Dealing with the “Disruptive” Physician Colleague
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This is the 32nd in a series of case studies with commentaries by ACP's Ethics, Professionalism and Human Rights Committee and the Center for Ethics and Professionalism. The series uses hypothetical examples to elaborate on controversial or subtle aspects of issues not addressed in detail in the College's Ethics Manual, the Physician Charter on Professionalism, or other College position statements. The fifth edition of the ACP Ethics Manual, the Professionalism Charter, and additional College policy on ethics, professionalism, and human rights issues are available at http://www.acponline.org/ethics/ethics_man.htm or by contacting the Center for Ethics and Professionalism at 215/351-2839.

Case history

William Smith, MD, a respected internist and nephrologist, is on the staff of a multi-specialty group practice affiliated with a medical school. He sees patients, teaches, and conducts research on hypertension.

Late one afternoon, Dr. Smith sees an established patient. The patient is a 51-year-old male executive who has struggled with obesity, hypertension, and type 2 diabetes mellitus. The patient does not have diabetic retinopathy or neuropathy, but does have nephropathy. His most recent serum creatinine was 1.8 mg/dL and hemoglobin A1C 7.9%. Because the patient previously reported some exertion-associated chest pain, Dr. Smith had him undergo an exercise treadmill study and consult with a cardiologist. The patient now returns to Dr. Smith for review of the treadmill test and consultation.

The patient appears upset. In response to Dr. Smith’s question, “Are you upset?” the patient exclaims, “I have never been as degraded as I was by the cardiologist. Without saying ‘Hello,’ he said that obesity was the cause of my problems and that people like me would save him a lot of time if we’d only lose weight. Needless to say, I was mortified and promptly left.” Dr. Smith notes that the patient’s treadmill study was diagnostic for ischemia and that the patient would likely need a coronary angiogram.

The patient was referring to Dr. White, a professor of medicine. Dr. White is an expert on ischemic heart disease and has published hundreds of papers. Because of his prodigious and successful research career, Dr. White has brought fame and millions of dollars of research grants to the institution.

On campus, however, Dr. White is known for treating physician colleagues and especially, nurses, administrators, and others, poorly. He berates trainees, calling them “stupid” or other pejorative terms in front of other colleagues and trainees, and even patients. He advocates that physicians should “Tell patients like it is” about diagnoses, treatment plans and prognoses without concern for empathy. Notably, some of Dr.
White’s former and current trainees have adopted some of his behaviors. Many physicians, allied health colleagues, and trainees avoid Dr. White. The institution’s patient affairs office receives a steady stream of complaints about Dr. White. But colleagues have not often formally complained.

Other patients of Dr. Smith have had bad experiences with Dr. White, returning in tears from a consultation. Colleagues have similar stories, with a common thread: despite Dr. White’s reputation as an expert in heart disease, his bedside manner frequently results in unhappy patients.

Dr. Smith is frustrated that Dr. White’s disruptive behavior results in poor patient care and wasted time. He calms his patient, explains the results of the treadmill study, and arranges for a consultation with a different cardiologist. After taking care of his patient and leaving his office late, Dr. Smith wonders what to do next.

Commentary

At the 1910 Rush College of Medicine commencement, speaker Dr. William J. Mayo noted, “As we grow in learning, we more justly appreciate our dependence upon each other. The sum-total of medical knowledge is now so great and wide-spreading that it would be futile for one man to attempt to acquire, or for one man to assume that he has, even a good working knowledge of any large part of the whole. The very necessities of the case are driving practitioners into cooperation. The best interest of the patient is the only interest to be considered, and in order that the sick may benefit of advancing knowledge, union of forces is necessary.”

At a time of rapidly expanding medical knowledge, Dr. Mayo recognized that no physician could function autonomously. Today, the need for cooperation in healthcare is especially relevant. To meet the best interests of patients, physicians must cooperate with each other and other members of multi-disciplinary teams. The conduct of physicians as professionals— and as individuals— should merit the respect of the community.

Unfortunately, disruptive physicians like Dr. White interfere with these goals.

Definition of the “disruptive physician”

Patients identify being confident, empathetic, humane, personal (i.e., viewing the patient as a person, not a disease), forthright, respectful, and thorough as ideal physician behaviors. Valuing teamwork, handling stress, punctuality, and self-motivation to pursue professional and personal growth are also ideal physician behaviors.

On the other hand, the American Medical Association, in its Code of Medical Ethics, states that “personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive [physician] behavior.” Such behaviors include inappropriate language, yelling, gossip, facial expressions and other mannerisms as well as physical boundary violations. Depending
on the scope of their activities, disruptive physicians can also negatively affect learning\(^6\) and other work (eg, research) environments.\(^7\)

**Prevalence of disruptive physician behaviors**

In a survey\(^8\) of 1,627 physician executives, 95.7% reported regularly encountering disruptive physician behavior, and 70.3% said disruptive behaviors nearly always involved the same physician(s). Common disruptive behaviors were disrespect, refusal to complete tasks and carry out duties, yelling, insults, and physical abuse (including throwing items). A majority (56.5%) reported that disruptive physician behaviors most often involve conflict with a nurse or other allied healthcare staff. Other respondents said disruptive behaviors most often involved other physicians (14.7%), administrators (14.5%), and patients (14.2%). Notably, nearly 80% of the respondents said disruptive physician behavior is under-reported because of victim fear of reprisal or is only reported when a serious violation occurs.

