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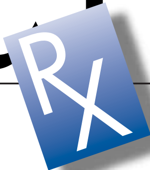
DOCTORS



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Summer 2007

A Letter from the Chair of the Board

Dear Colleague:

This issue of the Doctors RX profiles the disruptive Physician and provides insight in addressing those situations that detract from the primary goal of every Physician – quality patient care.

George S. Malouf, Jr., M.D.
Chair of the Board
MEDICAL MUTUAL Liability Insurance Society of Maryland
Professionals Advocate Insurance Company

The Difficult Doctor

"It is the characteristic of the magnanimous man to ask no favor but to be ready to do kindness to others."

- Aristotle, Greek Philosopher (320 B.C., approximately)

"I couldn't help it; it's all your fault."

- Alanis Morissette, American Rock Star, (1995, A.D., approximately)

A lot has changed since the days of Aristotle, and not all of it good. The decline of magnanimity in the Post-Modern age may or may not be an actual phenomenon, but few could argue with the perception that we live in a harsher, more abrasive culture than past generations. Nowhere is that harshness and abrasiveness more troubling than in the setting of the medical profession. And, just as with society in general, whether there truly has been an increase in abrasive or disruptive behavior on the part of Physicians, the public perception of such an increase is undeniable. Indeed, in late 2005, the New York Times ran an article decrying "the bane of the medical profession: the difficult Doctor." This statement may serve as something of a canary in a coal mine for the medical profession as it reflects the public's complaints of "Doctors [who] may be rude, highhanded or dismissive" with the ominous warning that "they drive away patients who may need help, and some have been magnets for malpractice actions."[1]

It is difficult to imagine a statement more illustrative of the seriousness of the situation than, "Some have been magnets for malpractice actions."

Continued on next page

[1] *"When the Doctor Is in, but You Wish He Weren't," by Gina Kolata, New York Times, Nov. 30, 2005.*

Benjamin S. Vaughan
Armstrong, Donohue, Ceppos & Vaughan

Sometimes a Physician's conduct is so disruptive to the operation of the hospital or office, that the value of the Physician's clinical work is outweighed by the negative impact of his or her behavior. Unacceptable behavior can take many forms – tirades in the operating room, abusive treatment of patients or staff, sexual harassment, or disruption of meetings.

The concern over the "difficult" or disruptive Doctor has caught not just the attention of the New York Times but also the AMA and JCAHO as well as a host of other medical societies and authors. A number of problem areas and suggested solutions have been proposed.

I. Defining and Recognizing "the Disruptive Doctor"

In addressing the concern of the Disruptive Doctor, the first step is defining the term. The AMA has provided this criterion, found in H-140-918, from which a definition may be derived:

> Personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.[2]

In a report from the AMA Council on Ethics and Judicial Affairs, upon which H-140-198 was based in large part, the authors provided additional illumination on this point:

> 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," it generally refers to a style of interaction with Physician, hospital personnel, patients, family members, or others that interferes with patient care. Such behavior may be expressed verbally by using foul or threatening language, or though 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.[3]

The most important point of these statements is the concept of behavior that negatively affects patient care. The impact may be either a direct offshoot of the Physician's contact with the patient or a more indirect result of impaired communications or diminished morale among the Physician's colleagues and staff.

Thus, the mere fact that a Physician's style of communication and interaction may be characterized by such terms as egotistical, abrupt, terse or any number of other terms which are less than charming does not necessarily make his or her behavior problematic. When those traits negatively affect patient care, directly or indirectly, they have become truly disruptive and abusive and warrant some form of intervention.

Behavior which is abrasive and mean-spirited may be the more obvious example of disruptive conduct. Less obvious, but equally troubling examples of disruptive behavior may be found in the Physician who steadfastly refuses to comply with requirements of paperwork or similar routines and then casts blame on other staff members, or upon more vague concepts as the health care profession as a whole, for thwarting his or her desire to practice medicine as he or she feels it should be practiced. This conduct may very well affect staff morale and patient care in a manner that could legitimately be thought of as disruptive. A quixotic effort to buck the system purely for the sake of bucking the system may be every bit as disruptive as the frankly abusive Physician when "the system" being bucked is nothing more than a network of colleagues and staff members simply trying to do their jobs according to the rules by which all practitioners have to practice in a complex and complicated health care system. In a profession that requires the quintessential team effort, the perpetual maverick may be just as disruptive as the constant bully.

