The Disruptive Radiologist

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Abstract

Radiologists interact with many individuals during daily practice, including patients, technologists, and other physicians. Some interactions may potentially negatively affect patient care and are termed "disruptive" behaviors. These actions are not uncommon and may begin during training, long before a radiologist enters clinical practice. The causes of disruptive behavior are multifactorial, and it is important that educators and radiologists in practice alike be able to identify them and respond accordingly. An escalated approach for both trainees and practicing radiologists is recommended, with substantial penalties after each incident that can include termination of employment. Training programs and practices must have clearly defined methods for confronting this potentially time-consuming and difficult issue.

Key Words: Physician behavior, workplace culture, patient satisfaction, health care team interactions, professional standards

J Am Coll Radiol 2015;12:800-804.

INTRODUCTION

One of the tasks of the ACR Human Resources Commission is to investigate, analyze, and make recommendations on issues affecting human resources in the field of radiology. Most radiologists work in an environment shared with other physicians, technologists, and patients. This situation has, in certain instances, resulted in inappropriate interactions between radiologists and 1 or more of these individuals. These radiologists can be classified as "disruptive physicians." Members of the Human Resources Commission subcommittee reviewed current literature and best-practice guidelines to determine which characteristics define "disruptive behavior" and accepted strategies and policies for confronting this issue in the workplace. This article summarizes the subcommittee's findings and recommendations regarding disruptive physician behavior.

The AMA, in its *Code of Medical Ethics*, indicates that "personal conduct, whether verbal or physical, which negatively affects or may potentially negatively affect patient care constitutes disruptive physician behavior" [1]. Examples of such types of behavior may include inappropriate language, facial expressions, and mannerisms, as well as violations of physical boundaries. Similarly, *The American College of Radiology 2014-2015 Bylaws* addresses members who may not act well toward or behave professionally with others [2]. Article XI, Section 3, of the bylaws, "Rules of Ethics," elaborates on minimal standards of professional conduct for all members of the College:

> Members' behavior should conform to high standards of ethical, legal, and professional conduct. Any activity that fails to conform to these standards compromises the member's personal integrity and casts aspersions on the College and the medical profession.…Members shall relate to other members of the health care team with mutual respect and refrain from harassment or unfair discriminatory behavior.

Disruptive behavior is, unfortunately, not uncommon. In a 2011 survey on disruptive physician behavior, 70% of the 840 physicians surveyed stated that they

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The authors have no conflicts of interest to disclose.

1546-1440/15/$36.00 ■ http://dx.doi.org/10.1016/j.jacr.2015.02.013

encountered disruptive behavior at least once a month [3]. Ten percent of these physicians noticed it on a daily basis, and more than 25% admitted to engaging in disruptive behaviors at least once during their careers.

Disruptive behavior can lead to stress, unhappiness, diminished productivity, and employee dissatisfaction, among both physicians and ancillary staff members. Furthermore, although disruptive physician behavior does not necessarily result in patient complaints, such complaints are not unusual. The consequences of disruptive behavior can have a significant impact on patient care and potential outcomes. Finally, disruptive behavior can also have economic consequences [4]. The behavior of a disruptive physician or radiologist may result in the loss of referrals to a practice and patients' desiring to disassociate with a practice group that tolerates such physicians. This discussion focuses on disruptive behavior in both trainees and practicing radiologists.

THE PROBLEM RADIOLOGY TRAINEE

Problem residents and fellows (referred to hereafter as trainees) form a decidedly small, but vitally important, part of most training programs and occupy a disproportionate amount of time for program directors and faculty members. There are 3 basic types of problematic behavior: academic problems (behavioral, attitudinal, cognitive, and psychomotor issues), disciplinary problems (specific infraction of rules or regulations), and impairments (diagnosed handicaps or burdens, including depression, alcoholism, or drug dependency) [5]. Other experts have categorized problems in residency as lack of knowledge, interpersonal skills, and professionalism [6,7]. The prevalence of this issue in training programs is significant, and estimates range from 6% to 9% of all trainees. Although much has been described about the nature and causes of the problem, restorative remedial programs, designed for "problem trainees," to assist them in improving and overcoming their deficits, have garnered much less attention in the literature [8].

Causes

Disruptive behavior often commences early in medical school, with continuation through residency training and into practice, creating devastating problems. Medical residency is often a midway stop on this long and tortuous journey and an important opportunity to identify these individuals and intervene. One study, looking at graduates of a prominent California medical school over 10 years, found that of those disciplined, 95% were later cited for unprofessional conduct by the state medical board [9]. Such offenders were 2 to 3 times as likely as medical school graduates in the control group to have negative comments in their records regarding professionalism. Background checks and even criminal records investigations are suggested for program directors before deciding on their rank lists, if any questions exist about a candidate [10]. Letters of reference have been notoriously unhelpful in detecting many of these "problem" trainees, with careful scrutiny required to glean much useful information from these "reluctant" referees. Letter writers may be inhibited by the current openness of recommendations to the trainees themselves and even by threatened legal proceedings in some situations. Obviously, early intervention (or prevention, by circumventing the candidacy of a problem applicant) seems to be much more highly regarded, and may have better outcomes, than later remediation.

Tackling the Problem

A severely impaired trainee reflects a systemic problem, one that will require changes at all levels of the medical education system. A method to increase communication about unlawful or dysfunctional behavior would clearly improve resident training outcomes.

Once a problem is identified, most experts recommend confronting the problem head on. The best constructive criticism is given in the moment, or shortly thereafter (<24 hours). Faculty members should be aware of the importance of timely feedback and trained to give immediate feedback to any trainee demonstrating unprofessional behavior, language, or attitudes. They should also strive to eliminate such negative attitudes or behaviors from their own repertoires ("the hidden curriculum"), so that trainees will receive a clear, consistent message of the unacceptability of such behavior [11].

The most common response to unprofessional behavior, in a survey of obstetrics and gynecology program directors (95%), is to meet with the resident and formally express an expectation of improvement without specific assistance [11]. Program directors may also require psychological counseling for a trainee (68%), place a resident on probation (59%), or require some other type of educational activity regarding professionalism (41%). One-third dismiss, or do not renew, the contract of the offending trainee. Approximately 60% believe that remediation efforts are only somewhat successful and 21% not "especially successful." These somewhat discouraging results reflect the lack of remedial results in well-established, chronic offenders (typically exhibiting behaviors before or during medical school).