A recent survey\(^9\) at 50 Veteran’s Administration hospitals found that 86% of 675 nurses have witnessed disruptive physician behavior. Other surveys\(^10\)\(^11\) have found that more than 90% of nurses experienced verbal abuse within the last year. Physician abuse of pharmacists\(^12\) and learners (eg, medical students) is also common.\(^13\)

Disruptive physician behaviors do not necessarily result in patient complaints to disciplinary boards. However, patient complaints to disciplinary boards are frequently due to disruptive physician behaviors. For example, a survey of patient complainants to the New South Wales (Australia) Health care Complaints Commission found that 36% of the complaints were due to rudeness or poor communication, and unethical or improper behavior.\(^14\)

**Consequences of disruptive physician behavior**

Disruptive physicians undermine morale, diminish productivity and quality of patient care, and cause work environment distress leading to heightened employee turnover.\(^6\)\(^7\) One survey\(^15\) found that most nurses believe physician disruptive behavior causes stress, frustration, impaired concentration, reduced collaboration and communication, and potentially negative patient outcomes. Another survey\(^16\) found that nurses see a direct link between physician disruptive behavior and nurse satisfaction, retention, and the quality of the nurse-physician relationship. Other consequences of disruptive physician behavior include disciplinary actions, dysfunctional physician colleague activities (eg, coverage, leadership, peer review, referral, etc), and compromised communication within and efficiency of healthcare teams.\(^17\)

Many physicians engage in teaching activities. Attending physicians should treat learners with respect, empathy, and compassion and should role model virtues.\(^2\) Abusive treatment, like that of Dr. White, and role model pessimism lead to learner dissatisfaction, burnout, depression and unprofessional behaviors.\(^6\)\(^18\) In fact, abuse of medical students is common and the main sources of the abuse are physicians.
Furthermore, compared to non-abused students, abused students experience more difficulty learning, anxiety, depression, and alcohol use.13

The disruptive physician and the Charter on Medical Professionalism

The Physician Charter on Medical Professionalism is comprised of 3 fundamental principles—the primacy of patient welfare, respect for patient autonomy, and social justice—and 10 professional responsibilities (Table).19 The disruptive physician probably violates many of these principles and responsibilities. Certainly patient welfare is affected and respect for patient autonomy, which requires discerning and acknowledging patient healthcare values and goals, is violated. Disruptive physicians are less likely to acknowledge these values and goals. They may also violate the principle of social justice by wasting scarce healthcare resources, diminishing productivity and heightening turnover of allied healthcare staff. Indeed, unnecessary staff turnover caused by disruptive physicians can cost institutions hundreds of thousands of dollars.7

And while physicians like Dr. White may be knowledgeable and skilled, they do not demonstrate “professional competence,” which, according to the Association of American Medical Colleges includes being altruistic and dutiful and to the Accreditation Council for Graduate Medical Education includes possessing effective interpersonal and communication skills and professionalism.20

Another physician responsibility in the Charter is honesty with patients. Physicians should ensure that patients are adequately informed of their diagnoses, the risks and benefits of and alternatives to treatments, and their prognoses. Being honest with patients, however, does not mean that physicians should bludgeon patients with information (eg, sad, bad or unexpected news). Such behavior is disruptive. Instead, physicians should convey information to patients with compassion and empathy and endeavor to meet patients’ informational, emotional, and spiritual needs.2

Disruptive physicians like Dr. White violate the commitment to maintaining appropriate relations with patients. Patients are inherently vulnerable and dependent on physicians and other healthcare providers. Patients must be confident that their needs, not the physician’s, will take priority. Physicians who violate sexual and financial boundaries with patients are obviously disruptive. In some ways, it is easier to deal with these behaviors through suspension or termination processes.8 But physicians who are abrupt and rude when interacting with patients are also disruptive.

Many disruptive physicians violate the Charter commitment to improving quality of care, which involves maintaining clinical competence and working collaboratively with colleagues and others to maximize patient outcomes and minimize waste of healthcare resources. Patients cared for by disruptive physicians with poor communication skills may not derive benefit from efforts to improve the quality of care since poor communication is associated with less adherence with treatment plans and worse medical outcomes. On the contrary, professionalism is associated with increased patient
satisfaction and trust, adherence with treatments, greater likelihood a patient will “stay with” and recommend a physician, fewer patient complaints, and less patient litigation.21

Disruptive physicians violate the commitments to improving access to care and a just distribution of finite resources. Disruptive physicians waste patient time, effort and financial resources (eg, patients seek consultation with other physicians after encountering the disruptive physician). Disruptive physicians waste colleague time, effort, and resources (eg, when the colleagues must see frustrated patients originally seen by the disruptive physician). Disruptive physicians waste institutional resources (eg, dealing with low morale and high turnover of nurses and allied healthcare employees).

