American Medical Association
Physicians dedicated to the health of America

Physicians and Disruptive Behavior

This packet of information includes excerpts from the American Medical Association (AMA) *PolicyFinder* [http://www.ama-assn.org/ama/noindex/category/11760.html] and Council reports. The packet is intended as general purpose background information on this topic, and is not represented as a comprehensive set of resources. Additional resources and information may be available on the AMA web site www.ama-assn.org.

July 2004

DISRUPTIVE PHYSICIANS

(AMA policy, excerpted from the AMA PolicyFinder)

H-140.918 Disruptive Physician

(1) Personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively constitutes disruptive behavior. (This includes but is not limited to conduct that interferes with one's ability to work with other members of the health care team.) However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.

(2) Each medical staff should develop and adopt bylaw provisions or policies for intervening in situations where a physician's behavior is identified as disruptive. The medical staff bylaw provisions of policies should contain procedural safeguards that protect due process. Physicians exhibiting disruptive behavior should be referred to a medical staff wellness - or equivalent- committee.

(3) In developing policies that address physicians with disruptive behavior, attention should be paid to the following elements: (a) Clearly stating principal objectives in terms that ensure high standards of patient care and promote a professional practice and work environment.
(b) Describing the behavior or types of behavior that will prompt intervention.
(c) Providing a channel through which disruptive behavior can be reported and appropriately recorded. A single incident may not be sufficient for action, but each individual report may help identify a pattern that requires intervention.
(d) Establishing a process to review or verify reports of disruptive behavior.
(e) Establishing a process to notify a physician whose behavior is disruptive that a report has been made, and providing the physician with an opportunity to respond to the report.
(f) Including means of monitoring whether a disruptive physician's conduct improves after intervention.
(g) Providing for evaluative and corrective actions that are commensurate with the behavior, such as self-correction and structured rehabilitation. Suspension of responsibilities or privileges should be a mechanism of final resort. Additionally, institutions should consider whether the reporting requirements of Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues" apply in particular cases.
(h) Identifying which individuals will be involved in the various stages of the process, from reviewing reports to notifying physicians and monitoring conduct after intervention.
(I) Providing clear guidelines for the protection of confidentiality.
(j) Ensuring that individuals who report disruptive physicians are duly protected. (CEJA Rep. 2, A-00)

D-450.998 Addressing the Disruptive Physician

Our AMA will: (1) identify and study behavior by physicians that is disruptive to high quality patient care, and (2) define the term "disruptive physician" and disseminate guidelines for managing the disruptive physician. (Res. 9, A-99)

E-9.045 Physicians with Disruptive Behavior

This Opinion is limited to the conduct of individual physicians and does not refer to physicians acting as a collective, which is considered separately in Opinion 9.025, "Collective Action and Patient Advocacy."

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(f) Including means of monitoring whether a physician's disruptive conduct improves after intervention.

(g) Providing for evaluative and corrective actions that are commensurate with the behavior, such as self-correction and structured rehabilitation. Suspension of responsibilities or privileges should be a mechanism of final resort. Additionally, institutions should consider whether the reporting requirements of Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues," apply in particular cases.

(h) Identifying which individuals will be involved in the various stages of the process, from reviewing reports to notifying physicians and monitoring conduct after intervention.

(i) Providing clear guidelines for the protection of confidentiality.

(j) Insuring that individuals who report physicians with disruptive behavior are duly protected. (I, II, VIII) Issued December 2000 based on the report "Physicians With Disruptive Behavior," adopted June 2000.

Report CC: **DISRUPTIVE PHYSICIAN**

OMSS ACTION: **ADOPTED GOVERNING COUNCIL REPORT CC**

HOD ACTION: **THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS AGREED TO CHANGE THE TITLE OF THE REPORT TO PHYSICIANS WITH DISRUPTIVE BEHAVIOR AND AMEND. ADOPTED THE RECOMMENDATIONS IN COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2-A-00**

Introduction

At the 1999 Annual Meeting, the American Medical Association House of Delegates (AMA-HOD) adopted Resolution 9, "Addressing the Disruptive Physician." Resolution 9 instructed the AMA to identify and study behavior by physicians that is disruptive to high quality patient care, define the term "disruptive physician," and disseminate guidelines for managing the disruptive physician. The Board of Trustees referred Resolution 9 to the Council on Ethical on Judicial Affairs (CEJA).

Discussion

CEJA Report 2-A-00, "Disruptive Physician," responds to Resolution 9 introduced by the Resident and Fellow Section. The Governing Council initiated a report regarding CEJA Report 2 because some hospitals are using disruptive physician behavior policies to terminate a physician's medical staff membership and clinical privileges without providing due process.

CEJA was aware of instances of hospitals using disruptive physician behavior policies to sanction or terminate physicians when they criticize or express concerns about quality of care issues or strongly advocate for medical staff bylaw provisions or policies that maintain medical staff self-governance, protect professionalism, and ensure quality patient care. As a result, CEJA provided a copy of their draft report to the Governing Council for their review and comment.

