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Obstetrics and Fetal Monitoring Course

January 2020 Topic: Communication

Activity #20003P

MANAGING THE DISRUPTIVE PHYSICIAN

Discussion, Clinical Case Study, and Fetal Heart Rate Interpretation

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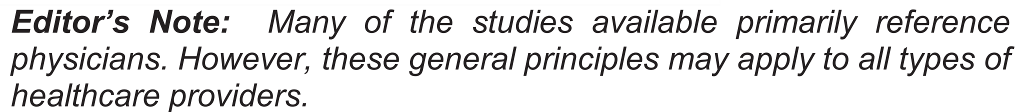
Learning Outcomes for **periFACTS®** Activity #20003P: **In addition to the overarching Obstetrics and Fetal Monitoring Course learning outcomes**, upon completion, the learner also will be able to:

- Describe two negative consequences for patient care that occur as a result of the disruptive behavior of physicians.
- Explain two predisposing, precipitating and perpetuating factors of disruptive behaviors in physicians.
- Interpret A.C.'s fetal heart rate tracing.



Editor's Note: *Many of the studies available primarily reference physicians. However, these general principles may apply to all types of healthcare providers.*

INTRODUCTION

Disruptive behaviors by physicians have been shown to foster medical errors, lead to poor patient satisfaction, and cause good clinical staff to seek positions elsewhere (The Joint Commission, 2008, and Cooper, 2019). Rosenstein and O'Daniel documented disruptive physician impact on colleagues including stress, frustration, loss of concentration, reduced team collaboration, reduced information transfer, reduced communication, and impaired MD-RN relationships (Rosenstein, 2005). The impact of the emotional abuse on a nurse's productivity includes tasks delayed per shift, tasks not done per shift, and an increase in burnout and percentage of nurses intending to leave their job (Roche, 2010).

This has been a difficult problem to address for a number of reasons that will be discussed. The disruptive behaviors sometimes fall under the category of workplace violence. According to the National Institute of Occupational Safety and Health (NIOSH) (a division of the Centers for Disease Control and Prevention), workplace violence consists of "Any physical assault, threatening behavior, or verbal abuse occurring in the workplace. It includes, but is not limited to, such events as beatings, shootings, rape, suicide or attempts, plus psychological traumas such as threats to harm, obscene phone calls, intimidation, bullying, incivility, harassment, including being followed or sworn at" (Department of Health and Human Services, 2008).

DEFINITIONS

A physician code of conduct has been written by the American Medical Association (AMA), which defines what behavior is appropriate for a physician. Appropriate behavior for a physician includes criticism that is communicated in a *reasonable* manner, offered in *good faith* with the *aim* of improving safety and quality of care (American Medical Association, 2008). These could include encouraging clear communication, concerns about patient care and safety, and even dissatisfaction with policies through appropriate grievance channels or other civil methods.

Professional competence has been defined as the consistent 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 (Epstein, 2002).

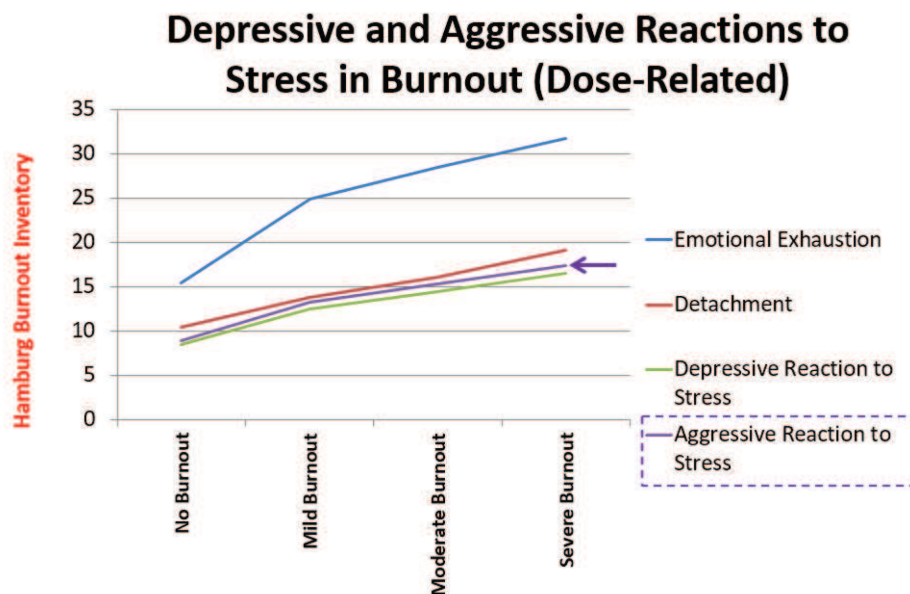
Sometimes the term "problem doctors" can be an umbrella term for both clinical incompetence, such as not keeping up sufficiently on clinical advances, or it may be lumped together along with problematic behaviors. The term "disruptive physician" has

