



Handling Distressed Physician Behavior

Medical staff leaders increasingly are calling upon the Tennessee Medical Foundation Physician's Health Program (TMF PHP) to assist them with colleagues who have behavioral problems. These "distressed physicians" can present quite a challenge to all parties who must interact with them in the workplace.

Therefore, the TMF PHP has drafted this document to provide information on how best to identify and deal with physicians who are behaviorally distressed. The TMF designed this document to be used by hospital chiefs of staff, administrators, and medical staff service coordinators. It also may be adapted for use in a medical group setting as well as for other settings.

Who or what is a distressed physician?

Since the decision of Darling v. Charleston Memorial Hospital, where the court decided that hospitals and their governing bodies were more than realtors in providing space for independent contractors (physicians) to practice their art and were responsible to patients for the competence and continued supervision of physicians granted medical staff privileges (corporate liability), hospitals have effectively devised bylaws, policies and procedures to address physicians impaired by reason of physical or mental illness, including drug and alcohol abuse.

In recent years, there has been a marked increase in the rather amorphous category of "distressed" or "behaviorally handicapped" physician. Some possible causes for this increase have been theorized:

- The empowerment of groups that previously suffered this behavior in silence, certain that any complaint would be ignored or result in retribution. Many companies now, at the insistence of their insurance carriers, require "sensitivity training" that describes unacceptable behavior and instructs employees on the channels available to voice their grievances.
- Physicians who perceived themselves as independent entrepreneurs now find themselves subject to scrutiny and control by multiple parties. These fearful, frustrated, angry physicians may act out more frequently than before in the work place.
- Rapid changes in the health care delivery system have stressed many physicians.
- Many physicians have grown up in an abusive environment. In medical school they may have been the object of physical, verbal and mental abuse. This behavior by their teachers and mentors may have left an imprint on them. Not only was this behavior previously tolerated but it was seen as a mark of the abuser's position and genius.

- Medical training has emphasized intellectual capacity at the expense of fostering and teaching interpersonal skills.

There are times when a physician's conduct is so distressing to the operation of the hospital or the medical staff review process that the value of the physician's clinical work is outweighed by the negative impact of his or her behavior. Such unacceptable behavior can take many forms, including tirades in the operating room, abusive treatment of patients/employees, sexual harassment, or the disruption of meetings. In any case, TMF recommends using the less pejorative and more accurate phrase "distressed behavior" instead of "distressed physician" when medical staffs begin to confront the problem.

It is difficult to precisely define "distressed behavior," but it encompasses **a chronic pattern of contentious, threatening, intractable, litigious behavior that deviates significantly from the cultural norm of the peer group, creating an atmosphere that interferes with the efficient functioning of the health care staff and the institution.** The use of the word "chronic" in this definition implies a habitual pattern of behavior as opposed to the rare or occasional outburst on the part of the acutely fatigued or stressed physician, which is usually recognized even by the offending physician as exaggerated and inappropriate.

- The distressed physician often lacks the ability of self-observation:
- They view themselves as clinically superior (and they often are).
- They view other members of the health care team as less competent or incompetent weak and vulnerable.
- They view themselves as champions for their patients (view often shared by patients).
- Their distressed behaviors are used either consciously or subconsciously to intimidate, control and blame others (for bad results). They are unable to perceive that the victims feel harassed, manipulated, controlled and abused.
- They feel misunderstood and the object of envy and jealousy by others when confronted.

Their actions cause:

- A decrease in morale.
- Increase in the level of workplace stress.
- Inordinate time spent by staff appeasing or avoiding them.
- Increased risk for errors - communication breakdown that can result in delays and mistakes in making and implementing critical medical decisions.
- Increased potential for malpractice litigation.

Distressed conduct is more than unusual or unorthodox behavior. It typically involves a pattern of behavior characterized by one or more of the following actions:

1. Inappropriate anger or resentment

- Intimidation
- Abusive language
- Demeaning other staff
- Blaming or shaming others for possible adverse outcomes
- Unnecessary sarcasm or cynicism
- Threats of violence, retribution or litigation

2. Inappropriate words or actions directed toward another person

- Sexual comments, jokes or innuendo
- Flirtation, sexual harassment
- Seductive, aggressive or assaultive behavior
- Racial, ethnic or socioeconomic bias or slurs
- Lack of regard for personal comfort and dignity of others

3. Inappropriate responses to patient needs or staff requests

- Uncooperative, defiant, rigid, inflexible
- Avoidant, unreliable
- Late or unsuitable replies to pages and calls or exaggerated response
- Unprofessional demeanor or conduct
- Arrogant, disrespectful
- Inadequate communication in quantity, quality and promptness
- Recurrent conflict with others, particularly authority figures; irrational, oppositional

Some specific examples include:

- Employs threatening or abusive language directed at nurses, hospital personnel, or other physicians (e.g. belittling, berating, and/or threatening). These attacks usually are personal, irrelevant, and go beyond the bounds of fair professional comment.
- Makes degrading or demeaning comments regarding patients, families, nurses, physicians, hospital personnel, or the hospital. The physician's non-constructive criticism often works to intimidate, undermine confidence, belittle, or imply stupidity or incompetence in his or her victims.
- Uses profanity or other grossly offensive language while in a professional setting. Refuses to accept medical staff assignments or participate in committee or departmental affairs on anything but his or her own terms.
- Utilizes threatening or intimidating physical contact.
- Makes public derogatory comments about the quality of care being provided by other physicians, nursing personnel, or the hospital.
- Writes inappropriate medical records entries concerning the quality of care being provided by the hospital or any other individual. (One may find illustrations in patient medical records, or other official documents. These

- communications are designed to impugn the quality of care in the hospital or attack particular physicians, nurses.)
- Imposes idiosyncratic requirements on ancillary staff which have nothing to do with better patient care, but serve only to burden staff with "special" techniques and procedures.

Note that we are talking about a pattern of behavior that may or may not overlap a psychiatric diagnosis and/or other impairment such as chemical dependence, major depression or personality disorder. The presence or absence of a diagnosis is important for many reasons, including the ability of the TMF PHP to help. The presence of a pattern is also very important. The TMF PHP usually does not (and generally should not) receive referrals for an isolated incident or very minor instances of distressed behavior.

A hospital is an especially stressful working environment, so outbursts or other misconduct that probably would not be tolerated elsewhere are often excused. If an isolated outburst is followed by an apology, there is most likely not a longer-term problem. There are clearly limits to tolerance, however. When a physician's conduct disrupts the operation of the hospital, affects the ability of others to get their jobs done, creates a "hostile work environment" for hospital employees or other physicians on the medical staff, or begins to interfere with the physician's own ability to practice competently, action must be taken.

Common Causes of Distressed Behavior

Chemical dependence: Hidden or occult substance abuse may cause significant distress and dysphoria and present as distressed behavior. If the chemical dependence is treated and the individual is subsequently involved in ongoing therapy, their entire personality can improve. However, sometimes substance use or abuse is just a coincident problem and not the cause of the distressed behavior.

Medical problem(s): While medical problems are not usually the cause of distressed behavior, other PHPs around the country have encountered poorly controlled diabetes, Cushings disease, and undiagnosed CNS tumors causing personality and behavior changes. If medical problems are a factor, there will often be an acute change in behavior or personality. Sleep deprivation/fatigue: This is usually due either to the consequences of the behavior (e.g. threatened loss of privileges, etc.), or related to overwork and other self-care issues. In other words, sleep problems are more of a symptom than a cause.

Adjustment disorder: Marital, financial, family, legal and other stresses are often found in conjunction with distressed behavior. Personal stress tends to exaggerate pre-existing personality traits, and it's typically not the healthy traits that blossom! Physicians referred to TMF PHP for distressed behavior often will minimize underlying stress, or say they have "already dealt with it." Unfortunately, life has a way of presenting new and recurrent stresses, and the development of healthy coping skills is necessary.

Personality disorder (or traits): The American Psychiatric Association's Diagnostic and Statistical Manual – Fourth Edition (DSM-IV) defines a personality disorder as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture" manifested in the person's cognition, emotional response, interpersonal relations and/or impulse control. Personality traits are those noticeable characteristics that do not rise to the level of a personality disorder. Obviously, we all have some pathological personality traits, and the line between "healthy" and "unhealthy" is often fuzzy.

The DSM lists 10 distinct personality disorders. The ones most commonly associated with distressed behavior are:

- Obsessive-Compulsive
- Narcissistic
- Borderline
- Schizoid
- Paranoid
- Antisocial

The two most frequently encountered are Obsessive-Compulsive and Narcissistic.

Obsessive-Compulsive (O-C): It can be very difficult to agree on what is acceptable vs. unacceptable behavior. At one end of the spectrum is the individual who is extremely rigid, domineering, stubborn, and so focused on getting the details perfect that they miss the major goal of the activity. The perfectionism interferes with task completion, and the O-C doctor will typically run way behind schedule or be hopelessly behind on documentation. They need to be in control and have trouble delegating tasks.

At the other end of the spectrum is the physician who is appropriately compulsive about patient care. All patients want their surgeon to be detail-oriented in the operating room, or their internist to be compulsive in doing a work-up for disease. Indeed, medicine is increasingly rule-driven, and the consequences of not being appropriately compulsive are steadily rising. The key is in the word "appropriate." The distressed O-C physician typically has trouble accepting input from anyone else as to what is appropriate, and almost always has problems in working out differences of opinion. They tend to avoid their anxious feelings through control and action rather than using introspection or diplomacy. Therefore, development of awareness, tolerance, and alternate coping skills for anxiety is crucial.

