Chapter 39
The Disruptive Surgeon

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"The disruptive surgeon" is a phrase we have all heard. Most of us have experienced it firsthand: as a student, resident, or fellow being berated by an attending; witnessing inappropriate comments; observing a colleague decompensating; or any combination of these events. Writing this chapter was actually a struggle for the authors, as it brought up a lot of PTSD-like memories of some of the behaviors we have personally witnessed over the years. As a resident, one author watched an attending throw an instrument at the scrub tech, which landed on the field and shattered, spraying pieces all over the patient which then had to be located. Both authors have witnessed attendings making inappropriate comments in the operating room, when no one felt comfortable saying something to stop the comments. During their first year as an attending, one author had a surgeon from another surgical subspecialty burst into the operating room while performing an emergency case on a weekend evening because the other

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attending was angry at the circulating nurse, start yelling, and then had to become the "disruptive surgeon" who yelled at the other attending to leave the operating room so the team could focus on the emergency case.

It is key to point out that disruptive behavior is not limited to physicians or surgeons. Nurses, scrub techs, patients, and family members are often guilty of disruptive behavior as well, all of which can have an equally negative impact on patient safety and quality of care. However, this chapter will focus on the disruptive surgeon.

Some of us may have been labeled as "a disruptive surgeon" ourselves. Whether it is unacceptable behavior such as anger or throwing instruments, inappropriate or derogatory language, or otherwise creating an environment that is not conducive to other members of the team speaking up, the disruptive surgeon is a definite threat to quality, outcomes, and safety in the operating room and beyond.

What Is Disruptive Behavior?

Disruptive behavior can be categorized into aggressive, passive, or passive-aggressive behaviors [1]. While the aggressive behaviors are "more disruptive" in the sense that they are usually more easily recognized, the passive or passive-aggressive behaviors can be harmful over the course of time as they will "build up" more to the point of breaking.

The behavior can be overt, as with the use of profane, disrespectful, insulting, demeaning, insensitive, or abusive language; negative comments about colleagues (either spoken or in the patient's chart); verbal intimidation; inappropriate arguments with patients, family members, or colleagues; rudeness; boundary violations; outbursts of anger; bullying behavior; throwing or breaking things; or the use of or the threat of unwarranted physical force with patients, family members, or colleagues [2].

Disruptive behavior can also be covert or passive, such as refusal to comply with known and generally accepted practice standards; repeated failure to respond or late response

to calls or requests for information or assistance when expected to be available; not working collaboratively with others; and creating rigid or inflexible barriers to requests for assistance [2].

There are some key terms that will be used through the remainder of this chapter that need to be clearly defined. These terms include:

1. *Professional competence*: "The habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and community being served" [3]. The Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) have divided competence into "competencies" in specific domains, including those that apply to all physicians and those that are unique to each specialty [3]. A deficiency in any of these domains can be referred to as a "dyscompetency," which can be a helpful term because no one is totally incompetent [3].
2. *Mental and behavioral problems*: Include depression, anxiety, substance abuse, personality disorders, and disruptive behavior with colleagues, patients, and subordinates [3].
3. *Disruptive physician*: A physician who exhibits abusive behavior that "interferes with patient care or could reasonably be expected to interfere with the process of delivering quality care" [3]. Examples include profane or disrespectful language, demeaning behavior, sexual comments or innuendo, outbursts of anger, throwing instruments or charts, criticizing hospital staff in front of patients or other staff, negative comments about another physician's care, boundary violations with staff or patients, inappropriate chart notes (e.g., criticizing the treatment provided by other caregivers), or unethical or dishonest behavior [3].
4. *Impaired physician*: Defined by the American Medical Association as a disability resulting from psychiatric illness, alcoholism, or drug dependence.
5. *Performance problems*: All types of deficiencies, regardless of cause [3].

Although surgeons have been the specialty most commonly identified as "disruptive physicians" [4], a disruptive physician in any field is an obvious source of concern in the patient care environment. The fact that surgeons have been most commonly identified as disruptive may be related to the higher stress environment of the operating room or the perceived high-stakes nature of surgical care.