referred to those who exhibit abusive behavior that "interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care" (Federation of State Medical Boards, 2000, and Leape, 2006).

Examples of Disruptive Behavior (Rosenstein, 2016, and Prom, 2018)

- Outbursts of anger toward colleague or subordinate
- Addressing others in disrespectful ways
- Insults
- Sexual harassment
- Passive-aggressive behaviors like refusing to attend certain meetings, refusing to answer e-mails or phone calls or perform other duties, or being chronically late
- Can also manifest by not letting others speak, belittling others or their opinions, or being excessively controlling
- Threats, assaults, throwing things
- Verbal or physical intimidation
- Bullying

Figure 1. Burnout, Depression, Aggression.



Adapted from: Wurm W, Vogel K, Holl A, Ebner C, Bayer D, Mörkl S, Szilagyi IS, Hotter E, Kapfhammer HP, and Hofmann P (2016). Depression-burnout overlap in physicians. PLoS One,11(3): e0149913. doi:10.1371/journal.pone.0149913.

Burnout, at its more extreme levels, is associated with both clinical depression and more outward aggressive behaviors in physicians (Wurm, 2016). The Hamburg Burnout Inventory picks up on aggressive reactions to stress in addition to depressive reactions

to stress. As a result, there now is direct evidence that the risk of aggressive reaction to stress increases with increasing severity of burnout, as does emotional exhaustion, detachment, and depressive reactions to stress. Therefore, it follows that reducing burnout may decrease the risk of disruptive behavior.

Having peer support and a sense of medical community can reduce burnout. Disruptive behavior is less frequent in settings with good teamwork culture, safety climate, and work-life balance (Hadley, 2018). A culture where this occurs is one where communication and respect are infused into all levels of responsibility so that everyone's role is recognized for its importance to the success of the organization.

POTENTIAL ADMINISTRATIVE MISSTEPS

Certain physicians may not fit any of the criteria above in "Examples of Disruptive Behavior" (Rosenstein, 2016, and Prom, 2018), but they simply may be disliked by administration, possibly for being outspoken about what they perceive to be unfair or unsafe practices promoted by the administration, or the physician may have called out the disruptive behavior of another physician who brings in high revenue to the hospital.

The physicians who, in the role of following the unspoken medical code of conduct or ignoring the "Culture of Silence," speak up about their concerns about patient care or hospital policies may need to defend themselves when their opinion runs counter to the administration's opinion. Physicians who expose flaws in the healthcare system may sometimes be labeled as "disruptive." Labeling certain physicians as "disruptive" can be used by hospital administration to report and silence physicians or even as revenge and punishment (Leape, 2006). Gaslighting (manipulating another individual psychologically to question his or her own sanity) by hospital administration can occur as a means of discrediting physicians' perceptions, causing them to question their own thinking processes as if they are misperceiving reality. Some hospital administrators who may not like a reporting physician may use the opportunity to engage the "termination without cause" clause in the physician's contract with a false sense of security. However, because such administrator dynamics often are well known to plaintiff attorneys, the institution may become vulnerable for a wrongful termination suit. Institutions should follow a consistent, transparent, and step-wise due process, as there is real risk of backfire for what could be considered administrator misbehavior.

Zero tolerance policies (ZTP), although consistent with the goal of not tolerating disruptive behaviors, should not be a knee jerk reaction to outspoken physicians. Understanding the content and context of the behavior is critical to a fair response. In less competently administrated organizational settings, ZTP has been used against appropriate "dissenters," possibly denying their human rights and presumption of innocence. Zero tolerance policies should not override the professional discretion and expertise of the evaluator. A standardized process of approach should have flexible rather than automatic responses, which are appropriate to the situation (Bowie, 2012).

