STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

NOTICE OF ADOPTION OF A POLICY STATEMENT

Title of Policy Statement: Practitioners Exhibiting Disruptive Behavior | Policy Number MD2021-01

Issuing Entity: Washington Medical Commission

Subject Matter: Disruptive Practitioners (MDs and PAs)

Effective Date: April 9, 2021

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Policy

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The Washington Medical Commission (Commission) considers disruptive behavior to be a threat to patient safety. If the Commission receives a complaint or report that a practitioner has engaged in disruptive behavior, the Commission may investigate a complaint and, if warranted, take disciplinary action against the practitioner to protect the public.

Disciplinary action may be based on the belief that the disruptive behavior constitutes unprofessional conduct under RCW 18.130.180(4) (negligence that creates an unreasonable risk of harm), RCW 18.130.180(1) (moral turpitude relating to the profession) or another subsection of RCW 18.130.180.

The Commission may also issue a statement of charges under RCW 18.130.170(1) if there is evidence that the practitioner is unable to practice with reasonable skill and safety due to a mental or physical condition. This statute does not require that the practitioner have a diagnosable mental condition under the DSM.[1]

If the Commission is unsure whether the practitioner has a mental or physical condition that may impact his or her ability to practice with reasonable skill and safety, the Commission may choose to order the practitioner undergo a mental or physical examination under RCW 18.130.170(2). The results of such an examination may provide evidence to support a statement of charges under RCW 18.130.170(1).

The Commission is aware that if a practitioner denies engaging in disruptive behavior, an evaluation under RCW 18.130.170(2) is particularly challenging, if not impossible, for the evaluator. In most cases, the preferred option is to issue a statement of charges under RCW 18.130.180 on the theory that the disruptive behavior constituted unprofessional conduct.

The Commission may refer the practitioner to the Washington Physician Health Program at any point in the process, beginning with making a recommendation during the initial investigation up to imposing a requirement in a disciplinary order.

Background

Most physicians and physician assistants enter the field of medicine for altruistic reasons and have a strong interest in caring for and helping other human beings. The majority of practitioners carry out their duties with high levels of professionalism and recognize that quality care requires teamwork, communication and a collaborative work environment. However, several studies show that behavior that impedes teamwork and communication, and interferes with patient care—often referred to as disruptive behavior—may be prevalent in somewhere between 1 and 5% of practitioners. [2]

Disruptive behavior has been defined as "an aberrant style of personal interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to interfere with the process of delivering good care."[3] Disruptive behavior comprises a wide variety of behaviors including overt actions such as verbal outbursts and physical threats, as well as passive activities such as failing to respond to repeated calls, not performing assigned tasks or quietly exhibiting uncooperative attitudes during routine activities.[4] A list of examples of disruptive behavior can be found in appendix A.

Disruptive behavior interferes with the ability to work with other members of the health care team, disrupts the effectiveness of team communication, and has been shown to be a root cause in a high percentage of anesthesia-related sentinel events.[5] The consequences of disruptive behavior include job dissatisfaction for physicians, nurses and other staff; voluntary turnover; increased stress; patient complaints; malpractice suits; medical errors; and compromised patient safety.

Disruptive behavior is not a diagnosis and should not be used to label a practitioner who has an occasional reaction out of character for that individual. The disruptive label should refer to a pattern of inappropriate behavior that is deep-seated, habitual, and pervasive.[6]

Disruptive behavior may be a sign of an illness or a condition that may affect clinical performance. Studies have shown that some physicians demonstrating disruptive behavior have subsequently been diagnosed with a range of psychiatric disorders and medical disorders with significant psychiatric symptoms, most of which were treatable.[7] Referral for evaluation of impairment can identify health conditions, distress and other psychosocial factors that may be contributing to the disruptive behavior. If this is the case, an effective treatment and monitoring plan may resolve the disruptive behavior.[8] On the other hand, ruling out impairment can provide reassurance in proceeding with progressive remediation. The Washington Physicians Health Program accepts referrals for disruptive behavior and will tailor its approach and recommendations based on the presence or absence of an impairing health condition.

