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# Disruptive Physicians: How Behavior Can Undermine Patient Safety

Leah Tatebe and Mamta Swaroop

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**Abstract**

Disruptive physician behavior is a pervasive threat to patient safety and a source of emotional and financial hardship on the health care system. It causes increases in medical errors, staff turnover, and risk of litigation. Behavioral problems can be symptoms of underlying issues that must be addressed, such as substance abuse, psychiatric conditions, or burnout. Reporting of disruptive behavior is low, especially by colleagues. Current methods in place in many health care systems do not adequately recognize warning signs or take appropriate corrective actions to limit the effects of disruptive physicians. Changes must be made at a system level to improve rehabilitation of problem physicians.

**Keywords:** disruptive physician, patient safety, physician behavior

## 1. Introduction

Professional physician *competence* is considered "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" [1]. When competence breaks down, a physician may become *impaired* if they have "any physical or mental condition that detrimentally affects or is likely to affect, [the] capacity to practice medicine" [2, 3]. At least 30% of all physicians will be impaired at some point in their career, with about 1–2 per 100 physicians per year being affected. Such impairments create a substantial burden on health care systems. In 2015, the Federation of State Medical Boards (FSMB) issued 7942 state medical board disciplinary actions. Over 4000 physicians were disciplined, with 655 placed on probation, 594 licenses suspended, and 267 licenses revoked [4]. Across multiple studies, it appears that only a subset of impaired physicians, about 3–5% overall, will become *disruptive* [5].

## 2. Clinical vignettes

Attending Vascular Surgeon, Dr. Brown is consulted for a cold leg on an intubated septic patient in the ICU requiring vasopressors. He evaluates the patient and finds a faint Doppler signal. As he is leaving, he brashly complains outside the patient's room to a medical student that the intensivist is a "bumbling idiot who probably couldn't even find his own pulse if he tried. Why am I being asked to waste my time on this? This is why I hate working here. I really should just go to the hospital across town where people aren't so incompetent."

The family in the patient's room overhears his comments and approaches the nurse very concerned if they should ask to have the patient transferred to the other hospital, asking, "If Dr. Brown doesn't trust this place, why should we?"

…

After a long day of rounding, seeing consults, and trying to sift through dispositions, Dr. Smith, the night House Officer, settles in for a brief rest in the call room. Ten minutes after her eyes close, the pager breaks the silence: "Question about medication order for patient in room 5312—Judy RN ext 1234." Cursing under her breath, Dr. Smith stuffs the pager under her pillow and goes back to sleep.

Thirty minutes later, it alarms again: "Second page—Question about patient in 5312—Judy RN ext 1234." Dr. Smith calls back: "What question could you possibly have? Read the orders. I was very clear about what I want."

Judy tries to get her question out, "You ordered ceftriaxone for this patient, but he is allergic to penicillin. Would you like…"

"I would like him to get the drugs I ordered! You want a new order? Nursing communication: Do not call me again!" Dr. Smith hangs up.

Frustrated, Judy goes to her supervisor and is advised: "Dr. Smith gets like that sometimes. It's better not to engage her after 10 pm. Don't give the antibiotic and clarify with a different hospitalist in the morning." Consequently, a patient with a serious infection had a 10-hour delay in the administration of appropriate antibiotics.

…

Interventional Radiologist, Dr. Jones, is performing an embolization for a bleeding ulcer. She calls for the next contrast bolus to be given only to find out there is no more contrast ready to be administered. Angered, she yells at the circulator, Michael: "I drove in here in the middle of the night to save this man's life and now he's going to die because you're not paying attention!" Flustered, Michael initially goes to the wrong cabinet to get more dye. Dr. Jones picks up a bloodied syringe and throws it at the appropriate cabinet. "In there! What the hell? Do I need to do everyone's job around here? It's on you if he dies!"

After having his self-confidence shattered, Michael requests transfer to another department the following morning.

## 3. What constitutes disruptive behavior?

While Dr. Jones clearly demonstrated unacceptable behavior, Dr. Smith's could be deemed a difficult night on call, except for the repetitive nature of the behavior. To the casual observer, Dr. Brown's could be simply expressing frustration; however, the patient's family saw it in a very different light. When does cathartic venting erode into disruptive behavior?