Disruptive behavior in the healthcare environment is not new, but in the past, the disruptive behavior has been ignored, tolerated, reinforced, or not reported [5]. We have all heard some version of the phrase "the squeaky wheel gets the oil," which is one way the behavior has been reinforced: surgeons who make a scene when they do not get what they want get things their way because the staff does not want to deal with the fallout if they don't get what they want, which reinforces the disruptive behavior. Conversely, surgeons who do not exhibit the disruptive behavior often get negative reinforcement of their good behavior because the staff knows they will not "erupt" and therefore will choose to give the disruptive surgeon what they want over the nondisruptive surgeon. Over time, this can lead to the nondisruptive surgeon becoming disruptive, and lead to a general decline in operating room staff morale.

In 2018 when the American College of Surgeons (ACS) conducted their annual survey, one of the topics addressed was the disruptive or impaired surgeon, and the Board of Governors then published feedback related to the disruptive or impaired surgeon. "Disruptive behavior by a physician, often called abusive behavior, generally refers to a style of interaction by physicians with others - including hospital personnel, patients, and family members - that interferes with patient care or adversely affects the health care team's ability to work effectively. It encompasses behavior that adversely affects morale, focus and concentration, collaboration, and communication and information transfer - all of which can lead to substandard patient care" [6].

What Are the Underlying Causes of Disruptive Behavior?

Disruptive behavior is driven by multiple factors. Staffing shortages, stress of the clinical environment, production pressures, financial constraints, increased governmental oversight with increasing managed care regulations, and greater liability risks have all been cited as factors that can increase pressure and may contribute to disruptive behavior.

Thinking of performance problems as *symptoms of underlying disorders* (rather than a disease in and of itself) can be helpful in understanding the underlying causes of performance problems and disruptive behavior. These can include mental and behavioral problems, including substance abuse or dependence (drugs or alcohol); physical illness, including age-related and disease-related cognitive impairment; a decline in surgeon wellness; and failure to maintain or acquire knowledge and skills [3].

Contributing to or compounding these underlying problems are fatigue, stress, isolation, and easy access to drugs [3]. The "normal stress" of medical practice has been exacerbated by increasing educational debt loads for graduating physicians, increasing malpractice premiums, decreasing reimbursement, and increasing pressure to see more patients in a shorter amount of time [3]. Stress can lead to isolation and maladaptive coping strategies such as alcohol or drug abuse [3]. By the time these issues appear in the workplace, the physician's relationships with significant others, family, friends, and community have typically been "impaired" for a long time [3]. A decline in wellness, with "burnout" being the end stage of the spectrum, is another underlying cause of performance problems, and subsequent disruptive behavior. This is discussed further in Chap. 38, Surgeon Wellness.

What Is the Extent of the Problem?

According to data provided by the Federation of State Medical Boards of the United States, 4081 physicians were disciplined by state medical boards in 2017 [7]. This number has remained relatively stable over the past decade. These figures are difficult to interpret within the realm of the disruptive physician, as there are a variety of reasons physicians may be disciplined by a state medical board.

With regard to mental illness, there were an estimated 17.3 million adults (aged 18 or older) in 2017 diagnosed with a major depressive episode, which represents 7.1% of all adults in the United States [8]. The prevalence may be higher in physicians, as rates of suicide are noted to be higher in physicians than in the general population: male physicians have suicide rates as much as 40% higher than the general population, and female doctors up to 130% higher than the general population [9]. Substance abuse or dependence rates may also be higher in physicians than in the general public, with female physicians in particular having a higher rate of alcoholism than women in the general population [10].

Despite a lack of data, it is estimated that 3–5% of physicians exhibit disruptive behavior [2, 3], although the negative effects are disproportionately felt [2].

Physical illness specifically in physicians has not been studied, but an estimated 10% of physicians must restrict their practice for several months or more during their career because of a disabling physical illness [3]. Although physicians are subject to age-related cognitive decline just like nonphysicians, cognitive decline in physicians has not been quantified [3].

Knowledge and skill dyscompetencies are also difficult to estimate as there is limited data such as failure rates on recertification examinations. An estimated 10% of physicians will demonstrate significant deficiencies in knowledge or skills at some point in their career [3].

When all these conditions are taken into account, **at least one-third of physicians** will experience a period during which

they have a condition that impairs their ability to practice medicine safely at some point in their career [3]. This translates into an average of 1–2 physicians per year in a hospital with a staff of 100 physicians. Referral rates to state physician health programs suggest that few practitioners get help, and even serious problems are often poorly handled at the hospital or practice level [3].

The impaired physician is in some ways easier to recognize and address, because there are defined metrics and pathways: substance tests, blood alcohol levels, and psychiatric evaluations. Most states have defined pathways for treatment for these issues, and there are delineated measurements and protocols for returning the impaired surgeon to clinical work.