If a physician rarely is disruptive or uncivil, then a single episode of disruptive behavior should be dealt with differently than recurring behaviors in a physician with a high disposition to disruptive behavior (see Figure 1). Low-disposition physicians with high enough stressors, burnout, and organizational contributions to the situation occasionally may display behaviors that go over the line to incivility or disruptive behavior (Privitera, 2019).

Figure 2A was created to visually depict a spectrum of nine physician scenarios that a hospital administrator or Chief Medical Officer may encounter. It illustrates the contributory components in each scenario to help evaluators understand the range of possible situations and to promote a fair and effective outcome from the investigation.

Figure 2A. Incivility and Disruptive Behavior. Nine reactions to individual physicians to illustrate contributions.

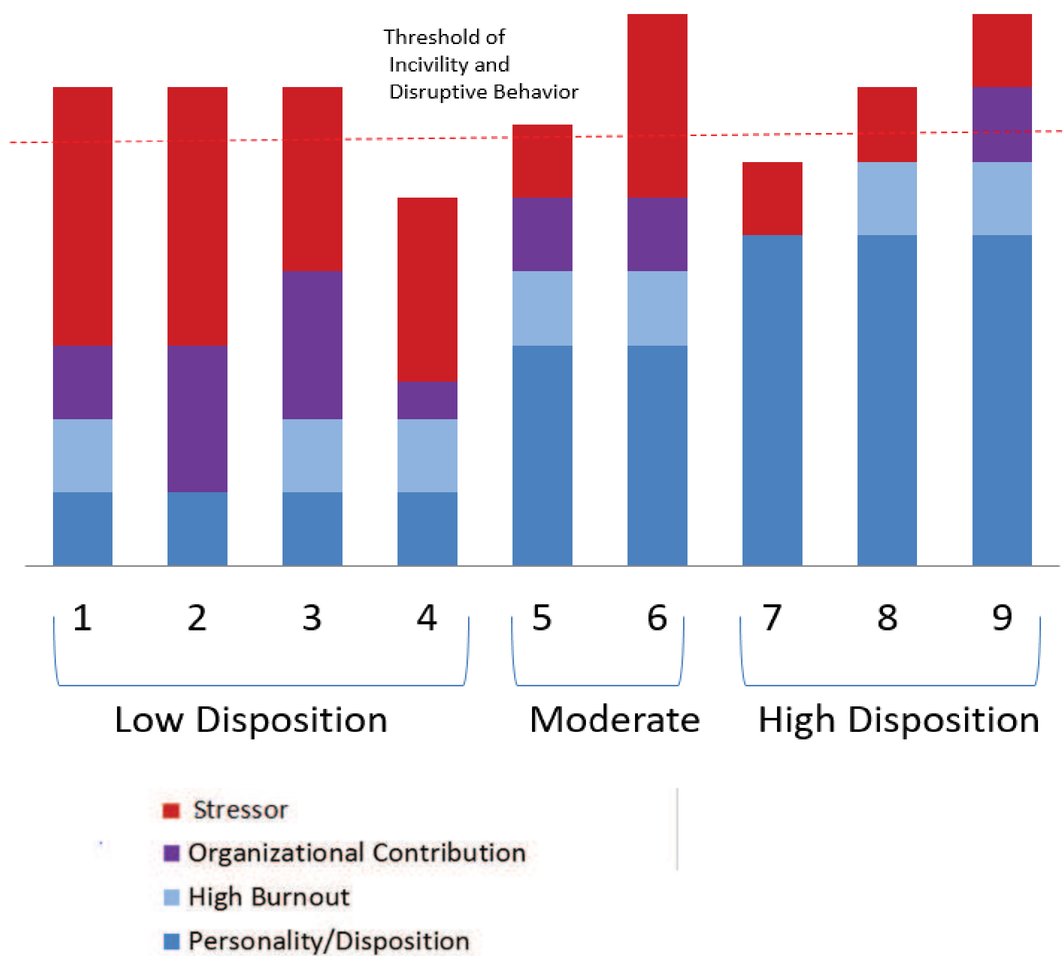


Figure 2B.

