not as important. His family is his support. Recently, his son, who is now 10, told him, "Since you have been working on anger management, I want to spend more and more time with you." That was very encouraging to hear, said the physician.

Reactor

Anderson Spickard Jr., MD

Director

The Center for Professional Health

Vanderbilt University Medical Center

With this surgeon, when his boy vomited, his door opened into remorse, but he didn't know how to handle his feelings. He reacted in the OR by saying, "I'm going to kill that SOB," and since he had a gun collection, the hospital credentialing committee and state medical board said he had to get help, and he came to Vanderbilt. A five-day evaluation showed that this surgeon did not have a psychiatric illness. He did not need long-term therapy but he did need to get into the distressed physician program.

Speaker

Wife of Program Participant at The Center for Professional Health

Vanderbilt University Medical Center

Living with a person who is so driven and a perfectionist can be very difficult for everybody in the family. She said her husband has had issues all the time that she has known him, from when they were dating through his residency and throughout their marriage, of overreacting to situations and showing explosive behavior. She used to wonder if he was able to control himself at work and only

really let things out at home. He's never had any issues with physical abuse toward anyone or anything, but he has had very pronounced episodes of really manipulating a person with his anger, his voice, his looks, or his demeanor.

It's been a long process. There were many ways that we as a family were affected by his inability to control himself when he is given information that he doesn't like. Everyone walked on eggshells. Nobody wanted to talk to him because they were scared to death of him. "I can't tell him this; I can't tell him that." They were be afraid of his reaction. He'd just go crazy. It became a self-perpetuating problem. The children were fearful about what their dad would do if they told him something, so they didn't. They did not have complete honesty as a family. She said her husband was always walking under a dark cloud, not knowing what was going on in the house. No one wanted to talk to him.

Problems came out at work when he was told he was fired from the residency program. A difficult instance like that made her realize that he has some issues going on, but she really couldn't tell him that. She felt he had to come to his own realization. She thinks the crux was when their little boy was unnerved by his dad's "big demeanor" and began to vomit when he was faced with questions from his dad. He just did not know how to react to the nervousness that he felt when his dad would come upon him. It's really hard to sit back and say, "Wait a minute, look at the effect you are having on your family. What will you do to change that?"

All through his life her husband has been protected by people. When he was fired from the residency program he had a lot of people who were on his side and worked very hard to get his job back. People always would say, "He really is an excellent surgeon and takes such good care of his patients and he really is under so much stress at work." They excused any bad behavior he might have had because he was so good at what he did. Well, that didn't work after a while. He misbehaved at the hospital enough that he made some people unhappy. But the culmination of his bad behavior was that he got into a wonderful place – Vanderbilt's program. He was ready to go. He knew there were problems that he didn't quite know how to get a handle on. He had been trying for years to modify his behavior. He knew he had to make a change, but he really didn't have the tools to do it. And the family did not know how to help him either.

It has been wonderful for her husband and for the family since he went into the Vanderbilt program. He has learned many coping skills that the family has learned as well. The wife said she knows that she can be a very passionate person at times and when something makes her mad she says she doesn't always react the right way. Her husband has been able to impart the tools he has learned to the entire family.

The program has really helped her. It has helped their relationship immensely. There was a time about 10 years ago when they were going to a marriage counselor and were ready to separate because there was too much pressure; too much that couldn't be resolved. They decided to stick together and try to do what they could to try to salvage their marriage. Since he has been in Vanderbilt's program, it seems that the black cloud has disappeared. He is much more peaceful and easy-going now. He is learning how to relax. He is learning how to really enjoy his hobbies and cut back on his work schedule.

It's going to be a life-long process for him but he's come almost full circle, she said. This change really has been a blessing for the entire family. Everybody in the family knows they can talk to him now and he's not going to explode. He's going to come back with a solution. He is such a different person. It has given him so much peace. It just flows out to everybody else.

Reactor

Anderson Spickard Jr., MD
Director
The Center for Professional Health
Vanderbilt University Medical Center

Patients at the center like this surgeon are what make us so committed to what we do. He was required to enroll in the program, as are about 10 percent of the enrollees. The rest volunteer, but of 20 who enrolled recently, only six actually came. He thinks they need to be required to enroll.