When the practitioner exhibiting disruptive behavior is part of an organization where the behavior can be identified, the organization should take steps to address it early before the quality of care suffers, or complaints are lodged. The best outcome is frequently accomplished through a combination of organizational accountability, individual treatment, education, a systems approach and a strong aftercare program.[9] The Joint Commission has developed a leadership standard that requires leaders to develop a code of conduct that defines behaviors that undermine a culture of safety, and to create and implement a process for managing such behaviors.[10] Psychiatrist Norman Reynolds, MD, has developed a set of strategies to manage this behavior and provides advice on the construction of medical staff policies and a program of remediation.[11]

While organizations may be the best place to address disruptive behavior, state medical boards may also play a role when the behavior is brought to their attention. The Federation of State Medical Boards recommends that legislatures amend the practice acts of state medical boards to include disruptive behavior as a grounds for disciplinary action, explaining that it is imperative that state medical boards have the power to investigate complaints of disruptive behavior and to take action to protect the public.[12]

The Commission has taken disciplinary action against several practitioners who exhibited disruptive behavior. In some cases, the basis for the action is that the conduct constitutes unprofessional conduct under RCW 18.130.180(4) because it is negligence that creates an unreasonable risk that a patient may be harmed. The Commission has also taken action under RCW 18.130.180(1) when it deemed that the conduct amounted to acts of moral turpitude relating to the profession.

In one case, the Commission took action against a physician engaging in disruptive behavior under RCW 18.130.170(1) on the theory that the practitioner had a mental condition that prevented him from practicing with reasonable skill and safety. The Washington State Court of Appeals, in a published opinion issued in 2017, upheld the Commission order imposing discipline for disruptive behavior, favorably citing the Commission's prior policy on disruptive behavior, and rejecting the respondent's argument that a diagnosable mental condition was required to proceed under RCW 18.130.170(1).[13]

Appendix A

Examples of disruptive behavior include, but are not limited to, the following:

Aggressive behaviors:

- Yelling
- Foul and abusive language
- Threatening gestures
- Public criticism of coworkers

- Insults and shaming others
- Intimidation
- Invading one's space
- Slamming down objects
- Physically aggressive or assaultive behavior

Passive-aggressive behaviors:

- Hostile avoidance or the "cold shoulder" treatment
- Intentional miscommunication
- Unavailability for professional matters, e.g., not answering pages or delays in doing so
- Speaking in a low or muffled voice
- Condescending language or tone
- Impatience with questions
- Malicious gossip
- Racial, gender, sexual, or religious slurs or "jokes"
- "Jokes" about a person's personal appearance, e.g., fat, skinny, short, ugly
- Sarcasm
- Implied threats, especially retribution for making complaints[14]

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[1] *Id*.

[2] Williams, B. W., and Williams M.V. The Disruptive Physician: A Conceptual Organization, *Journal of Medical Licensure and Discipline.* 2008; 94(3):13.

[3] Lang, D., and others. *The Disabled Physician: Problem-Solving Strategies for the Medical Staff.* Chicago, Ill.: American Hospital Publishing, Inc., 1989. *See also* Neff, K., Understanding and Managing Physicians with Disruptive Behaviors, pp. 45 – 72 (2000).

[4] The Joint Commission. Behaviors that undermine a culture of safety. *Joint Commission Sentinel Event Alert.* 2008; issue 40 (updated September 2016).

[5] *Id*.

[6] Reynolds, N., "Disruptive Physician Behavior: Use and Misuse of the Label, Journal of Medical Regulation, Vol. 98, No. 1, p. 9-10 (2012).

[7] Williams and Williams, p. 14.

[8] Reynolds, p. 19.

[9] Williams and Williams, p. 17.

[10] The Joint Commission, Leadership Standard Clarified to Address Behaviors that Undermine a Safety Culture. *See also* Reynolds at pp. 14-17 for an excellent discussion of strategies for managing disruptive behavior.

[11] Reynolds, pp 14-19.

[12] Federation of State Medical Boards. *Report of Special Committee on Professional Conduct and Ethics.* 2000. https://www.fsmb.org/siteassets/advocacy/policies/report-of-the-special-committee-on-professional-conduct-and-ethics.pdf

[13] *Neravetla v. Department of Health*, 198 Wn. App. 647, 394 P.2d 1028 (2017).

[14] This list comes from Reynolds, p. 9.