Narcissistic:

Many would say that the phrase "narcissistic physician" is redundant. Indeed, physicians are trained and expected to be confident in their abilities, and to forego self-doubt in times of crisis. The trick is to avoid what has been called the "M-Deity syndrome", or pathologic narcissism. DSM-IV criteria for Narcissistic Personality Disorder includes:

- Arrogance or "condescending superiority"
- Exaggerated sense of achievements and talents

- Lack of empathy
- Craving for admiration
- Strong sense of entitlement

In addition, the pathologically narcissistic physician often is intolerant of imperfection (or perceived imperfection) in others. As with all personality disorders, narcissism has its origin early in life. Parents may set unrealistically high standards for the child who begins to think of him or herself as "special." The parents typically are unable to emotionally nourish the child, and provide harsh criticism for failure. The child internalizes these attitudes and later is unable to empathize with others, etc. Otto Kernberg characterized the unconscious dynamic as: "I am grandiose because I feel unlovable; I cannot be loved unless I am perfect." While these underpinnings of the disorder do not excuse the problems, insight into the narcissist's deep-seated feelings of inadequacy can help the person begin to change behavior over the long term.

Hospital Management of the Distressed Physician

Each hospital should have **bylaws** in place. The recommendation is that each medical staff and hospital crafts its own bylaws in consultation with an attorney. Bylaws must emphasize the hospital's right to impose sanctions up to and including dismissal.

The second preparatory measure is the development of a clear corporate **policy** defining behaviors which are unacceptable. These policies, rules and regulations should be presented to all hospital employees and medical staff both in written form and in an ongoing series of educational seminars.

There should also be training in **documentation** of the unacceptable behaviors. Documentation should include:

- Time and place of the occurrence.
- Detailed factual description of the behavior.
- Circumstances that precipitated the behavior.
- List of others who observed the incident.
- Consequences this behavior had on patient care and hospital operations.

This documentation is vital. Unlike medical mishaps which are usually well documented, these incidents may be poorly recorded and it is often the collection of multiple reports from many observers that eventually become grounds for remedial action.

Reporting incidents is most difficult because:

- It may have a marked impact on the physician's career.
- It needs to be understood that reporters will be protected.
- The hospital itself may be reticent to interfere because of a desire to avoid unpleasant, possible litigious, confrontation. Some hospitals find themselves in

an economic bind where the distressed physician is a high volume admitter or the only practitioner of his/her specialty.

After the event has occurred, there should be an established progressive series of **interventions**. Depending on the seriousness of the occurrence, the initial intervention should be performed by two or more senior members of the staff and administration in order to establish:

- The seriousness of the situation.
- That this represents a unified group decision.

Before the intervention occurs, a clear set of goals should be agreed upon. The intervention should allow for the following:

- To occur in a private, quiet, neutral setting - so both parties can leave when the intervention is finished.
- Have sufficient time allotted.
- Assure the physician of privacy and confidentiality.
- Information should be presented in a clear non-judgmental, empathetic manner.
- It should consist of specific, factual data. This information should be related to how it interfered with patient care and hospital function.
- Help should be offered.
- Carefully and clearly state that the physician will be closely monitored to ensure that the behavior or similar behavior does not recur.
- Explanation of consequences for failure to change behavior.

The proceedings of the meeting should be fully documented. A copy of the minutes should be part of the physician's personnel file.

Recommendations for Action

Whatever hope a hospital medical staff may have for moderating a distressed physician's behavior will be best realized by addressing the problem immediately, before the attitudes of either party have hardened and while it is still possible that the matter is capable of collegial resolution. Certainly, this is so for the physician, but it is also true for the hospital and medical staff leaders. If the physician knows that his or her conduct is unacceptable and that the hospital and medical staff leaders are prepared to act, future incidents may be prevented.

However, just as surely as it is wise to address behavior problems as soon as they occur, it is also wise to do so with caution. Confronting the physician in a heavy-handed, accusatory manner is likely to invite resentment and possible retaliation. The initial approach should be undertaken as a helpful gesture. At the same time, it must be made clear that it is more than a difference of opinion; that is, if the behavior continues, more formal action will be taken to stop it.

Following are some actions which can be taken by hospital medical staffs to deal with the distressed physician:

1. Focused education dealing with the following areas:
 - Anger management
 - Conflict resolution
 - Sensitivity training skills
 - Communication
 - Behavioral modification: positive and negative incentives
 - Impulse control training
2. Peer monitoring
3. Leave of absence
4. Partial loss of privileges
5. Temporary suspension of privileges with a clear plan and requirements for re-entry
6. Suspension of privileges
7. Revocation of privileges
8. Denial of appointment or reappointment

If the Chief of Staff is reluctant to meet with the physician or if, for any other reason, the Chief of Staff or the Chief Executive Officer determines it to be appropriate, the Board Chairperson or another Board member could meet with the physician.