Doctors don't normally like to talk about themselves but in the program they open up. A genogram is used, a questionnaire that traces behavioral problems to the family of origin and beyond grandparents.

The program involves three days of continuing medical education. The physicians enter a small-group process with other physicians. It's not called treatment and no records are kept because they don't want "lawyers coming after them." Anonymity makes a big difference. Dr. Spickard wants to encourage other programs, such as the one at the USF-COM. He is thrilled about what they are doing there.

Question and Answer Session

Joseph R. Zanga, MD
Pediatrician
The Brody School of Medicine at East Carolina University

Over the years, I have helped a lot of physicians who have been labeled disruptive. It's not an encouraging experience. These physicians don't find out what they did wrong until months later, and their accusers are mostly anonymous. Is that the right way to identify disruptive physicians?

Dr. Anderson Spickard: When we go on grand rounds to explain the program to faculty leaders, we try to teach them how to report. The chair writes reports on specific events and sends them to us for an evaluation by an internist and psychiatrist before further steps are taken.

Dr. Jeff Fabri: We need to develop clear benchmarks on what behavior will not be tolerated, so it does not just depend on how people feel. Reporting can be very objective if it is done right. True, some people who complain about a particular person could just be taking pot shots at them, but if you receive consistent reports from many sources, you'll be able to say there probably is a pattern.

Erica Frank, MD, MPH
Vice Chair for Academic Affairs
Associate Professor, Department of Family and Preventive Medicine
Emory University School of Medicine

We have been calling this behavior outlier but in many ways it is just an intense expression of fairly normal physician behavior. We want perfectionistic doctors, so it should not surprise us that we end up with people who have a very large sense of entitlement. Belittlement and harassment is routine. More than 80 percent of graduating seniors in 2003 said they had been belittled and 50 percent said they had been harassed.

How can the AMA's Initiative to Transform Medical Education help create a system that rewards a certain amount of perfectionism without generating the negative outcomes we have been hearing about?

Modena H. Wilson, MD, MPH
AMA Senior Vice President, Professional Standards

The AMA Initiative to Transform Medical Education is looking at the gaps in physician preparation throughout the continuum of medical education. It is not at the point of designating objectives. But the AMA ethics group has a great deal of interest in professionalism and we anticipate it will be a very big part of the final report.

H. David Wilson, MD
Vice President for Health Affairs and Dean
University of North Dakota School of Medicine and Health Sciences

The surgeon's wife deserves the Purple Heart, but wasn't she being co-dependent by not intervening?

Dr. Anderson Spickard: Seeing what she has gone through, I can say she must love him a lot. Keep in mind that her co-dependent behavior was being validated by other doctors who would exhibit it, too. Everyone would excuse his behavior because he took good care of his patients. The patients loved him. The administrators loved him because he was bringing in money.

Co-dependent behavior is very common in addictions, and this is also an addiction — an anger addiction. From the spouse's point of view, survival of the fittest was the mode of operation. I don't think she knew where to go. If her husband had been taken to a psychologist, he would have nailed the psychologist to the wall because he knows how to use anger as a manipulative device. Out on the street, I don't think we have good people who are well trained in doctor behavior to give her the help that she needed. That's what we're trying to fix with Vanderbilt's program.

Larry Rues, MD
At-Large Member of the AMA Section on Medical Schools
Former Family Medicine Residency Director
Baptist Lutheran Medical Center, Kansas City, Mo.

When do you say to a disruptive physician, "You are fired?" It's easier to fire someone who is incompetent, but that's rare. Behaviorally disruptive people are tricky because they mean well but they make mistakes in judgment. What if the surgeon really had been fired? Would it have been enough of a slap? How do you get a person's attention?

Dr. Jeff Fabri: We tend to carry disruptive residents along until late in the program, and all of a sudden they become bad people. But if you actually go back to the beginning, the behavior was going on for a long time. As a routine part of our training programs, we need mechanisms for identifying disruptive behavior very early on, so that we can help them instead of devising ways to punish them. This should not be about finding bad people and cutting them out of the system. It should be about finding people early when they are still in a formative stage and then helping them. The programs we set up should identify problems in a kind way. Dr. Spickard has taught us that these programs work. This behavior can be modified.