Low Disposition to be Disruptive	Moderate-to-High Disposition to be Disruptive
Intervention: Look carefully at: • how to help the person with social and instrumental support to decrease stress and burnout. • examining and improving organizational staff dynamic and environmental contributions. **Single incident—**Hickson step* • "Informal conversation" = "Cup of coffee conversation" by colleague or authority • If mandated reporting requirement, must also go to appropriate authorities *Hickson GB, Pichert JW, Webb LE, and Gabbe SG (2007). A complementary approach to promoting professionalism: identifying, measuring, and addressing unprofessional behaviors. Academic Medicine, 82(11):1040-1048.	More likely to be **repetitive**. Consider interventions mentioned for low disposition as appropriate, but repetition requires Hickson's next steps of intervention. • **Level 1** Apparent pattern of behaviors: "Awareness" intervention by authority figure • **Level 2** Pattern persists: Authority-developed action plan with ongoing accountability of physician. • **Level 3**-No change: Disciplinary intervention.

Adapted from: Privitera MR and Bowen B (2016). Burnout and disruptive behavior: From theory to practice. In: I Needham, K McKenna, O Frank, N Oud (Eds.). Fifth International Conference on Violence in the Healthcare Sector, The Netherlands: Kavanagh, 440-442. Steinert T and Whittington R (2013). A bio-psycho-social model of violence related to mental health problems. International Journal of Law and Psychiatry, 36(2013) 168–175.

INVESTIGATION OF CONCERNS

It is important for the organization to have developed a code of conduct policy that sets the expectations for professional behaviors, defines disruptive behaviors, and outlines the process and ramifications for noncompliance. A part of this effort requires establishing a representative committee to hear and pass judgment that is weighed equally and is fair for all the individuals involved.

Any threat to the career of a physician is high stakes for that individual, as these professionals have invested decades of effort with personal sacrifice and often with large training debt. Physician suicides have been associated with work-related stressors and career threat (Gold, 2013, and Andrew, 2018), so it would be prudent to consider standard availability of some type of advocate such as a mentor, peer, or ombudsman to be made available to the physician during the investigation and possible intervention period. These built-in supports would increase the likelihood that a physician would be less defensive

and less emotional during these periods, optimizing the chance to get to the facts more rationally, while helping support the physician through the process.

An example of addressing this career jeopardy and emotional vulnerability in the resident population was the creation of a 'Policy for Residents in Formal Academic Transition-Wellness Support' at the University of Rochester Medical Center (Duecy, 2017). This policy grew out of a review of two resident suicides. The Employee Assistance Program (EAP) was suggested for both physicians but was turned down by both residents before their suicide. "Academic Transition" referred to an official change of a trainee's standing such as academic probation, non-promotion, dismissal, or non-renewal of contract. All trainees in such a situation now are required to meet with EAP once. Transitions identified by the program director before probation may require an EAP meeting based on the program director's assessment of needs. The substance of the EAP meeting is kept confidential. The program director only receives written confirmation that the EAP meeting occurred. This model for a mandatory EAP or private session when in career jeopardy would be useful for physician employees as well.

In most instances, cases are resolved outside of the legal system and within the institution. It is important to standardize due process, due diligence, compliance, and the consistency of the process for incident reporting, evaluation, and follow-through. A well thought-through intervention and follow-up process also is crucial.

When contended cases have gone to federal court, the most prevalent bases for appeal have been discrimination (37%), Healthcare Quality Improvement Act (33%), and antitrust issues (22%). At the state level, the main bases for legal action included antitrust issues (39%), due process arguments (52%), and breach of contract (52%) (Rosenstein, 2016).

Table 1. Possible Exploratory Questions in an Investigation

- Is the individual more distressed than his/her usual self for personal issues?
- Could s/he be burned out or manifesting symptoms of a psychiatric condition?
- How do the organizational processes and policies contribute to the behavior?
- What role does the other individual in the dyad play in either unprofessional or provocative behaviors or when the physician displays reactive "over-the-top" behaviors?
- Has the physician had problems like this before?
- Has the other person in the dyad been involved in problems with other physicians before?
- What is the level of the stressor associated with the over-the-top behavior?