Having a Board member meet with the physician has several advantages. It relieves the Chief of Staff of a responsibility for which he or she may have neither the taste nor the experience. And when a physician understands that he or she is accountable directly to the Board for his or her conduct, it may be easier to correct the situation in an informal manner. Alternately, if the physician perceives that he or she would be bending to the wishes of other physicians in matters that the physician considers none of their business, it may be more difficult to correct.

Addressing distressed conduct immediately will also strengthen the hospital's position if the physician subsequently challenges the disciplinary action in court. A hospital will want to limit the number of participants in any meeting with the physician, not only to minimize the doctor's feeling that he or she has been the object of widespread discussion, but also to limit the targets of any attempts at retaliation.

The record should not be a catalog of ineffective oral warnings, however. A hospital medical staff will protect itself by following up the warning(s) with written letters to the physician. These writings help to create a record showing that the medical staff made reasonable attempts to deal with the problem, short of terminating the physician's medical staff appointment and clinical privileges. This written record also prevents a physician's later claims that no one had ever discussed with him or her the distressed behavior in question.

It does not require medical expertise to determine whether as a qualification for appointment a physician possesses the ability to “work harmoniously with others....” A recommendation from the Medical Executive Committee (or any other medical staff committee) is not necessary in these situations and should not be required.

The TMF drafted this document with an eye towards ensuring necessary flexibility for dealing with these situations without immobilizing the medical staff or hospital administrative staff. This allows the Medical Executive Committee to refer these matters to the Board without recommendations. However, the Medical Executive Committee may handle the matter.

If the hospital follows the procedure either through the Medical Executive Committee or the Board and it is inherently fair and compliant with the staff bylaws, and there is a well-documented record of the physician’s conduct and the hospital’s attempts to deal with it, then in all likelihood the hospital’s action will be upheld should the matter proceed to litigation. There are many court decisions upholding hospitals’ disciplinary actions when confronted with a physician’s distressed conduct. The courts have made it abundantly clear that the provision of patient care in an atmosphere of calm, order and respect for the dignity of all need not be sacrificed to the distressed proclivities of any appointee to the medical staff, regardless of his or her clinical abilities.

No matter what action is taken, medical staffs should work with their legal counsel to address any required follow-up reporting to state and federal agencies. Please note that:

- Any change in privileges may be reportable to the state licensing board (for MD physicians, the Board of Medical Examiners (BME); for DO osteopathic physicians, the Board of Osteopathic Examination).
- Sanctions or other changes to a physician’s privileges that last for longer than 30 days are reportable to the National Practitioners Data Bank. [See 42 USC §11133.]

When can the TMF PHP be of help?

The distressed physician is a medical staff issue. Referral to the TMF PHP is appropriate only when corrective action has been taken by the hospital staff and has failed. The hospital or group must be willing to impose consequences.

The TMF PHP serves to advise medical staffs regarding resources available for corrective action. It is beyond the scope of the TMF PHP to do any assessments or to take corrective action.

Legal Considerations

At least one court has held that hospitals have a duty to take action in such situations. In Leach v. Jefferson Parish Hospital District, No. 2, 870 F.2d 300 (5th Cir. 1989), the Fifth Circuit Court of Appeals stated, "... the hospital clearly has an interest in providing quality medical care to its patients. If a physician is distressed or has personal problems, the hospital has a duty to intervene."

The first step in dealing with professional conduct is to implement a policy that makes the hospital's position clear.

Summary

- Distressed behavior by a physician may or may not relate to a psychiatric diagnosis.
- The hospital, clinic, or other referring entity should be prepared to impose consequences if the behavior continues unchanged. While it may be appropriate to "cut some slack" if the physician is working on underlying issues, few work settings will tolerate unabated distressed behavior for long.
- The physician with distressed behavior is often unaware of their effect on others. It is common for the physician themselves to be only vaguely aware of "a small problem," while nurses and other physicians around them are busy preparing their resumes.

Additional Points

- It's crucial to have appropriate expectations. The causes of distressed behavior do not develop overnight, and it's unrealistic to expect the physician to change his or her behavior overnight with no slip-ups. That's one reason it is important to address the behavior before the environment reaches the point of "zero tolerance" for minor infractions.
- The physician with distressed behavior is often a technically excellent clinician. However, their self-assessment often exceeds reality.



For more information or assistance, contact the TMF Physician's Health Program at 615-467-6411 or visit www.e-tmf.org.