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Five Tips For Addressing Disruptive Physician Behavior

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Recently, a colleague and I spoke at the NAMSS 37th Educational Conference & Exhibition to nearly 200 medical directors, chief medical officers, and credentialing staff about what constitutes disruptive physician conduct in the hospital setting, and what hospitals can do to manage it. When a few audience members volunteered to describe their own experiences with disruptive physicians, it was readily apparent that the untenable situations they described were ones with which the rest of the audience could relate: a physician writes highly inappropriate notes in a medical record, a surgeon refuses to listen to a nurse in the OR, a nurse feels intimidated by a doctor who either berates or ignores him/her when he/she asks questions. Other factors with which the audience agreed was the fallout from disruptive behavior: low morale, poor patient satisfaction, high staff turnover, and medical errors or near misses. And finally, there was no question that everyone wanted to find the path of least resistance by avoiding the dreaded peer review hearing.

Perhaps the most fascinating revelation was how often the same physician who is described as obstreperous and threatening is also described as the most intelligent and charming – indeed, it is this precise dichotomy that likely causes a hospital to disregard or condone the physician's behavior. But hospitals are obligated to create a work environment that promotes professionalism and a culture of safety for patients. This can be a difficult task, particularly when there is a staff physician who distracts colleagues and administrators from what is truly important: quality patient care. Below are five quick tips for proactively, rather than reactively, addressing disruptive and unprofessional physician conduct:

1. **Adopt a Code of Conduct**. Joint Commission Leadership Standards require hospitals to have a code of conduct that "defines acceptable and disruptive and inappropriate behaviors." The code of conduct should identify what types of behavior are considered intolerable so that there is clear guidance – and managed expectations – about what conduct is and is not acceptable at the hospital.

2. **Open the Lines of Communication**. Nothing good ever comes out of first addressing a situation in an adversarial manner. Make sure the physician is spoken to informally – by the department chair, by the medical director, and if necessary, by the entire medical board. Having discussions in which the physician is advised of the inappropriate conduct and gently warned of the consequences of continuing such conduct can have a lasting impact and help avoid a peer review hearing.

3. **Mentoring**. Hospitals should have a system in place whereby physicians can seek mentoring from their peers, particularly when informal meetings fail to adjust the physician's behavior. Mentoring can take place in or out of the hospital setting, but should be structured so that honest and objective feedback can be provided to the physician on issues ranging from the physician's technical competence to staff relations and, of course, behavioral attitudes.

4. **Performance Improvement Plans**. The performance improvement plan (PIP) is an excellent tool for hospitals to communicate specific expectations to a physician in a manner that shows the hospital is invested in the physician's success. The PIP sets forth the physician's deficiency, identifies the hospital's expectations for improvement, including a timeframe for resolving the deficiency, and notifies the physician of the consequences for non-compliance.

5. **Referrals to Professional Organizations for Treatment.** If the hospital does not think that a physician can be remediated with any of its own resources, referral for outside treatment should be considered. Options include everything from weekly psychiatric counseling to thirty-day inpatient programs, as well as anger management, emotional intelligence and behavioral modification courses. There also are state medical society resources, such as the Committee for Physician Health in New York, that provide confidential, non-disciplinary assistance to physicians.

Because disruptive physicians often lack the self-awareness to realize their behavior needs improvement, they also tend to resist adversarial processes and the proposed sanctions that go along with them. While there really is no easy way to address unprofessional behavior, doing nothing can be toxic for everyone involved. Hospitals need to ensure that they have a process in place for addressing disruptive behavior at the front end, and that each stage of remediation is documented. If and when that process fails, formal discipline, including probation, suspension and termination, will likely be necessary.

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