Disruptive physician behavior is defined as that which "interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care" [3, 5]. The FSMB outlines a number of behavioral sentinel events attributed to disruptive physicians (**Table 1**). While an event taken in isolation may only raise an eyebrow, a pattern of such behavior undermines a physician's ability to provide quality patient care.

| Behavioral sentinel events |
| --- |
| Profane or disruptive language |
| Demeaning or intimidating behavior |
| Sexual comments or innuendo |
| Inappropriate touching, sexual or otherwise |
| Racial or ethnic jokes |
| Outbursts of rage or violent behavior |
| Throwing instruments or charts or other objects |
| Inappropriately criticizing health care professionals in front of patients of other staff |
| Boundary violations with staff, patients, surrogates, or key third parties |
| Comments that undermine a patient's trust in a physician or hospital |
| Inappropriate chart notes |
| Unethical or dishonest behavior |
| Difficulty working collaboratively with others |
| Repeated failure to respond to calls |
| Inappropriate arguments with patients, family, staff, and other physicians |
| Resistance to recommended corrective action |
| Poor hygiene, slovenliness |

**Table 1.** Behavioral sentinel events of disruptive physicians from the Federation of State Medical Boards (FSMB) [6].

## 4. The ripple effect of disruptive behavior

Only over the last 20 years has the true effect of disruptive physician behavior begun to be understood. In 2008, a sentinel event alert was issued by the Joint Commission declaring

that "intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments" [7]. **Table 2** highlights a number of these effects [8]. Resident physicians are at increased risk of suffering from mood disorders partly because of high levels of work-place stress and exposure to abusive behaviors [3]. A prospective study of pediatric residents showed that depression was associated with six times the number of medication errors. Self-criticism over an error can lead to a deeper depression, thus worsening the issue [9].

Physician disruptive behavior is more commonly focused on nonphysicians, such as nursing staff [10]. Verbal abuse from a doctor was reported by 64% of nurses as occurring at least once every few months [10]. Members of the care team are less likely to approach disruptive physicians to clarify plans of care or speak up if they feel an error is being made. This may deeply compromise the quality of medicine provided [5, 11, 12]. A 2003 survey of over 2000 health care providers showed that 49% of responders changed the way they approached an order that required clarification because of intimidation. Many either asked a colleague for help or avoided calling the intimidating provider all together. Seven percent reported being involved in a medication error event as a result of intimidation [13]. A 2005 study of nurses cited disruptive behavior as contributing the most to decreased job satisfaction [14]. Approximately 20% of nursing turnover was as a result of abusive behaviors [10]. High nursing turnover rates not only put strain on management but also lead to less continuity of care for patients and situations where nurses are unfamiliar with the practice habits of physician's workflow.

When intimidating or abusive behaviors occur in front of patients, further issues arise. The trust in patient-physician relationship is compromised [15–17], and it has a "corrosive effect on morale" [5]. Not surprisingly, associations have been found between the number of patient complaints filed regarding a doctor and the likelihood of malpractice litigation against said clinician [18]. In the most extreme cases, news agencies pick up stories of inappropriate behaviors, severely tarnishing the reputation of a hospital. All of these reasons contribute to the way disruptive physician behavior can threaten patient safety and undermine quality care.

| Consequences of disruptive behavior |
| --- |
| Decreased morale and self-esteem among staff |
| Poor quality of patient care |
| Increased staff turnover |
| Incomplete and ineffective communication |
| Heightened financial risk and litigation |
| Reduced public image of hospital |
| Unhealthy and dysfunctional work environment |

**Table 2.** Consequences of disruptive behavior on the healthcare system, from Piper et al. [8].

## 5. The tip of the iceberg

Everyone is entitled to have a bad day. There are times when frustration builds, and the breaking point is reached; people lash out and say or do things they otherwise would not normally say or do. An adaptive behavior would then be to have insight and attempt to make amends by apologizing and taking responsibility. Maladaptive behavior exists when such events persist and become pathologic. Disruptive behavior should be considered a manifesta-tion of an underlying issue [5]. The most common include substance abuse, stress, burnout, and depression [3].