Finally, the results of the surveys discussed here reveal that disruptive physicians commonly violate the commitment to professional responsibilities. The ACP Ethics Manual states, “Physicians share their commitment to care for ill persons with a broad team of health professionals. The team’s ability to care effectively for the patient depends on the ability of individual persons to treat each other with integrity, honesty, and respect...Particular attention is warranted with regard to certain types of relationships and power imbalances that could be abusive or lead to harassment, such as those between attending physician and resident, resident and medical student, or physician and nurse.”2 Institutions also violate this commitment if they fail to identify and address disruptive physician behavior. Many institutions have adopted policies for acceptable physician behavior and established disciplinary procedures for physicians who breach these policies.8 In addition, the Joint Commission on Accreditation of Healthcare Organizations requires that institutions have a mechanism for handling physician health and behavior problems apart from the medical staff disciplinary process 22 and is considering a patient safety goal, “Discourage Disruptive Behavior” as a leadership standard to apply to all hospital staff.

Identifying and addressing disruptive physicians like Dr. White

Disruptive physicians are not usually difficult to identify since disruptive behaviors nearly always involve the same physician(s).8 23 A major reason for identifying and addressing disruptive physicians is to prevent adverse patient care and work environment outcomes. Indeed, the American Medical Association Code of Medical Ethics states that physicians and healthcare institutions have duties to identify and address “physicians deficient in character or competence.”5 Institutions affiliated with medical schools and other teaching programs should identify negative physician role models and sharply deal with abusive behavior.18 Additional reasons for identifying disruptive physicians are to address underlying causes for the behavior (eg, mental illness, substance abuse, etc) and to change learned attitudes and behaviors.23 In fact, evidence suggests that formal and informal curricula can change—for the better—disruptive attitudes and behaviors.21

On the other hand, physicians should not disparage the professional competence, knowledge, qualifications, or services of another physician without substantial evidence.2 And while physicians have a duty to promote standards of professionalism, they should
also avoid labeling “whistleblowers” and physicians with unique personality traits as “disruptive.”

Disruptive physicians can be identified by a number of means including patient complaints and surveys, peer assessments, and anonymous 360-degree reviews (eg, by nurses, allied health employees, learners, etc). Primary care and referring physicians should encourage patients to report back to them experiences with physicians—especially disruptive physicians—to whom they are referred.

Institutions should develop and implement formal processes for reporting disruptive physician behaviors. Clear descriptions of the disruptive behaviors (eg, date, time, parties involved, quotes, outcomes, etc) should be documented and reported to appropriate institutional leaders. Institutional policies should ensure that reporting disruptive physicians will not result in retaliation.

Institutions should be clear that disruptive behavior is unacceptable and develop formal processes for handling disruptive physicians. Policies should be applied fairly. For example, a physician may manifest disruptive behavior that for him or her is rare. Such physicians are likely to respond to timely feedback from colleagues. If disruptive behaviors persist, then the disruptive physician should be reported to institutional physician leaders.

One model for giving corrective feedback effectively includes preparing the disruptive physician for the feedback session (eg, informing the physician ahead of time, setting a date and time, providing a private and respectful atmosphere, and negotiating an agenda). At the meeting, the physician should be asked for a self-assessment of their behaviors and interactions with patients, colleagues, and others. Observations of specific disruptive behaviors (and why the behaviors are disruptive) should then be shared with the physician. Strategies for improvement should be elicited from and suggested to the disruptive physician. If necessary, the disruptive physician should be offered help (eg, counseling, communication training, etc). A shared plan for improvement should be developed and implemented. Expected improvements in behaviors, monitoring, and consequences of not improving (eg, disciplinary actions) should be clearly articulated.

Emotional responses (eg, anger, defensiveness, etc) to corrective feedback from disruptive physicians should be anticipated. Nevertheless, genuine concern for the disruptive physician should be demonstrated as appropriate. Physicians are first and foremost advocates for their patients. But they should also be advocates for their peers.
Table: Charter on Professionalism

Fundamental principles
1. Principle of primacy of patient welfare
2. Principle of patient autonomy
3. Principle of social justice

Professional Responsibilities
1. Commitment to professional competence
2. Commitment to honesty with patients
3. Commitment to patient confidentiality
4. Commitment to maintaining appropriate relations with patients
5. Commitment to improving quality of care
6. Commitment to improving access to care
7. Commitment to a just distribution of finite resources
8. Commitment to scientific knowledge
9. Commitment to maintaining trust by managing conflicts of interests
10. Commitment to professional responsibilities
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1 Mayo WJ. The necessity of cooperation in the practice of medicine. Commencement address, Rush Medical College (June 15, 1910).
4 Fabri PJ. Beyond competence: the case for emotional intelligence. Available at: http://www.ama-assn.org/ama1/pub/upload/mm/44/a-06pdfpresnt1.pdf
20 Accreditation Council for Graduate Medical Education. Outcome project: General competencies (1999).
22 Joint Commission on Accreditation of Healthcare Organizations Medical Staff Standard, Physician Health, MS 4.8