ABSTRACT
Disruptive physician behavior is now generally recognized to pose a potential threat to patient safety. Recent policy positions and sentinel event designations have acknowledged this. Disruptive behavior is a widespread event with some 1-5 percent of physicians acting in a disruptive manner although significantly higher rates are cited for incidents of verbal abuse. Disruptive behavior can be classified along at least two dimensions. The first dimension is whether the behavior is goal-oriented in the sense that the physician achieves some goal or end. The second dimension focuses on the physician’s social/behavioral competence. In addition, the disruptive physician should be assessed for psychological or psychiatric conditions (Axis I and II) as well as medical conditions that could be contributing.

After classification of the behavior and determination of the physician’s mental and physical functioning, it is possible to develop appropriate remedial strategies. These may include knowledge and skill development, psychiatric and psychological treatment, medical treatment and modifications to the hospital or clinical system in which the physician works. Failure to consider the multifactorial causes and manifestations of disruptive behavior could lead to ineffective approaches that do not successfully address the problem and present a high risk of relapse, thus posing a continuing threat to patient safety.

Disruptive behavior among physicians is an ongoing problem in the medical profession. Until recently there has been little consensus that such behavior has an adverse effect on patient safety or clinical outcomes. However, there has been increasing and converging evidence that such behavior does indeed threaten patient safety and clinical outcomes causing The Joint Commission to conclude: “To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.” After reviewing the literature and assessing and treating these physicians it is apparent to these authors that disruptive behavior in the workplace manifests in a variety of ways and has a number of different etiologies. As will be discussed, effective responses to disruptive behavior requires a thorough understanding of both the behavior and its causes. This paper reviews the literature on disruptive behavior and draws on our experience working with disruptive medical professionals. We then provide an organizational scheme for classifying disruptive behavior and its etiology.

DEFINITION AND DESCRIPTION
“A disruptive physician is best described as someone who undermines practice morale, steals from productive activities, intimidates or threatens harm to others and disproportionately causes distress to others in the work environment.” The American Medical Association (AMA) defines disruptive behavior as:

“Personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care. (This includes but is not limited to conduct that interferes with one’s ability to work with other members of the health care team.)”

The Joint Commission notes that disruptive behaviors include “overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities … Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions.” Disruptive behavior can also include criticizing staff or colleagues in front of patients or colleagues, writing inappropriate chart notes as well as non-
verbal behaviors that others perceive as threatening, hostile, intimidating or disrespectful. The Federation of State Medical Boards (FSMB) has recognized

“State medical boards, through legislative or regulatory process, should amend their medical practice acts or regulations to include disruptive behavior by physicians as grounds for disciplinary action. Due to the potential for patient harm, it is imperative that state medical boards be adequately empowered to investigate complaints of disruptive behavior by physicians and take appropriate action to protect the public.”

The Joint Commission recognizes the necessity of having policies and procedures in place to identify and respond to disruptive behavior. Effective Jan. 1, 2009, for all accreditation programs, The Joint Commission has a new Leadership standard (LD.03.01.01) that addresses disruptive and inappropriate behaviors in two of its elements of performance:

EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.

EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

In addition, standards in the Medical Staff chapter have been organized to follow six core competencies (see the introduction to MS.4) to be addressed in the credentialing process, including interpersonal skills and professionalism.

PREVALENCE

Although there are no data that conclusively demonstrates the prevalence of disruptive behavior, estimates are available from a variety of sources including survey, focus groups and discussions, rates of referral to physician health programs and international data.

Linney’s report of survey data obtained through the American College of Physician Executives (ACPE) found that 1-5 percent of physicians are disruptive. More recently Weber reported data on approximately 1,600 physician executive respondents. More than 95 percent of respondents reported encountering disruptive and/or potentially dangerous behavior on a regular basis while 70 percent indicated that the behavior “nearly always involves the same physician over and over”. More than half of those surveyed reported that the behavior most often occurred between the physician and nurses or physician assistants. Rosenstein and O’Daniel surveyed health care professionals and administrators within a health care organization. More than half reported that 1-5 percent of medical staff exhibits disruptive behavior. Leape and Fromson estimate the incidence of disruptive physician behavior to be 3-5 percent of physicians.