Lars Larsen, MD
Associate Dean, Academic & Faculty Development
The Brody School of Medical at East Carolina University

At our hospital, we have a chief-of-staff hotline where people can complain about the behavior of residents and attendings. My office sees the full spectrum, from doctors who act up once, which is rare, to those whose behaviors cycle every year or so. Many of them deny their behavior, which means there will have to be a long process of corrective action.

Can you expand on the concept of narcissistic remorse?

Dr. Anderson Spickard: I am not a psychiatrist, but my understanding is that narcissistic people cannot understand what they are doing. They can explain everything very articulately but they are isolated in their thought patterns. In their pain, they feel that everything is everybody else's fault. But the individual with narcissistic remorse begins to sense that something is wrong, and this makes it possible to engage them in a program like Vanderbilt's.

Carlyle H. Chan, MD
Former Program Director for Psychiatry
Medical College of Wisconsin Affiliated Hospitals

The European Union has proposed a maximum working week of 48 hours for both residents and practicing physicians. [This is a proposed standard that each EU member nation can choose to adopt, but reportedly none have done so yet.] A work hours standard for all physicians might be a good idea.

Dr. Jeff Fabri: Focusing on work hours makes sense. A study by David Dingus of the University of Pennsylvania asked volunteers to press a button when a light went on. When people were awake for more than 18 hours, they started making more mistakes, but they absolutely insisted that they were doing a good job. Since people's judgment will be impaired by longer hours and they won't even know it, we will need to have systems and processes that alert them when they need to stop working.

Physicians work long hours because they see themselves as indestructible. This is a macho culture and it's not limited to surgeons. We have to come up with systems that do not cram physicians into this macho mode. This surgeon is lucky that he got out of this with his marriage, his kids and his job intact. A whole lot of people would be trashed over this.

Behavioral Impairment in Physicians

Disruptive Behavior: Dealing with the Problem, Legal Implications and Future Directions

Speaker

Martha Brown, MD
Director, Division of Addiction Medicine, University of South Florida College of Medicine

Stress can predispose people to disruptive behavior. Since 9/11, we all feel a little more anxious, a little more stressed. Stress also arises from a malpractice suit or worrying about retirement or managed care. Any time we are "hungry, angry, lonely or tired," which we identify as "HALT," we are susceptible. Medical school and hospital environments present stresses that normally are not

found in the general workplace, such as life-and-death crises, long working hours and easy access to drugs.

Both a heavy drinker and a bipolar individual can be disruptive. We think that about 20 percent of medical students and professionals in their careers experience some type of a substance abuse problem, which can cause disruption in the workplace. Physicians with anxiety disorders may not be able to work with patients. Many times physicians do not have a primary psychiatric disorder but may be narcissistic, borderline or antisocial. Physicians with dementia may become disruptive when they can't understand something. There are sexual disorders, including harassment and stalking. In one case, a physician was first reported sexually harassing several nurses, then he became disruptive. Then an evaluation showed he had a sexual disorder, and only much later did we learn he had a cocaine problem.

There are several different types of disruptive physicians. The passive ones are chronically late, don't return phone calls and can have horrible fights in the chart. The passive-aggressive ones may send hostile e-mails, make derogatory comments or inappropriate jokes. The aggressive ones swear, push or throw objects across the OR, and then they may be horrified to learn that nurses or colleagues don't like them.

Why do some disruptive physicians go untreated? Authorities may be in denial. Drug or alcohol use may be viewed as acceptable. Colleagues may not want to report on colleagues. Some people say, "Well, this is a problem that he/she should be taking care of by themselves." Some disruptive physicians may read up on the literature about symptoms and then know the right answers when interviewed by someone like Dr. Brown.

Disruptive doctors may have all kinds of rationalizations for what happened, "That doctor really upset me" or "That doctor was really wrong." The other day, two doctors challenged each other to a fight in the parking lot of the ER and came to blows. They both came up with these great rationalizations about why they were duking it out in the parking lot — for example, it was off hospital property.

After listening to previous speakers, you probably can think of someone at your institution and say, "Ah, there's a poster child." There are warning signs that can show you when to identify attending physicians, residents or medical students and intervene before the person needs to be expelled or reported to the state medical board. A doctor may have a long list of medical problems that may mask anxiety disorders. They have been depressed and have been trying to find answers elsewhere. Or we may find out that the physician is self-medicating or has multiple charges for driving under the influence. A physician may come back from a party and get one DUI, but when he/she racks up several DUIs, it's a drinking problem. Dr. Brown recently saw a physician who came in with three DUIs and couldn't figure out why she thought that was a problem. He said he was just having a good time and it was really the fault of the Tampa police force.