The disruptive physician is more challenging in many ways. While recognizing the disruptive behavior may be easier, there are not standard pathways to manage the disruptive behavior or return the disruptive physician to clinical work. In addition, some surgeons have been labeled as "disruptive" for disagreeing with policies or changes. While many physicians labeled as disruptive have truly needed help, the ACS Board of Governors survey also revealed that more than one-third of Governors were aware of physicians being labeled as disruptive when they disagreed with policies at a hospital or system and/or disagreed with proposed changes [6]. Medical staff policies, procedures, and bylaws must be in place to protect due process. For those surgeons who exhibit disruptive behavior, we as colleagues need to provide them with assistance and training to address the disruptive behavior.

The best treatment for disruptive behavior is to prevent its development. Prevention can occur through a number of strategies, such as participation in an ongoing wellness program, improving surgeons' emotional intelligence, intervention from a colleague, or stress reduction activities. Establishing transparent rules for behavior, as well as the ramifications if the rules are breached, is a helpful adjunct. These actions can help improve morale and stave off conflict resulting from disruptive behavior [6].

Sadly, it is the case that physicians who generate high revenues for hospitals receive more favorable treatment when they are disruptive. Physician disruptive behavior is frequently ignored or tolerated, in part because those responsible for addressing the behavior find it to be a difficult and unpleasant task and because even when they undertake to do so, organizational mechanisms often prove inadequate to solve the problem [3]. Indeed, disruptive physicians are frequently "indulged," as healthcare managers give in to their demands simply to stop the disruptive behavior. This, in effect, rewards the disruptive behavior and has led to "normalization of deviance," with disruptive behavior becoming an accepted way of doing business for some physicians, and even for nonphysicians who imitate the behavior [11].

How Does Disruptive Behavior Impact Patient Safety?

The Joint Commission has reported in its root cause analysis of sentinel events that nearly 70% of the events can be traced back to a problem with communication [4]. Communication failures are the leading causes of inadvertent patient harm [12]. The Joint Commission also stated that "intimidating and disruptive behaviors" can result in medical errors that affect patient care and safety, which include "overt actions such as verbal outburst and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes," "reluctance or refusal to answer questions, return phone calls or pages, condescending language or voice intonation, and impatience with questions" [1]. All of these overt and passive actions can easily lead to a breakdown in communication, which can negatively impact patient safety.

Disruptive behavior can cause significant psychologic and behavioral disturbances that can have a critical effect on

focus, concentration, collaboration, communication, and information transfer, which can lead to potentially preventable adverse events, errors, compromises in safety and quality, and patient mortality [4]. These adverse events or patient mortality can lead to a decline in physician wellness, which can worsen the cycle of disruptive behavior.

There are multiple ways that disruptive behavior impacts patient safety. Disruptive behaviors can directly affect patient satisfaction, hospital reputation, and, in some cases, quality ratings [5], which can all financially impact a hospital and indirectly impact patient safety. Disruptive behavior can also lead to a decrease in job satisfaction with staff, leading to a higher rate of turnover, which can adversely impact the functioning of the team in the operating room.

Disruptive behavior undermines teamwork and collegiality, which can lead to medical errors. Staff experience tension around a disruptive clinician will hesitate to ask for help or clarification when unsure about orders or withhold useful suggestions for patient care due to fear of criticism or intimidation [2]. The creation of a tense or "hostile" environment due to fear of criticism can prevent someone pointing out a potential issue before it occurs. Instead of the "if you see something, say something" attitude that should be encouraged, a student, resident, or staff member might recognize a potential problem but not mention it so as to avoid causing an outburst from the surgeon. One author witnessed this firsthand as a third year medical student: a sponge was left inside a patient during a Cesarean section, because the attending surgeon at one point unclamped the clamp holding the sponge; during the count, the surgeon insisted a sponge could not be left inside the patient and closed the abdomen despite the sponge count being incorrect. The patient ultimately stayed in the operating room while getting an X-ray and was then opened again to retrieve the sponge that was retained. Hierarchy frequently inhibits people from speaking up [12]. While surgery has a natural hierarchy that is unavoidable to some extent, as the surgeon

must be the "captain of the ship," effective leaders flatten the hierarchy, which encourages team members to speak up and participate. Authoritarian leaders create unnecessary risk by reinforcing the hierarchy and creating an environment that does not feel "safe" to speak up [12]. These lessons have been introduced into the operative room environment by crew resource management techniques that were initially introduced in the United States Military.