Whittemore citing a descriptive study by the American Association of Critical Care Nurses in conjunction with Vital Smarts LC documented, “that most nurses and other health care providers had experienced some degree of condescending, insulting or rude behavior and a third had encountered verbal abuse” and that these behaviors are often not addressed. Likewise, the Institute for Safe Medication Practices conducted a survey and found that 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator.

There are also data from state medical societies indicating that disruptive behaviors (independent of substance abuse and other forms of impairment) comprise up to 30 percent of complaints received. There is data on disruptive behavior from other countries. There have been studies of disruptive behavior in Australia, New Zealand and England. Those data suggest that rates in those countries are similar to those in the United States.

CONSEQUENCES

Disruptive behavior can cause a multitude of problems for organizations. Keashley and Neuman report preliminary and accumulating data suggesting that workplace bullying and related forms of disruptive behavior adversely impacts individuals, workgroups and the organization. Specifically the impact of these behaviors include increasing levels of job dissatisfaction, voluntary turnover, increased levels of stress, as well as potential organizational costs including formal grievances. Studies link patient complaints about unprofessional, disruptive behaviors and malpractice risk. Since there is some evidence that malpractice lawsuits and findings do not have a strong correlation with actual medical errors the behavior of the physician and their communication may represent the greatest threat for litigation risk both to the physician as well as the hospital. Rosenstein and colleagues suggest that disruptive behavior is helping to fuel the nationwide nursing shortage and impacting job satisfaction as well as morale for nurses. Williams and Williams demonstrated decreased morale as well as decreased sense of affiliation with both the workplace and the profession among health care professionals who are part of a workgroup with a disruptive member.
The importance of communication and teamwork in the prevention of medical errors and in the delivery of quality health care has become increasing evident (see for example Crossing the Quality Chasm: A New Health System for the 21st Century and Chassin and Becher). Leape and Fromson citing Benzer and Miller and also Diaz and McMillin suggest that disruptive behavior can increase the likelihood of medical errors, secondary to nurses, residents and colleagues avoiding the disruptive physician and or causing these individuals to be afraid to offer suggestions or ask for help or clarification. Williams and colleagues have demonstrated the presence of role confusion, decreased morale and social distancing of teams with a disruptive physician. Poor communication can lead to compromised patient safety and has been identified as a root cause of percent of anesthesia related sentinel events. It appears that disruptive behavior reduces the quality of delivered care and threatens the health care workplace in two interrelated ways. First, because disruptive behavior interrupts the normal routine of the workplace, it places an unacceptable burden on the co-workers of the disruptive individual and affects the safety and quality of the workplace environment. Second, because disruptive behavior interferes with the smooth communication between professional colleagues and allied health professionals it impacts the functioning of the medical delivery team, and thus presents a threat to patient safety. Increased awareness about patient safety practices are clearly at odds with disruptive clinician behavior, and this is causing health care organizations and the industry as a whole to re-examine their long-standing tolerance of such behavior.

IDENTIFICATION

Identifying and addressing the issue of a disruptive physician in the workplace can be difficult for a number of reasons. Many organizations have not implemented a comprehensive and consistent plan that addresses all the pertinent issues and provides sufficient options for intervention. There may not be a consistent standard within the workplace of what constitutes disruptive behavior. Hospitals may have a higher tolerance level for behavior in those physicians who are highly productive although the new Joint Commission standards may help with this issue. Fear of repercussions can contribute to under-reporting, particularly by allied staff. If the disruptive behavior has been longstanding, staff may feel that the effort is not worthwhile since in their mind little has been done to remediate the problem. Frequently the complaint process is lengthy, and those who complain do not get feedback, again contributing to the notion that it is futile to complain. Disruptive behavior may take several different forms; some clearly identifiable others subtler and less obvious. If the behavior is passive (for example not responding to pages) others in the system may try to accommodate for this disruption by getting the necessary services or information in other ways making the disruptive behavior less apparent.