In other cases, the physician has been having family conflicts and comes to work smelling of alcohol or disheveled. These are signs to look deeper. When she saw a physician several years ago, it was very difficult to find out what was going on. Drugs were being shifted around between ORs and the physician looked very disheveled. His hair was dirty, he wore dirty socks and Dr. Brown looked for track marks. She saw what she considered track marks up his arm. But he wanted a second opinion, so he went to see another psychiatrist. This time, the physician brought in pictures of his birds and convinced the psychiatrist that he had talon marks on him from the birds. He was also having difficulties with the nurses and everybody around him. He was put into a monitoring program and the

tests came back positive for fentanyl. It turned out he was mixing and matching different drugs. Altogether, it took more than six months to determine the problem and to get treatment for him.

If you have a physician putting a hole in the wall, that's a problem. It's a real warning sign. Dr. Brown received a complaint that one physician would get angry in the exam room and would slam open the door, putting a hole in the wall with the door handle. He was not real happy to come to Dr. Brown's office and they talked about all of the complaints. He said a patient must have pushed the door and he had other explanations. Then Dr. Brown said, "Well, maybe I should talk to your hospital and your medical school and see what their perspectives are." That made him even angrier. When he left, he slammed her door and put a hole in the wall, then returned to her office astride a broom that was a Halloween decoration in her waiting room stating, "I guess this is what you rode in on this morning."

Another warning sign is an unusual schedule. In one case, the hospital's No. 1 producer for five years was making rounds later and later. Nobody wanted to touch him. He did a great job. The patients loved him. He came up with great excuses about why he started to make rounds at 6 o'clock, 7 o'clock, and 10 o'clock at night, and even at midnight. He would say, "I really need to go home first and see my kids." He said he needed to put them in bed before coming back. But the patients were starting to complain. It turned out he liked to run little motorized cars out in the parking lot. The head of the hospital thought about this and said, "You know, I really don't want my No. 1 producer out in the parking lot at 2 in the morning driving around little motorized cars, because it's sort of strange." But it went on for six months before they finally sent him over to see Dr. Brown. It turned out he was taking his kid's Ritalin and that's why he was able to do such a wonderful job. Meanwhile, his kid still had attention deficit disorder and wasn't being treated.

Barriers to diagnosing the impaired physician include fear of harming someone's career or the threat of a lawsuit. Colleagues may be enabling the doctor, particularly if he is a high producer. Hospital authorities might not be able to recognize symptoms, or they may lack knowledge about disorders or lack of policies or resources. It's important to have a plan in place to handle these doctors. The "fitness for duty" model, which Dr. Brown developed while at Louisiana State University, is on the LSU Web site. It lists expectations so that people can work in a safe and fit manner. It should be noted, however, that the functioning alcoholic often can handle his/her job for years, even as his/her home life disintegrates.

Some physicians have a "heal thyself" mentality. Institutions need programs that are especially tailored to the physician's resistance to seeking treatment. Institutions need to have drug testing and a behavioral checklist. It is important to recognize signs early on so that they can be documented. And you need to know when to intervene. You shouldn't jump to conclusions or wait until the situation is out of hand. And you have to be aware of your own motivations, such as knowing when your personal dislike of a physician may be affecting your professional judgment. Maintain confidentiality, document everything and perform a comprehensive evaluation. On a closer look, you'll find some complaints are malicious, especially where divorces and practice breakups are involved, and that some professional evaluations can be wrong.

Keep in mind that nobody tells the truth at first. In addition, not everybody wants to believe the truth. No one wants to believe that their No. 1 producer may be having a problem of some type. Dr. Brown has seen department chairs protect their faculty because they think that if the truth came out they're going to lose somehow. So behavior is sometimes not confronted. Make sure your policies and your power resources – support from the dean or the chancellor at your school – are in

place to ensure that problems will be adequately addressed. And understand you may not be able to get your man or woman the first time around.

