Intervention Programmes for Disruptive Physicians

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Introduction

Doctors are a highly trusted and valued group of professionals in all cultures. They enjoy social respect but also have significant social responsibilities. Doctors who fail to maintain professional standards and conduct cause social concern: first, because they may do harm to services and patients if they are performing poorly and because the loss of a doctor has effects on service provision, and may be expensive to health care providers.

Doctors may fail to perform well for a number of reasons. Stress related problems, depression and substance misuse are known to be commoner among doctors than other similar professional groups. One particular manifestation of poor performance has been described as "disruptive" behaviour or unprofessional conduct. These are situations where doctors are experienced by other professionals (or, less commonly, patients) as unhelpful, rude or even abusive. The 'disruption' really applies to professional services and relationships which can be threatened by one individual.

Disruptive behaviour: description and diagnosis

In the past, rude or disruptive behaviour was tolerated by medical services and was sometimes seen as being a mark of eccentricity and idiosyncratic approaches to practice. As long as patient care was not compromised, doctors who were difficult might be left alone or moved to other services. The doctors themselves typically would argue that they were being critical of services, and that complaints about their behaviour were attempts to silence or discredit them.

Changes in attitudes towards the professionals more generally, and a more litigious climate has made health care providers more cautious about tolerating disruptive doctors. In the USA, accounts of the problems of disruptive physicians first emerge in 1993. Disruptive behaviour by clinicians is a leading cause of disciplinary actions, and accounts for 4%-36% of referrals to state licensing boards or physicians' health programmes: it is likely that this figure is higher now because of increased awareness (Wilhelm & Lapsley, 2000; Kaufman, 2001; Papadakis et al, 2005).
Early accounts raised questions about the overlap with substance misuse and boundary violations in professional practice. The earliest programme for disruptive doctors dates from the 1990s. The Joint Commission on Health Organisations which has oversight of all health care providers requires such organisations to have policy for addressing disruptive behaviour as standard.

Studies in the US suggest that disruptive behaviour is often associated with either personality disorder or undiagnosed depression in doctors (Summer & Ford, 1998; Roback et al 2007). The problems may first present as substance misuse, especially alcohol: 59% of doctors treated for substance misuse have a personality disorder diagnosis (Nace et al, 1995). Antisocial or narcissistic personality traits may emerge in a previously well doctor as a result of stress, or traumatic events either at home or at work (Summer & Ford, 1998; Tyssen & Vaglum, 2002; Garelick et al, 2007; Myers & Gabbard, 2008). Both early and recent studies of doctors in difficulty have suggested that some doctors may be vulnerable to clinical stress and distress because of early family experiences (Vaillant et al, 1972; Spickard et al, 2002; Firth Cozens 2007).

The UK situation

There is evidence that behavioural problems in the workplace are an issue for UK doctors. In 2007, 65% of referrals to the National Clinical Assessment Service (NCAS) were for behavioural issues. In the same year, 83 doctors came before Fitness to Practise (FtP) hearings with complaints about disruptive behaviour. These represented 18% of all FtP hearings. The majority did NOT have a concurrent substance misuse problem.

At present, doctors with behaviour problems may or may not be identified as having a health problem. If this is the case, then the doctor is advised to get help; and the behaviour is assumed to be secondary to the illness. The doctor may be placed under medical supervision and have to undertake to have treatment, usually psychological.

The Department of Health has very recently (November 2008) opened the first Practitioner Health Programme (PHP) for doctors based in and around London. This offers assessment and referral for inpatient and outpatient treatment of all disorders, with particular emphasis on substance misuse. There is no specific mention of interventions aimed at problem behaviours; such as boundary violations, mis-prescribing or other misconduct.

Doctors who have a conduct problem but are identified as having personality or pure behavioural problems are rarely offered specific interventions. An exception is the University of Cardiff Deanery, which has a individualised programme for doctors with
behavioural problems, which has been running for several years. Apart from this service, the main approach seems to be ‘Stop it or else’.(Margerison, 2008). This is unsatisfactory at a number of levels: first, it is pedagogically unsound (people respond better to inducements than threats) and second, this has not been shown to be an effective approach with people who have personality problems. Failure to address this properly means that such doctors are likely to continue exhibiting behaviours which are alarming to others, personally as well as professionally disastrous for them, and have huge cost implications in terms of loss to services and legal costs. There is a parallel here between disruptive doctors and patients with personality disorders, who traditionally were excluded from mental health services. Better understanding of the cause of such disorders, and the suffering of those who have them, has led to improved interventions and services and a policy change which states categorically that personality problems are ‘no longer a diagnosis of exclusion’ (NIMHE, 2003).