[2] *AMA H-140-918, July, 2004*

[3] *CEJA Report 106, Physician with Disruptive Behavior, June 2000*

It should be noted that the American Medical Association has taken great pains to distinguish disruptive behavior from constructive criticism, stating, "Criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior."[4] Even criticism offered in an abusive manner, good faith notwithstanding, may be disruptive if, in fact, it has the effect of diminishing the ability to deliver patient care. In some cases, style may obviate substance.

Certainly, the practice of medicine is a collaborative endeavor. The collaboration may be general and indirect in the sense of information passed from one Physician to another in the form of published literature. More frequently, it is characterized by a far more direct and intimate relationship between the Physician and other health care workers including other Physician assistants, nurses, staff members and non-clinical administrative personnel.

Beyond all else, it is a collaboration of Physician and patient.

The practice of medicine will be successful only when the collaborative effort is permitted to flourish. When it is impaired by the conduct of the Physician, the patient will be the first to suffer. When the patient expresses his or her dissatisfaction in the form of a lawsuit, the Physician may find that he or she is the last to suffer.

II. The Health Care Industry's Response to Dealing with the Disruptive Doctor

A. AMA

The American Medical Association has made a number of recommendations regarding the appropriate response to the disruptive Physician as follows:

Each medical staff should develop and adopt bylaw provisions or policies for intervening in situations where a Physician's behavior is identified as disruptive. The medical staff bylaw provisions of policies should contain procedural safeguards that protect due process. Physicians exhibiting disruptive behavior should be referred to a medical staff wellness or equivalent committee.

In developing policies that address Physicians with disruptive behavior, attention should be paid to the following elements:

(a) Clearly stating principal objectives in terms that ensure high standards of patient care and promote a professional practice and work environment;

(b) Describing the behavior or types of behavior that will prompt intervention;

(c) Providing a channel through which disruptive behavior can be reported and appropriately recorded. A single incident may not be sufficient for action, but each individual report may help. Identify a pattern that requires intervention.

(d) Establishing a process to review or verify reports of disruptive behavior.

(e) Establishing a process to notify a Physician whose behavior is disruptive that a report has been made, and providing the Physician with an opportunity to respond to the report.

(f) Including means of monitoring whether a disruptive Physician's conduct improves after intervention.

(g) Providing for evaluative and corrective actions that are commensurate with the behavior, such as self correction and structured rehabilitation. Suspension of responsibilities or privileges should be a mechanism of final resort.

[4] *CEJA Report 106, June 2000; H-140.918.*

(h) Identifying which individuals will be involved in the various stages of the process, from reviewing reports to notifying Physician and monitoring conduct after intervention.

(i) Providing clear guidelines for the protection of confidentiality.

(j) Ensuring that individuals who report a disruptive Physician are duly protected.[5]

These recommendations are based upon a few fairly essential principles:

1. Due process for the Physician in question:

   – Notice, in advance, of the type of behavior which will be proscribed;

   – Notice that the Physician's behavior is falling within proscribed parameters – The Physician's opportunity to respond to the allegations and defend his or her conduct;

2. Protection of the person or persons making the complaint of improper behavior;

3. Establishing a channel for corrective action (which de-emphasizes punitive measures).

The recommendations of the AMA, above, add yet one more layer of structure to the workplace and to the lives of the workers. They will be helpful so long as they are used as a means of achieving the proper goal. Being a set of structures, however, they are also a potential source of abuse, and will become such if they are used to achieve a goal for which they

are not intended. In putting these principles into effect, care should be taken to ensure that the process, itself, does not become oppressive and heavy-handed to the point that it is the source of disruption rather than the cure. The goal is not to ensure conformity or uniformity of conduct. The hospital or medical office need not become an overly repressive environment. Indeed, the goal is not even to ensure an atmosphere of forced politeness nor the maintenance of an artificial working environment by means of suppressing or altering the personalities or relationships of the persons within that environment. The goal is simply to facilitate the delivery of patient care in a manner that stifles neither the caregiver nor the patient.

