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Dealing with Difficult Medical Colleagues

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Current health care requires effective collaboration among providers. Poor communication may lead to poor patient outcomes. Although emphasis has been placed on interprofessional communication (particularly between physicians and nurses) in the health system [1], little has been written about problems in communication within the medical profession. During medical school and residency training students and residents are often confronted with problems related not only to supervisors but also to people at the same training level, as well as ancillary staff. Problems may also arise in dealing with colleagues in collaborative care and consultations, and this may contribute to physician burnout. Furthermore, we believe that each physician, throughout his/her career, spends a substantial amount of time dealing with difficult colleagues.

First, we will discuss the notion of difficult colleagues on the basis of the available limited literature, which uses multiple overlapping terms. We will then attempt to sketch some of the communication difficulties that may occur among physicians, based on our own extensive experience in providing and receiving consultations.

Who Are the Difficult Colleagues?

There is not a single, unifying term or definition delineating difficult, impaired, disruptive, or problem doctors. Multiple PubMed searches from inception to January 2017 revealed the use of the adjectives "impaired," "disruptive," and "problem," besides "difficult," to classify doctors or physicians. Searches with any of these terms in the title or abstract were used to identify articles. Besides this literature search, several of the authors contribute with their deep knowledge of the consultation-liaison psychiatric literature [2–6].

"The Impaired Doctor/Physician"

The term "impaired doctor" usually describes the most troublesome of abnormal behavior, such as psychosis, cognitive impairment, or addiction [7]. Impaired doctors or doctor/physician impairment usually refers to a physician or situation in which physicians are considered unable to perform their professional duties, often due to issues including mental or physical illness. These doctors are dealt with by the medical profession

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sooner or later. Mandatory requirements for reporting impaired doctors have been developed in some countries [8].

"The Disruptive Doctor"

The term "disruptive doctor" is used to describe a lower level of abnormal behavior than that of the impaired physician. Although the term is used in other countries [9, 10], most articles have been published in US medical journals. Some of them express concern that failure to deal with disruptive physicians may interfere with hospital accreditation. They explain that medical executive committees that govern each US hospital are responsible for dealing with these physicians [11]. The literature provides multiple definitions of "disruptive doctors" [12–15], but according to Reynolds [16] this label should not be applied to physicians presenting controversial ideas or offering criticism of the medical system. In the US, the two most important definitions of disruptive behavior in physicians come from the American Medical Association (AMA) [13] and the organization responsible for hospital accreditation [15]. The AMA defines disruptive behavior as [13] "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." The organization responsible for hospital accreditation [15] defines disruptive doctors as those whose "intimidating and 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."

The operating room can be a particularly difficult work environment; it is characterized by a high level of complexity and high work volume in which the surgeon in charge of the operation needs to interact smoothly with the rest of the surgical team. Thus, it is not surprising that US surgeons appear to be particularly concerned about disruptive colleagues [14, 17–28], although, traditionally, many surgeons did not consider some of these behaviors to be disruptive [20, 25]. The available studies, although limited, suggest that disruptive behaviors may be more prominent in surgeons [17, 21, 29], but also in interventional physicians [21] and doctors working in emergency departments [21, 30, 31].

Myers [32] provided a host of examples of disruptive behavior, especially in academic settings: "crude language and swearing at residents; not being available when on call; drinking or using drugs on duty; discriminatory remarks toward minority colleagues; sexually harassing comments or actions with colleagues, staff, and trainees (unwanted sexual advances, offensive language, turning others against the person); unprofessional words and interventions with patients; lying about a colleague's integrity and swaying others against that person; splitting the treatment team; passively-aggressively not meeting academic responsibilities, expectations, and promotion standards; excessively using projection and threatening litigation during performance reviews or when confronted with complaints that have been filed about his or her behavior." Myers [32] also notes that disruptive behavior is always upsetting to the milieu and arouses high emotions in all of those involved.