ETIOLOGY OF DISRUPTIVE BEHAVIOR

The etiology of disruptive behavior is complex. Leape and Fromson conceptualize physician performance problems as symptoms of an underlying disorder with potential causes including mental or behavioral problems. According to Porto and Lauve and Weber disruptive behaviors are most often not associated with drug or alcohol impairment. Schouten (reported in an article by Splete) presented data from his experience with cases of physicians referred for disruptive behavior. The doctors were evaluated for psychiatric disorders. Schouten reported that the most common diagnosis in his sample was “personality disorder not otherwise specified,” for of the doctors, followed by 15 with major depression, 10 with substance abuse, nine diagnoses involving personality traits, seven cases of adjustment disorder and six cases each of bipolar disorder and sleep disorder. Other non-Axis I and II diagnoses included two cases of anxiety disorder, two cases of attention-deficit hyperactivity disorder and one case of obsessive-compulsive disorder. Neff, cited by Maier, reported on a cohort of disruptive physicians receiving assessment and treatment. Reportedly nearly 80 percent of these physicians had psychiatric illnesses, all of which were treatable. Nearly 30 percent had “challenging personalities.” Persons with the ‘dramatic, emotional or erratic’ personality disorders (antisocial, borderline, histrionic and narcissistic), paranoid personality disorder or a personality disorder with a combination of these traits, are most problematic. Although a more unusual presentation, we in our own practice have had a very small percentage of physicians referred for disruptive behavior that have had a neurological condition such as a dementia. Additionally external stressors such as fatigue, overwork and family strife can exacerbate mental or behavioral problems or can occur in absence of them.

Williams and colleagues assert that disruptive behavior has both a mental health component, as well as an intentional component, i.e., there are situations in which the disruptive behavior accomplishes certain goals within the system. The authors take a systems view of disruptive behavior in which the behavior is exhibited within a clinical micro-system and provides some response or result that is viewed as a reward by the physician. According to learn-
ing theory the behavior is thus “instrumental” in that it achieves something the physician wants, and, in doing so increases the probability the disruptive behavior will occur again. Examples of potential rewards for disruptive or abusive behavior include nursing staff not calling the physician and hospital staff providing the physician with the operating suite, team or start time he prefers.

CLASSIFICATION SYSTEM

The four quadrants represented in Figure 1 provide a classification system for disruptive physicians’ behavioral problems. The first dimension assesses the degree to which the behavior is goal oriented, the second assesses social/behavioral competence. These distinctions are important in identifying the causative factors, diagnosis and necessary remedial efforts. Goal oriented behavior implies that the person tends to achieve a goal. If the individual achieves the goal, this reinforces the behavior, then increasing the likelihood the behavior will recur. Examples of possible goals are decreasing the number of calls or questions from nursing staff or other allied health professionals, not getting disturbed when on call, sabotaging hospital policy, getting specific surgery times or surgical teams, discrediting other physicians or allied health professionals or controlling recovery beds to maximize surgical opportunities.

The second dimension refers to the individual’s competence in terms of interpersonal and communication skills as well as professionalism. This dimension is consistent with the conceptualization of the Accreditation Council for Graduate Medical Education (ACGME), American Board of Medical Specialties (ABMS) and Institute of Medicine (IOM) all of whom recognize the need for physicians to possess these skills and abilities in order to be able to competently function within an interdisciplinary medical team. Our approach to this dimension includes functioning in both personal and professional settings. Conceptualizing the disruptive behavior as having a foundation in a medical, mental or behavioral disorder, as well as providing some reward allows classification of the specific case along two dimensions that we label competence and degree of goal orientation of the behavior (see Figure 1).

