Disruptive Physician Behavior: To assist or discipline? That is the question.

Norman T. Reynolds, MD
Distinguished Life Fellow of the American Psychiatric Association
Comprehensive Psychiatric Consulting Services
408-264-3064
cpcs2001@hotmail.com
www. fitness-for-duty.com

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To discipline or to assist?

- At first glance, the disciplinary approach might seem the most appropriate way of addressing "bad behavior." But, on deeper examination, is this really the best way?
- What would an assistance approach consist of?
- Are there management and monitoring approaches that effectively address disruptive behavior?

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I. ROLE OF PWBC

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Refer to PWBC?
Refer to evaluator?

- Is there a basis for assistance?
- If not, clear the path to discipline.

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Refer to PWBC & Evaluation: Potential Downside

- Manipulation by physician to subvert discipline and gain accommodations

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Tips for Medical Staffs

Medical staff committees should:

- Identify and document disruptive behaviors.
- Thoroughly investigate complaints before referring for psychiatric evaluation.
- NOT make psychiatric diagnoses.
- For diagnosis and treatment planning, refer to a psychiatrist specializing in Comprehensive Psychiatric Fitness-for-Duty Evaluation.
- Be respectful in dealings with the physician.
- NOT violate due process rights.

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II. EVALUATION

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What to look for in an evaluation

- See handout Elements of Evaluation (See Table 4, Reynolds article Model Comprehensive FFD Eval.)
- In-depth evaluation of the physician (time consuming)
- Personality testing (hypotheses require clinical validation)
- Detailed report with specific recommendation for ongoing management
- Periodic follow-up evaluation as expert consultion to medical staff

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What to expect in the written evaluation report

- Adhere to conditions set forth in signed consent forms
- Response to referral questions
- Detailed plan for remediation and monitoring

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X. REMEDIATION: "TREATMENT" or "MANAGEMENT"

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What constitutes remediation?

- See Table 8 " Elements of a Program of Remediation" in the Reynolds article on Disruptive Physician Behavior.
- Constructive change in disruptive physician behavior comes through adherence to expected behaviors while providing educational and other supports to help the to teach the physician new coping skills.

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III. UNDERLYING DIAGNOSES

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Disruptive Physician Behavior

- Label, not a diagnosis
- Single episode v. pattern
- Personality Disorder rule out through evaluation:
  - Substance disorder
  - Psychiatric clinical disorder
  - Burnout and stress
  - Cross cultural factors

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What is a Personality Disorder?

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Personality Disorder: General Diagnostic Criteria

A. Enduring and deviant patterns of:
   - Cognition (ways of perceiving and interpreting self, others, and events)
   - Affectivity (range, intensity, lability, and appropriateness of response)
   - Interpersonal functioning
   - Impulse control

B. Inflexible and pervasive

C. Clinically significant distress or impairment in functioning

D. Stable and of lifelong duration

E. Not better accounted for as another mental disorder

F. Not due to direct physiological effects of a substance or a general medical condition

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Reynolds User Friendly Version of Personality Disorder

- Deficits of coping are imbedded in personality
- Lifelong, enduring pattern of thinking and behaving
- Can be adaptive under certain conditions; maladaptive when flexibility is required
- View themselves as right and others as wrong
- Do not seek help to change themselves; instead, want other to change & validation for their positions
- Not a symptom of a psychiatric clinical disorder
- No insight

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Typical Personality Diagnoses in Mean/Disruptive Physicians

- **Paranoid Personality Disorder: pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent.**
- **Narcissistic Personality Disorder: pattern of grandiosity, need for admiration, and lack of empathy.**
- **Passive-aggressive Personality Disorder: pattern of negativistic attitudes and passive resistance to requirements for adequate performance in social and occupational situations.**
- **Personality Disorder Not Otherwise Specified**

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Psychiatric Clinical Conditions Associated with Disruptive Behavior

- Bipolar Disorder
- Chronic depression
- Substance related disorders
- Intermittent Explosive Disorder
- ADHD

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Physician Burnout Syndrome
Maslach & Jackson

1. Emotional exhaustion
2. Depersonalization
3. Lack of feelings of personal accomplishment

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Cross Cultural Factors

Cases involving cross cultural factors:

- Typically, the physician is open-minded rather than defensive.
- Inform the physician of laws, ethics, and potential risks/ negative outcomes from continuation of behavior.
- Simple discussion and education take care of the problem.