**Programmes in the USA**

The first programme for disruptive physicians was set up in 1991 by Dr Glen Gabbard and was based at the Menninger clinic in Topeka. The principal focus then was doctors who violated professional boundaries with patients; usually sexually. Since then a small number of programmes in the USA specifically address disruptive behaviour or misconduct (as opposed to substance misuse programmes or programmes using an addictions paradigm, such as the Twelve Steps). I selected three for study:

1. Individual therapy programmes delivered by local clinicians
2. A 6 day programme (3 days residential plus 3 days of follow up)
3. A 6 week residential programme.

**Referral process**

I discussed this issue with Dr Luis Sanchez, current chair of the federation of Physician Health Programmes (PHPs) in the USA. Nearly all the states have a PHP, where doctors can be referred for assessment. The current emphasis is on prevention and physician wellness: so those working in the PHPs teach in medical schools and try to develop resilience and support programmes that doctors can access before they get into difficulties.
Typically, physicians referred to the PHP have usually been the subject of a local complaint or complaints. These may have been investigated and upheld. At this point, the doctor’s licensing authority/employers will be considering whether he can continue to practice. It is at this point that doctors either refer themselves or are referred for evaluation for interventions. Doctors may be advised to undergo evaluation by their lawyers or employers. The PHP may recommend monitoring and also refer physicians to therapeutic programmes like the ones described below.

Each of the programmes requires an extensive Evaluation to be done before intervention. The evaluation of disruptive physicians is comprehensive and usually takes place over 2-3 days (Meyer & Price, 2006; Gabbard pc). It includes a full psychiatric work up as well as a battery of psychological testing. Information from other sources is obtained: especially from friends, family and workplace collaterals. Discussion with employers is essential to get a full understanding of the alleged behaviour and the organisational dynamics that may be at play. Meyer & Price note that it is essential that the evaluating psychiatrist has some expertise in the diagnosis and treatment of character pathology.

Two key issues are identified: the extent to which this is a new phenomenon for this doctor (as opposed to a repetitive problem); and the doctor’s own attitude to the complaints. Doctors who are willing to enter the programmes (and can pay for them) will be enrolled. Alternatively, they may be ‘sent’ for therapy by their employing hospitals or as part of an agreement with their licensing authorities. Doctors therefore come to the programmes in varying degrees of willingness and engagement. There do not appear to be any bars to enrolment apart from an active substance misuse problem or a concurrent psychiatric disorder, such as depression or psychotic illness. In all cases, there is transparency that there will be some feedback to third parties, such as the PHP referrer, the licensing board or the employing hospital.

(1) The Myers/Gabbard Model: individual programmes delivered locally

After evaluation, individual psychological therapies are arranged through a network of local practitioners. Only those physicians with entrenched antisocial features will not be offered treatment (this group is rare). Individual therapy may be short term (6 months or less) or long term, and utilise either a psychodynamic structure or a cognitive behavioural structure. The aim, in either case, is to improve the physician’s capacity to mentalise: to keep their own mind in mind (Allen & Fonagy, 2006).

To some extent this is a traditional model of psychological treatment for patients with non-psychotic mental disorders. The evidence base for both forms of therapy is good, especially for the treatment of complex disorders such as personality disorders. The
authors note that cognitive approaches may be of particular value to physicians because it is goal oriented and utilises their intellectual abilities. It also engages the ‘student’ part of the doctor which has been historically successful for them, and so builds up confidence.

The authors also note that group therapy may be especially useful for physicians, who otherwise may feel isolated and ashamed of being ‘a patient’ for the first time. It also enables physicians to act as ‘helpers’ to each other, so their professional identity as a healer is supported, and their effectiveness as clinicians is reinforced. The authors also point to the extensive literature on the value of group therapy for difficult personality problems.

Relapse prevention should also be offered to those doctors with substance misuse problems. However, this is a minority of disruptive doctors. These doctors should be helped to become abstinent and helped to engage in therapy, as described above.

This model may be understood as ‘Treatment as Usual’; and has not been evaluated specifically in relation to disruptive doctors.

(2) The Vanderbilt model: Distressed Physicians Programme

The VUMC has been delivering programmes for distressed doctors for 25 years. Their initial programmes focussed mainly on doctors who were sexual boundary violators or who had unprofessional prescribing habits. From this experience, Dr Andrew Spickard and colleagues developed a 6 day cognitive psychoeducation programme for distressed physicians, which focussed on improving emotional intelligence, especially in the management of negative emotions such as stress and anger.

The 6 day programme is comprised of 3 full days at the VUMC. Participants are expected to take 3 days leave and stay in local accommodation so that they can attend the course which is 830 am to 430 pm. There is homework to be done each day. At the end of this course, there are 3 further follow up days which all participants must attend.

The course is comprised of a mixture of psychoeducational modules, cognitive skills based modules and personal reflection time in the group. Typically there are 6-7 participants and three therapists. Many, if not most, participants are poorly educated about emotional health and stress management, and have little understanding of how negative emotions may be expressed or experienced by others.