Critical to making appropriate recommendations about how best to address the disruptive behavior is also a consideration of whether the physician has any medical or psychiatric conditions that might be either causing or contributing to the behavior. Medical conditions such as some forms of dementia or epilepsy for example can be associated with behavioral changes that can include disruptive outbursts. Likewise various psychiatric conditions (Axis I clinical disorders) such as substance use, bipolar, anxiety and impulse disorders can all be associated with disruptive outbursts. Additionally, personality disorders and even personality traits can contribute to maladaptive behavior. In fact, the Diagnostic and Statistical Manual-Fourth Edition Technical Revision (DSM-IV-TR) defines personality disorder as an enduring pattern of inner experience and behavior that deviates markedly from the expectation of the individual’s culture and leads to clinically significant distress or impairment in social, occupational or other important areas of functioning.

The physician’s status on the above domains can be determined by looking at the history of the behavior (this can sometimes be accomplished through reviewing incident reports and talking with key personnel that interact with the physician), having a sense of the physician’s functioning during non-disruptive episodes, gathering medical and psychiatric information or through referral of the physician for an independent evaluation. Taken together classifying the behavior according to competence and goal focus, and considering medical and psychiatric conditions and knowledge provides a useful way of categorizing cases.

Physicians who have low competence and low goal directed behavior would be found in the lower left quadrant. These physicians behave in ways that are ineffective and inarticulate. Their behavior is not targeted and often expressed to individuals or occasionally systems that are not contributing to the issue that is causing the discomfort that motivates the disruptive behavior. Considering this in the context of medical and psychiatric conditions, as well as their level of knowledge and skill, further clarifies steps necessary to
Physicians who are competent and whose disruptive behavior is directed toward defined goals or objectives are placed in the upper right quadrant. These physicians manifest their behavior in ways that can be articulate and is frequently very effective. While occasionally such behavior is directed at an individual or individuals, frequently the behavior is directed at the workplace system in an effort to achieve a personal or business advantage. For this reason the quadrant is labeled “gaming.” The behavior is often directed toward design weaknesses in the system that can be exploited to the advantage of the disruptive physician.

To illustrate this, the following case vignettes are presented.

Case 1: High Goal Oriented, Low Competency
A 49-year-old male hospitalist repeatedly hung up on nursing staff, yelled when asked for clarification and did not respond to pages. These behaviors were described as longstanding in nature and most frequent during the evening. Another frequent complaint was that he was unavailable to speak with patient’s families. Nursing staff would contact other physicians for both medical information and to provide families with information. Assessment results suggested that his social competence was poor; additionally he had characterological issues that contributed to the behaviors. His behavior was purposeful in that he recognized that his behavior helped him get the desired result (not to be contacted).

Case 2: High Goal Oriented, High Competency
A 68-year-old cardiac surgeon was referred as a result of a number of complaints from colleagues who cited inappropriate behavior in the operating room (taking outside calls), poor patient follow-up, inappropriate use of nursing staff and abuse of operating room privileges (claiming cases to be emergent when they were scheduled to extend hours to weekends and evenings). The behavior was described as longstanding, though it recently exacerbated. Also, for the first time, accusations of substandard care were raised. Upon investigation the physician was found to have no remarkable psychological issues. A separate investigation of the quality of care issue was found to be baseless. Investigation of the hospital found considerable acrimony among the surgeons, and the index physician was found to have nearly twice as many cases as the next most active surgeon. The conclusion was that the disruption stemmed from competition among the surgeons and, in specific from the index physician using and abusing certain operating room rules and procedures to preferentially slot his cases into the schedule.
Case 3: Low Goal Oriented, Low Competency
A 54-year-old orthopedic surgeon was referred as a result of complaints from nursing staff that described him as condescending, directive, rude and derogatory. They further indicated that he became angry when they asked for clarification. The behavior was described as long-standing and not specific to the workplace — his wife and children reported similar behavior at home. The physician was born, raised and educated abroad. Assessment results suggested a strong cultural component.