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Mean/Disruptive Behavior

- MD can translate into "mean & disruptive"
- Ranges from difficult (narcissistic and paranoid) to very difficult (antisocial)

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Overview: Definition & Dynamics

Pure mean/disruptive (M/D) behavior consists of a practice pattern of personality traits that interferes with the physician's effective clinical performance.

Manifestations include:

- ***inappropriate anger or resentment,***
- ***inappropriate words or actions directed toward another person,***
- ***and inappropriate responses to patients' needs or staff requests.***

The behavior can be expressed directly to patients or indirectly through impeding the health care delivery team, or it may potentially compromise the quality of care of patients.

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Pure M/D behavior is not caused by substance abuse or an Axis I psychiatric clinical condition. It can arise from the physician's personality or basic character. Typical diagnoses among disruptive physicians include paranoid, narcissistic, and passive-aggressive disorders.

Pure M/D behavior is motivated by the physician's need for power and control in relationships. M/D physicians "habitually resent, oppose, and resist demands to function at a level expected by others." They fear domination. Ironically, their behaviors provoke the very domination they fear.

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Typically, M/D physicians are successful and accomplished subspecialists, who hold to high standards, lack closeness in relationships, lack insight, and resist treatment.

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IV. ASSISTANCE v. DISCIPLINE

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Why bother to assist?

- Practical issues
- Humanitarian factors

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Practical Issues

ASSISTANCE

- Time consuming
- Relatively efficient to get results
- Expensive
- Compromising
- Win/Win model:
  Positive impact on work culture
- Remediation
- Effective in curtailing behaviors

DISCIPLINE

- Very time consuming
- Very inefficient to get results
- Very expensive
- Adversarial/polarizing
- Win/Lose Model:
  Negative impact on work culture
- No remediation
- MD who prevails, feels emboldened to continue disruption

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When to give up?

- The physician refuses assistance
- Fails to comply with PWBC expectations
- Risks harm to patients or coworkers

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Humanitarian Factors

- Compassion and understanding of others regardless of how they view us

  Do we offer assistance only to those who like and appreciate us?
- Keep a well qualified and expert physician in practice to benefit patients

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Challenges to Medical Staffs

Tough Love:

- Show compassion without enabling
- Set reasonable and fair limits
- Expect hard work and frustration to achieve results

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V. REMEDIATION & MONITORING

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Keys to Success

The goal of remediation is behavioral compliance, not psychological insight.

Management approaches can be highly effective.

At all stages, physician due process rights should be respected. If assistance fails, follow a procedure of "progressive discipline," and termination can be considered.

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"Elements of Program of Remediation"

See Table 4, Reynolds article on Disruptive Physician Behavior:

- Tight monitoring contract (PIP)
- Coping skills training sessions
- "Treatment" options
- Ongoing assessment by expert evaluator
- Oversite and monitoring

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Monitoring of Disruptive Behavior

- **Develop a tight written agreement for monitoring incorporating recommendations from an experienced evaluator.**
- **Primary goal of monitoring is protection of others; secondary is rehabilitation of the physician**
- **Specify clear consequences for non-compliance**
- **Refer for periodic psychiatric re-evaluation**
- **Monitoring is supported by adherence to a good remediation program**

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Keys to Success

- Create disruptive behavior policy in the bylaws
- Periodic education of medical staff to achieve buy-in to policy
- Complaint verification prior to intervention
- Comprehensive evaluation prior to referral for treatment/ management
- Written agreement with no loop holes prior to management/ monitoring
- Reinforcement through re-credentialing
- Progressive discipline procedure for cases that fail

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VI. TIPS FOR PWBC

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Medical Staff Committees should:

- **Refer to psychiatric evaluator for diagnosis, management plan, and monitoring plan**
- **Adhere to laws/limits/boundaries**
- **Avoid "splitting" dynamics**
- **Anticipate frustrations for everyone in the system**

Assistance and monitoring are compatible/mutually reinforcing

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Develop Realistic Expectations

- Do NOT expect insight or empathy
- Do NOT expect a "cure" of the personality disorder
- Do NOT assume or expect that the physician will express gratitude
- Do NOT assume trust in the physician
- Do NOT become lax in applying expectations and limits
- Do NOT violate rights of the physician, e.g., confidentiality, due process

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