"The Problem Doctor"

The term "problem doctor" [33, 34] and related terms [35–37] are used in two ways. Some articles restrictively define "problem doctors" as those with poor clinical skills [33], but in other papers definitions are broader, including physicians who commit sexual offenses, are impaired, are disruptive, or are less than competent. There are no sound investigations on the prevalence of physicians exhibiting problematic behaviors. In 1994, Donaldson [35] studied 850 physicians of the British National Health System during a 5-year period. He found that about 6% (49/850) had been considered for disciplinary actions. Interestingly, an area which has frequently been explored in psychiatry is sexual misconduct. In 2001, Morrison and Morrison [38] studied physicians disciplined by the California Board of Medicine during a 30-month period. Female physicians were underrepresented among disciplined physicians. Psychiatrists accounted for 13% (75/584), which is nearly twice their percentage among physicians who were not disciplined, and were significantly more likely than non-psychiatrists to be disciplined for sexual relationships with patients and about as likely to be charged with negligence and incompetence. In 1997, Smith [39] proposed that if doctors want to maintain "self-regulation" in the medical profession, they must do better with managing problem colleagues. More recently, definitions of medical professionalism have been published [40].

"The Difficult Doctor" as Viewed by Other Health Providers and Patients

In PubMed, the term "difficult doctor" has been used in articles written from the perspective of patients, nurses,

and hospital administrators. For example, articles using patients' perspectives focused on physicians with poor social skills and little empathy [41, 42]. Some were written by nurses dealing with the issue of power differences [43, 44]. Yet others featured hospital administrators discussing the worst type of doctors to hire or supervise [45, 46]. A 2004 survey of US physician leaders estimated that approximately 5% of US physicians demonstrate disruptive behaviors [21, 47], but no details were provided on how this figure was established [48].

Defining "the Difficult Doctor" from the Doctor's Perspective

After reading all prior articles written from the perspectives of other health providers or patients and not finding articles written by physicians, one is left with the impression that doctors do not like to write about "difficult doctors" from the perspective of a colleague. We believe that doctors can recognize "difficult colleagues" but they do not write about them because their traditional code of ethics encourages respecting other physicians as if they are family members [49], and because the pattern of medical education follows what is called "tacit learning" from a physician mentor, but does not include questioning how doctors think [50, 51]. Most doctors would agree that "impaired physicians" or "disruptive physicians" should be disciplined to avoid negative consequences to patients. Beyond the individual cases that may require disciplinary actions, we believe it is important to outline an interpersonal perspective in the next section.

Communication Difficulties among Physicians

Based on our longstanding experience, communication difficulties occur from (1) stable patterns of negative behavior on the part of physicians, which psychiatrists call personality disorders, and (2) situational issues related to trust, clinical judgment, and interactions with consultants.

Personality Disturbances

Traditionally, psychiatrists diagnose personality disorders when "personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself, and are exhibited in a wide range of important social and personal contexts." [52]

Actually, little is known about the frequency of personality disorders in physicians or whether physicians have different trait frequencies than the general population. In 1985, Gabbard [53], a psychoanalyst, proposed that compulsiveness manifested as doubt, guilty feelings, and an exaggerated sense of responsibility may be frequent among physicians. In the UK, Bucknall et al. [54] found that within a group of physicians, surgeons acknowledged significantly higher levels of narcissism. A study reviewed 381 doctors assessed over 12 years in a US program dealing with disruptive doctors from medical networks. Most (90%) of the 13 "disruptive doctors" were diagnosed with a personality disorder [55]. Severe personality disorders are the norm in physicians "caught" after serious offenses and subsequently assessed by forensic psychiatrists [56, 57].

Personality characteristics, even when they do not reach the threshold of a specific psychiatric disorder, are likely to affect the interpersonal patterns of a physician. For instance, obsessive features and need for control may lead doctors to double-check and modify prescriptions of other doctors.