Case 4: Low Goal Oriented, High Competency
A 52-year-old family practice physician was referred as a result of his two-year history of “snapping at nursing and administrative staff.” Prior to this point in time he was described as being collegial and collaborative. The group was concerned about possible turnover in support staff as a result of the more recent behavior. The group also reported some problems with his charting in that he was no longer timely with his charts. Assessment results indicated that he and his wife had separated approximately two years ago, they were in the process of filing for divorce and he was depressed. The group was unaware of these external stressors and was both surprised and relieved when the association between the external stressors and problematic behaviors became apparent.

ASSESSMENT/DIAGNOSIS
Recognizing the antecedents, pattern, duration, response and outcome of the behavior assists in determining how to proceed. Additionally, it is important to consider whether the physician is competent in the domain of professional-interpersonal behavior and communication and whether the physician’s behavior aimed at a specific goal. If the behavior is particularly egregious, the physician appears unremorseful or unconcerned about the behavior, the physician has not responded to prior informal interventions, the physician has been at a number of different work settings or if the disruptive behavior has characteristics that include a sudden onset or a marked change from previous behavior, then a comprehensive evaluation may be indicated. A comprehensive assessment can be helpful in determining the etiology of the disruptive behavior and thus informs the design of an appropriate remediation/treatment strategy. Psychiatric and psychological assessment (including testing), urine toxicology screens, physical examination, record review and collateral phone calls are frequently required to elucidate the contribution of mental disorders (Axis I) and/or characterological issues (Axis II issues). We also believe that it is important to gain an understanding of the origin and instrumentality of the disruptive behavior. This requires collecting comprehensive data including a history of the behavior, the events preceding the disruptive behavior, a description of the event, consequences of the behavior for the physician and health care team, patient management and outcome data.

TREATMENT
Treatment can take many forms. We believe that treatment decisions informed by a thorough understanding have the best chance of success. The goals of treatment are to address any medical or psychiatric disorder, reduce the level of disruptive behavior, assist the physician in developing new skills, address issues related to patient safety, minimize the re-occurrence of disruptive behavior and foster a collegial and collaborative work environment. The best outcome is frequently accomplished through a combination of individual treatment, psychoeducation, a systems approach and a strong aftercare program.

Disruptive physicians who have low competence in social/professional team behavior and whose behavior is not effectively goal oriented (displaced frustration-the lower left quadrant of Figure 1) are most effectively treated/managed by focusing on approaches to increase their social competence. Depending on the individual, this might take the form of psycho-educational instruction, coaching, modeling, psychological treatment focusing on emotional-interpersonal competence, training on professional-team collaborative practice or often a combination of these modalities. In addition, it is not infrequent that these individuals require individual therapy for either Axis I or Axis II disorders. Because these disruptive physicians misdirect their disruptive behavior, there is commonly little necessity of interventions into the organizational systems in the workplace; however, successful reentry often requires working with the teams who were subject to the disruptive behavior to effectively reintegrate the physician back into the workplace.

Disruptive physicians who are low in competence in social/professional team behavior and whose behavior is effectively goal oriented (aggressive behavior-upper left quadrant of Figure 1) require a similar approach to that previously described. However to effectively change and maintain the changes in their behavior also requires changes to the systems within the work environment. Their behavior, by accomplishing some goal, is reinforced by the system on its occurrence. Even if the individual treatment is effective, if they revert to their behavior even occasionally on return to work, the behavior’s efficacy will reward the disruptive phy-
Disruptive physicians who are highly competent in social/professional team behavior and whose behavior is effective-ly goal oriented (gaming behavior-upper right quadrant of Figure 1) require a system intervention to effectively address and remediate the behavioral issues. These individuals are often quite skilled in manipulating the system and people within the system. The most effective way of eliminating the unwanted behavior is to insure that the system does not provide them with the goal they are seeking. Even more effective, where possible is to change the system so that to achieve something that they want they cannot also continue to behave in a disruptive manner. Optimally the desired behavior is reinforced while the competing or negative behavior is no longer tolerated by the system. Frequently it is necessary to work with team members as well as administration to accomplish the desired outcome in these cases.