Table 2. Contributory Factors to Disruptive Behaviors

Predisposing factors

- Personality—narcissistic, obsessive compulsive/perfectionistic, antisocial if staff are getting in the way of some financial goal
- Personal trauma history—increases the risk of overreaction to events that may be similar to their past experiences
- Burnout—both depression risk and aggression risk increase as burnout increases
- Depression—irritability and low tolerance can be symptoms of depression
- Hypomania or mania—overly high expectations of self and others during their hypomanic/manic phases, triggering irritability
- Organizational contributions—upstream administrative decisions, policies, expectations
- Business mission outweighing importance of care delivery mission.

Precipitating factors

- Medical acuity of the patient in setting of overwork, lack of sleep, additive stressors, substance use, and counter personality challenges in the dyad.

Perpetuating factors

- Poor leadership skills
- Fear of confrontation with colleague
- Fear of retribution for whistleblowing
- No efforts to reduce organizational contributions
- Toxic Buffers* (those that protect the team from toxic behaviors)
- Toxic Protectors* of high revenue-generating providers (those with something to gain by the team tolerating the behavior)
- High occupational stress at institution
- High frequency of burnout in other staff
- System factors (loss of autonomy, electronic medical record (EMR) operability, social determinates, culture breakdown. Lack of team-based care, leadership failures).

*Holloway EL and Kusy M (2010). Disruptive and toxic behaviors in healthcare: Zero tolerance, the bottom line, and what to do about it. The Journal of Medical Practice Management, 25(6):335-340.

PHYSICIAN RELUCTANCE TO GET HELP

Physicians are trained to demonstrate a sense of strength and competence and show self-effacement, i.e., how they feel should not matter in the clinical situation, and they should control their emotions. These behaviors of self-regulation, as well as medical decision-making, use neural resources that support executive functions of the brain

controlled by the prefrontal cortex. The toll this neural resource drain has on subsequent control of behavior and thinking is underappreciated (Privitera, 2016). Physicians in general often have a belief of the need for perfection in their work and may be unable to acknowledge weakness or ask for assistance. These traits have been shown to be ingrained as early as medical school. The stigma of admitting this weakness and fear of repercussions from peers, a hospital credentialing committee, or a state medical licensing board has, in many cases, prevented physicians from seeking help when they become burned out or develop more serious medical or mental health issues. Physicians are keenly aware that careers can be halted by external perceptions of competence.

The result of this concern in the “House of Medicine” and the awareness that a number of state medical boards were aggressive in their questions about mental health issues led the Federation of State Medical Boards (FSMB) to convene a work group to study the issue. In April of 2018, the FSMB passed a new set of guidelines found in the “FSMB Workgroup on Physician Wellness and Burnout” (Federation of State Medical Boards, 2018). The document contains more than 25 recommendations that are germane to the issue. Most important for this discussion is that the questions asked on a state license application should not ask about past mental health diagnoses and treatment rendered more than two years previously. In addition, the following wording related to current impairment is recommended: “Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or would adversely affect your ability to practice medicine in a competent, ethical, and professional manner? Yes/No.” This verbiage is in compliance with the guidelines of the American Psychological Association (APA) and Americans with Disabilities (ADA) for health concerns. Many states now are reviewing and potentially making those changes to encourage physicians to seek help when they recognize their own needs, which enables them to better serve their patients.

As previously discussed, threats to the career of an individual who has invested a tremendous amount of time, money, and self-sacrifice to become a physician elevate the risk for suicide in providers (Gold, 2013, and Andrew, 2018). Physicians sometimes have a rigidity of thought and focus that helped them achieve their goals. This same rigidity of thought creates difficulty in being able to see valid alternatives and options in resolving disputes or managing complex situations—elevating the sense of being overwhelmed, hopeless, and trapped.

Career threat can come with a sense of shame in the medical culture. It is important to develop an institutional wellness program that addresses methods to fix the systemic factors that contribute to high occupational stress as well as methods that help physicians adjust to the ongoing stressors.

Wellness management is in the category of self-improvement, maintaining one’s health, and dealing with life stressors. Disease management relates to treatment for a medical condition such as an anxiety disorder, depression, or other mood disorder that may or may not have been caused or exacerbated by occupational stressors (Figure 3).

Figure 3. Options for Help are on a Spectrum from Wellness Management to Disease Management.