As a result of the Governing Council's comments, CEFA narrowed the definition of disruptive physician behavior and modified several other recommendations. The Governing Council believes that the recommendations in CEJA Report 2 will provide guidance and some protection to medical staffs from hospitals and other institutions that are inappropriately using disruptive physicians policies to terminate or sanction physicians without providing due process.

Recommendation

The Governing Council recommends that the AMA-OMSS Delegate to the AMA House of Delegate be instructed to support the recommendations in CEJA Report 2-A-00.

Report 106. PHYSICIANS WITH DISRUPTIVE BEHAVIOR

Introduction

Resolution 9 (A-99), "Addressing the Disruptive Physician," instructed the AMA to identify and study behavior by physicians that is disruptive to patient care, define the term 'disruptive physician,' and disseminate guidelines for managing the disruptive physician. The resolution was forwarded to the Council on Ethical and Judicial Affairs.

Provisions of the Code that refer to behavior

The importance of respect among all health professionals as a means of ensuring good patient care is at the very foundation of the ethics advocated by the American Medical Association. The preamble to the Principles of Medical Ethics included in the Code of Medical Ethics clearly states: "As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, *to other health professionals*, and to self" (emphasis added). Many of the seven Principles at least indirectly address various aspects of this notion of professional responsibility. Principle II refers to honest dealings among colleagues and adds an obligation to expose "physicians deficient in character or competence." Principle IV requires physicians to respect the rights of colleagues and other health professionals, in addition to those of patients.

Principle V partly refers to the obligation to make relevant information available to colleagues, as well as to obtain consultation and use talents of other health professionals when indicated. Together, these brief statements clearly depict medical care as an endeavor built on collegiality and the mutual respect of all those involved in patient care.

Conversely, deficiencies in this collaborative effort are viewed critically throughout the Code, and several Opinions address these concerns directly. Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues," provides a broad frame for "intervention" when inappropriate physician behavior constitutes a threat to patient care. Although the Opinion emphasizes reporting, it implies that institutions where medical care is provided should have in place mechanisms "to assess the potential impact" of such behavior and "to facilitate remedial action." Opinion 9.04, "Discipline and Medicine," addresses incompetence, corruption, dishonest or unethical conduct that poses a real or potential threat to patients and undermines the public's confidence in the profession. Opinion 9.10, "Peer Review" refers to various entities that "scrutinize physicians' professional conduct," to ensure that a physician's exercise of medical judgment meets professional standards of competent care.

Defining "disruptive behavior"

The Code already addresses a few forms of conduct that could lead to disruptions in the delivery of care, such as substance abuse (Opinion 8.15), disputes between supervisors and trainees (Opinion 9.055), and sexual harassment and exploitation between supervisors and trainees (Opinion 3.08). This report is limited to the conduct of individual physicians and does not refer to physicians acting as a collective, which is considered separately in Opinion 9.025, "Collective

Action and Patient Advocacy."

In fact, disruptive behavior may be viewed along a spectrum. Although there is no agreed-upon definition, and the term "disruptive" is sometimes interchanged with the term "abusive,"2 it generally refers to a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care.3 Such behavior may be expressed verbally by using foul or threatening language, or through non-verbal behavior such as personal habits, for example facial expressions or manners. It may affect the broader operations of an institution, or relate more narrowly to one's ability to work with others, such as unwillingness to work with or inability to relate to other staff in ways that affect patient care. In addition, it may have negative effects on the learning environment of an educational institution—by modeling inappropriate behaviors for students and residents, and by impairing their ability to achieve clinical skills. Behavior that tends to cause distress among other staff and affect overall morale within the work environment, undermining productivity and possibly leading to high staff turnover or even resulting in ineffective or substandard care would fall within the definition of disruptive behavior.4 However, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.

In some instances, disruptive behavior may be the manifestation of an underlying condition that requires special attention. Disruptive behavior, such as aggressiveness, intrusiveness, and hyperactivity, or irritability and argumentativeness can be the effects of stress, substance abuse or withdrawal, or dementia. Also of concern are other psychiatric illnesses or organic disorders that affect physicians in ways that cause disruption within the medical care environment.

Intervention

Whether the disruptive behavior is the manifestation of an underlying pathology or not, it is important that it be addressed. In some instances, processes that already are established for grievances or for dealing with impaired workers may be expanded or may serve as models to address disruptive physicians. Policies can help ensure that the intervention process is a fair and objective one, as provided for in Opinion 9.05, "Due Process."

In developing institutional policies, it is also important to recognize that the same behavior in different environments may not result in the same degree of disruption. Policies, therefore, should be crafted carefully, keeping in mind the characteristics of the setting where they will be applied. Finally, as was emphasized in Opinion 4.07, "Staff Privileges" policies should make clear that interventions should be guided by the welfare and best interest of patients, rather than based on personal friendships and dislikes, antagonisms, jurisdictional disagreements or competitiveness among members of the staff.