Disruptive physicians who are competent in social/professional team behavior and whose behavior is not goal oriented (anger management-lower right quadrant of Figure 1) understand the appropriate social roles but cannot uniformly and consistently maintain their emotional control. While typically the disruptive behavior is active (they yell) it may also be passive. Remedial strategies often take the form of education, modeling and coaching. Often in these cases, there is some external stressor that is contributing to the difficulties. The behavioral response may arise in connection with reactive depression or situational anxiety. In such cases individualized therapy and/or medication may be indicated. An understanding of the contributing factors is helpful in fully addressing the situation.

In terms of approaches, role modeling, coaching and educational interventions address deficits in skills. Individual treatment addresses psychiatric and psychological factors. It may include medication management for Axis I disorders such as a mood or anxiety disorder; as well as insight oriented work and a psycho-educational component. When characterological issues (Axis II disorders) are the primary etiology, group therapy in combination with insight and psycho-educational modalities is a particularly helpful methodology. It is often important for primary treatment providers to assist the physician in identifying an appropriate mentor within the workplace and to work with the organization to develop a mechanism that clearly lays out appropriate and inappropriate behavior and the consequences of each. An intensive treatment experience that includes each of these components can be quite helpful in addressing the multiple issues that are associated with disruptive behavior. Focused and intensive educational programs have also been demonstrated to be a useful remedial strategy.44 These are particularly helpful for physicians with low social and interpersonal competence (lower right and left quadrants) and also can be useful as a means of reinforcing knowledge and skills gained during an intensive treatment experience.

Because it is important that the treatment gains are consolidated and transferred to the workplace environment we have found that gathering data post re-entry (see for example Harmon and Pomm19), follow-up visits and focused remedial training are helpful as part of follow-up and aftercare that foster consolidation and transfer of primary treatment gains. The treatment for system based behavioral disorders should also be informed by the assessment and diagnosis. The nature of the intervention must address the specific benefit, or instrumentality, sought by the individual through their disruptive behavior. Appropriate resolution of these cases often requires recognition of both psychological and legal factors.46

**CONCLUSIONS**

Disruptive behavior threatens patient safety and effective functioning in the workplace. Disruptive behavior contributes to medical errors by disrupting the effectiveness of team communication. The potential negative sequelae of the behavior coupled with its prevalence necessitates that consistent and effective policies to address and remediate the behavior are in place. The seriousness of this problem is recognized by a broad spectrum of medical agencies concerned with delivering high quality medicine including the FSMB30, ACGME36, ABMS41, IOM42, IHI47, Association of American Medical Colleges (AAMC)48, AMA3 and The Joint Commission1.

The behavior of disruptive physicians is heterogeneous, both in its expression and etiology. This heterogeneity requires a careful assessment of the disruptive physician in order to effectively design an appropriate intervention strategy. Depending upon specific situation, this might
include treatment or discipline. The characteristics of effective treatment range from education to changes in workplace systems. Treatment optimally addresses both the cause and/or motivation of the disruptive behavior and teaches the physician new and more adaptive ways of interacting. Effective treatment can range from educational instruction and remediation for those with a knowledge deficit to more intensive therapeutic work. Frequently effective treatment requires multiple modalities including treatment of the individual, psychological, psychiatric, medical and instructional; as well as changes in the work environment including modification of medical systems and training of medical and support staff.

Ignoring disruptive workplace behavior potentially endangers patient and places unacceptable burdens on the workplace and co-workers. Disruptive physicians are impaired in their ability to function within a medical team. Effective response requires an approach that responds to the individual differences that contribute to the disruptive behavior.

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