Narcissism and arrogance leading to a self-inflated view of the physician leads to "knowing better than the consultant or colleagues" and causing difficulties in the workflow of a medical organization. The values of intellectual humility and respect for one's colleagues that are described in the original Hippocratic Oath are essential for clinical practice. A self-perceived degree of accomplishment, professional success, and institutional roles may foster arrogance and disrespect for positions that are not shared [58]. Some difficult colleagues may lack the values of intellectual humility and respect. In our clinical experience, severe complications or deaths associated with adverse drug reactions in the context of poorly considered pharmacological treatments may be associated with denials or gross justification such as "I have done this all my life." After decades of working as physicians and consultants, the authors propose that a reasonable way of framing the discussion about "disruptive doctors" is by focusing on "empathy." [59] Individuals who have little or no "empathy" do not do well in medical specialties requiring interacting with patients but tend to do well with medical specialties focused on procedures. Other individuals have greater capacity for "empathy" but use it to "manipulate" people instead of trying to help them [59, 60].

Situational Issues

The situational issues that may interfere with physician communication include problems with trust, differences in clinical judgment, and interactions with consultants.

Problems with Trust. For the patient-doctor relationship, Mechanic [61] considers five dimensions: (a) expectations about physician competence, (b) the extent to which doctors are concerned with patient welfare, (c) physician control over decision making, (d) physician management of confidential information, and (e) physicians' openness in providing and receiving information. The same dimensions are operational in relationships among physicians, along a continuum of perceptions ranging from the assumption that the colleague will be competent and act in accordance with generally understood norms to total distrust requiring continuous vigilance. Difficult doctors may be colleagues one is unable to trust on the basis of repeated previous experiences or doctors who are substantially unable to trust anyone and never give up full control. There is very little literature on physicians' trust [62]. Poor communication about patients and care roles, clinical knowledge gaps, superficiality, and misunderstandings can breed distrust.

Differences in Clinical Judgment. The problem of variability in clinical judgment occurs in virtually all medical fields [63]. In addition to the variations in clinical judgment among physicians who share the same specialty, there are difficulties among specialists of different disciplines, which may be due to the tendency of a physician to restrict focus to specific areas of competence, disregarding the total clinical picture. For instance, an endocrinologist was requested for a consultation by a psychiatrist due to the onset of hypothyroidism in a patient on long-term treatment with lithium. The patient had displayed a good and lasting response to the medication. The endocrinologist suggested the patient discontinue lithium: "Your thyroid will go back to normal and you will feel much better." This was correct, to a certain degree, but totally ignored the bipolar illness of the patient, the total clinical picture, and the opportunity of prescribing a thyroid supplement.

Interactions with Consultants. The difficult physician may ask for consultation but disregard any recommendations by the consultant. A stable and consistent pattern of disregard for consultants may indicate that a physician (1) devaluates and distrusts consultants when compared to his/her own sense of clinical excellence and/or (2) uses consultations just to allay any medicolegal fears rather than trying to improve his/her patient's care. Interactions with difficult colleagues may contribute to burnout of psychiatric consultants [64].

What to Do when Dealing with "Disruptive" or "Difficult" Colleagues

Reporting "impaired doctors" with obvious psychosis or signs of addiction is a straightforward, clear-cut responsibility for their colleagues [65]. Doctors have a moral and legal responsibility to report colleagues with obvious criminal behaviors to the law, including cases involving having sex with patients and/or medical trainees [66].

We think addressing problems that result in difficult communications between physicians requires interventions at different yet integrated levels starting with medical education, dealing with situational issues, and dealing with physicians with personality disturbances.