B. JCAHO Regulations

It should be noted that the Joint Commission for the Accreditation of Healthcare Organizations has proposed "Standards for Disruptive Behavior," scheduled for approval in April, 2007. The JCAHO has taken an approach not dissimilar to the AMA. Proposed LD.3.15 encompasses the philosophy of respect among co-workers regardless of the relative position of those workers. The Rationale for LD.3.15 provides that "safety and quality thrive in an environment that supports working in teams and respecting other people, regardless of their position in the organization."

The concern for disruptive behavior is expressed, again, in terms of patient safety and the quality of care: "Undesirable behaviors that intimidate staff, decrease morale, or increase

[5] *AMA H-140.918; E-9.045, 2000*

staff turnover can threaten the safety and quality of care." Finally, explicit in the proposed standard is the recognition that disruptive behavior can take many forms: "These behaviors may be verbal or non-verbal, and may involve the use of rude language, threatening manners, or even physical abuse. Anyone who works in the organization can display these disruptive behaviors, including management, clinical and administrative staff, volunteers, licensed independent practitioners, and governing body members."[6]

As a means of putting these concepts into effect, the JCAHO has proposed the following:

Elements of Performance for LD.3.15:

1. The leaders develop a code of conduct that applies to everyone who works in the organization.

2. The code of conduct defines desirable and disruptive behavior.

3. All who work in the organization are educated about both desirable and disruptive behaviors.

4. The leaders develop processes for managing disruptive behavior.

5. Leaders identify the roles of individual leadership groups in managing disruptive behavior.

6. The organized medical staff manages disruptive behavior exhibited by Physician or individuals who are granted clinical privileges.

7. Leaders establish a fair hearing process for those who exhibit disruptive behavior.

The JCAHO proposals are less specific than those recommended by the AMA; nonetheless, they reflect the same principles. As the primary concern is for patient care, all procedures in compliance should be developed, implemented and maintained with that objective in mind with care being taken to strike a balance between over-regimentation of the work environment on the one hand, and a work environment rendered caustic and untenable by the conduct of one or more individuals, on the other.

III. Practical Considerations for You

A. What if you are the difficult Doctor?

The issue of recognizing, confronting and curing the difficult Doctor syndrome is never more daunting than when the difficult Doctor is yourself. As difficult as it may be, however, it is even more important that one be able to recognize in yourself those behavioral habits that may have the effect of compromising the work environment or the Physician-patient relationship.

There are two sources of information:

1. your own manner of thinking with regard to your patients and colleagues

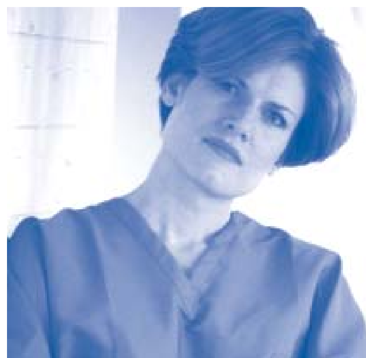
2. the reactions of those around you

Manner of thinking:

Conduct begins as thought, conscious or otherwise. In examining your conduct, your attitude and inner thoughts make a good starting point.

The questions to ask yourself may include the following:

- Is your general attitude characterized to any degree by anger or impatience?



[6] *Rationale for LD.3.15.*

– Do your interactions with staff, colleagues and/or patients involve regular or frequent confrontations?

– Do you view your staff, colleagues or patients as less intelligent or capable (or more intelligent or capable) than you?

– Do you react to the comments or actions of your colleagues, staff or patients with disdain or derision (whether or not you are aware of expressing it)?