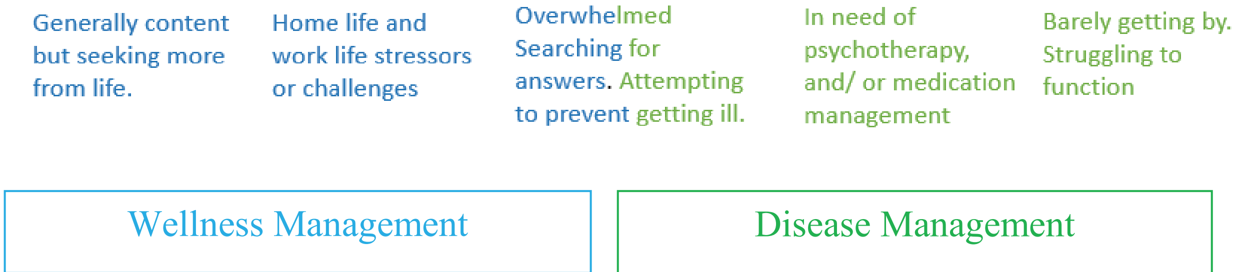


Figure 4. Spectrum of Options for Occupational Stress and Burnout

1. Self-referral/ **prevention driven**
2. Clinical or administrative referral/ **event driven**
3. In house referral from other entry.

Wellness Management | **Disease Management**

Self Help External or Internal

Reading Videos Online resources

Peer Support Programs

Balint Groups

Schwartz Rounds on difficult or emotional cases

Coaching Institution or Community

Coaching focus determined by evaluation
Types of Coaching Professionals:

- **Personal coach/Life coach**
- **Executive coach /Leadership Development**
- **Career coach**
- **Health coach**
- **Other: Business, entrepreneurial, financial, conflict coaches.**

Wellness Program Resources Counselling in Employee Assistance Program

Disease Manage-ment Programs

Mental Health Treatment at Institution or Community

Individuals most often are self-referred for health issues but can be referred by an administrator as a result of circumstances or events.

Multiple options are available in the wellness management category that may include self-help offered by the institution to external, peer support programs, coaching, and employee assistance programs. Disease management options might be available at the institution, often in behavioral health departments or through community practitioners (Figure 4). Some institution administrators keep a list of community clinicians who may be particularly suited for assisting physicians.

REPORTING AND REFERRAL ISSUES

Self-referral to physician health programs (PHPs) in almost all states gives an opportunity to be free of consequences, provided no acts of misconduct have occurred and the physician complies with the treatment plan instituted. If misconduct occurred, the case likely will require referral to the State Medical Board in addition to the individual having to continue to comply with the treatment prescribed. However, concerns have been raised about the variations of sanctions enacted by different medical regulatory agencies for those referred to or by PHPs in the various states. Since these institutions vary, and their decisions can have a significant and lasting impact on a physician's career and livelihood, they instill great fear and, at times, a sense of powerlessness over the decisions rendered. There have been reports of problems with mental health evaluations and treatment centers acting inappropriately that add to the anxiety of physicians (Emmons, 2018). However, their recommendations to PHPs generally are valuable to the program and physician recovery. There always is due process for physicians, and they should learn the laws of the state and what they are afforded in these situations to protect themselves when addressing these circumstances. Because these concerns exist, several grants have been submitted to the FSMB Foundation from medical regulators and PHPs to track physician suicides or new mental disorders that occur following discipline referrals or negative board actions. Hence, there is a call for the assessment to be conducted "with the utmost integrity and delicacy" (Emmons, 2018).

DUTY TO REPORT MISCONDUCT

In order for state medical boards to fulfill their responsibility to regulate the medical profession in the interests of the public and patients, they must rely upon individuals and institutions to provide the information. This process is necessary to fulfill their mission to prevent harm to patients and remove conditions that may lead to their harm. Therefore, these duties reside with other physicians and organizations, hospitals, chief executive officers, medical officers, and medical staff to report to the state medical board when there is evidence or information that appears to show that a physician is incompetent, guilty of negligence, has violated the medical practice act, has had inappropriate relationships with patients, demonstrates physical or mental reasons for not being able to practice safely, or has alcohol or drug abuse problems (Federation of State Medical Boards, 2016). As mentioned above, PHPs provide a safe haven if the physician is self-referred, if no acts of misconduct have occurred, and s/he complies with the terms of treatment. These laws

have been necessary to guard against the culture of silence and fear of reporting other colleagues that are known to exist in medicine. One of the criteria in the laws of misconduct is the duty to report the above behaviors for public protection.

