9.4.4 Physicians with Disruptive Behavior

The importance of respect among all health professionals as a means of ensuring good patient care is foundational to ethics. Physicians have a responsibility to address situations in which individual physicians behave disruptively, that is, speak or act in ways that may negatively affect patient care, including conduct that interferes with the individual's ability to work with other members of the health care team, or for others to work with the physician.

Disruptive behavior is different from criticism offered in good faith with the aim of improving patient care and from collective action on the part of physicians. Physicians must not submit false or malicious reports of disruptive behavior.

Physicians who have leadership roles in a health care institution must be sensitive to the unintended effects institutional structures, policies, and practices may have on patient care and professional staff.

As members of the medical staff, physicians should develop and adopt policies or bylaw provisions that:

(a) Establish a body authorized to receive, review, and act on reports of disruptive behavior, such as a medical staff wellness committee. Members must be required to disclose relevant conflicts of interest and to recuse themselves from any hearing in which they have a conflict.

(b) Establish procedural safeguards that protect due process.

(c) Clearly state principal objectives in terms that ensure high standards of patient care, and promote a professional practice and work environment.

(d) Clearly describe the behaviors or types of behavior that will prompt intervention.

(e) Provide a channel for reporting and appropriately recording instances of disruptive behavior. A single incident may not warrant action, but individual reports may help identify a pattern that requires intervention.

(f) Establish a process to review or verify reports of disruptive behavior.

(g) Establish a process to notify a physician that his or her behavior has been reported as disruptive, and provide opportunity for the physician to respond to the report.

(h) Provide for monitoring and assessing whether a physician's disruptive conduct improves after intervention.

(i) Provide for evaluative and corrective actions that are commensurate with the behavior, such as self-correction and structured rehabilitation. Suspending the individual's responsibilities or privileges should be a mechanism of final resort.

(j) Identify who will be involved in the various stages of the process, from reviewing reports to notifying physicians and monitoring conduct after intervention.

(k) Provide clear guidelines for protecting confidentiality.

(l) Ensure that individuals who report instances of disruptive behavior are appropriately protected.

AMA Principles of Medical Ethics: I, II, VIII

Background report(s):

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*
CEJA Report 2-A-00 Physicians with disruptive behavior

9.4.4 Physicians with Disruptive Behavior

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Physicians who have leadership roles in a health care institution must be sensitive to the unintended effects institutional structures, policies, and practices may have on patient care and professional staff. [*new content addresses gap in current guidance*]

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AMA Principles of Medical Ethics: I, II, VIII

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 2-A-00

Subject: Physicians With Disruptive Behavior [1]

Presented by: Herbert Rakatansky, MD, Chair

Presented to: Reference Committee on Amendments to Constitution and Bylaws (Jimmie A. Gleason, MD, Chair)

Introduction

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

Provisions of the Code that refer to behavior

The importance of respect among all health professionals as a means of ensuring good patient care is at the very foundation of the ethics 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" (emphasis added). Many of the seven Principles at least indirectly address various aspects of this notion of professional responsibility. Principle II refers to honest dealings among colleagues and adds an obligation to expose "physicians deficient in character or competence." Principle IV requires physicians to respect the rights of colleagues and other health professionals, in addition to those of patients. Principle V partly refers to the obligation to make relevant information available to colleagues, as well as to obtain consultation and use talents of other health professionals when indicated. Together, these brief statements clearly depict medical care as an endeavor built on collegiality and the mutual respect of all those involved in patient care.

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

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

Defining "disruptive behavior"

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

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

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

Intervention

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

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

Elements of a Policy on Disruptive Behavior

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

disruptive behavior or categories of disruptive behavior that will trigger intervention. They should provide 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. Policies should establish a clear review or verification process. They also should establish a process to notify a disruptive physician that a report has been made, and provide the physician with an opportunity to respond to the report. Furthermore, they should include means of monitoring whether a disruptive physician's conduct improves. Proposed corrective actions should be commensurate with the behavior. Policies, therefore, should allow for self-correction, as well as structured rehabilitation. Institutions should consider whether the reporting requirements of Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues" apply in particular cases. Suspension of responsibilities or privileges should be a mechanism of final resort if the behavior persists despite attempts to intervene. In addition, policies should establish which individuals will be involved in the various stages of the process (from reviewing reports to notifying physicians and monitoring conduct after intervention), and should provide guidelines for confidentiality. Finally, policies should ensure that individuals who report disruptive physicians are duly protected.

Conclusion

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

Recommendations

For the foregoing reasons, the Council recommends that the following be adopted and that the remainder of this report be filed:

This report is limited to the conduct of individual physicians and does not refer to physicians acting as a collective, which is considered separately in Opinion 9.025, "Collective Action and Patient Advocacy."

(1) 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) 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.

(3) 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. Additionally, institutions should consider whether the reporting requirements of Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues" apply in particular cases.

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

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

(j) Ensuring that individuals who report disruptive physicians are duly protected.

REFERENCES

[1] In developing this report, the Council contacted the AMA's Governing Councils of the Resident and Fellow Section and the Organized Medical Staff Section, as well as the American Psychiatric Association, the Federation of Medical State Boards, and the American College of Legal Medicine.
[2] Benzer DG, Miller MM. The Disruptive – Abusive Physician: A New Look at an Old Problem. Wisconsin Med J. 1995;94:455-459.
[3] Lang DA. The Disabled Physician: Problem Solving Strategies for the Medical Staff. AHA, Chicago, Ill., 1989.
[4] Pfifferling J-H. Managing the Unmanageable: The Disruptive Physician. Family Practice Management. 1997; Nov/Dec:77-92.