– Do you react to the comments or actions of your colleagues, staff or patients with defensiveness (whether or not you are aware of expressing it)?

If you recognize these types of thought patterns, they may be translating into conduct which makes the workplace unpleasant and less productive for those around you, and makes the professional relationship with your patients untenable.

Reactions of other people

The people with whom you come in contact throughout the day – your staff, your colleagues and your patients may serve as something of a mirror in assessing the effects of your conduct. The overt reaction – the staff member who shrinks away after a scolding; the colleague who expresses dismay after a confrontation; a patient who asks to change providers to avoid having to deal with you – may be easy to recognize, particularly if it appears to be part of a consistent pattern of responses by more than one person.The more subtle clues may be more difficult to catch. When you have answered the question of a patient, did the patient respond to your answer with an expression of understanding or a follow-up question that might suggest that the patient feels comfortable discussing the issue with you, or did the patient simply respond with silence? Was your answer to the question designed to provide the patient with information, or was the answer designed, in its substance or its mode of expression, simply to make the patient shut up? Did the answer, in fact, provide the patient with information, or did it simply make the patient shut up.

The same sort of inquiry might be made regarding the Physician's interactions with colleagues and staff members.

An occasional confrontation or awkward conversation may have little or no significance; a pattern of such events or a generalized attitude of this nature may be a signal that you have to investigate your own behavior.

B. When to deal with a disruptive Doctor with whom you share a patient.

The question of when to intervene with a difficult Doctor with whom you might share a patient should probably depend upon the well-being of the patient. If the difficulty is compromising, or potentially compromising the patient's care, then intervention of some sort is appropriate. A patient's care may be compromised in any number of ways. The patient may be failing to get sufficient information from a colleague who evades the patient's questions or fails to pay attention to the patient's inquiries; the patient may avoid asking questions if the response is demeaning or otherwise unpleasant; the colleague's general attitude may be so difficult for the patient that the patient avoids beneficial treatment or therapies. There are undoubtedly as many ways in which such difficulties may become manifest as there are Doctors and patients. If it becomes apparent to you that your mutual patient's health, care or treatment is being potentially or actually compromised by your colleague's attitude, it is time to intervene.

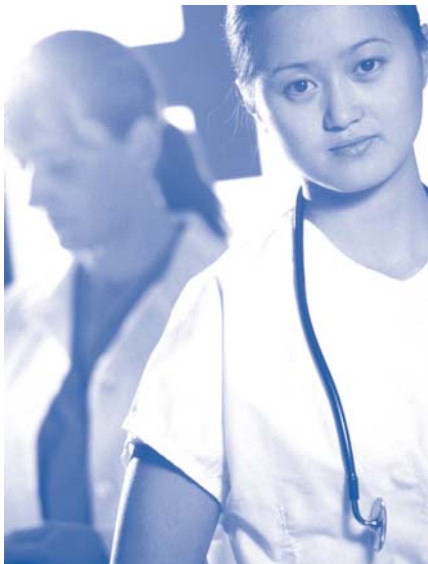
C. How to intervene if you're dealing with a disruptive Doctor.

If the disruptive Doctor is a member of your practice, the first step in dealing with the situation is the development of policies and procedures in accordance with the recommendations of the AMA, above. The second step is to access the appropriate channels pursuant to those policies and procedures.

If those policies have not been put in to place, yet, and the situation requires immediate attention, the method of intervention should follow the most analogous procedures that are in place.

If no analogous procedures are in place, the problem should be brought to the attention of the managing partner of the practice and a means of addressing the problem should be developed which take into account the issues referenced above in AMA H-140.918; E-9.045.

It may be best to avoid a simple one-on-one intervention that may be all too easily dismissed by the subject Physician as a mere personal issue with a single colleague. It may also be advisable to avoid un-witnessed interventions.