Approximately 10% of doctors will struggle with substance abuse at some point in their careers [19]. While often sensationalized, substance abuse is associated with only 10% of disruptive behaviors [10]. High functioning substance abusers will often be able to compartmentalize and keep issues outside of work before spilling into the professional realm [5]. Nevertheless, this needs to remain on the radar when addressing a disruptive physician.

It is no secret the medical field is wrought with high-stress environments. A survey of 700 physicians revealed a 31% incidence of excessive anxiety and a 60% incidence of exhaustion and stress [20]. This can lead to burnout a "pathological syndrome in which emotional deple-tion and maladaptive detachment develop in response to prolonged occupational stress" and is comprised of the constellation of emotional exhaustion, depersonalization, and low sense of personal accomplishment [21]. Burnout is universal across all specialties; physician burn out rates now exceed 50% [22]. The behaviors listed in **Table 1** can be easily tied to indicators of burnout. Disruptive physicians are often less able to cope with these high levels of stress [23].

Mood disorders such as depression and bipolar disorder have the same incidence in physi-cians as the population at large [3]. Some reports cite even higher rates of depression [24] and suicide [25] in physicians. Risk factors for psychiatric morbidity include being a resident physician, of advanced age, female, and having personality traits such as perfectionism, self-criticism, discipline, idealism, and high degrees of empathy [3]. Emotional lability as exhib-ited by disruptive physicians can be related to these underlying conditions.

## 6. Barriers to improvement

Physicians have been long held to a different standard of professional conduct. Often to the highest standard, but also considered untouchable, exempt from the norms because of their place in the hierarchy of medicine [8, 26]. Medical billing is the backbone of health care sys-tems. Hospitals are dependent on the revenue streams created by physicians; this shields phy-sicians such that many otherwise intolerable behaviors have been overlooked. In addition, particularly high-producing service lines subscribe to the "squeaky wheel" phenomenon. Through attempts to placate disruptive yet valuable physicians, inappropriate behaviors can result in changes in allocation of resources [10]. A survey of physician executives revealed that nearly 40% felt that "physicians who generate high amounts of revenue are treated more

leniently when it comes to behavior problems than those who bring in less revenue" [27]. This behavior can further be propagated through the hidden curriculum of attending physicians to residents [28].

Lesser infractions and herald events are often overlooked [5]. Part of the delay is due to the lack of objective evidence to an often subjective problem [8]. Many situations can be spun to favor one side or the other. When there is a hierarchical difference in physician-nursing confrontations, this becomes even more difficult. Despite that over half of physicians are witness to disruptive behavior in colleagues [29], peer reporting rates remain low. Reporting is more common for gambling and substance abuse than for emotional outbursts [30]. Colleagues who witness disruptive behavior may have concerns about being stigmatized themselves if they report the issue, or they may be conflicted over protecting the privacy of the impaired individual. They may fear social, financial, or legal repercussions [3]. This is especially true when the physician in question is a partner or part of the referral base [5]. When disagreements do surface between physicians, tensions escalate with egos preventing either party from backing down. As high-functioning individuals working in stressful environments, physicians are prone to denial and/or to attempt management of the situation on their own, which may lead to further disruptive behaviors [3].

## 7. Corrective actions

In a system where physicians were all independent practitioners, little oversight existed outside of hospital credentialing committees and state licensing boards. As the landscape of health care transitions physicians into employees of conglomerate medical groups, more managerial roles to address practice-based issues including disruptive behavior are being created. Hospitals have been mandated for some time to have systems in place to maintain credentialing and disciplinary actions, but receive little guidance on how to do so [5].

The Joint Commission actively pushed to remedy this over the last decade [7, 31, 32]. **Table 3** outlines basic recommendations for a framework on how to build policy for managing disruptive behavior. First, there must be a clear understanding of performance standards from not only the standpoint of practicing medicine, but also professionalism [15, 16, 33]. Health care systems are leading the way in developing said standards and are mandating new hires agree to comply otherwise be subject to remediation, disciplinary action, or termination. Being upfront with expectations and holding firm to a zero-tolerance policy for unprofessional behavior is essential to objectifying this difficult issue [11, 34].