CREATING A CODE OF CONDUCT FOR YOUR INSTITUTION

In 2009, the Joint Commission mandated that any hospital seeking accreditation must meet the two leadership standards below with regard to disruptive and inappropriate behaviors of physicians or all healthcare professionals.

1. Have a code of conduct that defines acceptable and inappropriate behaviors.
2. Create and implement a process for managing the behaviors that undermine a culture of safety (The Joint Commission, 2008).

Maimonides Hospital in Brooklyn, New York developed a matrix that defines conduct and process for management (Kaplan, 2010). They described *respectful behavior* as that which supports a positive work environment, promoting high quality care and joy in work. *Lower level disrespectful behavior* is incivility. It is low-intensity, deviant behavior, but violates norms of mutual respect. *Higher level disrespectful behavior* includes intimidation or bullying. *Bad behavior* is flatly unacceptable behavior such as threats of violence or violence itself, putting patients in immediate danger, harassment, or other criminal activity.

THE LIFE EXPERIENCES OF THE CHIEF MEDICAL OFFICER (CMO) IN DEALING WITH DISRUPTIVE PHYSICIANS

The Chief Medical Officer (CMO) often is tasked with dealing with reports of physician behaviors, which necessitates engaging the chair of the physician's department. These issues generally come through electronic reporting systems or reports sent directly to supervisors. These concerns regarding professionalism most often are related to interpersonal issues. The CMO works closely with the chair/chief of the department to determine who will meet first with the physician/faculty member to understand his/her assessment of the concern raised. Almost invariably, the physician's view of the situation is different from the reporter's. Many times, the physician feels justified in how s/he acted due to concerns for patient safety or with system inefficiency. Another common scenario is that the physician has limited insight into how others perceived his/her actions. The former suggests leadership education/training may be beneficial for the physician through acquiring skills that help lead problem solving in order to improve the system and keep patients safe. The latter suggests that professional coaching on interpersonal relationships may be in order.

At the outset of this process, it is vitally important to reassure physicians of their safety in the process and assess if they are impaired due to psychiatric illness, drugs, or alcohol as a cause for the reported behaviors. The CMO is responsible for ensuring that physicians are healthy, both mentally and physically. If there are concerns in this regard, the physician may be referred to EAP or, alternatively, to the state's committee for

physician health. The latter can be the choice of the physician concerned with privacy or because of the severity of the behavior.

The majority of the time, the initial discussions with physicians are successful (Martinez, 2018). Physicians generally are appropriately conciliatory and apologetic for their actions being brought to leadership. If appropriate, they usually are willing to undergo coaching and have the insight to modify their behavior. On occasion, the physician's aberrant behaviors are repeated. For repeat offenders or for more egregious infractions of professionalism, the stakes become higher. Most medical staff bylaws contain professionalism clauses describing and mandating appropriate behavior. Recurrence of problems with professionalism issues for physicians/faculty may lead to sanctions including, but not limited to, loss of privileges. The consequences of this may lead to the ultimate loss of their job and difficulty obtaining privileges at other facilities in the future. When sanctions are anticipated, risk management/legal consultation should be obtained. For academic organizations, the Dean for Academic Affairs should be notified and consulted, in that the physician's faculty appointment may be at risk. The CEO of the organization as well as the CEO for the physician group employing said physician should be involved at this stage as well. Medical staff bylaws contain a fair hearing and appeals process for any sanctions levied. These often are utilized by physicians being sanctioned. Final recommendations for sanctioning the physician with recurrent or egregious professionalism issues are made by the CMO to the CEO to the organization's board of directors who is charged with the final decision. For repeat offenders who are facing these sanctions, they should be made aware that the decisions that result in loss of hospital privileges or termination require reporting to the state medical board for investigation. The outcome could cause possible actions against their license in their present state as well as any other states with active licenses with obvious serious consequences for future practice.

CONCLUSIONS

Managing physician disruptive behavior is complex, and it helps to have some understanding of the multiple factors that may be at play. Some assessment of the individual physician traits (personality/disposition), mental state (burnout, depression), and propensity to disruption may give an initial clue as to how to examine the organizational/environmental factors that may contribute to that physician's behavior. A spectrum of interventions must be considered rather than reflex responses to a complex problem.

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