If intervention is early enough, doctors can enter a CME course, but some of them need actual treatment or medications. You might think a comprehensive physician impairment program costs too much, but actually it can save the organization \$5 to \$16 for every dollar invested, in terms of malpractice and other costs. And it works, physicians can change.

Speaker

R.B. Friedlander, JD

Senior Legal Counsel, University of South Florida College of Medicine

Ms. Friedlander used to run the juvenile justice programs for the state of Arkansas and she sees certain analogies between juvenile justice programs and disruptive physicians. In the juvenile programs, the message they wanted to convey was, “We love you,” because love was often missing in these young people’s lives. A lot of physicians also don’t really feel loved, but in both cases, they have to understand that negative behavior has negative consequences. We have to say to them, “We’ll take it to a point where we think we can help you but after that you’re going to be locked in a cell with a large man named Bubba. That may be what it takes to get through to you.” Of course, we don’t have a man named Bubba, but sometimes the threat of Bubba needs to be out there. Sometimes there is no possibility of educating a disruptive physician.

Before you take disciplinary action against a physician, you need to know a little bit about your rights and their rights, and then put your attorney on speed dial. To lay the groundwork, create clear, well written policies, educate everybody about them and then follow them consistently. For example, the University of South Florida requires supervisors to report whatever is reported to them. Typically, you should discipline progressively, using the steps of counseling, reprimands and suspension. But when the situation is egregious you may have to jump right to termination. Complaints from support staff are a useful early warning system that should not be ignored.

Keep in mind that the institution is automatically liable for sexual harassment from supervisor to supervisee in which a tangible job or educational detriment results. When that happens, the only thing you can say is, “How big a check to do I write?” You should know that actions like slamming people up against the wall are criminal acts – that’s both assault and battery — but in many cases criminal prosecution may only escalate the situation.

When you confront physicians, focus on their workplace behaviors, not their personal characteristics. If Bob shows up to work disheveled with alcohol on his breath, don’t say, “Bob, I think you’re an alcoholic.” You’re not there to diagnose a medical condition. You’re there to address that person’s workplace behavior. You should say, “This is what you did, Bob. You showed up looking this way. You acted this way. You said this. Your documentation is lousy. Your chart notes are unreadable.” That’s objective.

When you take action against a disruptive physician, the right to a fair trial and rules of evidence do not apply. In a court, relying on what someone heard people saying about you is hearsay and usually is not admissible, but it can be used for actions within your institution. You can rely on whatever anybody is telling you. Courts also require full due process and you must offer substantive due process, which means giving people notice of the charges made against them. For example, you can say, “This is what Resident A told me about your behavior. What is your response?” Your own

documentation of past incidents is important here. Otherwise it will seem like the physician was perfect until the incident occurred.

If the disruptive physician is leaving your institution, keep in mind that giving a glowing reference for someone with violent tendencies can make you liable for negligence. Let's say you get a call from a perspective employer who asks, "Have you ever had any problems with Dr. X?" And you say, "He does have a little anger management problem." You've raised a red flag about Dr. X to the perspective employer. If you didn't tell him that, your institution can be liable for negligence. There is such a thing as negligent retention of people and negligent hiring of people and negligence in providing references, and plaintiff's lawyers are out there zealously pursuing these causes of action.

Don't be intimidated by threats from the person you are accusing of disruptive behavior. The only thing we have to fear is not doing anything. Keep in mind that many threatened lawsuits never materialize and many filed actions are eventually thrown out. The accused physician will inundate you with requests for records, such as e-mails going back several years. And that will require editing out confidential material before handing them over. It may take years to win some cases, but sometimes you have to fight.

The accused physician may claim defamation, but you have clear protections. In order to prove defamation, the statement must be untrue, there must be a resulting damage and you must publish the statement. Passing information through the normal chain of command does not constitute publishing. But to be safe, you may want to use the phrase "in my opinion" before sentences that you think might be defaming.

The disciplined physician may also allege retaliation – for example, that he or she was fired after criticizing the quality of care at your institution — but a clear link would need to be established. Sometimes when disruptive physicians know you are about to take a negative personnel action, they think, "I better protect myself. I better go and complain about something real quick here, so that they can't do anything against me." Oh yes, they can. Institutions can take a negative action if the record supports it. But be careful. Retaliation is one of the most common, well founded claims against institutions. Years ago, Ms. Friedlander represented a client in a jury trial where the issue was reverse discrimination. The jury actually found that her client had not engaged in reverse discrimination but, in the end, decided for a verdict of retaliation against him. That's because her client was asked on the witness stand why he had not hired this person when they were applying and he said, "Well, because they sued me." That's retaliation.