When patients or families witness disruptive behavior, it undermines their confidence in the physician and the institution, as well as their willingness to participate in their own care [3]. They may not ask questions or admit they do not understand, so as to avoid having the disruptive behavior targeted toward themselves.

Outbursts or disruptive behavior from the surgeon causes a shift in the focus of those in the room from the care of the patient to managing the surgeon's behavior [13]. Rather than paying attention to the procedure or the patient or the safety of the patient, as well as the safety of the team, the members of the team become focused on de-escalating or pacifying the surgeon to try to prevent further outbursts [13]. There can also be a "snowball effect" of increasingly frequent errors, which may be due to impaired decision-making by team members, decreased efficacy of communication, or heightened anxiety in team members [3, 13].

The inherently stressful environment of the operating room becomes exponentially more stressful if the staff is worrying about the surgeon demonstrating disruptive behavior [13]. In addition, because of this, communication suffers as a result of members of the team being unwilling to speak up if they notice a problem. Repeated exposure to disruptive behavior can also lead to increased staff turnover due to the corrosive effect on morale [3], which can decrease the efficacy of the surgical team as a whole. These effects on quality, safety, and staff wellness can lead to large economic losses for healthcare institutions [5].

How Do we Identify the Disruptive Surgeon?

There are several issues surrounding the timely reporting of and intervention for disruptive behavior. One is that since the disruptive behavior is often exhibited by healthcare professionals in positions of power, healthcare workers are often concerned about retaliation [2]. There is also a pervasive culture of "medical *omertà*" (a code of silence) that makes healthcare workers reluctant to report performance problems in their colleagues [2].

The Joint Commission requires that hospitals have a code of conduct defining acceptable behavior and behavior that undermines a culture of safety, documenting behavioral standards and the repercussions of failure to comply, and establishing a process for managing disruptive behavior, but the extent to which these policies are enforced, compliance is tracked, or disruptive behavior is addressed is unknown [2]. Although hospitals are required to have credentialing and disciplinary processes, the details of implementing these processes are left up to the institutions [3]. There are few national or state standards of conduct or competence, or measures for monitoring performance [3]. This leads to widely varying institutional responses to disruptive behavior.

Hospitals, physician practices, and other healthcare institutions should not only have written standards and policies that set expectations for physician professional behavior but should also address unprofessional behavior in a strict but fair way, using an approach that escalates from coaching and counseling to punitive measures if the disruptive behavior persists after early interventions [2]. A recent study by Swiggart et al. indicates that many physicians who exhibit persistent patterns of disruptive behavior and undergo intensive programs can demonstrate improved behavior [1, 2].

Healthcare leaders and institutions must set expectations for professional behavior, enforce policies, and invest resources in programs to help distressed physicians [2]. The goal should always be remediation first, with appropriate escalation in severity as needed. Ideally, the goal would be to

identify "at-risk" doctors before they become "problem" doctors and certainly before patient safety is affected. We need better metrics for identifying physicians who need help, and better programs for providing help to the physicians who need it [3]. The three essential characteristics of a system to identify these physicians are:

1. An *objective* system with a basis in data, as much of the criticism of the current methods is that they are based on subjective judgments of personality, motivation, or character instead of performance [3].
2. A *fair* system, where all physicians are evaluated on an annual basis according to the same measures in an open, unbiased, and labor-regulation-compliant manner [3].
3. A *responsive* system, with prompt intervention when a problem physician is identified [3].

The first step of developing this system is the creation of explicit performance standards of behavior and competence, which need to be developed at a national level and should address all aspects of professional behavior [3]. This would also remove the variability between institutions and would set professional standards across all levels.

The second step is that all physicians be required to acknowledge that they have read and understand the standards, have a responsibility to follow the standards, are aware that adherence will be monitored, and understand that persistent failure will lead to loss of privileges and dismissal [3]. This acknowledgment should be given in writing or as a part of annual web-based training as a condition of being granted clinical privileges [3]. This step would ensure that the policies are transparent to all involved.

The third step is monitoring for adherence to the explicitly stated standards by formal annual evaluations of all members of the staff using accepted and validated measures of competence and behavior, including confidential evaluations by colleagues and coworkers with analysis of complaints by patients or others [3]. It is important to have evaluations by colleagues and coworkers and not only supervisors as these

disruptive behaviors are masked from supervisors until the physician is "past the point of no return." In order to identify "at-risk" physicians, early identification is crucial.

