Treatment Program Targets 'Disruptive Physicians'

Reasons for program referral include anger, performance and compliance issues, sexual misconduct, and theft.

BY HEIDI SPLETE
Senior Writer

ARLINGTON, VA. — Can a surgeon who brings a gun to the operating room be trusted not to use it? That's an extreme example of the kinds of questions that psychiatrists must address when doctors are referred to them for evaluations.

"Disruptive physicians" are doctors whose behavior undermines their personal and professional effectiveness, Ronald Schouten, M.D., said at the annual conference of the Academy of Organizational and Occupational Psychiatry.

"We are talking about people who engage in problematic behavior that interferes with their relationships at work or at home and has a potential impact on patient care, productivity, and administrative functions," said Dr. Schouten, director of the law and psychiatry service at Massachusetts General Hospital, Boston.

Dr. Schouten presented data from his experience with 82 cases of physicians who had been referred for disruptive behavior. The doctors studied were evaluated for Axis I disorders, but the primary problems proved to be disruptive or noncompliant behavior. The sample excluded disability cases.

Overall, 69 doctors were referred by Physicians' Health Services at their hospitals, 7 by their practices or facilities, 3 by attorneys, 2 by residency programs, and 1 by the medical board.

Surprisingly, 15 were internists and family practice physicians, compared with only 3 general surgeons. "We expected to see more surgical specialists," since surgery is stereotypically considered to be a particularly stressful field, he said. The average age was 48 years, and most of the doctors (82%) were men. Six of the internal medicine physicians were cardiologists, making cardiology the most common subspecialty in the sample.

Anesthesia was the most common specialty, comprising 13 cases, followed by ob.gyn., with 12 cases. Four of the cases involved emergency medicine physicians, three involved neurologists, and two involved psychiatrists.

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Displays of anger proved to be the most common reason for referrals. In 36 cases, doctors were referred because they had lashed out physically or verbally, or because they had spooked their colleagues with behaviors such as wearing a gun in the operating room.

An additional 19 cases involved performance and compliance issues, and 11 cases involved sexual misconduct by the doctors. Other problems included sexual harassment, suspicion of substance abuse, communication problems with staff or peers, theft, and antisocial behavior.

Dr. Schouten noted that in California, the state medical board investigates about 10,000 complaints about disruptive physicians per year. Typically, nearly 80% of these are closed after an initial inquiry, but 20% are investigated further.

In this review, which looked at 584 physicians who had been disciplined by a state medical board over a 30-month period, 75 or 12.8% were psychiatrists—although psychiatrists make up only 7.2% of the percentage of physicians in California, he said.

Diagnosing disruptive doctors involves a caveat, Dr. Schouten said. When physician referral programs send doctors for a psychiatric evaluation, they often are unable to keep physicians in a behavior improvement program without a diagnosis of an Axis I or II disorder.

"There is a bias in favor of finding something to write on the form," Dr. Schouten said. As a result of that bias, the most common diagnosis in his sample was "personality disorder not otherwise specified," for 37 doctors, followed by 15 cases of major depression. There were also 10 cases of substance abuse, 9 diagnoses involving personality traits, 7 cases of adjustment disorder, and 6 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.

Complete medical screening is an important part of a fitness for work evaluation. Hypertension, found in six cases, was the most common medical problem in the group, followed by hypothyroidism in five cases, and sleep apnea in four. In addition, there were two cases of diabetes, two of obesity, and one case each of Lyme disease, colon cancer, and irritable bowel syndrome.

Among the postevaluation recommendations for these physicians were initiation or continuation of psychiatric treatment, including psychotherapy with a focus on gaining insight into the reasons for the bad behavior; anger management; cognitive-behavioral therapy; and random urine screens in cases of substance abuse. Dr. Schouten strongly recommended that physicians receive follow-up treatment from someone of the same cultural background if possible who is not a colleague, even if that means traveling out of town. Bringing in a business consultant may help a stressed solo practitioner.