Conclusion

The medical profession is one that involves elements of selflessness to no small degree. At its core, it is the act of helping another human being with regard to matters both elemental and profound and under circumstances that may literally be matters of life and death. It is a profession worthy of respect. Its practitioners and its patients, similarly, are deserving of respect. The concern with regard to the disruptive Physician, tied as it is to issues of patient care, is nothing more and nothing less than a matter of respect. This has been recognized by JCAHO in its reference to "respecting other people, regardless of their position in the organization." Similarly, it has been recognized by the American Medical Association in Report 106, which states, "The importance of respect among all health professionals as a means of ensuring good patient care is at the very foundation of the ethic advocated by the American Medical Association. The preamble to the Principles of Medical Ethics included in the Code of Medical Ethics clearly states: 'As a member of this profession, a Physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self.'"

This simple concept should be born in mind by every practitioner. It is at the very heart of recognizing the extent to which one's own or a colleague's behavior may be affecting the ability of others to perform their jobs; it is essential to appreciating one's own role in working with others to provide the most important of services to others, an endeavor which is, indeed, deserving of respect.

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Doctors RX

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CME Evaluation Form

Statement of Educational Purpose

"Doctors RX" is a newsletter sent twice each year to the Insured Physicians of MEDICAL MUTUAL/Professionals Advocate. Its mission and educational purpose is to identify current health care related risk management issues and provide Physicians with educational information that will enable them to reduce their malpractice liability risk.

Readers of the newsletter should be able to obtain the following educational objectives:
1) gain information on topics of particular importance to them as Physicians,
2) assess the newsletter's value to them as practicing Physicians, and
3) assess how this information may influence their own practices.

CME Objectives for "*The Difficult Doctor*"

Educational Objectives: Participants should be able to:
1) Define and recognize the disruptive Physician
2) Develop ways to deal with disruptive Physicians in the health care arena
3) Examine individual habits that could effect patient care

	Strongly Agree				Strongly Disagree
Part I. Educational Value:	5	4	3	2	1
I learned something new that was important.	❑	❑	❑	❑	❑
I verified some important information.	❑	❑	❑	❑	❑
I plan to seek more information on this topic.	❑	❑	❑	❑	❑
This information is likely to have an impact on my practice.	❑	❑	❑	❑	❑

Part 2. Commitment to Change: What change(s) (if any) do you plan to make in your practice as a result of reading this newsletter?

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Part 3. Statement of Completion: I attest to having completed the CME activity.

Signature: ______________________________ Date: ______________________

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CME Test Questions

Instructions for CME Participation

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Instructions—to receive credit, please follow these steps:

1. Read the articles contained in the newsletter and then answer the test questions.
2. Mail or fax your completed answers for grading:

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3. One of our goals is to assess the continuing educational needs of our readers so we may enhance the educational effectiveness of the Doctors RX. To achieve this goal, we need your help. You must complete the CME evaluation form to receive credit.
4. Completion Deadline: September 14, 2007.
5. Upon completion of the test and evaluation form, a certificate of credit will be mailed to you. Please allow three weeks to receive your certificate.

1. "Disruptive" behavior is defined as that behavior that negatively impacts patient care.

   A. True B. False

2. Due Process should not be an issue in dealing with a disruptive physician.

   A. True B. False

3. Colleagues should address only the verbal tirade form of disruptive behavior.

   A. True B. False

4. The goal of the AMA recommendations is to ensure uniformity of conduct.

   A. True B. False

5. Safety and quality thrive in a respectful environment.

   A. True B. False

6. Codes of conduct should be instituted which define appropriate staff behavior.

   A. True B. False

7. It is vitally important that the AMA recommendations be utilized to stifle the care-giver.

   A. True B. False

8. The JCAHO proposals are more specific than those recommended by the AMA.

   A. True B. False

9. A problem closely related to the disruptive Physician is Physician impaired by alcohol or drug abuse.

   A. True B. False

10. The "maverick" Physician may be just as disruptive as the "bully."

    A. True B. False

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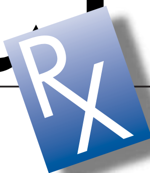

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