If an impaired physician seeks to leave work temporarily, the Family Medical Leave Act requires you to hold a job open for 12 weeks. Also, the impaired physician has rights under Title II of the Americans with Disabilities Act, which prohibits discrimination based on disability. Both the employer and the employee have responsibilities under that act. In order to have a disability you must have something that substantially limits one or more of your major life activities, it is not a transitory illness and is not a correctible condition. Alcoholism, personality disorders and mental-type disorders are disabilities under the ADA and can qualify as such. But keep in mind that even if somebody is disabled under that act, a reasonable accommodation may not be possible. For example, if you have a surgeon who can no longer perform surgery because of a disability, there may be no reasonable accommodation.

A physician entering a CME program to deal with disruptive behavior would want to have information about that protected from public disclosure. Confidentiality laws vary by state and some

states may make it more difficult to confidentially place a physician in a program. However, medical information is confidential in almost all states.

When you need to deal with a disruptive physician, get professional legal advice and understand your options. But in the end, you should follow your own gut. When Ms. Friedlander was a manager, she said she sometimes acted against her lawyer's advice when she thought it was the right thing to do. "The lawyer is there to advise you but you're there to make the decision. Do the right thing."

Question and Answer Session

Peter "Jeff" Fabri, MD
Section on Medical Schools Member-At-Large

Is it true that substance impairment can take 20 years to show up on the job?

Dr. Martha Brown: Yes and no. In some cases, it can have a rapid progression.

Lars Larsen, MD
Associate Dean, Academic & Faculty Development, the Brody School of Medical at East Carolina University, Greenville, NC

When a person's behavior has a negative consequence and you knew about that behavior beforehand, how could you be held liable?

Ms. R.B. Friedlander: When you knew or should have known that that behavior would probably continue.

Warren Jones, MD
Professor of Health Policy
University of Mississippi School of Medicine

Recognizing that staff and students at teaching institutions are more diverse, how can you identify potential problems in individuals from other cultures?

Dr. Martha Brown: Regardless of culture, you should not tolerate behavior that hurts people. Even if one event happened, you should be sitting down and talking with that student, resident or physician and trying to address the issue. Many times we are rushed and we don't do it. We don't want to get in a confrontation so we just ignore it. By the way, we have a stereotype of the disruptive physician, but the most disruptive physician I ever dealt with was female and she was not a surgeon.

Carlyle H. Chan, MD
Former program director for Psychiatry
Medical College of Wisconsin Affiliated Hospitals

How does the use of continuing medical education (CME) play in to your model?

Dr. Martha Brown: Some behavior is too egregious for CME. Take, for example, the surgeon who throws a scalpel across the room and hits a medical student. You may find that CME does not work and then you'll need to do something else. You can use initial evaluations to help determine if a disruptive physician can make a change through CME. Options beyond CME include entering a

residential facility or even losing the right to practice. But if you start intervening early enough, you can avoid a great deal of egregious behavior.

Ms. R.B. Friedlander: Whether rehabilitation can be classified as CME depends on the law in that state.

Dr. Jeff Fabri: Once you have to report the matter to the state, CME is not going to work. States like Florida have strict reporting laws.

*Gary Gaddis, MD-PhD
Chairman of Emergency Medicine
University of Missouri at Kansas City*

Are spouses or other immediate family member's useful sources for reporting?

Dr. Martha Brown: You don't want to go on a witch hunt but you do need to talk to family members. But keep in mind they do not always tell you the truth. For example, one spouse insisted that her husband did not have an alcohol problem until she called me to say he was having an affair, and suddenly he was drinking a quart a day.

*Barbara Schneidman, MD
AMA Vice President for Medical Education*

I was always concerned when I was in practice by the number of physicians who were self-medicating, especially for anxiety and depression.

Dr. Martha Brown: It's a huge issue. The Drug Enforcement Administration looks very poorly on physicians who prescribe for themselves as well as for family members. I think we have to be very careful. I have seen many physicians misdiagnose themselves and end up hurting themselves or dying from it.