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Constantine A. Manthous and Michael Ivy
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What is This?
Disruptive Physicians

Constantine A. Manthous, MD,1 and Michael Ivy, MD1

On January 1, 2009, the Joint Commission (JC) initiated a new leadership requirement that addresses disruptive or inappropriate behaviors.1 Such behaviors are reported to be prevalent2-5 and undesirable because they may promote errors that harm patients.6 This article presents 4 brief examples and explores the use of the new standard and potential unintended consequences.

Case 1
A critical care physician leads daily rounds, involving nurses and respiratory therapists, in the intensive care unit each morning. Because he conducts a busy outpatient practice, he must complete rounds briskly to get to his first scheduled patient at 9 AM. During rounds, team members’ views are seldom elicited, and all focus is on registering his dictated plan for the day so he can depart. Occasionally, he is short with team members, especially when they ask questions or share their opinions. Several hours after rounds, a 38-year-old female patient, who is recovering from a sickle cell crisis, develops septic shock resulting from a femoral vein catheter that was in place, out of sight (under the covers), for >7 days. The first-year graduate bedside nurse used the catheter daily and was aware that it was in place for longer than normal. Inquiry revealed that she did not mention it during rounds because she felt too junior to interrupt the flow of rounds.

Case 2
A 57-year-old male patient is undergoing liver transplantation for fulminant hepatic failure. In the seventh hour of a particularly difficult surgery, a scrub nurse’s glove is inadvertently sewn into a suture line. The surgeon explodes, throwing a forceps against the wall and deriding nursing team members. This behavior is not atypical; it occurs at least weekly. “Cup of coffee” (ie, informal) conversations1 with the chairman of surgery to explore the impact of the surgeon’s misbehavior on team performance had been unsuccessful in modifying his behavior. His chairman now insists that he receive formal counseling for anger management and warns that a written letter that could affect future credentialing is forthcoming for future recurrences.

Case 3
The critical care committee of a hospital is discussing evidence-based justification for full-time physician staffing. The topic had been discussed for years with little progress because some physician staff members had blocked implementation. A meta-analysis published in the Journal of the American Medical Association 4 years before,6 demonstrating strong evidence (average 29% reduction) for mortality benefit, is discussed again. A new nurse committee member comments, “If patients benefit so much, I don’t understand why we can’t do it.”7 A physician member of the committee blurs: “Financial conflicts of interest.” He is later summoned to the chief administrator’s office, formally reprimanded, and required to receive “executive counseling” for his “disruptive behavior.”

Case 4
A physician resident is sitting by the phone in the emergency department. Her supervisor passes by and asks why the resident is just sitting there looking at the phone. The resident responds that she has been waiting for Dr X to call back, so that she can discuss his patient who is being admitted to the ICU. Dr X has failed to adhere to hospital policy, and house staff have complained that he sometimes does not return calls at all, leaving them without supervision with his patients. He had been counseled in the past. The attending physician requests that Dr X’s admitting privileges to teaching services be suspended. An administrator refuses; Dr X is known to admit many patients to the hospital. The attending physician informs the administrator that if patients are harmed, the administrator must bear the responsibility for Dr X’s misconduct going forward. The administrator finds this assertion disrespectful and complains to the attending’s chair, who issues a written reprimand for disruptive behavior (ie, disrespectfulness).

1Bridgeport Hospital, Bridgeport, CT

Corresponding Author:
Constantine A. Manthous, MD, Bridgeport Hospital, 267 Grant Street, Bridgeport, CT 06610
Email: pcmant@bpthosp.org
Discussion

In all 4 cases, physicians exhibit what is technically known as disruptive behavior. For many readers, at least some of the cases (ie, cases 1 and 2) are all too familiar. Although not explicitly stated in the JC’s policy, the intent of the disruptive physician standard appears to be stated in the title: “Behaviors that undermine a culture of safety.”

A recent review by Saxton and colleagues suggests that a majority of health care personnel, sampled in 10 studies, had witnessed or been on the receiving end of disruptive behavior. Although the impact of this phenomenon is not rigorously studied, it is believed to undermine patient safety by stifling the often critical contributions of nonphysician health care team members.

Although the physician in the first case was not punished or labeled as disruptive, his conduct undermines teamwork and “psychological safety” that is critical to safe care. The conduct described in this case is arguably the most prevalent manner in which physicians’ behavior “undermines a culture of safety” by quashing input from others who may have critical information to contribute. Although the behavior of the physician in case 2 is familiar to most hospital leaders, it is slowly waning and addressed directly through proper application of the disruptive physician mechanisms, which are to discourage bad behavior and to follow a deliberate, fair process to remedy it when it occurs.

Cases 3 and 4 are less common but could be an unintended consequence of “disruptive physician” policies. They share a common feature: The clinician’s behavior “undermines a culture of safety” by quashing input from others who may have critical information to contribute. Although the behavior of the physician in case 2 is familiar to most hospital leaders, it is slowly waning and addressed directly through proper application of the disruptive physician mechanisms, which are to discourage bad behavior and to follow a deliberate, fair process to remedy it when it occurs.

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All these cases hinge on the definition of disruptive behavior, which is not explicit in the JC document. Several interpretations can be found in the published literature. Although application of a process to address physician behavior is likely to benefit patients and staff in the first 2 cases, it may harm patients in cases 3 and 4. In this way—as a weapon to discourage dissent, even when it is on behalf of patient safety—JC policies can be misused to undermine a just culture and greater patient safety. Accordingly, alternative, more accurate terminology or, better yet, precise definitions that delineate improper use may be helpful.

The JC is an increasingly muscular force to promote safer health care institutions. Some clarification of the definition of “disruptive” and prohibitions against institutional abuse (perhaps permitting appeal to the JC itself) might strengthen this important new tool intended to promote patient safety.

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References


