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Resolving Disruptive Physician Behavior

WHAT TO DO ABOUT THE DISRUPTIVE PHYSICIAN?

Up to a third of complaints received by state medical societies are for disruptive behavior. Often disruptive behavior is tolerated until a crisis emerges, which then triggers disciplinary action. How else might we handle this very delicate situation?

Welcome to the clinicians roundtable. I am Dr. Leslie Lundt, your host and with me today is William Swiggart. Mr. Swiggart is the co-director for the Center for Professional Health at Vanderbilt University Medical Center in Nashville, Tennessee.

Dr. LUNDT:

Welcome to Reach MD.

Mr. SWIGGART:

Thank you.

Dr. LUNDT:

Bill, tell us about the Center for Professional Health.

Mr. SWIGGART:

Well, we are a center that actually was established in the late 90s, and we really began as a continuing medical education center to deal with physicians who got in trouble for misprescribing scheduled drugs and then shortly after that, we added a course on sexual boundary violations for physicians who get in some trouble for a variety of sexual boundary issues, may be as serious as having an affair with the patient or staff or sexual harassment charges or just inappropriate behavior joking those kinds of things, so we are on a pretty large gamut of problems. We have national programs, so we get referrals really from all over the country to our courses. Our courses are run on about a 3-day format of pretty intense CME activity, and then most recently we added a third course on disruptive behavior that we call the Program for Distressed Physicians.

Dr. LUNDT:

And how did that program begin?

Mr. SWIGGART:

Well, it began because when we noticed that there was a big need in the country and both need for physicians to learn alternative behaviors to deal with their frustrations and issues and for institutions, practices, hospitals so forth to have a strategy for working with these docs that they want to keep their valuable members of the medical community, but their behavior is causing problems that make it hard for them to work with.

Dr. LUNDT:

So is this a CME course or is this a separate treatment program?

Mr. SWIGGART:

It is a CME course one term I would like to use as we are a mid-level response that there are certainly people who can make corrections in their behavior with less intervention and there are certainly some people that need may be to leave their practice or may be to get real psychiatric treatment to deal with their behavior and then there are those in the middle that hopefully an educational approach can be beneficial and workable.

Dr. LUNDT:

And I guess I am just not clear why a CME course versus what we would consider to be a traditional treatment kind of program?

Mr. SWIGGART:

Well, couple of reasons – (1) I think it destigmatizes the intervention for the physician themselves. (2) I think there are a lot of issues around or lack of skills, lack of alternative behaviors, and CME course is a perfect venue for teaching some of those behaviors and skills that physician may not have learnt any other way.

Dr. LUNDT:

Now I know at our professional society and psychiatry at the APA, you also give this course.

Mr. SWIGGART:

Correct, we offered it for the first time last year and we will be offering it again in San Francisco.

Dr. LUNDT:

So at least for a psychiatrist that would be a way for people interested to receive this information?

Mr. SWIGGART:

Correct.

Dr. LUNDT:

Are you planning to do that with other specialties?

Mr. SWIGGART:

I have not as of yet. We have done some grand rounds at some different places and have talked to some medical boards around the

country, but that all we could put on our plate right now.

Dr. LUNDT:

I would think you are really busy, now where did your referrals come from, you said nationally, but who typically refers physicians to you?

Mr. SWIGGART:

Normally in our other courses, it is physicians' health programs and physician boards and to a small degree lawyers. For this course, the referrers tend to be large practices or large groups or hospitals, areas that really this kind of behavior did not come before the board or the physicians' health program regularly like may be just prescribing _____ or something else. So there are really these practices that are interested.

Dr. LUNDT:

And what do the physicians that I referred to you, what do they do while they are there?

Mr. SWIGGART:

Several things. We spent sometime looking at what I would call both internal and external factors, so what kind of skills or deficits did you come to the practice with that we can teach and then some external things, what are some things you can change, how can you do some things differently so that you are not the eye of the storm anymore or not attracting wrong kind of attention.

Dr. LUNDT:

Is there one specialty that might be over represented among these disruptive physicians?

Mr. SWIGGART:

You know, this is the place where we say surgeons are terrible, but actually they are not necessarily overly represented. What is represented highly are interventionalists. So whether they are from internal medicine or surgery or whatever, it is those interventionalists that seem to be the heavy hitters. We get about 20% from either specialty or general surgery, about 25% our medicine specialties, and then OB/GYN, anesthesiology, neurology, other psychiatrists too.

Dr. LUNDT:

No, no, do not tell me that.

Mr. SWIGGART:

You know.

Dr. LUNDT:

Well, I guess we are human after all, huh?

Mr. SWIGGART:

Absolutely.