Two key therapeutic aspects are the group aspect and the role play. The group
process not only helps to reduce shame and promote curiosity; it also emphasises the reality of the problem. It is often easier for participants to identify behavioural problems in others than themselves. The role play is a key feature of cognitive skills programmes, and offers enhanced perspective taking, so that participants can 'see' how others may have seen them, from the others' perspective.

Homework is also an essential feature of cognitive skills programmes. Completion of homework tasks assists adherence to the model and usually predicts programme completion.

Participants return for 3 separate follow up days at 3 monthly intervals: so that the programme actually lasts for a year overall. During that period, participants are required to find a mentor to assist them with maintaining the programme goals and also have homework. They are expected to feedback at the follow-up days and information will be sought from the collaterals and mentors.

There is published follow up data for 20 doctors who completed the programme (Samenow et al, 2008). The best evidence suggests that 80% have other-rated improvement: that is, others have seen a beneficial change in behaviour. Interestingly, the self-rated improvement is less (at 54%).

(3) The Menninger Model: Professionals in Crisis

The programme was developed by Drs Jon Allen and Efrain Bleiberg. It is a 6 week residential programme, which is open to all types of professionals (i.e. not just doctors) who have got into some sort of difficulty at work; usually involving violating professional conduct boundaries of some kind.

The programme is intensive for 6 weeks. Participants are expected to stay for the duration of the programme. Follow up is not possible, although local feedback is obtained. The programme uses a variety of psychological techniques: individual sessions, group work, psychoeducation, cognitive skills, addictions work and techniques to improve mentalisation (the capacity to reflect on mental functioning). Each participant has a tailored programme, although there are core elements they are expected to attend. The approach is a traditional medical inpatient one, with wards rounds and consults. Participants may or may not be on psychotropic medication, usually antidepressants.

The aim of the programme is improve mentalising capacity (Haslam Hopwood et al, 2006): especially to help participants understand how they came to break boundaries at work, and to encourage them to get more help in the future. Self-report data at
discharge is very positive and participants seem to have improved mindfulness. Obtaining follow up data is difficult without scheduled follow up contact, and the MC have limited data. To some extent, this is a function of the geography of the USA and the fact that the MC is a nationally recognised centre for psychological therapy: participants focus their time and resources on the 6 week programme.

Costs

The VUMC course costs $4000 and the PIC package is approximately $50 000. Usually, the doctor themselves will pay for the evaluation and the treatment.

(4) Report from the 2008 International Conference on Doctors’ Health

The conference this year was in London; and this enabled me to connect with a wider group of colleagues, form the US, UK and Europe. There is increased interest in the needs of behaviourally disruptive physicians; and an important emphasis on identifying this as early as possible, since there is some evidence that later behavioural problems were evident at the medical school stage (Papadakis et al, 2005).

The new PHP service is an excellent development, and no doubt will act as a pilot for services to develop outside London. This will be vital, since psychological therapy services outside London are sparse; and not sophisticated in this area. Also NHS referral may still generate professional boundary problems: especially for psychiatrists with mental health problems. The private health sector does offer treatment programmes for professionals, but they tend to be substance misuse/12 step focussed and not looking at the individual or behaviour problems.

Little group work is on offer, despite the evidence that, groups are effective with behavioural problems. Group work would also be indicated if (as suspected) a subgroup of these doctors have personality disorders. It is likely that these disorders will be mild in severity, and be composed of mainly borderline and narcissistic traits, which can respond well to therapeutic interventions. The best evidence suggests that group psychotherapy with cognitive and reflective components is optimal for these conditions. Both the Menninger and the VUMC emphasise the importance of group work. At present, disruptive doctors cannot access a programme specifically for them: and especially cannot access a group programme.

Conclusions and recommendations

(1) The numbers of doctors in the UK who present with behavioural problems at
work are increasing. There is therefore a need to offer a programme like the Distressed Physicians CME course. A residential programme is too costly, given the limited outcome data; and the new PHP will offer treatment as usual, and excellent GP support.

(2) The CME course approach has several strengths. It would be comparatively cheap. It has positive outcome data, and an evaluation base that a UK programme could join. It has a cognitive group format (which fits the evidence base) and is also psychoeducational, so that it draws on participants’ strengths. If only 50% of doctors improved after attending, so that they could return to work, then this would be a big saving in costs all round.

(3) I suggest that it be run as a pilot twice a year for 2 years and then review. Referrals could come from PHP, NCAS or GMC Fitness to Practise Directorate. This programme could be supported by a Trust in the ordinary way; or it could be based at the PHP. It would need some extra resources for staffing; consumables like paper; accommodation and support for audit and evaluation.

(4) It will be important to consider the ethical issues involved in assessment and treatment of doctors (Adshead, 2005).

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References