Elements of a Policy on Disruptive Behavior
The principal objectives of the policy should be aimed at ensuring high standards of patient care and preserving a professional work environment. Policies should include a definition of disruptive behavior or categories of disruptive behavior that will trigger intervention. They should provide a channel through which disruptive behavior can be reported and appropriately recorded. A single incident may not be sufficient for action, but each individual report may help identify a pattern that requires intervention. Policies should establish a clear review or verification process. They also should establish a process to notify a disruptive physician that a report has been made, and provide the physician with an opportunity to respond to the report. Furthermore, they should include means of monitoring whether a disruptive physician's conduct improves. Proposed corrective actions should be commensurate with the behavior. Policies,

therefore, should allow for self-correction, as well as structured rehabilitation. Institutions should consider whether the reporting requirements of Opinion 9.031, "Reporting Impaired, Incompetent, or Unethical Colleagues" apply in particular cases. Suspension of responsibilities or privileges should be a mechanism of final resort if the behavior persists despite attempts to intervene. In addition, policies should establish which individuals will be involved in the various stages of the process (from reviewing reports to notifying physicians and monitoring conduct after intervention), and should provide guidelines for confidentiality. Finally, policies should ensure that individuals who report disruptive physicians are duly protected.

Conclusion

Behavior that disrupts the delivery of care has many facets. It may be verbal or physical, may be targeted at colleagues or patients. Since disruptive behavior ultimately can result in substandard patient care, it is important for institutions to have policies in place that will facilitate prompt and fair intervention. The Council on Ethical and Judicial Affairs previously provided detailed guidelines on reporting impaired, incompetent, or unethical conduct. Institutional processes that already have been established to address these matters may be expanded or similar ones developed to address disruptive physicians. Such a process should include an opportunity for the disruptive physician to respond to such claims and, where appropriate, to alter his or her behavior without further action. Policies also should allow for self-correction, as well as structured rehabilitation. In addition, policies should establish proper means of monitoring changes in behavior. If disruptive behavior does not improve or when patient care is jeopardized, it may be necessary for responsibilities to be removed or privileges suspended.

Recommendations

For the foregoing reasons, the Council recommends that the following be adopted and that the remainder of this report be filed:

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REFERENCES

1 In developing this report, the Council contacted the AMA's Governing Councils of the Resident and Fellow Section and the Organized Medical Staff Section, as well as the American Psychiatric Association,
the Federation of Medical State Boards, and the American College of Legal Medicine.
2 Benzer DG, Miller MM. The Disruptive – Abusive Physician: A New Look at an Old Problem. Wisconsin Med J. 1995;94:455-459.
3 Lang DA. The Disabled Physician: Problem Solving Strategies for the Medical Staff. AHA, Chicago, Ill.,
1989.
4 Pfifferling J-H. Managing the Unmanageable: The Disruptive Physician. Family Practice Management.
1997; Nov/Dec:77-92.

ADDITIONAL RESOURCES

Physicians Guide to Medical staff Organization Bylaws

The following text has been extracted from the AMA publication *Physicians Guide to Medical Staff Organization Bylaws, Second Edition,*(published 2002), and the entire publication can be downloaded at http://www.ama-assn.org/ama1/x-ama/upload/mm/395/bylaws090602.pdf.

> ***Disruptive Behavior***
> Disruptive behavior by a member can become an issue within the medical staff and should be addressed in the bylaws. Caution should be exercised to ensure that disruptive behavior is subject to corrective action to the extent that patient care is affected. Medical staff bylaws provisions that broadly prohibit activities that are "disruptive to hospital operations" can be interpreted to block legitimate medical staff opposition to proposed hospital services and plans, or to terminate members who disagree with hospital administrators or compete with hospital based services.
>
> Disruptive behavior should be carefully assessed, including clinical examination where indicated, to determine whether a referral to the medical staff wellness committee for behavioral therapy or discipline is warranted. Due to the complexity and evolution of disruptive behavior issues, the medical staff should include provisions in the bylaws for disruptive behavior that adversely affects patient care as the basis for corrective action. Details for evaluation and resolution of disruptive behavior problems may be outlined in medical staff policy.

AMA-OMSS Education Program

AMA-OMSS Education Program: **"Disruptive Behavior and the Medical Staff"** by Kent E. Neff, MD, Abbott Northwestern Hospital, and Elizabeth A. Snelson, Esq., Legal Counsel to Medical Staffs. [Contact the AMA-OMSS at (312) 464-4761]

"Sexual Misconduct, Sexual Harassment or Disruptive Behavior," September/October 1998, *OMSS Legal Advisor*. [Contact the AMA-OMSS at (312) 464-4761, to request a copy].

Federation of State Physician Health Programs
http://www.ama-assn.org/ama/pub/category/5705.html

The Federation of State Physician Health Programs, Inc. (FSPHP), is a nonprofit corporation whose purpose is to provide a forum for education and exchange of information among state programs, to develop common objectives and goals, to develop standards, to enhance awareness of issues related to physician health and impairment, to provide advocacy for physicians and their health issues at local, state, and national levels, and to assist state programs in their quest to protect the public.

Journal Articles

Reentry Into Clinical Practice, Challenges and Strategies
Saralyn Mark, MD; Jhumka Gupta, MPH, JAMA. 2002;288:1091-1096. http://jama.ama-assn.org/cgi/reprint/288/9/1091.pdf