The fourth step is communication of the (de-identified) results to the individual. Identified deficiencies should prompt a response from the department chair, which could include evaluative testing, counseling, or referral for further assessment and treatment, or immediate action to limit practice during assessment and rehabilitation in the setting of cases that threaten patient welfare [3]. The de-identified results of evaluations are to protect the evaluators, but the communication of the results is critical for transparency. If the results are not shared with the physician, he or she will not be able to address the problems that are identified.

A system with these clearly delineated steps would serve several purposes: every person would understand their roles and responsibilities when a practitioner with performance issues has been identified, and there would be accountability on all levels, from the physician to the chair of the department to the hospital administration to the state boards [3]. Again, this would remove some of the variability from institution to institution. Once this standard system is in place, the next step is to develop a defined remediation pathway with clear metrics for evaluating the success of the remediation.

How Do we Remediate the Disruptive Surgeon?

A key aspect of managing the disruptive surgeon is the question of whether surgeons who exhibit disruptive behavior can be "trained" – can they be taught to behave more appropriately under stressful conditions, or do they need to be removed from the profession [13]? Remediation can include providing education and training to improve communication skills and professional interactions of physicians and medical students [1].

A program targeting the root causes of physician misbehavior (such as burnout, poor stress management, poor self-care, and inability to manage the demands of work and personal life) can help coach physicians to improve their behavior [1, 2]. As with any problem, getting to the root cause is one of the most important aspects of managing the issue. Programs like this can succeed when there is institutional commitment to physician professionalism and wellness, there are structured curricula, and there are quantitative metrics to assess improvement in behavior [1, 2].

One of the obstacles to developing strong remediation programs is a lack of expertise to oversee the programs. Few national programs exist, and hospital-level programs are often poorly organized [3]. In order to appropriately address this widespread issue, we should focus on developing a national quality program that will allow remediation. This would also address the issue of each individual hospital not having appropriately trained staff to help with remediation.

Another barrier is that often hospitals and physicians are reluctant to voluntarily guide, mentor, and supervise remediation activities, as department chairs and other leaders often lack the formal supervisory training or experience needed to effectively manage physicians with performance problems of any type [3]. Remediation will be ineffective if the program is not adequate, so the development of a national, standardized program is crucial. Following the COVID-19 pandemic, most meetings have been forced to be hosted virtually, and therefore it is possible that these remediation programs could be conducted virtually.

A separate but related barrier is the financial aspect: physicians may be unwilling to participate in the remediation programs due to financial burden, as they are already going to lose practice income during the programs and then are also responsible for paying for the cost of the program [3]. To ensure these programs are the most effective, the direct and indirect costs to the physician attending the program would need to be minimal, or covered in some other fashion.

Reimbursement for time spent at the remediation program would be challenging, but one option would be to schedule the program for alternative times or days that would not require the physician to lose income as a result of attending the program. One potential solution would be to offer some sort of incentive to all physicians who elected to preemptively attend these programs, similar to a new driver getting a lower insurance rate if they attended driver's education.

Documentation of evaluations, events, and interventions is an essential component of the remediation process. Clear communication also is critical in the prevention and management of disruptive behavior. As cases are reported, investigated, and adjudicated, differences of opinion can be part of the problem, and many stem from miscommunication. With prevention in mind, surgeons should be taught effective listening skills and work to improve their emotional intelligence to avoid conflict and escalating confrontations. Surgeons are natural problem solvers; given the appropriate tools and resources, they can handily deal with this challenge to improve their working environments [6]. Again, the focus on the "disruptive surgeon" should be at prevention rather than waiting to address the problem. As with many other wellness-related issues, we need to start these preventative measures earlier – most likely these measures should be started during medical school, but certainly during residency, if the ultimate goal is to prevent the behavior. Again, national standards would facilitate adopting the preventative measures.

Summary

Healthcare leaders and institutions must set expectations for professional behavior, enforce policies, and invest resources in programs to help distressed and disruptive physicians. The ideal solution would aim to prevent the disruptive behavior before it starts and focus on early identification and remediation. It is crucial to point out that while much of the literature

focuses on the disruptive physician, disruptive behavior is not limited to physicians or surgeons. Disruptive behavior in other members of the healthcare team can equally impact patient safety and outcomes.

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