Commitment to professionalism must come from all levels of the health care system hierarchy [35, 36]. In 2011, the American College of Physician Executives conducted a survey of members regarding the prevalence, impact, and management of disruptive behaviors. Only 17% of male and 11% of female physician executives strongly agreed that they were "well prepared to deal with disruptive behavior," and 61% of respondents wanted more training in confronting disruptive behavior [37]. The medical field cannot hope to make strides in correcting behavioral issues without providing those asked to intervene with the tools to do so.

| Managing disruptive behavior |
| --- |
| Making expectations explicit by having a code of conduct supported by appropriate policies |
| Ensuring robust board support for clinical leaders in implementation |
| Support and training for those dealing with disruptive and intimidating behaviors |
| Screening for health and personal issues |
| Proactive surveillance systems |
| Dealing consistently and transparently with infringements |
| Dealing with lower level aberrant behavior early |
| Having graded set of responses (informal, formal, disciplinary, regulatory) depending on the severity of the incident |
| Making resources available to help those displaying and those affected by disruptive and intimidating behavior |

**Table 3.** Joint Commission recommendations on managing disruptive behavior [31].

Much debate remains over the appropriate way to screen for health and personal issues among physicians. Letters of reference have been shown to not be a reliable way to identify potential problem physicians [38], likely an effect of selection bias. There was significant interest in utilizing emotional intelligence scores during residency interviews as a predictor for future success; however, studies have shown mixed results [39–41]. Further research into this area is needed.

Proactive preparation and screening alone cannot correct behavioral issues. Minor deviations from appropriate behavior must be recognized and intervened upon to prevent escalation [18, 42]. Anonymity of reporting parties must be assured to reduce the fear of retaliation [43]. However, there also must be a commitment, from all members of the treatment team, to quality patient care. Physicians who are reluctant to report disruptive events should remember that "failure to ensure the quality and safety of the performance of colleagues is a breach of medicine's fiduciary responsibility to the public" [5]. Health care systems should "promote willingness to confront disruptive coworkers and subordinates in a nonthreatening and beneficent manner" [3]. A formal evaluation process annually to ensure competence and compliance to standards is strongly recommended [5, 31]. Others have suggested using Root Cause Analysis to help tease out when the physician's frustrations are justified, but perhaps, the resulting behavior is not [44]. However, several court cases have held up hospitals' right to deny or revoke the credentials of a physician because of disruptive behavior, even if it did not directly cause patient harm [45, 46].

