

# Disruptive Doctors:

## CAN DOCTORS DEAL WITH THEIR OWN?

By Adam Frederic Dorin, MD, MBA

### The Problem

The problem of doctors who have deviated from the norm in clinical practice, competence, and/or behavioral patterns is often beyond the ability of individual hospitals to correct. In the January 2006 edition of *Annals of Internal Medicine*, the article "Problem Doctors: Is There a System-level Solution?" poses the premise that physician quality issues are a significant threat to patient well-being. The authors go on to state that hospitals are ill-equipped (or unwilling politically) to identify and correct problems, especially when they involve behavioral aberrations. Their conclusion is that a larger, systemic (national) approach to doctor deficiencies is necessary and will require the cooperation of such entities as the Federation of State Medical Boards, the American Board of Medical Specialties, and the Joint Commission on the Accreditation of Healthcare Organizations.

Physicians have come under more difficult times over the past few decades, with increasing regulations, more burdensome oversight, and decreased reimbursement. These external pressures can exert substantial stress upon the already demanding job of a physician. Nevertheless, it is incumbent upon the greater specialty of medicine to come to terms with its responsibility to reign in poor performance and behavioral problems at the level of the individual practitioner. Although many medical-related complications arise out of purely 'system' failures, doctors wield great influence over the lives of their patients, and deficiencies in skills, continuing education, addiction, personality issues/psychiatric disorders, etc., can pose great harm to those we swore to 'help ... and do no harm.'

In JAMA 2002, Epstein and Hundert describe "dyscompetency" as a breach in professional competency that would normally entail "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." The Federation of State Medical Boards describes the abusive physician as someone who exhibits abusive behavior that "interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care."

Disruptive behavior by a physician leads to a corrosive erosion of morale and ultimately to the delivery of poor patient care. Physicians who berate, belittle, and otherwise intimidate col-

leagues, residents, nurses, and staff, ultimately create a climate of fear and distrust. Co-workers may find themselves spending more time trying to avoid triggering the undesired behavioral patterns of the offending doctor and less time concentrating on doing their job on behalf of the patient. Colleagues may be less inclined to point out errors or make suggestions for fear of unleashing the predictable, and previously witnessed, behavior. In times of natural stress — such as an emergency code situation — those working besides the disruptive physician may feel betrayed and ambushed in their attempts to work as a team. Disruptive physicians often try to deflect attention from their own questionable practice, falsely accusing or questioning others — again, only to the detriment of the patient. Healthcare workers operate under the premise of an 'implied contract,' wherein all involved integrate as a functioning unit to give quality care and save lives. When abusive, irrational, and hurtful interpersonal patterns enter into this work arena, the disruptive physician is breaking this 'contract' and everyone loses.

Many associate the term 'impaired physician' with someone who is under the influence of habitual, addictive substances, but the impaired physician may also be suffering from an acute or chronic psychiatric illness. Often, the disruptive physician has a pathologic personality disorder, which may pose even greater challenges for a sustained, improved treatment outcome. Regardless of the etiology of the disruptive behavior, it is incumbent on medical groups, hospitals, and healthcare organizations to do everything in their power to identify and provide treatment options for the offending physician. When necessary, the physician may need to be temporarily or permanently removed from the direct delivery of patient care.

### The Numbers

In 2002, nationwide, 0.5 percent of physicians were disciplined — 1,739 had their licenses revoked, and 1,218 had restrictions imposed on their practices. The Medical Board of California estimates that 18 percent of physicians abuse alcohol or other drugs at some point during their career. There is suggestion that the rate of mental illness may be higher in physicians than the population at large, with the rate of suicide 40 percent higher in male physicians and two-fold higher in female physicians than the general population (*Am J Psychiatry* 2004).

It has been postulated that, considering the larger body of statistics regarding physician impairment of all causes, about one-third of physicians — at some point in their careers — will experience at least a temporary condition that significantly impairs their ability to competently practice medicine. These same studies extrapolate the numbers to suggest that about 1–2 percent of physicians in any given year should be remediated or removed from clinical practice.

*"Failure to ensure the quality and safety of the performance of colleagues is a breach of medicine's fiduciary responsibility to the public."*

Leape and Fromson, *Annals of Internal Medicine*, January 2006

### The Inadequate System

Hospital-based peer-review systems are considered by many to be inadequate mechanisms for the assessment, management, and correction of disruptive physicians. The reasons are legion and range from the 'corrective body' being composed of financial partners or others who are financially dependent on the practice of the problem physician, to friendship, familiarity, and even hospital dependence on big-name physicians to pull in millions of dollars per year for the institutional bottom line. Even in egregious situations of abusive behavior and clinically subpar performance by doctors, hospitals are often reluctant to refer problems to outside review boards for fear of drawing attention to their own inadequate processes.

### Fixing the Systemic Problem

Until the systemic problem can be fixed, there is no hope for America's hospitals in reforming individual doctors. Entire textbooks have been written on the implementation and maintenance of institutional quality assurance programs, but the key ingredients of a successful system are very simple: objectivity, professionalism, adherence to standards, compliance, and monitoring of performance. This may be much easier said than done, but each and every physician can make a significant contribution to their own institution's quality management system by a willingness to stand up and speak out — even if it means stirring the waters a bit.

Most physicians would likely admit, if candid, that hospitals probably cannot adequately deal with disruptive physicians if left to their own internal mechanisms. This conclusion does not need the foundation of statistics but only an honest appraisal of the demeanor and behavioral patterns of our own work environments. Although true of most states, California is blessed with a very talented Medical Board — one which is well-equipped to make referrals to community remediation and treatment programs for impaired and disruptive physicians. ☺

### References

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