The data on outcomes for doctors who have psychiatric referrals are soft, he admitted, but about 80% of physicians whom he has evaluated returned to work. About 9% went out on disability.

Motivating anyone—even physicians—to sustain behavioral change is difficult, Dr. Schouten said. The process of seeing a psychiatrist causes a short-term change in behavior, but over time, people tend to revert to their baseline habits. Many physicians who are referred for a psychiatric consultation resent any suggestion that they be held accountable for their actions. But the term "anger management" meets with less resistance than does "psychotherapy" because it lacks the stigma associated with a mental health problem, he noted.

"Physicians are amazingly lacking in insight into their own behavior," Dr. Schouten said. "One of the things treatment programs struggle with is how to teach insight to these very bright, well-trained people." ■

Planning Ahead Called Best Defense Against Workplace Violence

BY DOUG BRUNK
San Diego Bureau

SAN DIEGO — There is no one technique or strategy that will protect you from the risk of physical attacks in your workplace by patients or coworkers, Donna Pence declared at a conference sponsored by the Chadwick Center for Children and Families at Children's Hospital and Health Center, San Diego.

"There is nothing about who and what you are that makes you immune from people intent on doing bad things," said Ms. Pence, training coordinator for San Diego State University's Public Child Welfare Training Academy. "Not looks, not money, not profession, not uniform, not where you live, not how religious you are, or how good you are."

The best self-protection involves a combination of factors, including being aware of your capabilities, your environment, your habits, realistic hazards, and your options should a violent episode occur.

She offered the following tips:

► **Do some self-reflection.** What is your history of violence and anger and your response to it? Have you been in situations where you felt threatened, and now you feel hypervigilant? Your personal history of violence "will affect your response to situations," said Ms. Pence, who spent 25 years as a special agent with the Tennessee Bureau of Investigation. "It will impact the lens through which you view [someone's] behavior. That can be good, but it also could lead you to jump the gun and have a perception of violence and danger when it doesn't really exist."

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► **Make an effort to understand your colleague's attitudes about personal safety and anger in the workplace.** Are you allowed to talk about it? Are you encouraged to talk about it? "Is there a forum where you can ventilate about any anxieties you have about a client, or any anger you may have toward the client?" Ms. Pence asked. "Because if you're angry and they're angry, that's not a real healthy combination."

Also, ask yourself, are there people in the office who can hear you if you yell for help? Is there an emergency buzzer nearby? If somebody enters the office and a buzzer goes off, do we have a plan on what to do?

► **Think twice before visiting a patient in his or her home.** Look at prior referrals. Consult with social workers or other physicians to see if the patient has a history of violent behavior. "If I have somebody who's been arrested for drugs, weapons, domestic violence, or child abuse, I'm going to think twice before going out to their turf by myself," she said.

To protect against workplace violence and abuse, Ms. Pence recommended working on "target hardening." Target hardening is a military term that refers to the notion that you are the person you are trying to make most safe.

"Until you recognize your personal, physical, mental, and environmental culpabilities and the possibility of victimization and do what you can realistically to reduce these, you're not a hard target," she explained.

This means:

► **You must be aware.**

► **You must think in a different way.** For example, "Don't walk down a sidewalk that has doors on one side and bushes on the other," she advised. Also, when you approach a parking lot, don't skirt the edge of it. Rather, "walk toward the middle of the parking lot and look to the left and right."

► **You must act in a different way.** "The way you walk, look, and carry yourself makes a difference in the degree of vulnerability that is ascribed to you by someone looking to attack," Ms. Pence said. "Look confident, look aware, and be in the present."

► **You must recognize your personal vulnerabilities.** Ask yourself, how could I defend myself in the event of a personal attack? "For example, I'm not a long distance runner," Ms. Pence said. "I don't aspire to be a runner. That's a realistic assessment of my physical abilities. If there are areas where you have a deficit, ask, what can I do to enhance my abilities? Maybe it's learning some form of self-protection or learning verbal de-escalation techniques." ■