If you are just joining us, you are listening to the clinicians' roundtable on ReachMD XM157, the channel for medical professionals. I am Dr. Leslie Lundt, your host and with me today is William Swiggart. We are discussing what to do about the disruptive physician.

Dr. LUNDT:

Bill, what interventions typically occur before the physicians come to your CME course?

Mr. SWIGGART:

Well, a variety of things. Sometimes there is a confrontation by the practice manager or the group or may be one physician is practice got together and tell him who has taken a month off and that he had a month to figure out what to do about his behavior. He found us that way, but others have been assessed, sometimes a group or hospital or entity will mandate or suggest a full psychiatric assessment. Occasionally there is a form of disciplinary action by credentialing board or medical board of some sort, but that is actually fairly rare at least without referrals that being disruptive in a hospital generally does not violate board action. So generally the practices and now a fear from lawyers, physicians felt threatened and hardly could counsel and sometimes they suggested that as part of their working and their situation and this course might be a good alternative.

Dr. LUNDT:

Hmm, and what have the results been for the physicians who have completed your program?

Mr. SWIGGART:

Well, I think actually pretty good. We have a paper that came out and a physician executive, which has kinds of results of our initial study and it was interesting that physicians often overestimate how well they are liked and appreciated on the initial kind of pre-course study. Their colleagues and other staff tend to rate their improvement though higher than they do , that is interesting they either they are overestimating themselves or underestimated how much they changed, so it indicates to me that often these physicians have not a great idea about how they come across, how people are perceiving them, which I think can be part of the issue that if they are not kind of able to read social cues from those around them, then it is awfully hard to know how they are coming across.

Dr. LUNDT:

But of course what seems to have made the most important measure of change is what their coworkers and colleagues think for them?

Mr. SWIGGART:

Absolutely because their coworkers and colleagues are what is driving their attendance, so absolutely.

Dr. LUNDT:

Ya, now thinking about our listeners and perhaps there are somebody out there that does work in a group practice setting or in a hospital, and there is a fellow physician that perhaps meets some of the criteria as being a disruptive physician, you know I would think certainly, but me and I am, assuming not alone here, that the tendency for us, not to act on it, to hope that it is going to go away or that the person is going to go away and that we do not have to voice our concerns in a public sort of way. What are the consequences of disruptive physician behavior if we do not address it earlier?

Mr. SWIGGART:

Well, lots of different consequences. Some are staff turnover, heard a nurse talk the other day that said that they drew straws to see who worked with Doctor so and so in the emergency room because he was so disruptive, so staff turnover, staff morale, obviously one of the sticking points if a physician is verbally disruptive and angry and demeaning, a nurse or colleague may be less apt to report a problem or make a phone call, so sometimes they do not get information that they need because of their attitude. I think the patient can suffer sometimes for some of the same reasons, but a lot of the problems tend to be around staff.

Dr. LUNDT:

That actually is for me to know. A question, do patients see this behavior in their physicians who are disruptive or are people able to compartmentalize and only act like this among their colleagues and keep it from the patients.

Mr. SWIGGART:

Well, sometimes it is not the patient who gets the burn of it; for instance, if your surgeon, you come to him and you want to sign off for surgery and he is a bully and he gets the first operating room in the morning, gets you the best time, and gets your operation a week before somebody else might have, then you are going to think he is a pretty great guy. A lot of the physicians that we get are going to be ones that have problem with staff as opposed to, though there are some that might have a high complaint ratio from patients and they will come to the administrator or the practice leaders' attention in that way.

Dr. LUNDT:

How can our listeners find out more information about the Center for Professional Health?

Mr. SWIGGART:

Well, we have a website and on that website, we have all the papers that we have written their links to them, we have written papers on each course, and couple of other things; so that is certainly available.

Dr. LUNDT:

And what is the website address?

Mr. SWIGGART:

The website is www.mc.vanderbilt.edu/cph.

Dr. LUNDT:

CPH for Center for Professional Health.

Mr. SWIGGART:

The easiest way to probably do this to google Center for Professional Health and we usually come up first or second on that.

Dr. LUNDT:

Great. Well, thank you so much for being on our show today.

Mr. SWIGGART:

Well, thank you.

Dr. LUNDT:

I would like to thank our guest today, William Swiggart who is the co-director for the Center for Professional Health at Vanderbilt University Medical Center in Nashville. I am Dr. Leslie Lundt. We have been discussing what to do about the disruptive physician.

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This is Dr. Jennifer Shu. This week we will be speaking with Jeffery Hagerman, an epidemiologist at the Centers for Disease Control and Prevention in Atlanta. We will be talking about the national MRSA education initiative.

I am Dr. Bruce Loom inviting you to tune in this week to a special public policy segment and our guest will be Dr. Jordan Berlin at the Vanderbilt University Medical Center. We will be discussing the impact of cutbacks in federal funding for cancer research.

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