Medical Education

Formal medical education concerning interpersonal communication, professionalism, disruptive behavior, and dealing with disruptive or difficult physicians is crucial in dealing with the outlined issues and hopefully preventing them. Morrison and Morrison [38] suggested that some issues related to dealing with difficult doctors may be addressed through residency training, recertification examinations, and other means of education. Four decades ago, Engel [67] underscored that "the average physician today completes his formal education with impressive capabilities to deal with the more technical aspects of bodily disease, yet when it comes to dealing with the human side of illness and patient care he displays little more than the native ability and personal qualities with which he entered medical school. The considerable body of knowledge about human behavior which has accumulated since the turn of the century and how this may be applied to achieve more effective patient care and health maintenance remains largely unknown to him. Neglect of this important dimension of the physician's education lies at the root of frequently voiced complaints by patients that physicians are insensitive, callous, neglectful, arrogant and mechanical in their approaches." (p. 169) [67] Such neglect also has profound effects on the relationships of a physician with his/her colleagues. It has been suggested that humility [58] and respect [68, 69] should be core values in medical education. There is no indication that improvements have been made regarding these issues. However, according to a US plastic surgeon [70], the issue of "disruptive surgeons" has a good prognosis since current and future medical students (those born into Generation Y: 1985–2004) may be better equipped to engage in collaborative behaviors than prior generations.

Organized medicine has started to address the issues of educating doctors in training in unprofessional behavior and interpersonal communication. The US Accreditation Council for Graduate Medical Education established six competencies (and subsequently the concept of "milestones" which was developed specifically for each main medical specialty) around which postgraduate education should evolve and be organized starting in July of 2013 [71]. Two of these competencies are "professionalism" and "interpersonal and communication skills." The milestones under these competencies require achieving skills and practicing behaviors at certain levels. Examples of expected skills are seen in, for instance, the second milestone under the interpersonal and communication skills, which requires, among others, being able to negotiate and manage simple patient/family-related conflicts at level 2, and sustaining working relationships in the face of conflict at level 3. The second milestone under professionalism requires, among others, following institutional policies for physician conduct at level 2, or knowing how to take steps to address impairment in self and in colleagues. Though this does not necessarily address all difficult doctor behavior, it seems to be a good start.

Dealing with Situational Issues

The type of workplace and the opportunity to discuss and receive advice about interpersonal issues appear to be important in dealing with some difficulties (e.g., overcoming misunderstandings).

Dealing with Physicians with Personality Disturbances

Bringing awareness of communication styles is a first worthwhile step, which can be implemented by using learning modules on communication skills, programs, and simulation training [1].

Understanding complex communication problems between physicians requires attention to the classic theories of group dynamics [72–74]. Dealing with physicians with personality disorders should include implementing strict rules and boundaries. Recommendations for therapy and disciplinary actions including suspension and/or dismissal should be considered if initial corrective actions fail.

Some remedial programs for impaired physicians using psychiatrists from other institutions have been described [55]. The management of physicians impaired by psychosis or addiction may be challenging when they do not acknowledge that they have problems ("others" are the problem) but it may be successful when the impaired physicians understand that psychiatric treatment is a requirement for being reinstated in the job. There are no easy answers for handling the most "difficult doctors": physicians who have been getting away with unethical or even criminal behaviors for years. Those who are caught and reach the judicial system are frequently diagnosed with serious personality disorders by forensic psychiatrists [57, 58] when it is too late.

Being "Difficult" in Problematic Institutions

In Western countries, few physicians practice in isolation or small medical groups; most work in institutions, such as academic centers, hospitals or outpatient organizations. This increases the possibility that communication problems may not be associated with a problematic physician but with a problematic institution that tries to control or force physicians to do things the physician finds unethical or inappropriate. Moreover, problematic institutions may empower problematic physicians to reach positions of power, making the institution progressively more abnormal. In this type of situation, physicians who do not comply with these views may be considered the "problematic" ones and blamed for not following instructions.

Not acknowledging the possibility of problematic institutions scapegoating good physicians may leave some ethical physicians feeling isolated and abandoned when trying to do the "right thing" while working for problematic medical institutions that label them problematic or disruptive. If a physician is found in this situation, there are no easy recommendations, since changing problematic institutions is not always an option. After consulting trusted colleagues, the physician may need to decide whether he/she can practice there without compromising his/her integrity or whether it is better to leave.

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