**Figure 1** illustrates a graded response to levels of disruptive behavior. Lesser events can be managed internally to guide the physician back to professional standards. Escalation occurs with the severity of the disruption [17]. Several Continuing Medical Education courses have been developed to facilitate remediation of disruptive physicians [42, 47, 48]. This can include communication skills training to improve the physician-nurse working relationship [49]. Others explore comprehensive assessments and "fitness-for-duty" evaluations to determine if remediation has been achieved [50, 51]. Additionally, the stigma of mental health must be
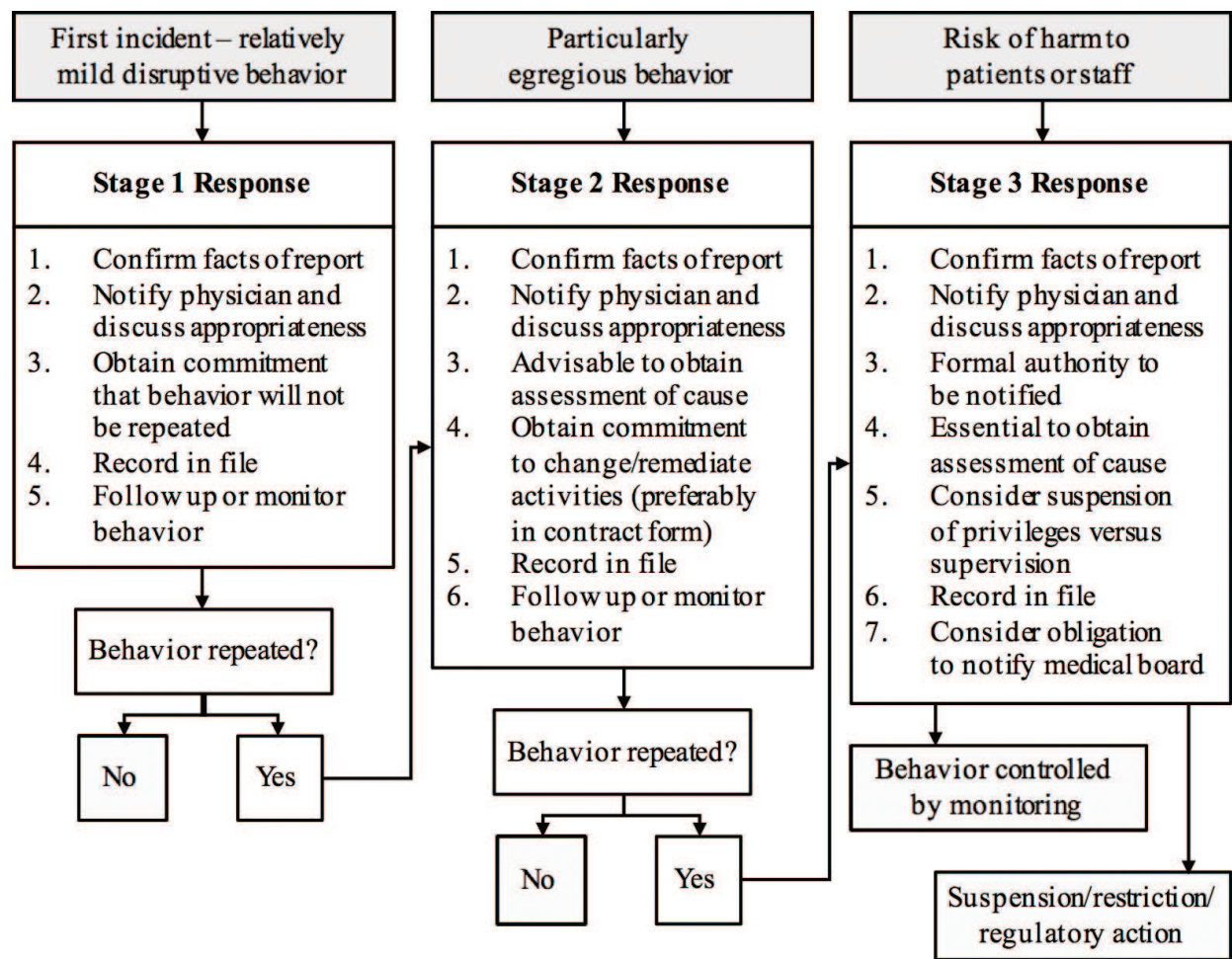
**Figure 1.** Behavior management flowchart, adapted from College of Physicians and Surgeons of Ontario [53].

eliminated and utilization of supportive resources encouraged, including stress management education, and counseling [3]. In response to a survey demonstrating a limited capacity by state medical boards to act as there is a lack of standards of behavior, the FSMB Essentials published a mandate in 2015 stating disciplinary action may be taken on physicians who exhibit "disruptive behavior and/or interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient" [6, 52].

# 8. Conclusions

Disruptive physicians pose a substantial threat to patient safety that is often unrecognized or unsatisfactorily addressed in hospitals and other health care organizations [5]. It is a universal concern that is pervasive throughout medicine. Early warning signs need to be recognized, and "the most effective surveillance tools for detecting unprofessional behavior are the eyes and ears of patients, visitors, and health care team members" [54]. Attention must be paid

to mitigating risk factors for deviant behavior and breaking down barriers for those seeking assistance. The current reactionary system appears only aware of the most egregious behaviors and should be set aside for a regular monitoring system with set standards of professionalism [5]. Through a comprehensive policy of appropriate expectations, zero-tolerance policy for nonadherence, and utilization of rehabilitation techniques, the negative effects of disruptive physician behavior on patient safety can be corrected.

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